

Agenda – Meeting in Public

Tuesday 18 March 2025 – 11.30am to 12.30pm

Online via MS Teams

Chair: Priya Singh

The quorum for a meeting will be seven members, including:

- a) Either the Chair or Vice Chair*
- b) Either the Chief Executive or the Chief Finance Officer*
- c) Either the Chief Medical Officer or the Chief Nursing Officer*
- d) At least one non-executive member*
- e) At least one Provider Member*
- f) At least one Practice Member*
- g) At least one Local Authority Member*

Timing	No.	Item	Action	Delivery	Lead
11.30	1.	Welcome, apologies for absence and Chair’s introduction	-	Verbal	Priya Singh - Chair
	2.	Conflicts of Interest Register and declarations of any interests relating to this agenda	Note	Paper	Priya Singh - Chair
	3.	Minutes of the last meeting in Public held on 21 January 2025 and matters arising	Approve	Paper	Priya Singh - Chair
	4.	Chief Executive Update	Note	Verbal	Fiona Edwards - Chief Executive
	5.	Leadership and Culture			
11.40	5.1	EDI Update including: <ul style="list-style-type: none"> • Gender Pay Gap • Annual EDI report 	Approve	Papers	Caroline Corrigan - Chief People Officer
	5.2				
	6.	Outstanding Use of Resources			
11.45	6.1	25/26 Financial Planning - Final Submission	Approve	Paper	Rich Chapman- Chief Finance Officer
11.55	6.2	Delegated Specialised Commissioning Services	Approve	Paper	Fiona Edwards - Chief Executive
	7.	Performance Reporting			

Timing	No.	Item	Action	Delivery	Lead
12.05	7.1	Frimley ICB Quality Performance Report	Note	Slides	Lalitha Iyer, Chief Medical Officer
	7.1.2	Assertive Outreach Programme	Note	Paper	Graham Wareham, Chief Executive - Surrey and Borders Partnership
	7.2	Frimley ICB Finance and Performance Report	Note	Slides	Richard Chapman - Chief Finance Officer
	7.3	Frimley ICB Workforce Performance Report	Note	Slides	Caroline Corrigan – Chief People Officer
	8.	Business Items			
12.20	8.1	Board Assurance Framework	Note	Paper	Caroline Corrigan - Chief People Officer
	9.	Close of Business			
12.25	9.1	Questions from the public received in advance of today's meeting	-	Verbal	Priya Singh - Chair
12.30	9.2	Any Other Business and Close	-	Verbal	Priya Singh - Chair
Date of next meeting in public: 20 May 2025, 11.30 – 12.30					

Frimley ICB Board Register of Interest v. 12.03.25

Job Title	Firstname	Lastname	Interest	Description of Interest	Type of interest			Actions agreed with line manager to mitigate risk
Chief Nursing Officer	Sarah	Bellars	FHFT	Son and Daughter in Law work for FHFT	Declarations of Interest – Other	Indirect	Indirect	Seek the advice of other senior members of the executive and Non-executive team if there is a potential conflict
Frimley ICB Non Executive Member	Ilona	Blue	General Dental Council	Lay Council Member	Declarations of Interest – Other	Non-Financial Professional	Direct	I do not anticipate any direct conflicts of interest as I do not expect the ICB or its audit committee to engage in direct discussions/decisions related to individual dental professionals; or dental education establishments. My role in GDC does not involve any direct decisions about individual professionals as these are handled through independent hearing panels.
Frimley ICB Non Executive Member	Ilona	Blue	Accent Housing Group Limited	Non-executive director	Declarations of Interest – Other	Non-Financial Professional	Direct	I don't anticipate any direct conflicts, but should any discussions arise relating to housing in Frimley I would flag my interest and if necessary recuse myself from any discussions/decisions.
Frimley ICB Non Executive Member	Ilona	Blue	NB Solutions	I am a director (I own 25% and my husband Robert Nichols owns 75%) of NB Solutions. My husband is the sole employee.	Declarations of Interest – Other	Financial	Direct	I do not anticipate any conflicts of interest. NB Solutions' clients could sell into the NHS but my husband would not be directly involved in such commercial arrangements and I do not expect the ICB to be directly engaged with third party suppliers to provider organisations in the patch. My lack of direct involvement in any such commercial arrangements mitigates the risk of conflict.

Frimley ICB Non Executive Member	Ilona	Blue	Defence Equipment and Support, an arms' length body of the MoD	Non-executive member of the Audit and Risk Assurance Committee	Declarations of Interest – Other	Non-Financial Professional	Direct	No conflicts anticipated.
Frimley ICB Non Executive Member	Ilona	Blue	Active Travel England, an executive agency of the Department for Transport	I am a non-executive director and Audit Chair	Declarations of Interest – Other	Non-Financial Professional	Direct	No conflicts anticipated
Frimley ICB Non Executive Member	Ilona	Blue	Network Rail, an arms' length body of the Department for Transport	I am an independent advisor to the Audit & Risk Committee and the Treasury Committee	Declarations of Interest – Other	Non-Financial Professional	Direct	None anticipated
Frimley ICB Non Executive Member	Ilona	Blue	Maritime and Coastguard Agency, an executive agency of the Department for Transport	Interim Non-executive director and Audit Chair. Term of appointment 1/2/25 to 31/10/25.	Declarations of Interest – Other	Non-Financial Professional	Direct	No conflicts anticipated
Chief Transformation Digital and Delivery Officer	Samuel	Burrows	Eightway Solutions Ltd	My spouse is the owner and operator of the company Eightway Solutions Ltd.	Declarations of Interest – Other	Indirect	Indirect	Sought advice from the Governance team and communicated to Line Manager. Will ensure that if this conflict of interest has the potential to become direct this will be immediately disclosed in order to identify further mitigations.
Chief Finance Officer	Richard	Chapman			Nil Declaration			
Chief People Officer	Caroline	Corrigan			Nil Declaration			
Chief Executive	Fiona	Edwards	NHS Confederation	Board Trustee	Declarations of Interest – Other	Non-Financial Professional	Indirect	Will be managed in accordance with policy.
Chief Executive	Fiona	Edwards	Law For Life	Chair	Declarations of Interest – Other	Non-Financial Professional	Direct	Will be managed in accordance with policy.

Local Authority Partner Member from Rushmoor Borough Council	Karen	Edwards	Land and property from which Rushmoor Borough Council as my employer would receive an income or profit may be under discussion	As an Executive Director of Rushmoor Borough Council with the responsibility for land and property there will be occasions when land and property from which the Council would receive an income or profit may be under discussion.	Declarations of Interest – Other	Non-Financial Professional	Direct	In the event that a land or property transaction comes forward to the benefit of the Council and it is a decision of the Board then I would ensure that proposals were submitted by another officer of the Council and I would not take part in any decision making unless clarifications were helpful and requested.
Frimley ICB Non Executive Member	Paul	Farmer	Frimley ICS	My son works for the Public Affairs agency PLMR. On occasion, he works with their healthcare clients.	Declarations of Interest – Other	Indirect	Indirect	
Frimley ICB Non Executive Member	Paul	Farmer	Frimley ICS	I am employed by Age UK as Chief Executive. Age UK is a charity which works with older people. It is federated with independent local charities, which may work with Frimley ICS in the provision of services.	Declarations of Interest – Other	Financial	Indirect	If contracts related to Age UK are discussed, I will recuse myself from discussions.
NHS Provider Partner Member from Berkshire Healthcare FT	Alex	Gild	Berkshire Healthcare NHS Foundation Trust	I am Deputy Chief Executive and voting Board member of Berkshire Healthcare NHS Foundation Trust, and provider partner member of the Frimley ICB	Declarations of Interest – Other	Non-Financial Professional	Direct	Will declare interests on specific ICB business if and when needed.
Chief Medical Officer	Lalitha	Iyer	Women's Scan Clinic	Director of private scanning company (company listed as Polar Diagnostics LLP)	Declarations of Interest – Other	Financial	Direct	Will declare COI and leave meetings if any relevant discussions take place
Chief Medical Officer	Lalitha	Iyer	Globe Management Consultants	I am the Secretary of the company which is owned by my spouse. I have no shareholding in this company.	Declarations of Interest – Other	Non-Financial Professional	Indirect	This company has no dealings with the Health Sector/NHS/CCG
Chief Medical Officer	Lalitha	Iyer	Magna Konserv	I am a Director of this company and have no financial interest or shareholding	Declarations of Interest – Other	Non-Financial Professional	Indirect	This company has no dealings with the Health Sector/NHS/CCG

Chief Medical Officer	Lalitha	Iyer	Solutions for Health	I am a Medical Advisor on the Board of 'Solutions for Health'	Declarations of Interest – Other	Non-Financial Professional	Direct	I will declare COI and will leave meetings if any relevant discussions take place
Chief Medical Officer	Lalitha	Iyer	Daughter working as an intern with Graphnet who is one of our providers in the digital space	Indirect	Declarations of Interest – Other	Indirect	Indirect	I am not involved in any procurement conversations directly and will recuse myself from such decisions. I have also informed my colleagues (chiefs) and line manager.
Non-Executive Member	Sajjad	Khan	States Consulting Ltd	Director and Shareholder	Declarations of Interest – Other	Financial	Direct	No work currently being done within healthcare or public sector
Chief Executive - FHFT	Lance	McCarthy	Frimley Health NHS Foundation Trust	I am the Chief Executive of Frimley Health NHS Foundation Trust, an acute and community provider in the Frimley Health system	Declarations of Interest – Other	Non-Financial Professional	Direct	Will excuse myself if there is a conflict of interests in any agenda items.
ED & I System Lead	Safina	Nadeem	Purple Infusion Ltd	Director of a limited company which provides training to health and social care sectors	Declarations of Interest – Other	Financial	Indirect	Do no provide any training via company to Frimley ICS
ED & I System Lead	Safina	Nadeem	BHA	Trustee for a Charity	Declarations of Interest – Other	Indirect	Indirect	
ED & I System Lead	Safina	Nadeem	Lancashire Cricket Foundation	No conflicts anticipated	Declarations of Interest – Other	Non-Financial Professional	Indirect	
Primary Care Partner Member	Prash	Patel	Magnolia House	I am a profit sharing GP Partner	Declarations of Interest – Other	Financial	Direct	
Primary Care Partner Member	Prash	Patel	Frimley Health Foundation Trust	I am an employee of the FHFT	Declarations of Interest – Other	Non-Financial Professional	Direct	
Primary Care Partner Member	Prash	Patel	Berkshire Primary Care Ltd	I am the CEO and Medical Director	Declarations of Interest – Other	Financial	Direct	
Primary Care Partner Member	Prash	Patel	Ascot Primary Care Network	I am the Clinical Director of the Primary Care Network under the PCN Direct Enhanced Service Specification	Declarations of Interest – Other	Financial	Direct	

NHS Frimley Non-Executive Member	Gareth	Shepherd			Nil Declaration			
Bracknell Forest Council	Grainne	Siggins	Association of Directors of Social Services	Member of ADASS. Joint Chair of South East ADASS Regional Branch	Declarations of Interest – Other	Non-Financial Professional	Direct	Declaration was needed, however, membership of ADASS does not present as a risk.
Bracknell Forest Council	Grainne	Siggins	Bracknell Forest Council	Employed as Executive Director of People Services	Declarations of Interest – Other	Financial	Direct	
Bracknell Forest Council	Grainne	Siggins	Association of Directors of Children Services	Member of ADCS	Declarations of Interest – Other	Non-Financial Professional	Indirect	
Chair of Frimley ICB	Priya	Singh	National Council for Voluntary Organisations	Appointed November 2020 - Chair of Board of Trustees	Outside Employment			
Chair of Frimley ICB	Priya	Singh	Society for Assistance of Medical Families	Appointed January 2018 - Executive Director	Outside Employment			
Chair of Frimley ICB	Priya	Singh	PG Mutual Insurance	Non-Executive Director	Declarations of Interest – Other	Financial	Indirect	Manage in accordance with COI policy.
Chair of Frimley ICB	Priya	Singh	CAF Nominees	Charitable Trustee	Declarations of Interest – Other	Non-Financial Professional	Direct	
Chair of Frimley ICB	Priya	Singh	Royal Trinity Hospice	Trustee	Declarations of Interest – Other	Non-Financial Professional	Indirect	In line of the COI policy.
Chair of Frimley ICB	Priya	Singh	Regulatory Oversight Board (Cricket Regulator)	Non Executive Director	Declarations of Interest – Other	Non-Financial Professional	Indirect	In line with the COI policy.
Chair of Frimley ICB	Priya	Singh	BOB ICB	Chair	Declarations of Interest – Other	Financial	Direct	Managed in accordance with policy.
Place Clinical Lead RBWM	Huw	Thomas	Claremont and Holyport practice	Partner in the practice	Declarations of Interest – Other	Financial	Direct	Will be managed in accordance with policy
Place Clinical Lead RBWM	Huw	Thomas	Maidenhead Primary Care Network	Practice is a member of Maidenhead PCN	Declarations of Interest – Other	Financial	Direct	Will be managed in accordance with policy
Place Clinical Lead RBWM	Huw	Thomas	Frimley Health NHS Foundation Trust	Spouse employed by Trust as Clinical Nurse Specialist	Declarations of Interest – Other	Indirect	Indirect	Will be managed in accordance with policy

Place Clinical Lead RBWM	Huw	Thomas	East Berkshire Primary Care	Work on sessional basis for East Berkshire Primary Care. EBPC provide out of hours care and other primary care services.	Declarations of Interest – Other	Financial	Direct	Will be managed in accordance with policy
Place Clinical Lead RBWM	Huw	Thomas	Holy Trinity Primary School, Cookham	Governor at school	Declarations of Interest – Other	Indirect	Indirect	Will be managed in accordance with policy
Place Clinical Lead RBWM	Huw	Thomas	Royal Borough of Windsor and Maidenhead	Practice subcontracted to provide opiate substitute prescribing services for the Royal Borough of Windsor and Maidenhead	Declarations of Interest – Other	Financial	Direct	Manage in accordance with policy
Local Authority Partner Member from Surrey County Council	Rachael	Wardell	Become - The Charity for Children in Care and Care Leavers	Trustee and Board Member since September 2019	Declarations of Interest – Other	Non-Financial Professional	Direct	Will be managed in accordance with the Conflicts of Interest policy.
Local Authority Partner Member from Surrey County Council	Rachael	Wardell	Association of Directors of Children's Services	Member of Professional Association since October 2009 and Vice President of the Association since 1 April 2024	Declarations of Interest – Other	Non-Financial Professional	Direct	Will be managed in accordance with the Conflicts of Interest policy.
Local Authority Partner Member from Surrey County Council	Rachael	Wardell	Surrey County Council	Executive Director of Children, Families and Lifelong Learning since 07-12-2020	Declarations of Interest – Other	Non-Financial Professional	Direct	Will be managed in accordance with the Conflicts of Interest policy.
NHS Provider Partner Member	Graham	Wareham	Friends of Chambo Seminary	Trustee	Declarations of Interest – Other	Non-Financial Personal	Indirect	No conflict anticipated
NHS Provider Partner Member	Graham	Wareham	Surrey and Borders Partnership NHS FT	Employed as CEO	Declarations of Interest – Other	Non-Financial Professional	Direct	Will excuse if conflict of interest occurs

Minutes of NHS Frimley Integrated Care Board
Held in Public on Tuesday 21 January 2024 from 11.30am-12.30pm
Via Microsoft Teams

Chair – Priya Singh

Present:	
Dr Priya Singh	Chair
Fiona Edwards	Chief Executive
Sam Burrows	Chief Transformation & Digital Officer
Richard Chapman	Chief Finance Officer
Dr Lalitha Iyer	Chief Medical Officer
Ilona Blue	Non-Executive Member
Paul Farmer	Non-Executive Member
Gareth Shephard	Non-Executive Member
Sajjad Khan	Non-Executive Member
Alex Gild	NHS Provider Partner Member
Lance McCarthy	Chief Executive, FHFT
Graham Wareham	NHS Provider Partner Member
Grainne Siggins	Local Authority Partner Member
Dr Prash Patel	Primary Care Partner Member
Dr Huw Thomas	Primary Care Partner Member
Safina Nadeem	Equality, Diversity, and Inclusion System Lead
In Attendance:	
David Radbourne	Regional Director of Strategy and Transformation (NHSE)
Mary-Jane Steijger	Head of Governance (secretariat)
Tom Allinson	Governance Manager
Apologies for Absence:	
Caroline Corrigan	Chief People Officer
Sarah Bellars	Chief Nursing Officer
Karen Edwards	Local Authority Partner Member
Rachael Wardell	Local Authority Partner Member

1.	Welcome and Apologies for Absence
	<p>The Chair opened the meeting and welcomed members of the NHS Frimley Integrated Care Board, in particular, the Chair gave a warm welcome to Gareth Shephard and Sajjad Khan the two newly appointed Non-Executive Members.</p> <p>The meeting was noted to be quorate. Apologies were received as recorded above.</p> <p>Members agreed for the meeting to be recorded. The recording would then be uploaded to the public website along with the meeting papers.</p>

	<p>Nine members of the public had signed up to attend the meeting. One question had been received in advance of the meeting. The Chair confirmed that a written response would be sent out after the meeting to the provider who had submitted the question.</p> <p>Members of the ICB Board’s Mirror Board were in attendance.</p>
2.	Declaration of Conflicts of Interest
	<p>Members noted the Conflicts of Interest register, and there were no specific declarations made for the contents of the meeting’s agenda.</p>
3.	Minutes of the last meeting in Public held on 19 November 2024, Action Tracker, and matters arising
	<p>The minutes of the last meeting in public were taken as accurate and approved without further comment.</p> <p>There were no matters arising.</p>
4.	ICB Chief Executive’s Update
	<p>The Chief Executive gave a verbal update, reflecting on the challenging environment across the system in primary care, mental health, social care and urgent and emergency care. The scale of covid, flu and RSV viruses across the Frimley System over the Christmas and New Year period, had resulted in high attendances in primary care and increased hospital admissions. Notwithstanding these seasonal pressures, staff had done amazing work to maintain good performance for (i) urgent and emergency care (patients seen within four hours) and (ii) waiting list initiatives (to reduce the number of long waits).</p> <p>The Chief Executive highlighted the elective care plans recently issued by The Secretary for State for Health and Care entitled: “Reforming elective care for patients”. The key aims were to “<i>reform elective care, return to the constitutional standard of 92% of patients receiving care within 18 weeks, and to build a sustainable NHS that is fit for the future</i>”. The Chief Executive said partners were working collaboratively across the Frimley system to meet the 18-week referral to treatment target.</p> <p>The Chief Executive informed the Board that Julian Emms the Chief Executive of Berkshire Health NHS Foundation Trust had recently been awarded an Officer of the British Empire (OBE) in the New Year Honours List. The Chief Executive congratulated Julian Emms on this well-deserved achievement as a leader of high performing provider organisation within the Frimley System; in particular, she thanked Julian Emms for his continued leadership role on behalf of the South East Region Temporary Staffing Collaborative and for his strong commitment to the system’s shared Anti-Racism goals.</p> <p>The Chief Executive was delighted to report that on 20 January 2025 Frimley Park Hospital had been confirmed by The Secretary of State for Health and Social Care, as one of the Wave 1 Schemes in the New Hospital Programme. The ICB was working to ensure that its planning, transformation, and engagement workstreams created the enabling conditions within which the Frimley System would be able to build a new hospital that was fit for the future, enabled new models of care, and met the needs of the local population.</p> <p>From 1 April 2025 onwards, ICBs will be asked to assume delegated responsibility from NHS England for the commissioning of 59 Specialised Services (including ambulance services). The Chief Executive reflected that whilst working through the detail of the delegation agreements for Specialised Commissioning Services from national to regional levels was technically very complex, it would provide ICBs with a significant opportunity to improve the service offer to their local populations. NHS Frimley was working at scale with the other five ICBs in the South East Region to ensure a fully aligned population management approach.</p> <p>NHS Frimley ICB currently acts as the lead ICB for the Delegated Pharmacy, Optometry and Dentistry Services, in addition, NHS Frimley would also assume the lead role (on behalf for the other ICBs within the South East Region) for the hosting arrangements for Specialised Commissioning Services.</p> <p><i>The Board noted the update.</i></p>

5.	<p>“Planning 2025/26”</p> <p>Sam Burrows provided an interim update on 2025/26 Planning, noting that formal Planning Guidance had not yet been issued by NHSE but that this was due to be published imminently and Plans would be further updated as appropriate and required. Output from the ICB Board’s Seminar meeting in December 2024 was also presented, showing the support and commitment from the Board to the approach outlined within the slides for 2024/25 and beyond.</p> <ul style="list-style-type: none"> • The Board reaffirmed its commitment to the reform agenda and main focus of the Darzi Review, anticipating a Ten Year Plan for the NHS confirming this approach and aligned to work underway since 2016 to deliver a more integrated local health and care system. Continued commitment to the following themes detailed therein - “Hospital to Neighbourhood”, “Analogue to Digital” and “Sickness to Prevention”. • The Board would need to anticipate its response to the Government’s Ten Year Plan published in the Spring / Summer. • The importance of the ICB’s role as Strategic Commissioner in ensuring that local delivery plans remained additive to the ICS’ overall vision was stressed, and the ICB’s commitment to its partnership way of working was affirmed. • There was commitment to the importance of understanding the system’s population, bringing a true “Population Health Management” approach to how care is planned and delivered and the use of new digital tools and innovations to improve efficiency, quality and outcomes. • As a health and care partnership there was also a need to magnify the things that work; this included “getting the basics right” and achieving maximum compliance with evidence-based interventions effective at lowering the need for higher acuity services. <p>An update on the “Reconnect, Reset, Rebuild” Engagement programme was then given – this was first presented to the Board in November 2024.</p> <p>The exercise was now at its halfway point, with phase one seeing a significant amount of activity with over 100 partners taking part in stakeholder sessions from across 44 different organisations by the end of 2024.</p> <p>Phase Two would continue over January and February 2025 and would focus on two main elements – the continuation of the Community Engagement Fund and holding further bespoke stakeholder sessions in request, with final feedback presented to the Board in March.</p> <p><i>The Board noted the update.</i></p>
6.1	<p>Frimley ICB Quality Performance Report</p> <p>Lalitha Iyer provided the Quality Performance report, highlighting the following areas for the Board’s attention:</p> <ul style="list-style-type: none"> • Vaccine programme update covering Covid vaccine uptake across all cohorts at 47.1%, and Flu Vaccination uptake across all cohorts at 53.4%. • Primary care transformation including the “Get You Better” App aimed at MSK patients. • Public consultation for the relocation of Jubilee Ward, a community hospital ward currently located at Upton Hospital in Slough to St Mark’s Hospital, Maidenhead. • Medicine optimisation update with detail including current Pharmacy Workforce Transformation work underway. • CQC System Compliance <p><i>The Board noted the update.</i></p>

6.2	Frimley ICB Finance and Performance Report									
	<p>Rich Chapman presented the Finance and Performance position at M7 for the Board’s attention, including YTD forecast, out/turn, and actions underway to deliver year end.</p> <p>The Frimley System year to date position was £3.1m behind the planned deficit of £2.4m. The ICB was £1.1m behind a breakeven plan and FHFT were £2m behind the planned position.</p> <p>The System forecast remained at break even. However, the plan relied upon a step change in efficiency delivery at month 8 and a material over performance of ERF.</p> <p>An update on performance data was then provided, covering Urgent and Emergency Care (UEC) 4 hour wait performance, ambulance handover time, patients with no criteria to reside, bed occupancy, planned care recovery, and 78 week waits.</p> <p><i>The Board noted the update.</i></p>									
6.3	Frimley ICB Workforce Performance Report									
	<p>Rich Chapman presented the ICB’s Workforce Performance Report, noting headlines against 24/25 Operational plans as at M7 across the Frimley System including Substantive, Bank, and Agency staffing levels and workforce metrics.</p> <p>Primary Care workforce was further expanded upon as follows:</p> <ul style="list-style-type: none"> • YTD expenditure was on track. • There was a known Primary Care Transformation System Development Funding (SDF) – pay cost pressure. • Costs against Continuous Professional Development (CPD) allocation were currently being mapped. <p>An update on the work underway across the Frimley Academy was also provided.</p> <p><i>The Board noted the update.</i></p>									
7.1	Board Assurance Framework									
	<p>Rich Chapman provided the Board with an overview Board Assurance Framework (BAF) for 2024/25, noting the updates to the mitigating actions that have been made since the document was last reviewed in Public at the November 2024 meeting.</p> <p>The BAF reported on the ICB’s Strategic Objectives and detailed the significant long-term risks to the achievement of these. The document provided assurance that the ICB was on track to deliver its Strategic Objectives and highlighted where necessary any gaps in controls and assurances and the associated actions.</p> <p>Each of the following Strategic Objectives had been scored with an inherent (current) and residual risk (score after the risk has been mitigated) for Q3. The effects of the controls showed whether the Strategic Objective sat in or out of Risk Appetite Statement. At present, three Strategic Objectives were within appetite and three sat outside of the appetite.</p> <table border="1" data-bbox="167 1906 1256 2027"> <thead> <tr> <th>Strategic Objective</th> <th>Q3 2024-25</th> <th>Change since Q2</th> </tr> </thead> <tbody> <tr> <td>Starting Well</td> <td>9 Out of Risk Appetite (8)</td> <td>No change</td> </tr> <tr> <td>Living Well</td> <td>9 Out of Risk Appetite (8)</td> <td>Downgraded 12 -> 9</td> </tr> </tbody> </table>	Strategic Objective	Q3 2024-25	Change since Q2	Starting Well	9 Out of Risk Appetite (8)	No change	Living Well	9 Out of Risk Appetite (8)	Downgraded 12 -> 9
Strategic Objective	Q3 2024-25	Change since Q2								
Starting Well	9 Out of Risk Appetite (8)	No change								
Living Well	9 Out of Risk Appetite (8)	Downgraded 12 -> 9								

	Places, People and Communities	9 Within Risk Appetite (16)	No change
	Our People	12 Within Risk Appetite (12)	No change
	Leadership and Culture	12 Within Risk Appetite (12)	No change
	Outstanding use of resource	16 Out of Risk Appetite (12)	No change
<i>The Board noted the update.</i>			
8.	Close of Business		
8.1	Questions from the public received in advance of the meeting One question had been received by members of the Public in advance of the meeting, and the Chair confirmed that a response would be provided via email following the meeting.		
8.2	Any Other Business <i>None.</i>		
8.3	Close The Chair closed the meeting at 12.30.		
Date of the next meeting in public: 18 March 2025			

FRIMLEY INTEGRATED CARE BOARD

Board Meeting

Title of Paper	Frimley Gender Pay Gap – Annual update		
Agenda Item	5.1	Date of meeting	18 March 2025
Exec Lead	Caroline Corrigan		
Author(s)	Caroline Corrigan/Lisa Cully/Sue Lowe		

Purpose	To Approve	<input checked="" type="checkbox"/>
	To Ratify	<input type="checkbox"/>
	To Discuss	<input type="checkbox"/>
	To Note	<input checked="" type="checkbox"/>

Link to Strategic Objective	Our People
	Leadership and Cultures

Executive Summary	
<p>The purpose of the report is to present the Frimley Integrated Care Board's Gender Pay Gap report and data covering the period from 01/04/2023 to 31/03/2024. Elements of this report must be uploaded to the government portal by 31/03/2025.</p> <p>The report contains legal context and our obligations under The Equality Act 2010.</p> <p>A yearly update must be reported and published within a year of the snapshot date of 31st March. It is against the law to fail to report our gender pay gap data by the deadline. Our update must also be published on our website and should be kept online for 3 years. We must ensure that our employees are told where to find the information.</p> <p>The report also summarises actions that have taken place in the last 12 months, the effects of the change programme on the lack of progress on some streams of work, and the planned work for the coming year</p>	
Recommendation	The board are requested to support the approach, actions and governance proposals

Please provide details on the impact of following aspects	
Risk and Assurance	
Equality and Quality Impact Assessment	
Patient and Stakeholder Engagement	
Financial Impact and Legal implications	
Please indicate which CQC Theme and Quality Statements this QIA supports. Interim guidance for assessing integrated care systems March 2023 (cqc.org.uk)	Choose a Quality Statement.

Reporting – has this paper been discussed at other meetings		
Committee Name	Date discussed	Outcome
SLT	25/02/25	Agreed
RemCom	10/03/25	Agreed

NHS Frimley

Gender Pay Gap

Update
January 2025



Gender Pay Gap – context

Legal Context: The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 require public sector organisations employing 250 staff and over to publish their Gender Pay Gap Report by end of March annually, providing ‘snapshot data’ for 31 March of the previous year. This is part of our Public Sector Equality Duty.

This report has been prepared in accordance with guidance published by the Government Equalities Office and the ‘snapshot’ information includes staff holding an employment contract on 31 March 2024, based on our Employee Staff Records (ESR).

Why is Gender Pay Gap reporting important? Gender pay gap reporting highlights differences in the average (mean or median) earnings of men and women - expressed as a percentage of men’s earnings. For example, women earn 15% less than men.

How does it help? It helps to understand equality gaps at the workplace, female and male participation at different levels and if talent is maximised and rewarded fairly and effectively. Gender Pay Gap reporting promotes accountability and transparency and informs actions to minimise equality gaps.

How is Gender Pay Gap different from Equal Pay: Equal pay deals with pay differences between men and women carrying out same jobs, similar jobs or work of equal value. Failure to ensure equal pay for roles of equal value between men and women is unlawful.

Gender Pay Gap reporting shows the average hourly pay differences between men and women and whether any one gender is disproportionately over-represented at a particular salary band. Individual component calculations (mean, median, bonus and by pay quarter) help identify what is causing the difference and inform action plans to minimise the gaps.

Data from the Kings Fund in 2024 shows that three-quarters (74%) of NHS England staff are female and 31% are from an ethnic minority background – higher than the population average in England; but disability rates among staff in NHS England are 7%, which is below the England average. These rates vary by role; for example, the proportion of female staff ranges from nearly 100% of midwives to 46% of doctors. In Frimley ICB, 75% of staff are female (1% higher than the national rate of 74%).



Gender Pay Gap – Requirements of the organisation

A yearly update report must be reported and published within a year of the snapshot date of 31st March. It is against the law to fail to report our gender pay gap data by the deadline.

The update must also be published on our website and should be kept online for 3 years. Our employees should be told where to find the information.

Alongside the report, best practice from the Government Equalities Office suggests including the following:

- A supporting narrative to help people to understand why we think we have a gender pay gap and what action we have taken to analyse and close it. The narrative could include:
 - a more detailed analysis of our gender pay gap, and explanations for each of the figures in our report
 - information about what we have already done to close our gap
 - reasons why some actions may take a while to affect our gap
 - workforce statistics, to give a clearer picture of why our gap exists
- An action plan

This report has been prepared in accordance with guidance published by the Government Equalities Office and the 'snapshot' information includes staff holding an employment contract on 31 March 2024, based on our Employee Staff Records (ESR).



Our commitment to EDI



NHS Frimley is committed to and actively promotes a fair and inclusive environment where everyone feels valued and respected. Our aim is to create a workplace where every individual has a sense of belonging and is empowered to reach their full potential. We recognise that diversity is our strength, and inclusion is essential to achieving our mission of providing high-quality healthcare and addressing health inequalities. We work closely with our strategic partners to promote equality of access and treatment and by addressing health inequalities, we ensure that all individuals receive the care and support they need. Throughout 2024/25, as an Integrated Care System, we have introduced several anti-racism commitments with our partners.

Our Commitment to EDI:

- We strive to create an environment where everyone, including patients, visitors and community members feel welcomed and included.
- We celebrate the diverse backgrounds and perspectives of our people and communities
- We aim to empower everyone to achieve their best, recognising that each person's contribution is essential to our success.
- Ensuring that all members of our community have equal access to healthcare services.
- Promoting fair treatment in all aspects of our work.
- Actively working to reduce inequalities in health

Our EDI ambition is to:

- Ensure staff fully understand equality and diversity issues
- Make staff feel empowered to challenge prejudice and make reasonable adjustments in their own work areas
- Include equality and diversity training for all staff
- Ensure all staff promote the cultural and behavioural changes to ensure equality and diversity is demonstrated in all aspects of NHS Frimley's work
- We are currently setting our objectives for 2025-2027. This process includes reviewing our latest workforce data and collaborating with staff across the Integrated Care Board.



The Remuneration Committee (RemCom) reviewed the Gender Pay Gap report in March 2024. Feedback included the need for a refined EDI action plan with clear milestones, details of staff networks to be added and a lead named Executive Sponsor within the ICB. Work continues in Q4 to provide further assurance to RemCom.

The ICB has undergone a significant change programme and ensuing restructure which has impacted progress on streams of work including this one. The areas we have prioritised and focussed on are shown on slide 7

During 2023/2024;

- On 1st July 2023, 50 staff members (39 Pharmacy, Ophthalmic and Dentistry and 11 Complaints) TUPE transferred from NHSE to Frimley ICB under a host arrangement
- On 1st February 2024 Frimley ICB in housed 25 staff members of staff from South, Central and West Commissioning Support Unit from Commissioning Performance (Contracting) and Financial Services departments

The organisational change programme has seen a change in the ICB Directorates formation and structure.

During the organisation change programme

To ensure we positively promoted gender equality through our organisational change process:

- The original consultation report was reviewed through an inclusion lens, to support use of inclusive language and to highlight the ICS ambition to improve workforce and health inequalities.
- Inclusion messages were embedded into the 'managing change sessions' that were delivered to line managers and drew out key equality themes from the post-consultation responses to ensure they were amplified.
- Created a consistent template to ensure that job descriptions for new roles were developed with inclusivity and accessibility in mind including inclusive language that did not have a negative impact on women.
- Completed ongoing Equality & Health Inequality Assessments (EHIAAs), ensuring that at each decision-making point, anonymised ESR data was reviewed and any impact on gender equality was highlighted including through an intersectional lens
- Job matching and potential job interview processes were reviewed from an equality perspective – constantly asking whether we are doing enough to ensure that people will feel equally and fairly treated and that their needs will be considered.
- Equality Advocates were recruited, trained and formed part of the interview panels to challenge any bias decisions.



Work undertaken and in progress

- Frimley ICB, has signed up to the Sexual Safety in Healthcare Charter and has dedicated resource to meet the requirements under the 10 commitments.
- We have actively ensured that women were not adversely affected within the organisational change programme through ongoing EHAs and analysis of workforce data at each stage.
- Inclusive approaches have been developed within the recruitment process including the inclusive recruitment toolkit. We continue to ensure these practices are embedded and will further upskill our line managers.
- A System-wide Women's network commenced in March 2024 and will be relaunched in conjunction with International Women's day on 8th March 2025.
- Benchmarking against regional data has been reviewed, and actions will form part of the action plan.
- The following policies have been launched which all support women in the workplace
 - Flexible Working
 - Working Carers
 - Pregnancy and Baby Loss



Comparison of data

31/03/23 against 31/04/24

Metric	2023		2024		
Headcount	339 25% men (78) 75% women (261)		438 25% men (111) 75% women (327)		Increased numbers due to intake of NHSE and SCW staff * ref slide 6 for details
Median hourly rate	£34 per hour – men £26 per hour - women		£36 per hour – men £27 per hour - women		Women have consistently earned 25% lower- 75p for every £1 that men earned
Mean hourly rate	£39 per hour – men £31 per hour – women		£41 per hour – men £32 per hour – women		Women have consistently earned 20% lower; men had a 5% mean increase, while women had a 3.2% increase from 2023 to 2024
Quartiles (1 being lowest paid) Percentage of women	4	65.9%	4	61.8%	As at 31/03/23 women were over-represented in the lower pay quartiles (1st and 2nd) and men were over-represented in the 4 th . As at 31/03/24 the position had improved in the 2nd but declined in the others
	3	75.8%	3	72.5%	
	2	85.0%	2	80.1%	
	1	82.7%	1	83.5%	



Gender by quartile

The Proportion of men and women in each pay quartile (%) is calculated by ranking all employees from highest to lowest paid, dividing the workforce into four numerically equal parts ('quartiles') and working out the percentage of men and women in each of the four parts. (The lowest paid jobs are in quartile one).

31/03/2023				
Quartile	Female	Male	Female %	Male %
4 Upper	56	29	65.88	34.12
3 Upper middle	75	24	75.76	24.24
2 Lower middle	68	12	85.00	15.00
1 Lower	62	13	82.67	17.33

31/03/2024				
Quartile	Female	Male	Female %	Male %
4 Upper	91	18	61.82	38.18
3 Upper middle	89	21	72.48	27.52
2 Lower middle	79	30	80.91	19.09
1 Lower	68	42	83.49	16.51

Gender by AFC pay grade

31/03/2023				
Band	Female	Male	Female %	Male %
2	1	0	100%	0%
3	2	1	67%	33%
4	12	3	80%	20%
5	26	5	84%	16%
6	38	6	86%	14%
7	48	13	79%	21%
8A	61	9	87%	13%
8B	26	10	72%	28%
8C	31	9	78%	23%
8D	14	7	67%	33%
9	6	3	67%	33%
Other	29	22	57%	43%

31/03/2024				
Band	Female	Male	Female %	Male %
2	0	0	0%	0%
3	2	0	100%	0%
4	17	6	74%	26%
5	30	3	91%	9%
6	42	8	84%	16%
7	56	18	76%	24%
8A	67	12	85%	15%
8B	32	16	67%	33%
8C	29	9	76%	24%
8D	16	6	73%	27%
9	3	5	38%	63%
Other	33	28	54%	46%

*Does not include FTCs/ Secondments or acting up arrangements during Organisational Change process



Regional comparison

as of 1st March 2023



During 2024/25 Frimley and Buckinghamshire Oxfordshire and Berkshire West (BOB) ICBs were working collaboratively with an interim joint Chief People Officer.

The team at BOB reviewed the regional statistics available on the Government Equalities Office website and prepared the data on the following 2 slides

Further analysis will be carried out post 31st March 2025 when the recent data will be available

Comparison of South - East ICBs

as of 1st March 2023

Mean and Median

Integrated Care Board	Mean Pay Gap %	Median Pay Gap %	Bonus Pay Gap %
Buckinghamshire Oxfordshire and Berkshire West	24.9%	13.6%	No bonuses were paid.
Surrey Heartlands	6.9%	2.8%	No bonuses were paid.
Kent and Medway	25.6%	17.3%	No bonuses were paid.
Sussex	20.6%	14.2%	No bonuses were paid.
Hampshire and Isle of Wight	26.8%	24.7%	No bonuses were paid.
Frimley	20%	25%	No bonuses were paid.

The above information is drawn from the Government Equalities Office website. ICBs with the highest Pay Gap are in Red, whilst those with the lowest Pay Gap are in Green. Surrey Heartlands ICB had the lowest Mean and Median Pay Gap, while Hampshire and Isle of Wight ICB had the highest Mean Pay Gap and Frimley ICB had the highest Median Pay Gap.



Comparison of South - East ICBs

as of 1st March 2023

Pay Quartile

Integrated Care Board	Quartile 1	Quartile 2	Quartile 3	Quartile 4 (highest paid)
Buckinghamshire Oxfordshire and Berkshire West	86.1%	73.5%	78.7%	57.3%
Surrey Heartlands	83.5%	81.5%	78.5%	74.3%
Kent and Medway	89%	79%	74%	62%
Sussex ICB	81.4%	87.2%	75.1%	66%
Hampshire and Isle of Wight	88.4%	84.8%	74.7%	64.7%
Frimley	82.7%	85%	75.8%	65.9%

This Table highlights comparisons across pay quarters – focussing on the lowest pay quarter (Quartile 1) and highest pay quarter (Quartile 4). The ICBs with the lowest representation at Quartile 4 and highest representation at Quartile 1 are highlighted Red. BOB ICB had the lowest representation at Quartile 4 in March 2023.

Actions to be built into Task and Finish project plan:

Action	Timescale	Delivery Group
1. Establish a Task and Finish group reporting to EDI Group	April 2025	EDI Group / OD Group
2. Use data from 31/03 to inform action plan into 2025/26 (ensuring actions have clear timescales and benefit realisation – how we are closing the pay gap and how long it may take)	April 2025	Gender Pay Task and Finish Group
3. Publication of Sexual Misconduct Policy	April 2025	EDI Group / OD Group
4. Review Staff survey data from gender equality perspective and derive actions	April 2025	Gender Pay Task and Finish Group
5. Roll out OD plan (including inclusive talent strategy) across the ICB	Quarter 1	OD Group
6. Violence and aggression workstream through People Board	Quarter 1	People Board
7. Comparison of ICB's Gender Pay Gap results with ICB comparator groups.	Quarter 2	Gender Pay Task and Finish Group



Next steps in 2025/26

- Establish a Task and finish group, reporting to the EDI working group and onward to SLT
- Use the data at 31/03/25 to pull together an action plan which will be monitored within the Organisation Development delivery plan
- Engage with stakeholders and interested individuals identified through a variety of routes, such as all staff communications, Staff Partnership Forum, Line Manager Forum and the EDI Working Group
- Provide quarterly progress reports back to RemCom
- Publish our Sexual Misconduct policy alongside a full communications plan to inform and educate all staff. An e-learning module will be completed by all staff and more detailed training will be made available for those staff who may need to support an employee making a report of misconduct. Continued progress against the 10 commitments will be led and monitored by the steering group and reported on the to EDI working group
- Review our Staff survey from a gender equality perspective and report on key themes
- Gender focused sessions will be held with staff networks to identify intersectionality issues
- Relaunch of women's network in conjunction with International Women's Day
- Continue to promote ICB's flexible working arrangements to support work life balance and reduce need for part-time hours
- Review appraisals process to ensure all staff have career conversations and are supported to develop their personal development plans.
- Compare the ICB's Gender Pay Gap results with ICB comparator groups.
- The Organisation Development delivery plan as signed off by SLT includes the development of an inclusive talent strategy to create career development opportunities for everyone both internally and at system level.
- A dedicated violence and aggression workstream will be established through our system People Board



FRIMLEY INTEGRATED CARE BOARD

Title of Paper	EDI Annual Report, Workforce Race & Disability Equality Standard Action Plans		
Agenda Item	5.2.0	Date of meeting	18 March 2024
Exec Lead	Safina Nadeem, EDI System Lead		
Author(s)	<ul style="list-style-type: none"> Equality, Diversity & Inclusion Project Manager - Frimley Health Integrated Care System People & OD Project Manager – NHS Frimley ICB Performance Analyst –Frimley Health and Care Integrated Care System 		

Purpose	To Approve	<input checked="" type="checkbox"/>
	To Ratify	<input type="checkbox"/>
	To Discuss	<input type="checkbox"/>
	To Note	<input checked="" type="checkbox"/>

Link to Strategic Objective	<i>Leadership and Culture for Improvement Our People</i>
------------------------------------	--

Executive Summary	
<p>This year's Annual Equality Report highlights the ongoing commitment across the system to fostering a diverse, inclusive, and equitable environment. Equality is recognised not only as a responsibility but as a key driver of success, innovation, and impact. Over the past year, significant steps have been taken to embed equality, diversity, and inclusion into culture, policies, and practices. Key achievements include:</p> <ul style="list-style-type: none"> Strengthening recruitment processes to promote fair opportunities. Developing resources to challenge poor behaviours. Launching the Mirror Board Programme to enhance leadership inclusivity. Introducing a system anti-racism framework to address inequalities. <p>These initiatives demonstrate a clear commitment to creating workplaces where individuals feel valued and respected. However, achieving true equality is an ongoing journey that requires continuous effort, accountability, and collaboration. This report not only highlights progress but also acknowledges the challenges that remain, and the commitments being made to reduce workforce and health inequalities.</p> <p>To help address these challenges both the Workforce Race and Disability Equality Standard (WRES & WDES respectively) reports have been produced utilising workforce data, WRES and WDES indicators, and Staff Survey results.</p> <p>Our WRES Action Plan outlines NHS Frimley's commitment to addressing workforce inequalities and fostering an inclusive environment for Black, Asian, and Minority Ethnic staff. This plan identifies key priorities such as strengthening accountability, supporting career development, and tackling structural inequalities. It also sets clear success measures for the future.</p> <p>Similarly, our WDES Action Plan outlines our commitment to improving workplace experiences and opportunities for disabled staff. This plan identifies key priorities such as enhancing representation, improving recruitment and retention, and ensuring a safe, supportive workplace. It sets clear success measures for the future.</p> <p>While progress has been made, disparities remain as highlighted by both reports, and ongoing action is essential to improve representation, career progression, and workplace culture.</p>	
Recommendation	<ul style="list-style-type: none"> EDI Annual reporting is to be noted by the Board. Recommendation to approve both the Workforce Race Equality Standard and Workforce Disability Equality Standard Action Plans.

Please provide details on the impact of following aspects	
Risk and Assurance	These reports outline key risks and suggested mitigations for the organisation pertaining to EDI.
Equality and Quality Impact Assessment	EDI data utilised to assess equality and quality impact – this document collates data points and suggested actions to improve equality and quality impact.
Patient and Stakeholder Engagement	Build and testing at multiple committee's for stakeholder engagement – committee's listed in reporting line below.
Financial Impact and Legal implications	Our annual reporting and equality standard reports follow national guidance which have been informed by financial impact and legal implications.
Please indicate which CQC Theme and Quality Statements this QIA supports. Interim guidance for assessing integrated care systems March 2023 (cqc.org.uk)	Wokforce equality, diversity & inclusion

Reporting – has this paper been discussed at other meetings		
Committee Name	Date discussed	Outcome
EDI Working Group	January 2025	Feedback received and updates made
HR Policy Group	January 2025	Feedback received and updates made
Staff Networks	November 24 – March 25	Feedback received and updates made



Equality, Diversity, and Inclusion

Annual Report

Part A: Public Sector Equality Duty

1st April 2024 to 31st March 2025





Contents

Contents	2
Foreword	3
Introduction	4
Public Sector Equality Duty	4
Eliminating prohibited conduct	5
Sexual Misconduct.....	5
Violence Against Women & Girls at Frimley Health NHS Foundation Trust	5
Hate Crime Awareness	7
Advancing equality of opportunity.....	7
Mirror Board.....	7
Equality and Health Inequality Assessment (EHIA) Refresh	9
Embedding EDI best practice in Radiography	10
Fostering good relations.....	11
System Anti-Racism Alliance	11
EDI Champions in Allied Health Professions.....	11
EDI Conference	12
Next steps in 2025: Integrated Care Board	13
Next steps in 2025: Integrated Care System	14



Foreword

I am pleased to introduce this year's Annual Equality Report, which reflects our ongoing commitment to fostering a diverse, inclusive, and equitable environment for everyone. At Frimley ICB we believe that equality is not just a responsibility, it is a key driver of our success, innovation, and impact.

Over the past year, we have made significant strides in integrating equality, diversity, and inclusion (EDI) into our culture, policies, and practices. We have strengthened our recruitment processes to ensure fair opportunities, developed resources to challenge poor behaviours, launched our innovative Mirror Board Programme, and introduced our system anti-racism framework. These meaningful steps reflect our commitment to fostering a workplace where everyone feels valued and respected.

We recognise that there is still work to be done and true equality is an ongoing journey that requires continuous effort, accountability, and collaboration. This report not only highlights our achievements but also outlines the challenges we must address and the commitments we are making for the future to reduce workforce and health inequalities.

As we move forward, we remain committed to building a truly inclusive organisation and striving for a more just and equitable future for our people and communities.



Fiona Edwards
Chief Executive,
NHS Frimley



Introduction

This report is written to accompany the ICB's overall Annual Report ([available here](#)). It demonstrates how Frimley Integrated Care Board (ICB) and the wider Integrated Care System (ICS) are achieving their Public Sector Equality Duty through case study examples.

Part B of this report details case studies that meet the Equality and Human Rights Commission's (EHRC) and NHS England's Monitoring Projects. Part C of this report gives details on the demographics of our ICB workforce and ICS communities.

Frimley ICS covers five main 'Places': **Royal Borough of Windsor and Maidenhead**, **Slough**, **Bracknell Forest**, **Surrey Heath** and **North East Hampshire and Farnham** (comprising Hart, Rushmoor and Waverley Local Authority Districts).

Public Sector Equality Duty

This Annual Report provides an overview of the work we have delivered this year to meet our [Public Sector Equality Duty](#), which states that we must work to:

- Eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the [Equality Act 2010](#);
- Advance equality of opportunity between people who share a [protected characteristic](#) and people who do not share it;
- Foster good relations between people who share a protected characteristic and people who do not share it.

Within Frimley ICB and the wider ICS, we have delivered this work by embedding our EDI strategy. We continue to use the data contained in our Data Report to understand the lived experiences of our people, and use identified challenges to drive change for equity of outcomes for our staff, volunteers, and the people we serve.

[Back to contents page](#)



Eliminating prohibited conduct

Proactive work has been seen addressing discrimination, harassment, victimisation and any other prohibited conduct across Frimley ICS.

Sexual Misconduct

The [Worker Protection Act](#) (2024, as an amendment of the Equality Act, 2010) came into effect in October 2024. This amendment introduces a legal duty for all employers to proactively take reasonable steps to prevent sexual harassment.

Frimley ICS has seen multiple organisations review their Human Resources and People Team policies on Sexual Misconduct, as well as wider policies on discrimination, harassment and victimisation, to bring content into alignment with the Act in an effective and timely manner. This has been pertinent given the [extension to work functions](#), such as Christmas parties.

Frimley ICB proactively formed a small ‘task and finish’ group for this work. They identified overlapping policies and procedures, bringing them all into alignment with the NHS England template policy for Sexual Safety in the Workplace. A local Equality and Health Inequality Assessment (EHIA) was undertaken for our specific workforce and geography. We liaised with our Freedom To Speak Up Guardians to include a robust, supported route for staff reporting incidents, and are developing an anonymous survey for staff who don’t wish to be identified during their process

Both the template and EHIA were collaboratively peer reviewed by Staff Network members and EDI stakeholders across ICB directorates before completing our internal Governance process and being signed off. The ICB are committed to understanding how this Policy embeds over the next 12 months. We will continue holding the task & finish group quarterly to review whether incidents are reported and the learning that has been gathered; this information will feed back into our ICB EDI Working Group.

[Back to contents page](#)

Violence Against Women & Girls at Frimley Health NHS Foundation Trust

In response to our National Staff Survey Results, November 2024 saw Frimley Health NHS Foundation Trust (FHFT) embrace The People Promise component of ‘We Are Safe and Healthy’ by running a month-long campaign dedicated to raising awareness and supporting our staff about all aspects of Managing Violence & Aggression:



31 st October 11.30-12.30	STAFF BRIEFING: Protecting you from aggressive and abusive behaviour. Find out more about what the Trust is doing to protect everyone from aggressive and abusive behaviours. This is a chance to share your views with Lance and Matt.
4 th November 2-3pm	De-escalation Awareness Skills, hints and tips to help de-escalate potential issues
11 th November 1.30-2.45pm	Civility in Healthcare Why this matters & what we all can do
13 th November 1.45-3pm	Introduction to Human Factors Relationships and Teams
19 th November 10.30-11.30am	Sexual safety in the workplace An introduction session on this topic, highlighting the Trusts standards of behaviour and why it is important that we all act.
20 th November 10-11am	De-escalation Awareness Skills, hints and tips to help de-escalate potential issues
20 th November 12.30-1.30	Lunch & Learn with Najeeb Rehman Microaggressions in the Workplace
25 th November 3-4pm	De-escalation Awareness Skills, hints and tips to help de-escalate potential issues
28 th November 2.30-3.30pm	Awareness of Domestic Abuse
29 th November 9.45-11am	Human Factors Remaining human in challenging times

Sponsored by the Chief Executive, each and every staff member was invited to join these sessions and we saw record numbers of staff; circa 1500 in total, attend the different workshops, enabling us to signal a strong commitment about supporting our people. Other demonstrable actions have included:

- A dedicated campaign to promote safety
- Signing the Sexual Safety Charter
- Reworking our values to have a stronger focus on EDI

This has now evolved into a broader workstream: ‘Protecting Our People’, enabling us to stay focused on responding to our results from the National Staff Survey, Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES), following Frimley Excellence methodology.

[Back to contents page](#)



Hate Crime Awareness

Events during 2024 saw Islamophobia, Anti-Semitism and other forms of hate crime, most notably through national protests. Frimley ICB were prompt in reaching out to EDI Leads across organisations and establishing where support was required for staff across health and social care who may be feeling unsafe.

The ICB facilitated an online safe space for any person working across health and social care in the ICS, including the Voluntary, Charity and Social Enterprise sector. Chaired by the ICB's EDI Director, Safina Nadeem, the session allowed people to explore their reactions to national events, support one another and reduce feelings of isolation. Written information, which gave information about what a Hate Crime is and how to report it was developed. It signposted local and national support services that staff could independently access. The information was shared before, during and after the webinar by email and our EDI Newsletter.

Staff directly impacted by national events fed back that they were grateful for the safe space to gain peer support. Allies who joined the call stated they were grateful for the opportunity to better understand events for their colleagues, and felt empowered and more confident to advocate for someone who may be impacted.

This work has identified that, while local organisations may understand their quantitative hate crime rates through Freedom To Speak Up and other data, there is a gap in understanding the ICS picture for this. We have escalated this to the Freedom To Speak Up Guardians and will look to report this data to our ICS People Board in 2025.

[Back to contents page](#)

Advancing equality of opportunity

Frimley ICS enjoys a diverse population and workforce across health and social care. We understand that this brings huge talent and experience into the ICS, but also know that some protected characteristic groups experience inequality in accessing opportunities. Work is being undertaken to reduce these inequalities, some of which is presented here.

Mirror Board

Frimley ICS have had a [Mirror Board](#) in place since January 2024. This innovative programme consciously recruited members from across protected characteristic groups and health and social care organisations. Members come together to develop their leadership skills ready for the Board room, and hold up a mirror to our ICB Board during dually held meetings. Their different perspectives enrich decision-making processes and influence key decisions made in the ICS, improving outcomes for our workforces and population.



The Mirror Board objectives and priorities are to:

- Develop talent for the future
- Increase representation from protected characteristic groups at Board level
- Promote collaborative working across organisations
- Encourage diversity of thought in decision making
- Supporting the delivery of ICS EDI Strategic Ambitions

Members are supported to understand one another's personal and professional experiences and challenges. They undertake Reciprocal Mentoring with a member of the ICB Board to share insights, exchange ideas and learn from one another. This gives members experience of operating at a Director / Board level, while using learning to identify and close gaps between different protected characteristic groups.

Key discussions and decisions that members have undertaken to develop their skills include:

- Frimley Financial Sustainability Plan
- Core 20 Plus 5 (addressing inequalities in our ICS)
- Building a System Anti-Racism Framework
- NHS Frimley Academy – *What Next?*
- Reconnect, Reset, Rebuild Community Engagement 2024 – *Enabling Leadership Connections within the Community*

Though this programme is ongoing, there are several strengths that have already been identified, including:

- Developing leadership and leveraging mentoring
 - Taking on more senior roles in their current or new jobs
- Ability to evolve strategic contributions, including
 - Advocating for one's own protected characteristic(s) in discussion, and
 - Improving understanding from members in other groups
- Building growth and confidence
- Strengthening collaborative problem-solving between
 - Protected characteristic and deprivation groups
 - Health and Social Care organisations across the ICS

“The Mirror Board provided a fascinating experience of real decision-making processes and the functioning of the Board. The reciprocal mentoring of the Mirror Board programme was an opportunity to understand and share experiences and insights in an open and authentic way with a Board member.”

Mirror Board Member, 2024



Equality and Health Inequality Assessment (EHIA) Refresh

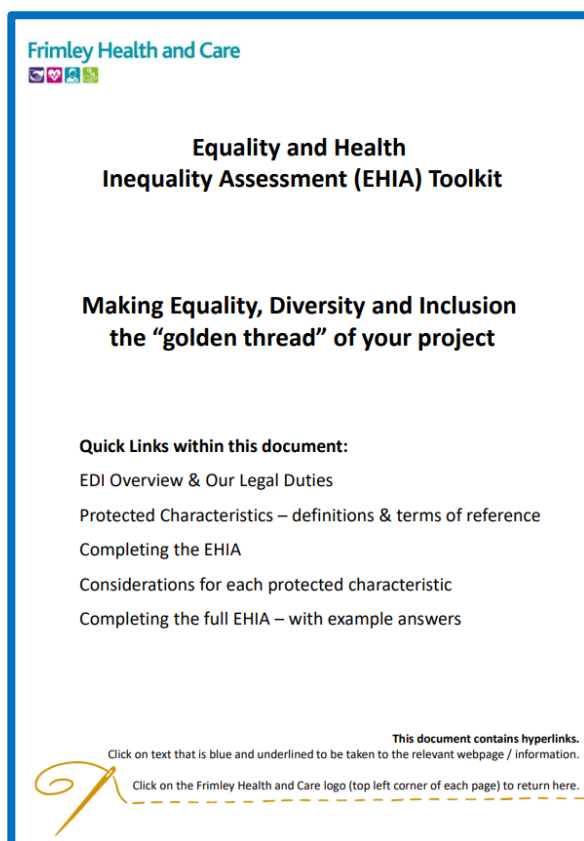
As part of our commitment to embedding EDI in our decision making, the ICB undertook a review and update of our EHIA form and governance process. Historically this was a 2-step EHIA process. All staff commencing, reviewing or decommissioning a piece of work had to complete an initial EHIA. If this showed negative impacts on a minority group, a full EHIA needed completing. Feedback on this process from staff included that it felt duplicative, confusing, and intimidating.

The EDI Team designed a revised single-step form and embedded firm governance for EHIA's being completed. This included that the EHIA should be collaborative with relevant stakeholders including staff networks. Where a neutral or negative impact is identified, the EHIA should be reviewed and agreed by the ICB's EDI Working Group and co-signed by an EDI Team member to ensure that we are mitigating the risks identified as completely as possible.

A toolkit was designed alongside the form to assist staff in understanding their legal duty, as well as giving an example form. Workforce and local community data are given in the form appendix so that staff have reference points to refer to. The form and toolkit were launched during an all-staff briefing, with training sessions delivered over Microsoft Teams for 6 months.

One of the programmes that has benefitted from a detailed EHIA is the 2024 COVID Vaccination programme. Completing the EHIA for this work allowed staff to understand access needs for different members of our communities, improving their ability to advocate for minority groups and implement adjustments. These included learning the intersectional needs of minority groups such as children at clinical risk and their caregivers, proactively advocating those needs across complex multi-professional teams and strengthening trusting professional relationships between minority communities and healthcare providers. This work also supports the wider vaccination Marguerite. It is ongoing at the time of writing the report but will be evaluated on completion.

This revision and implementation of our EHIA form and governance process has seen submissions to the EDI Working Group increase by 425% in 2024-2025





compared to the previous financial year. We are continuing to monitor EHAs and help increase the quality of submissions, which in turn will help improve the quality and experience of colleagues and communities using health and social care services in Frimley.

[Back to contents page](#)

Embedding EDI best practice in Radiography

To engage Radiographers in research, a steering group was developed to explore and discuss EDI principles, and identify where improvements could be made in the service. Drawing on personal and professional qualitative lived experiences, best practice from research journals and policies, the group identified core areas where interventions would make meaningful change. The overall goal is to reduce barriers and give minoritized groups the opportunity to have equal access to good quality medical imaging and onward medical care.

Starting with small interventions that wouldn't disrupt clinical workflow, the group developed a 'foreign language sheet'. This was designed for patients whose first language is not English, or those with impaired communication such as [dDeafness](#), or [aphasia](#). It supports accurate completion of the 3-point identification check. The team used local population data to understand the most prevalent locally spoken languages to each hospital site and had the sheets translated accordingly.

Further interventions to support patients from protected characteristic groups include posters that ask patients to notify the reception team if they have any additional needs so that they can be accommodated. The steering group continue planning and delivering other projects through 2025, including introducing "quiet sessions" in the x-ray department. These sessions will reduce sensory overwhelm for patients and allow Radiographers more time to make adjustments to each patient's needs. A third workstream includes a concise "additional needs" passport. This is completed by the patient and shared with the Radiographer prior to examination to help the practitioner meet the needs of the patient to achieve high quality imaging.

All of these workstreams aim to improve understanding between staff and patients from different demographics, so that the best quality service can be provided. They are in pilot and launching phases at present so do not have outcomes yet. The steering group are gaining valuable feedback from patients using the pilots and will create a feedback cycle to measure and evaluate their impacts.

[Back to contents page](#)



Fostering good relations

Frimley ICS enjoys an internationally diverse population across health and social care.

System Anti-Racism Alliance

A key focus over the 2024-2025 financial year has been progression of our Anti-Racism work, both in individual organisations, and across Frimley ICS.

This work has been spearheaded by Berkshire Healthcare NHS Foundation Trust, whose [Unity Against Racism](#) and [taskforce](#) workstreams can be read about [online](#). They have documented their Anti-Racism journey, along with barriers they faced, and presented this work to the Frimley Integrated Care Partnership (ICP) – which is attended by senior leaders from each of the System’s partner organisations.

Frimley ICS are now in a collaborative phase in this work. We are developing an Anti-Racism Framework for organisations to:

- Measure themselves against five key pillars,
- Identify areas for improvement by using a maturity model for each of the pillars, and
- Establish [SMART goals](#) for their organisation to progress through the Framework’s maturity model.

The Framework is being co-designed with self-identified groups of staff from across the ICS (recruited from EDI webinars, advertised in our ICS EDI Newsletter), and Staff Network members. We are also drawing on our symbiotic ICP leaders across EDI, Human Resources, People Teams, Learning and Development colleagues and wider.

[Back to contents page](#)

EDI Champions in Allied Health Professions

Frimley ICS have a dedicated team of Allied Health Professionals (AHPs) who support students and staff across organisations. They are keenly aware of issues faced by the 14 different professions included in the “Allied Health Professionals” umbrella and, to address some of the challenges being faced, have begun developing an EDI Champions Network.

ICS providers were invited to put volunteers forward as EDI Champions during AHP Board meetings. Advertisement was also undertaken through the AHP Staff



Newsletter, where colleagues could submit expressions of interest. The team have identified a good representation of EDI Champions across pay bands and providers.

Once launched in 2025, the EDI Champions will:

- Have a safe space for their own learning and development,
- Advocate for minority groups,
- Share knowledge to improve colleagues' awareness of:
 - Protected characteristics,
 - Disparity in access and outcomes, and
 - Fostering good relations between different groups of staff and service users.

Updates and learning from the AHP EDI Champions will feed into the ICS EDI Professionals Network. We will review progress iteratively and update on the group's first year progress in next Annual Report.

[Back to contents page](#)

EDI Conference

One of the key ways that Frimley ICS foster good relations between people with and without protected characteristics is through our annual EDI Conference. This ran from 4th to 13th November 2024. It contained webinars delivering content across protected characteristic groups, speaking to the title: “**Breaking boundaries: How Inclusive are we Really?**”. [A full evaluation is available here.](#)

The following webinars were delivered as part of our 2024 EDI Conference

Breaking Boundaries: How Inclusive are we Really?

You can watch the webinars on YouTube by clicking on their titles below.

Getting Your EDI Journey Right	Listen Up	Neurodivergence
Cultural Safety	Working Carers	Disabilities
Health Inequalities	LGBTQ+ in Health & Social Care	The limit of my ambition

Breaking Boundaries: How Inclusive are we Really?

ASCOT • BRACKNELL • FARNHAM • MAIDENHEAD • NORTH EAST HAMPSHIRE • SLOUGH • SURREY HEATH • WINDSOR

[Back to contents page](#)

Next steps in 2025: Integrated Care Board

Action	Lead	Updates	Target date	Outcome measures
1. Continuing to improve staff declaration of protected characteristics.				
Increase the percentage of staff declaring their protected characteristics to 90% within the next two years. This will be done by: <ul style="list-style-type: none"> Enhancing staff understanding/trust in declaration process by awareness sessions Adding to induction, work with staff networks & Equality Advocates to share Develop short toolkit 	EDI Team Co-leads: People Team, Organisational Development Team	“One pager” already developed; to use as base for a toolkit / training (depending on staff engagement preferences)	January 2027	By 2027 we will have 90% declaration rates of all protected characteristics
2. Improve the representation and experiences of Global Majority staff				
We will build a programme of work to ensure that our leadership teams are representative of the communities we serve in the next two years and have a positive experience at work. This will be done by: <ul style="list-style-type: none"> Continuing to deliver and monitor the NHS workforce race equality standard (WRES) ensuring we improve on metrics year on year Delivery of a reciprocal mentoring programme Delivery of the System Anti-Racism Framework Creating an inclusive talent management strategy 	EDI Team Stakeholders: Staff network, People Team, Organisational Development Team	System anti-racism framework being finalised by March 2025	March 2025 - 2028	By 2028 our workforce will be representative by ethnic diversity . Our WRES scores will show positive experiences for Global Majority staff
3. Create a positive and inclusive culture.				
We will continue to enhance workplace inclusivity and belonging, so all our staff feel valued and respected. We will do this by: <ul style="list-style-type: none"> Delivering a series of awareness sessions across the year highlighting diversity e.g. Black History Month, LGBT History Month Achieve 50% staff participation: improvement in Org. culture metrics on NHS Staff Survey at end of 2025 Empowering staff to understand / actively challenge microaggressions using the microaggression toolkit Develop training conversations for Toolkit Continue to support our equality staff networks to have a voice in decision making and raise issues with senior leaders 	EDI & Organisational Development Teams	Toolkit in place	March 2025 - 2026	Delivery of 6 awareness sessions covering various diversity areas Improved participation rate on staff survey Improved staff survey results by Protected characteristics Delivery on an annual EDI conference Empowered, supported staff networks



Next steps in 2025: Integrated Care System

1. Launching and delivering our Anti-Racism Framework.

- Collaborative design across the System, including Senior Leaders, EDI Leads and Staff Network members
- Formal agreement to participate by Chief Executives of our System organisations
- Regular collaboration opportunities for EDI Leads to deliver measurable workstreams via our Anti-Racism Alliance and EDI Professionals Network
- Accountability for embedding the Framework held via our ICP

2. Working with System organisations to support their analysis and submission of Ethnicity Pay Gap data and improvement plans where required in 2025-26.

- Regular check-in points through EDI Professionals Network
- Sharing best practice on our FutureNHS Platform

3. Collaboration to organise, promote and deliver 2025 EDI Conference.

- Gathering key stakeholders for design, development and delivery of the Conference
- Understanding the learning opportunities from 2024 EDI Conference
- Leveraging data from across the System to understand key themes for 2025
- Designing Conference title, aims and objectives, and timetable of events
- Supporting design and delivery of virtually delivered educational webinars
- Working with local providers to arrange and deliver a final in-person event at the end of the timetable



Equality, Diversity, and Inclusion

Annual Report

Part B: EHRC Monitoring Project

& NHSE Priorities

Case Studies Report

1st April 2024 to 31st March 2025



Contents

Background	3
Introduction.....	3
The inappropriate detention of people with Learning Disabilities and Autism	4
The disproportionate detention of people from ethnic minorities under the Mental Health Act	5
Ethnic disparities in maternity care.....	6
Race equality in NHS recruitment and retention.....	7
LGBTQ+ Healthcare	8
AI & Digitisation	9
NHS England Priorities	10
Sexual Safety in Healthcare.....	10
Additional EDI Workstreams across the ICB and ICS	11
EDI Improvement Plan.....	11
1. Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.	11
2. Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.	11
3. Develop and implement an improvement plan to eliminate pay gaps.....	12
4. Develop and implement an improvement plan to address health inequalities within the workforce.	13
5. Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff.....	14
6. Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.	14
Next steps in 2025.....	15



Background

This document is Part B of Frimley Integrated Care Board’s “EDI Annual Report”. It aims to demonstrate how organisations across the Frimley Integrated Care System (ICS) collaborate to improve inequalities identified in the [Equality and Human Rights Commission \(EHRC\) Monitor \(2023\)](#).

The key areas identified by the EHRC Monitoring Project were:

- [Inappropriate Detention of People with Learning Disabilities and Autism](#)
- [Disproportionate Detention of People from Ethnic Minorities under the Mental Health Act](#)
- [Ethnic Disparities in Maternity Care](#)
- [Race Equality in NHS Recruitment & Retention](#)
- [LGBTQ+ Healthcare](#)
- [AI & Digitisation](#)

Additionally, NHS England have launched its [Sexual Safety in Healthcare Charter](#). NHS Frimley ICB and its’ partner NHS organisations have committed to this Charter, and an update of our progress against this is contained within this report.

Introduction



Frimley Integrated Care System covers five main ‘Places’: **Royal Borough of Windsor and Maidenhead**, **Slough**, **Bracknell Forest**, **Surrey Heath** and **North East Hampshire and Farnham** (comprising Hart, Rushmoor and Waverley Local Authority Districts).

Data used in this report for our population is taken from submissions given by our NHS partner organisations.

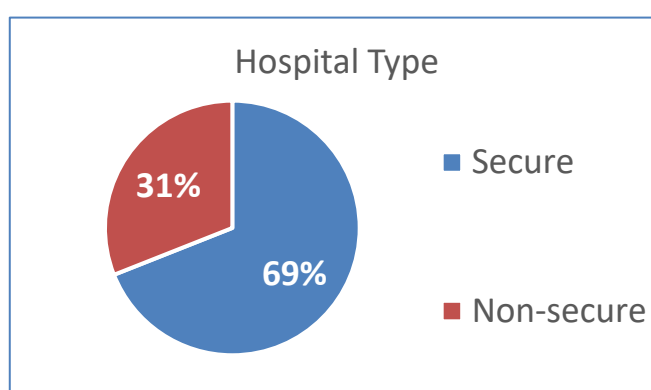
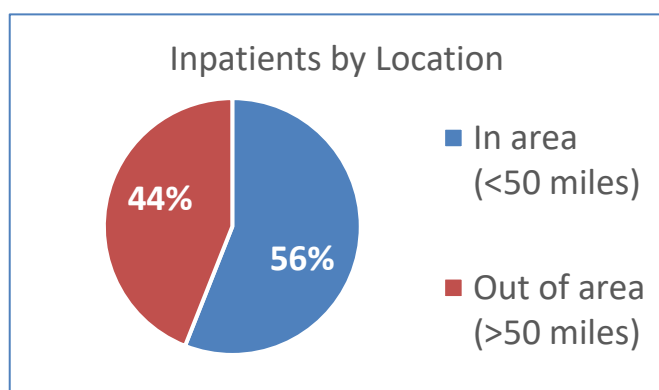
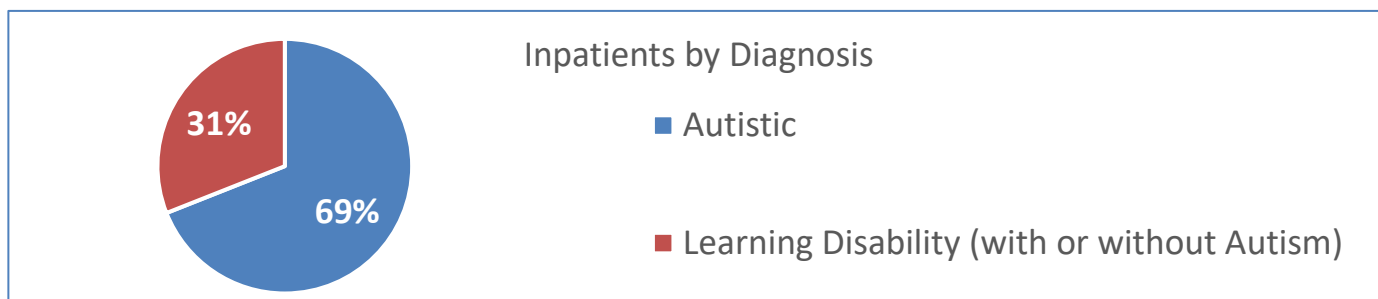
For information on how we are meeting our Public Sector Equality Duty, please read Part A of this Annual Report [here](#).

For information on our population & workforce, please read Part C of this Annual Report [here](#).



The inappropriate detention of people with Learning Disabilities and Autism

NHS Frimley comply with regulatory requirements to report data on inpatients with Learning Disabilities and/or who are autistic, and working to reduce and maintain our inpatient numbers below NHSE trajectories.



Frimley ICB’s Learning Disability and Autism (LDA) Programme has an operational team consisting of an Inpatient Oversight Lead, a Dynamic Support Practitioner, and a Care, Education and Treatment Review.

There are several workstreams to prevent inappropriate admissions to mental health settings, and also to reduce the length of stay for anyone who does need admission for assessment and/or treatment:

1. Frimley ICB hold the East Berkshire Dynamic Support Register (DSR) which operates on a needs-leds, rather than diagnostic-led, basis. Other DSRs nationally require someone to have formal diagnosis of autism and/or learning disability to access DSR input.
2. BHFT have an Intensive Support Team, who work with adults with Learning Disabilities in the community. Frimley ICB’s LDA staff meet with the IST weekly to discuss patients who may require DSR input and to support timely discharge from our local inpatient facility.
3. There are monthly Dynamic Support Forums with Local Authorities and CAMHS to ensure that children and young people who are at risk of inpatient admission have their needs meet using a proactive and multi-agency approach in the community.



4. There has been an ongoing piece of work with our local inpatient facility to improve standards of care for autistic inpatients, including staff training, environmental assessments and adaptations to suit the sensory differences of autistic patients.
5. 8-weekly Commissioner Oversight visits to all inpatients who are autistic and/or have a learning disability in Mental Health wards from East Berkshire, working closely with our neighbouring ICBs and local providers who oversee inpatients with a GP in North East Hampshire, Farnham and Surrey Heath.

Close Multi-Disciplinary Team working by the ICB's DSR and Section 117 team to facilitate complex discharges into appropriate long-term placements, with appropriate oversight via the DSR to ensure that people settle into their homes in the community.

[Back to contents page](#)

The disproportionate detention of people from ethnic minorities under the Mental Health Act

In the year to March 2023, National Government Ethnicity Facts and Figures showed Black people were almost 3.5 times as likely as white people to be detained under the Mental Health Act. This is 228 detentions per 100,000 Black people, versus 64 per 100,000 white people.

Focused work is being undertaken at Berkshire Healthcare NHS Foundation Trust to understand why there is an overrepresentation of Black people being detained in Berkshire and work towards reducing this. Collaboration between the Trust, Thames Valley Police, Approved Mental Health Practitioner, Grassroot community organisations, People with Lived Experience and their carers are reviewing access, experience and pathways. This aligns with the Trust's Anti-Racism strategy to rebuild trust with the community they serve.

The main aims of this work are:

1. Reduce detention rates (including re-detention) of Black people in Berkshire
2. Research and analysis
 - Reviewing existing studies on this issue
 - Examining patient records to understand treatment paths and outcomes
3. Mapping services
 - Creating a map of all Mental Health services across Berkshire
 - Understand whether services are physically accessible for patients, families



and friends

- Building a better network of Mental Health services including Voluntary organisations

4. Developing Advanced Choice Documents which details the Care Plan and wishes of the patient and carers – “If I become unwell, try these things before I’m detained”

5. Encouraging closer collaboration between Advanced Mental Health Practitioners and the Police, strengthening two-way support between professionals.

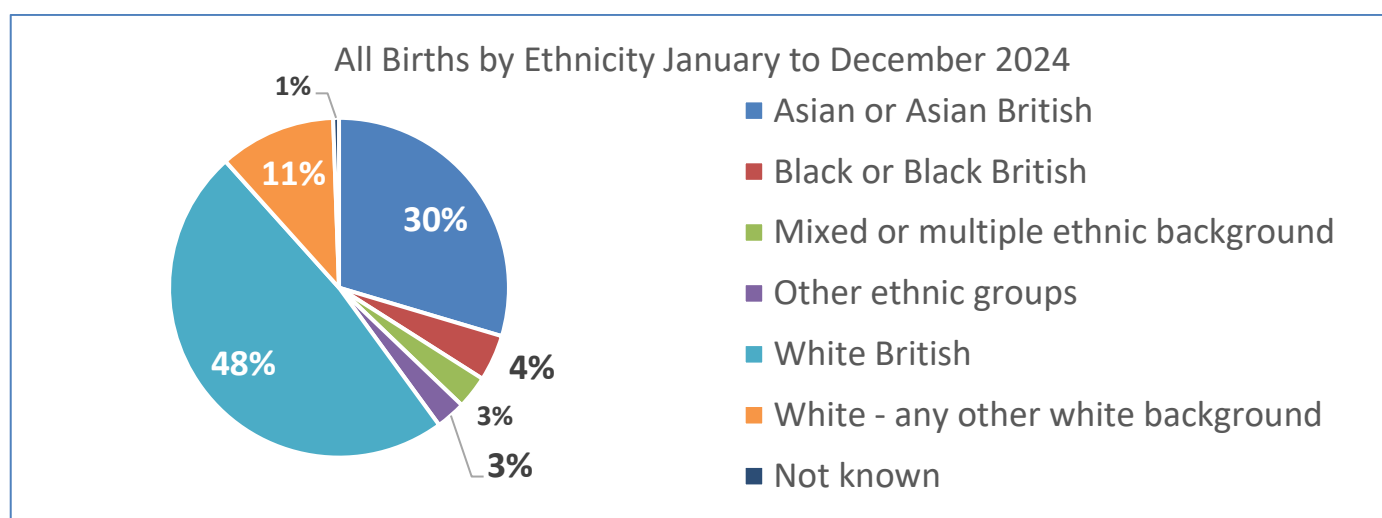
This work is in early stages but will be evaluated throughout its’ delivery and on completion of the project.

[Back to contents page](#)

Ethnic disparities in maternity care

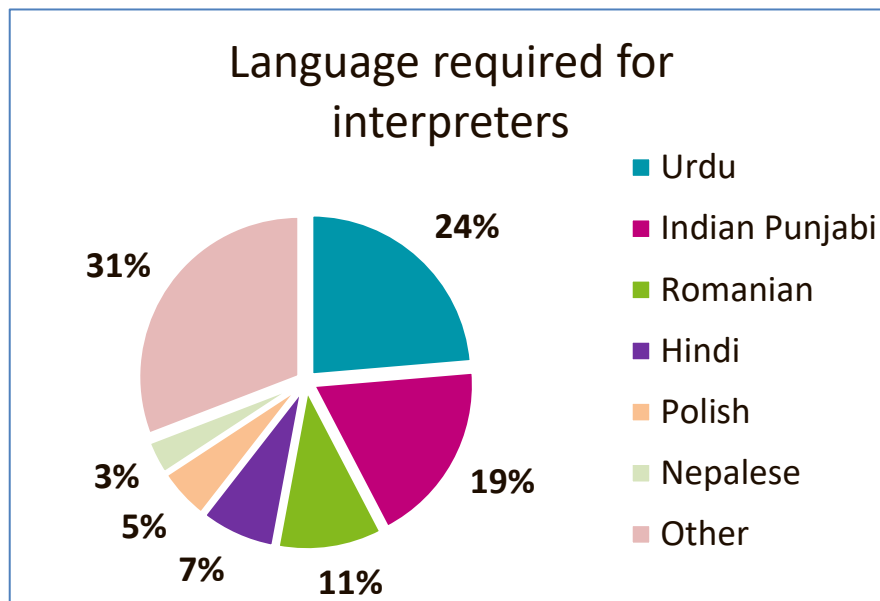
While many women and babies experience excellent personalized care, it is clear from independent reports that not all do. The Frimley Local Maternity and Neonatal System (LMNS) is working to deliver the Perinatal Equity and Equality 5-Year Plan to better understand the experiences of maternity service users and address barriers they are facing to obtain equitable care.

The LMNS have been progressing four main workstreams: Translation and Interpreter Services, Perinatal Mental Health, Preconception and Early Antenatal Education and Workforce. This report provides an update on Translation and Interpreter Services to demonstrate how we are addressing ethnic disparities in maternity care.





Local data shows that language barriers are associated with poorer outcomes. This is also demonstrated in Heathwatch England’s 2022 report “Lost for Words”.



The LMNS has progressed initiatives to accelerate awareness and use of interpreting services with our staff. This includes:

- Helping staff to identify when someone may benefit from interpreting services
- Considering booking the interpreters in advance of appointments.

This is particularly effective in the Antenatal Clinic.

Education has been delivered to staff to reinforce that interpreter services should be offered to service users, even if someone speaks conversational English due to the complexities of medical terminology. In cases where an interpreter has not been booked, or has been declined by the person, language cards with key phrases in English and the respective language have been developed. In addition, the LMNS team have supported the development and delivery of antenatal education classes in Nepali and Urdu in Aldershot and Slough, respectively.

We are keen to see the outcomes of these initiatives over the coming year, and will share learning from these initiatives in future reports.

[Back to contents page](#)

Race equality in NHS recruitment and retention

NHS Frimley ICB developed and released an Inclusive Recruitment Toolkit (the Toolkit) in September 2023. This document was compiled best practice available online and was then collaborated upon by staff from across our networks. Our commitment to embedding this work was demonstrated by its’ implementation during the ICB’s “Change Programme” restructure in 2024.

The Change Programme saw some job roles removed, while others were updated to reflect the needs of our local services and community. A number of our workforce had to compete at interview for roles in this new structure.

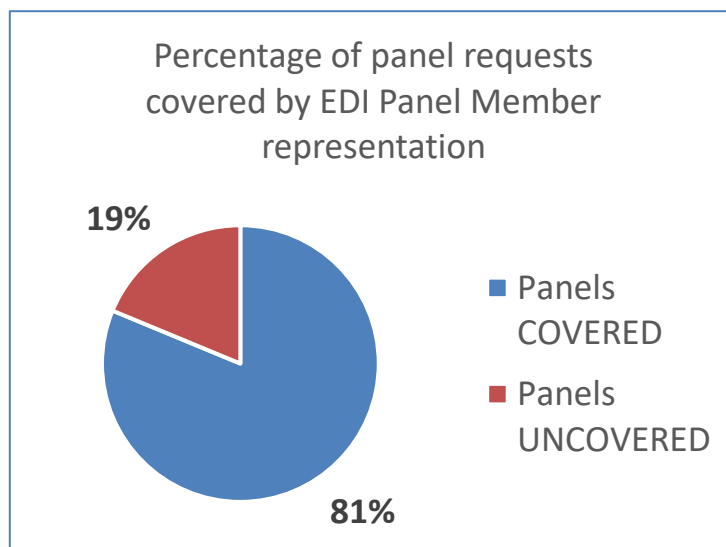
We ensured that colleagues in our People Team were confident with the content of the Toolkit. It was included in guidance for panel members and shared with all



recruiting line managers prior to their roles being advertised, shortlisted and interviewed for.

A new process was developed, allowing managers to contact the EDI Team and request an EDI-trained interview panel member for each of the roles being interviewed for. The EDI representatives were full members of each interview panel.

During this process, 64 requests were made for a panel member. We were able to ensure that 81% of all panels had an EDI-trained member attending. Colleagues across the ICB valued an EDI expert on the panel, welcoming the knowledge and feedback in evaluation and selection processes.



The impact of this work could be seen in the feedback given by people who had been interviewed. This included:

- Feeling valued and more calm “seeing someone like me on the panel”
- Feeling that the process was more fair and that bias would be challenged
- Opportunities for outstanding candidates who weren’t successful to be highlighted to our People Team for further support in gaining employment with the ICB

Since the completion of our Change Programme, we have continued the model of advocating having EDI-trained panel members at interviews.

[Back to contents page](#)

LGBTQ+ Healthcare

The 2021 Census states that the Frimley System is home to over 21,600 LGBTQ+ people. This is 2.7% of our population. We continue supporting this community in a number of ways:

Supporting our adult LGBTQ+ community

Frimley continues to benefit from community-level peer support groups that are run by Thames Valley Positive Support and SupportU. These groups continue to liaise with health and social care providers if feedback around services is received. Thames Valley Positive Support are further delivering educational sessions to some System organisations. Topics usually include an overview to the LGBTQ+ community and their experiences, and/or HIV services that they also provide.



Supporting our LGBTQ+ children and young people

Frimley has continued strengthening its' offer for LGBTQ+ Children and Young People (CYP). There are youth peer support groups and family-oriented groups running across our System through Brighter Futures Together and SupportU. We have introduced staff from Brighter Futures Together and Thames Valley Positive Support, as the two organisations support people in and around Slough. They have designed informal pathways for CYPs who are at the age of moving up into adult services, so that their peer support networks do not erode or suddenly change. We are optimistic that this arrangement will provide effective support when it begins being used, and will monitor its' progress.

PRIDE

Frimley System are developing trust in local communities and seeing them flourish! Despite being the second smallest System in the UK, we are proud to host 4 different pride events in our geography. These occur in Burnham, Windsor and Eton, Bracknell and Rushmoor. Each event is community led and Frimley endeavors to ensure attendance by Health and Social Care organisations if the event organisers would like them present.

[Back to contents page](#)

AI & Digitisation

The Wavelength Leadership Programme, delivered by Frimley Academy, plays a key role in fostering system-wide digital transformation. This five-month programme develops the skills, mindset, knowledge, and relationships needed to drive integrated digital innovation. It brings together frontline clinical, operational, and digital staff across all levels of experience and sectors, including providers, commissioners, community organisations, voluntary services, local authorities, police, fire, and ambulance services within Frimley ICS.

One thing we have introduced in the previous few cohorts has been digital demonstrations (Digi Demos), which showcase best practices in digitisation that have already been successfully adopted by others. An example is the automation of workflows through intelligent processes—demonstrated by Chris Johnson-Idan (BHFT from Cohort 5 and Rob Sweetman (West Berks Council) from cohort 8—which align with broader digitisation efforts. Additionally, the Connected Care digital immersions on Day 2 of the programme highlight real-world applications in public health data, data analytics, patient-facing technology, and patient records. Guest speakers such as Ed Williams (Connected Care Clinical Lead & GP), Lalitha Iyer (Chief Medical Officer, NHS Frimley) and Imran Qureshi (Deputy Chief Medical Officer, NHS Frimley) have further contributed insights into digital innovation.

Some participants often come from backgrounds in analytics, EPIC systems, and



UX design, offering valuable peer support to fellow cohort members. Through its collaborative and cross-functional approach, Wavelength fosters a positively disruptive conversation around digital transformation and population health analytics. By empowering leaders—regardless of their technical expertise—to integrate digital and data-driven solutions into their transformation efforts, the programme helps embed a more joined-up approach to digital innovation across the system.

For more information, click here: [Wavelength](#)

[Back to contents page](#)

NHS England Priorities

Sexual Safety in Healthcare

NHS England launched its' Sexual Safety Charter in September 2023. Frimley ICB and its' System NHS organisations have signed up to this in commitment to embedding a zero-tolerance approach to unwanted, inappropriate or harmful sexual behaviours in the workplace.

Each NHS organisation has developed its' own Working Group to identify key initiatives required by the Charter and how they can be implemented locally. This workstream has been discussed, and cross-System collaboration has occurred through discussions and sharing templates in the ICS EDI Leads' "Professionals Network" meetings.

Interventions have included developing eLearning for staff to upskill, Sexual Safety Policies, ensuring robust Governance reporting and supportive processes including links to Human Resources and Freedom To Speak Up Guardians.

Each ICS organisation is at different stages in this workstream. For example, the ICB is currently agreeing and embedding its' Sexual Misconduct Policy based on NHS England's recently published template. As such, the ICB continue facilitating safe spaces when required for the ongoing development of this work. Meanwhile, Frimley Health NHS Foundation Trust have identified ongoing need for work around discrimination and harassment, and have designed a "Protecting Our People" workstream to address incidents and concerns within workforces as well as involving community members.

For more information about work happening in this space, please see the "Eliminating prohibited conduct" section of our document "Annual Report Part A: Public Sector Equality Duty".



Additional EDI Workstreams across the ICB and ICS

EDI Improvement Plan

The Equality Delivery System was complimented by the publication of the Equality, Diversity and Inclusion Improvement Plan in June 2023. This body of work set six High Impact Actions for NHS organisations to address between its' publication date and March 2026. In recognising the duality of this reporting we are showcasing some workstreams that demonstrate our ongoing efforts in this section.

1. Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.

All of the members of NHS Frimley's Board and Senior Leadership team have EDI-committed SMART goals. These are collectively shared so that our Senior Leaders can keep one another accountable to achieving their expected outcomes.

2. Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.

As demonstrated in the section above, Frimley ICB has remained committed to embedding its' Inclusive Recruitment Toolkit through our Organisational Change programme. This saw the toolkit shared with all recruiting managers and EDI trained panel members on interview panels as a matter of routine. This allowed a small number of opportunities for positive action to be identified.

Where staff with protected characteristics were scored a close second for getting the role, their talent was highlighted to our People Team and they were pooled to be offered other suitable roles that may be of interest. This allowed the organisation to retain incredible talent through its' recruitment process and further diversify our workforce.



Frimley Health NHS Foundation Trust are also focusing on this piece of work. They have run Inclusive Recruitment pilots and most recent Workforce Race Equality Standard data shows that they are closing the equality gap, with 48.4% of all staff from Global Majority backgrounds (compared to a 20% average in the south east).



3. Develop and implement an improvement plan to eliminate pay gaps.

Organisations across the System are committed to embedding “so what” thinking after analysing pay gaps. Frimley ICB have identified key stakeholders within our organisation for this work, and have looked through data before and after completion of our Organisational Change programme to establish where inequalities sit for our staff. Now that this has concluded, we are strengthening working between People, Organisational Development and EDI teams, as well as EDI Working Group and Staff Networks, to drive an action plan with SMART goals for gender & ethnicity pay gaps in 2025.

Action	Timescale	Delivery Group
1. Establish a Task and Finish Group (TFG) reporting to EDI Group	April 2025	EDI Group / OD Group
2. Use data from 31/03 to inform action plan into 2025/26 (ensuring actions have clear timescales and benefit realisation – how we are closing the pay gap and how long it may take)	April 2025	Gender Pay TFG
3. Publication of Sexual Misconduct Policy	April 2025	EDI Group / OD Group
4. Review Staff survey data from gender equality perspective and derive actions	April 2025	Gender Pay TFG
5. Roll out OD plan (including inclusive talent strategy) across the ICB	Quarter 1	OD Group
6. Violence and aggression workstream through People Board	Quarter 1	People Board
7. Comparison of ICB’s Gender Pay Gap results with ICB comparator groups	Quarter 2	Gender Pay TFG

FHFT have continued to meet reporting timelines and link their Pay Gap action plans to organisational priorities. Bespoke reports have been commissioned to support work in relation to eliminating pay gaps, and that work continues at the time of writing this report.



4. Develop and implement an improvement plan to address health inequalities within the workforce.

Staff wellbeing is of paramount importance to Frimley ICB. [NHS England](#) mandated that ICB's should firstly work to reduce bullying, increase civility and have a robust approach to all abuse and harassment. We have delivered this by:

Action	Lead	Updates	Date delivered	Outcome measures
1. Developing & embedding a Zero Tolerance Statement.				
<p>Create a clear and concise Zero Tolerance Statement to support staff to challenge bullying, harassment or discrimination, reducing inequalities found in Workforce Race and Disability Equality Standards.</p> <p>This was be done by:</p> <ul style="list-style-type: none"> Initial scoping of other statements publicly available Presenting a variety of findings to the ICB's EDI Working Group, Staff Networks, and Organisational Development Teams. ICS EDI Leads were also scoped into this work for diversity of thought and development. Drafted wording collated and reviewed in the above groups. Finalised wording agreed by ICB's Senior Leadership Team. 	<p>EDI Team</p> <p>Co-leads: People Team, Staff Networks, Organisational Development Team</p>	<p>Our Zero Tolerance Statement is publicly available here and is used throughout our ICB policies and documents.</p>	<p>July 2024</p>	<p>By 2027 we will see an initial uptick and then settling in WRES Indicator 5 & 6 and WDES Metric 4 & 5 reporting, with eventual outcome of less than 0.5% difference between white and Global Majority staff.</p>
2. Developing & embedding a Microaggressions Toolkit.				
<p>Create a clear Toolkit to support staff understanding of what constitutes a microaggression, how to identify them in practice, how to challenge them or escalate appropriately on behalf of oneself or one's colleagues. This was achieved using the same steps as the Zero Tolerance Statement.</p>	<p>EDI Team</p> <p>Co-leads: People Team, Staff Networks, Organisational Development Team</p>	<p>Our Microaggressions Toolkit is available on request by emailing Chey Sparks</p>	<p>Sept 2024</p>	<p>By 2026 we will see an uptick in reported microaggressions via Staff networks and Freedom To Speak Up. Comparatively, this should then decrease incrementally from 2027</p>

We are in the process of designing the ongoing Workforce Health Inequalities plan for 2025-26. It will bring together workstreams already in place, such as our Menopause Café, Wellbeing Champions, and Staff Networks. It will also bring closer working with wider health and social care organisations to reduce health inequalities.



5. Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff.

At present, Frimley ICB doesn't recruit staff directly from other countries. Having said this, we do have a Visa sponsorship route and we support these staff through existing induction, onboarding and development programmes. Staff are also signposted to the organisation's 'B.A.M.E. Network' for professional networking across the organisation and peer support.

If the ICB did recognise a need to advertise internationally, we would link with partner organisations in our geography to learn from and embed their best practice. For example, the System's Allied Health Professionals Team have a Workbook that could be shared (featured in our report last year), and Berkshire Healthcare NHSFT have a staff network where 'buddies' from the same country can be sought to help a member of staff make cultural adjustments in their personal and professional lives.

In addition to their induction, FHFT continues to support their Internationally Educated Workforce with their dedicated recruitment and onboarding team, which includes pastoral support. The team facilitates regular listening events which enable them to stay close to community concerns and questions, answering them in a timely manner and working with staff to resolve tricky issues.

6. Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

Frimley ICB and the wider System recognise that leaders are embedded throughout our organisations. Strong leadership from people in senior positions sets the vision and direction of our System and its' organisations. The Mirror Board members have undertaken reciprocal mentoring with ICB Board members to broaden their understanding of lived experiences and barriers faced by staff from all protected characteristics. For more information about our Mirror Board work, please see "Annual Report Part A: Public Sector Equality Duty".

But work must be done at every level to reduce bullying, discrimination and harassment, and to foster better relations between groups of staff from different backgrounds. To support this, Frimley ICB have trained "Equality Advocates" from across the organisation to act as proactive challenges to poor behaviour and signposting colleagues with poor experiences to appropriate routes such as Freedom To Speak Up, Bullying and Harassment Policy etc. We are also in the process of increasing our cohort of Cultural Intelligence trainers in the ICB and across the System in order to deliver workshops to upskill staff at all levels of our organisations.



Next steps in 2025

The targets for both Frimley ICB and the wider ICS are included in our Public Sector Equality Duty Annual Report, which is [available here](#).



Equality, Diversity, and Inclusion

Annual Report

Part C: Community and Workforce

demographics

1st April 2024 to 31st March 2025



Contents

Contents	2
Introduction	3
Our Communities	4
Age	4
Disability	5
Gender.....	5
Marriage & Civil Partnership	6
Pregnancy & Maternity.....	6
Race & Ethnicity	7
Religion or Belief.....	8
Sex	8
Sexual Orientation	9
Socio-economic vulnerabilities & deprivation	9
Our Workforce.....	10
Age	10
Disability	10
Gender Reassignment.....	11
Marriage or Civil Partnership.....	12
Race	12
Religion or Belief.....	13
Sex	13
Sexual Orientation	14
Pregnancy & Maternity.....	14



Introduction



This document forms part of our Annual Report for Public Sector Equality Duty and Equality and Human Rights Commission.

It looks at the demographics of our health and social care workforce, as well as the population living in Frimley Integrated Care System (ICS). We have looked at these groups by Protected Characteristics, which are set out in the [Equality Act \(2010\)](#).

Our ICS covers five main 'Places': **Royal Borough of Windsor and Maidenhead**, **Slough**, **Bracknell Forest**, **Surrey Heath** and **North East Hampshire and Farnham** (comprising Hart, Rushmoor and Waverley Local Authority Districts).



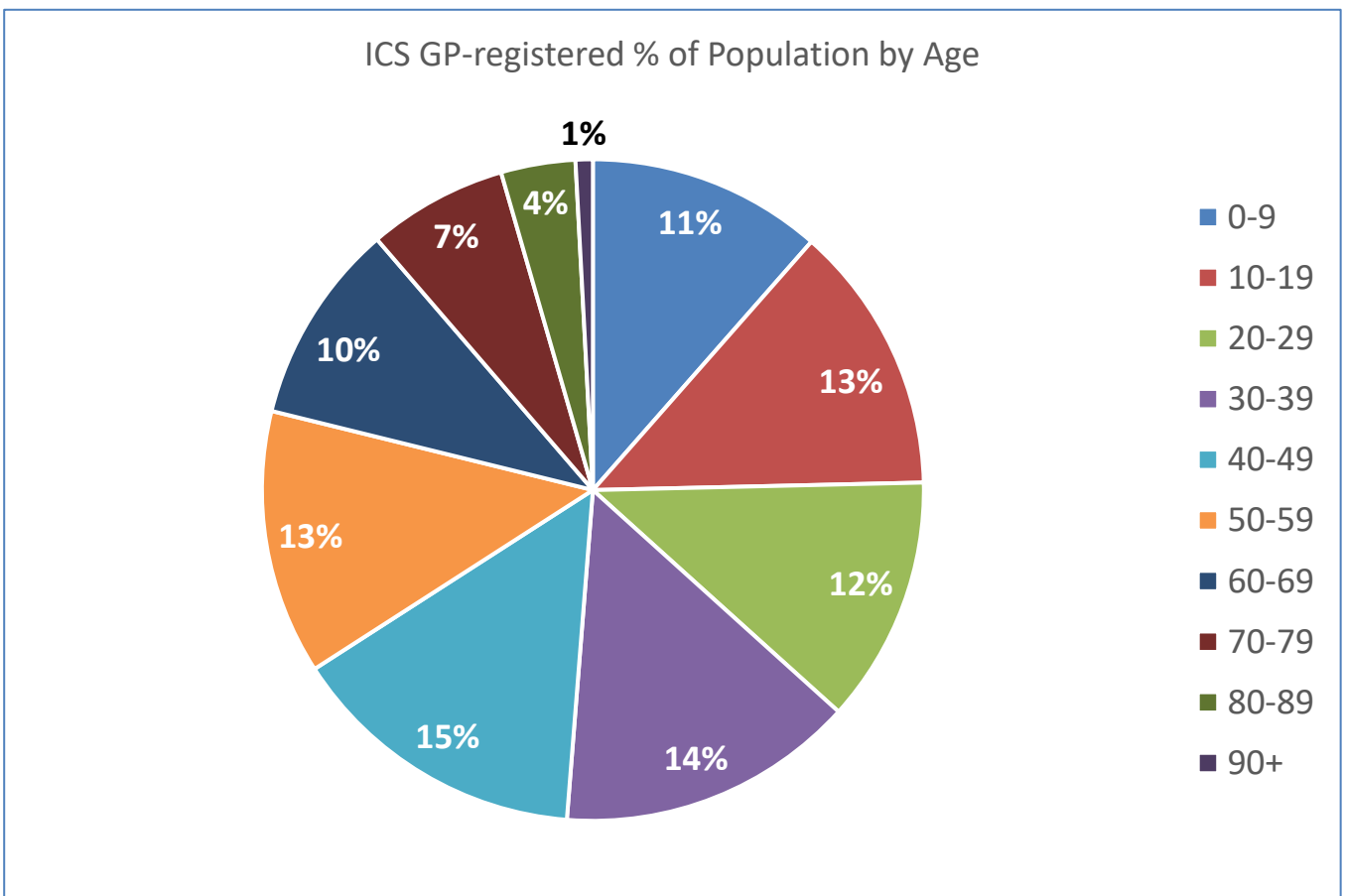
Our Communities

Frimley ICS is privileged to have a bespoke database known as Connected Care. It links information from our General Practice surgeries and other key providers so that we can identify areas of deprivation, or where there are high instances of people living in different protected characteristic groups. For other reporting, the latest (2021) Census data is used.

Age

Data from our Connected Care system shows that:

- Nearly a quarter of our GP-registered population are Children and Young People under the age of 20.
- Our population are distributed fairly equally between the ages of 20 and 59 years.
- We can see a decline in patient numbers from the age of 60 years.
- This trend is consistent with data that was analyzed in January 2024.





Disability

Census data from 2021 shows that:

- 9% of our residential population have declared having a disability that limits their daily activities a little.
- 5% of our residential population have a disability that limits their daily activities a lot.

Frimley ICS Residential Population by Disability Status



Gender

Census data from 2021 shows that 93.5% of our residents state their gender identity is the same as the sex they were registered at birth. Of the remaining 6.5% of our residents, 5.94% chose not to answer the question. The remaining 0.56% of our residents identify as follows:

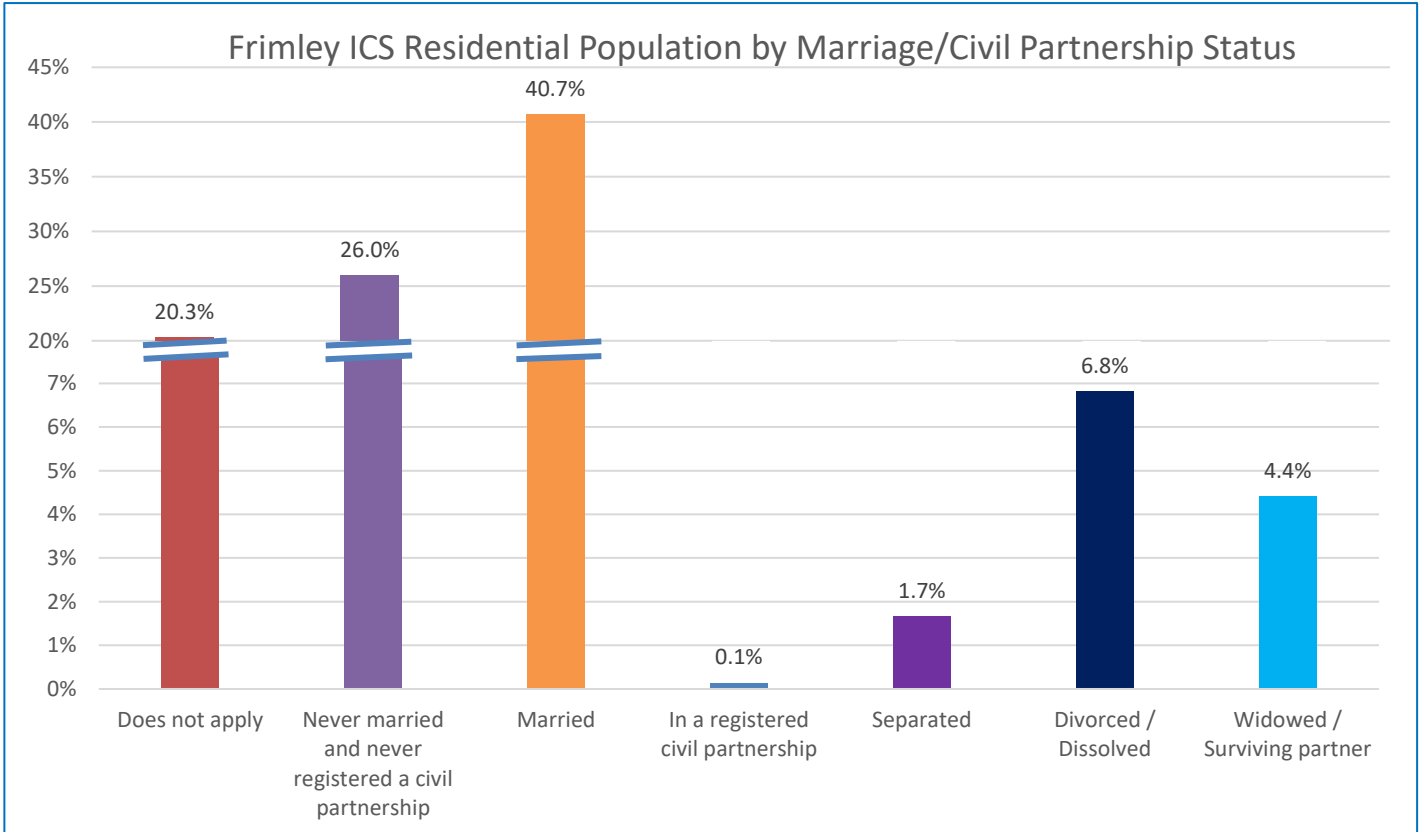
Frimley ICS Residential Population by Gender Identity





Marriage & Civil Partnership

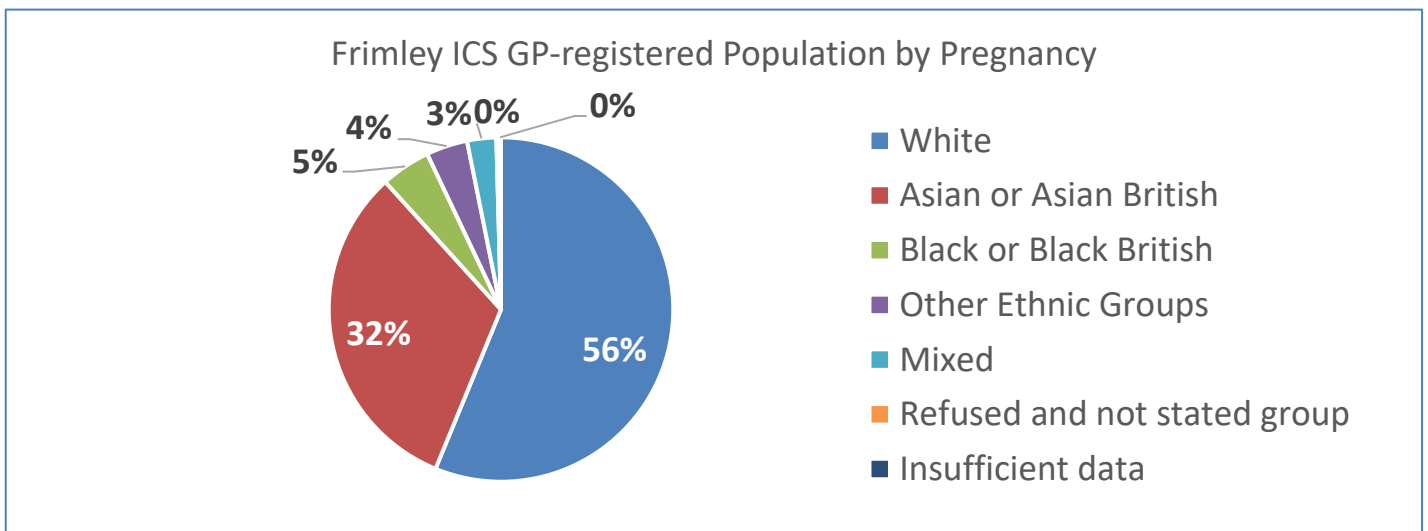
Census data from 2021 shows that most of our residents are married. 26% have never registered a marriage or civil partnership, and a further 20% of our residential population stated that this metric ‘does not apply’.



Pregnancy & Maternity

Connected Care data shows that 1.3% of GP-registered patients are pregnant or have been pregnant within the last 12 months of January 2025.

The ethnicity of our pregnant patients remains similar to 2025, as shown below:



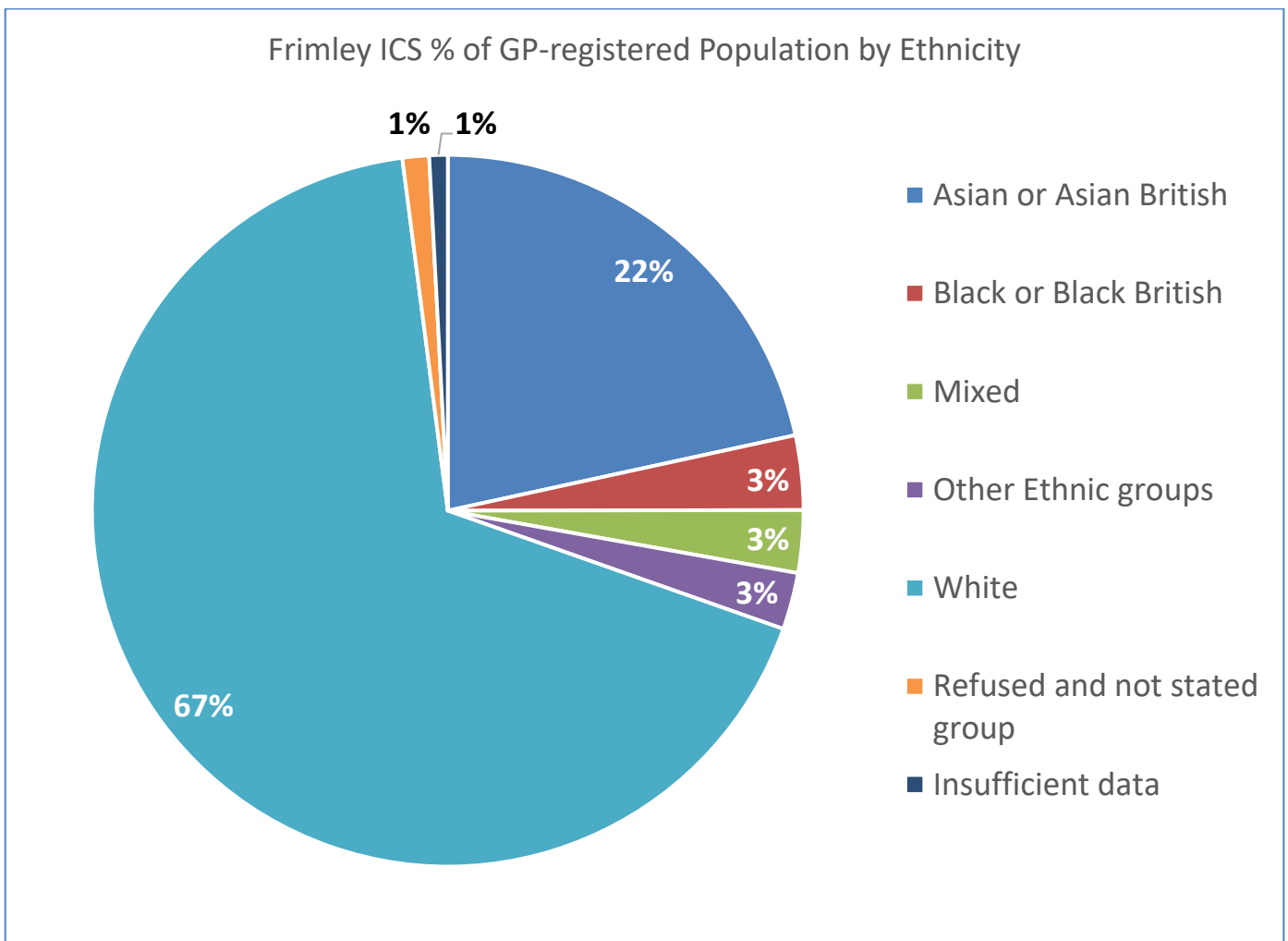


Race & Ethnicity

Connected Care data shows that the majority of GP-registered population of Frimley ICS are white. The pie chart below gives the breakdown of our groups by broad demographics.

Further breakdown shows that our “White British” population have increased from 46.5% in January 2024 to 54% in January 2025. Combining this with our “White and Asian / Black African / Black Caribbean” and “Any other white background” groups increases our overall white population to 67%.

Our next biggest demographic are Asian, who make up just over 20% of our population. This is divided mostly between “Indian,” “Pakistani” and “Any other Asian background”.





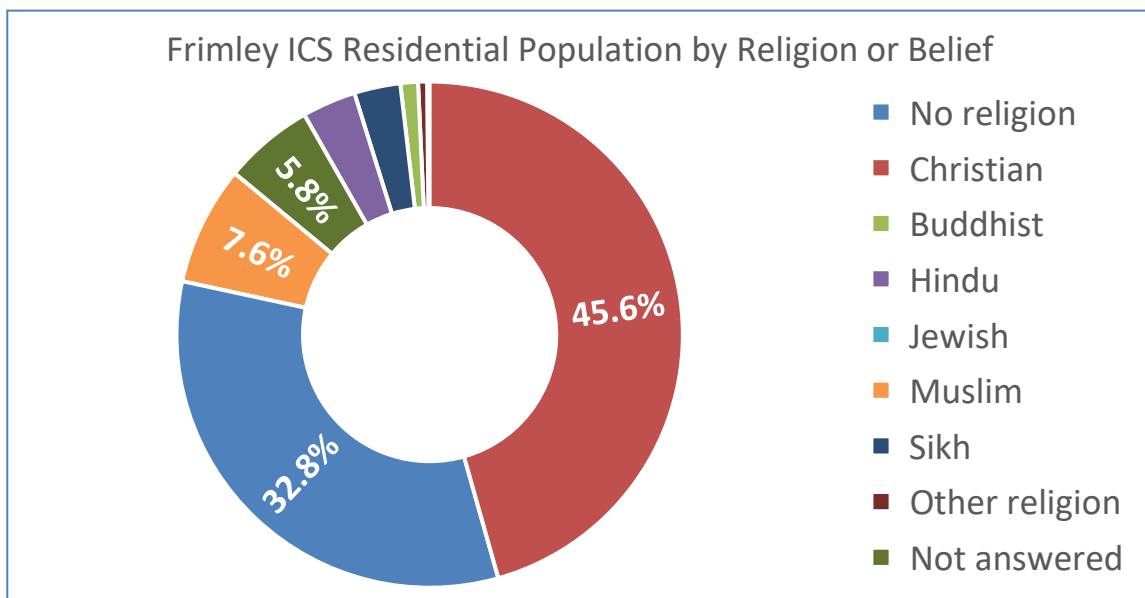
Religion or Belief

Census data from 2021 shows that over 45% of our residential population are Christian, while just under 33% reported having no religion.

We have a higher number of Muslim residents than the national average, and most of this population live in and around Slough.

The majority of our Sikh community also live in Slough, although the opening of a new Gurdwara in Surrey Heath in late 2024 may influence this demographic.

The majority of our Buddhist residents live in Rushmoor.

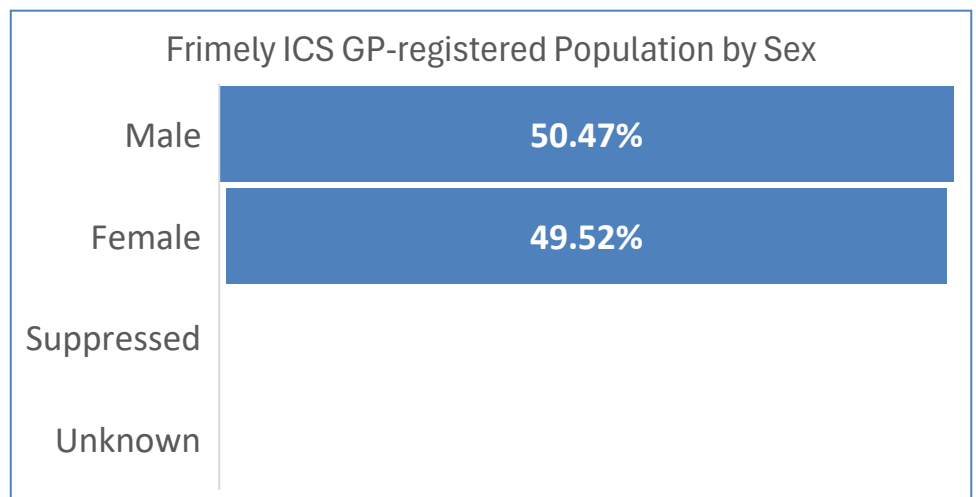


Sex

Data from this year is similar to 2024. We have a higher population of males than females.

Our male population has increased by around 0.04% (about 320 people).

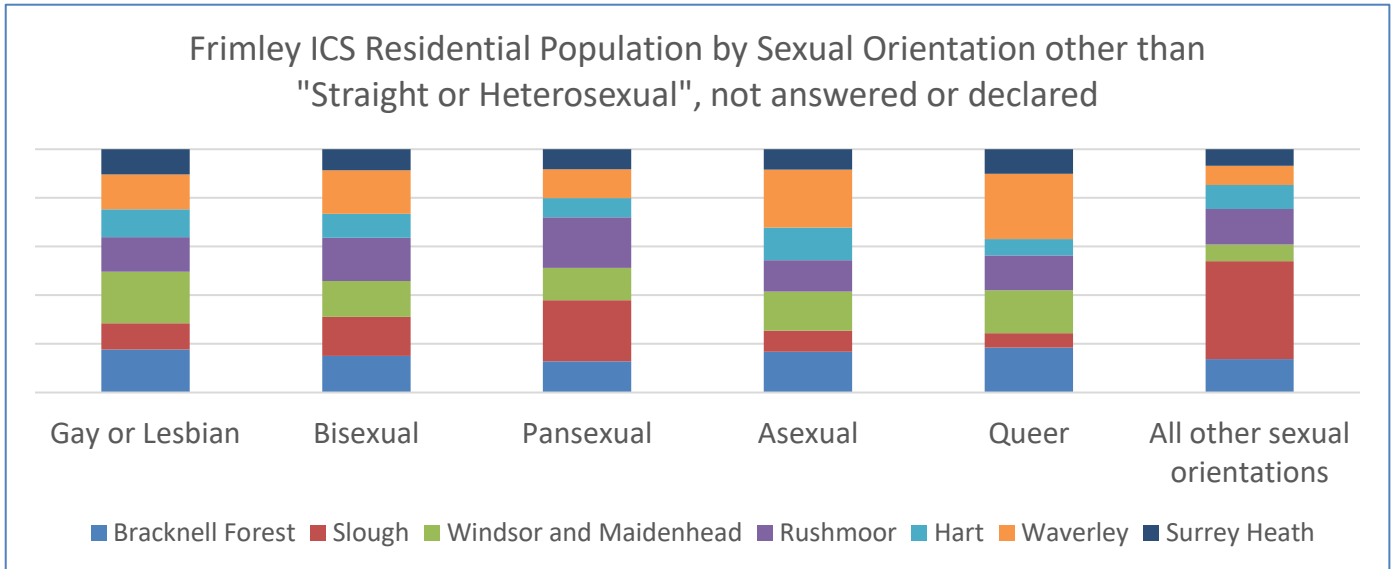
Our female population has decreased by 0.03% (about 240 people).





Sexual Orientation

Census data from 2021 shows that 90% of our residential population are Heterosexual, while a further 7.3% of our residential population did not answer or declare their sexual orientation.

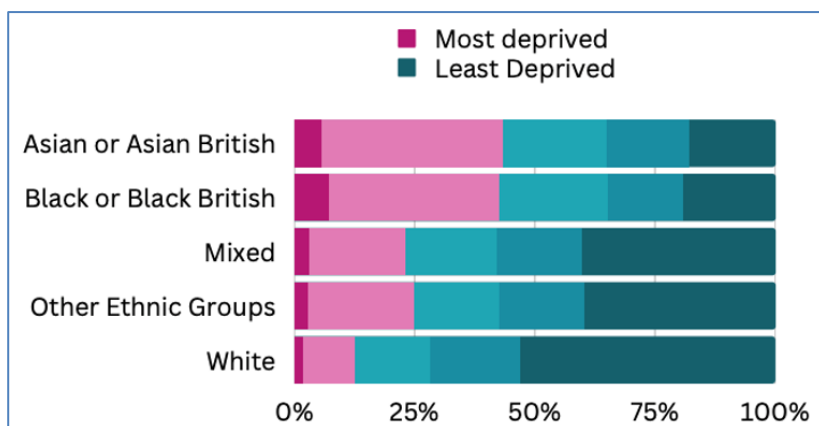


The remaining 2.4% of our residential population identified as above. Our largest demographics in this chart sit within the “Gay or Lesbian” and “Bisexual” categories. Windsor and Maidenhead Place hosts the largest population of people who are not heterosexual, followed by Rushmoor and Bracknell Forest Places respectively.

Socio-economic vulnerabilities & deprivation

Frimley ICS enjoys an internationally diverse population across health and social care. Around 3% of our population live in the most deprived areas of England. Of those living in deprivation, over 30% of residents are from Black, Asian and Minority Ethnicity backgrounds.

Our Gypsy Roma Traveler community are seven times more likely, and our Nepalese community are three times more likely to live in deprivation than our white community.





Our Workforce

In order to remain comparative with last year's report, our workforce data was pulled on 30th January 2025. On this date we had 474 members of staff.

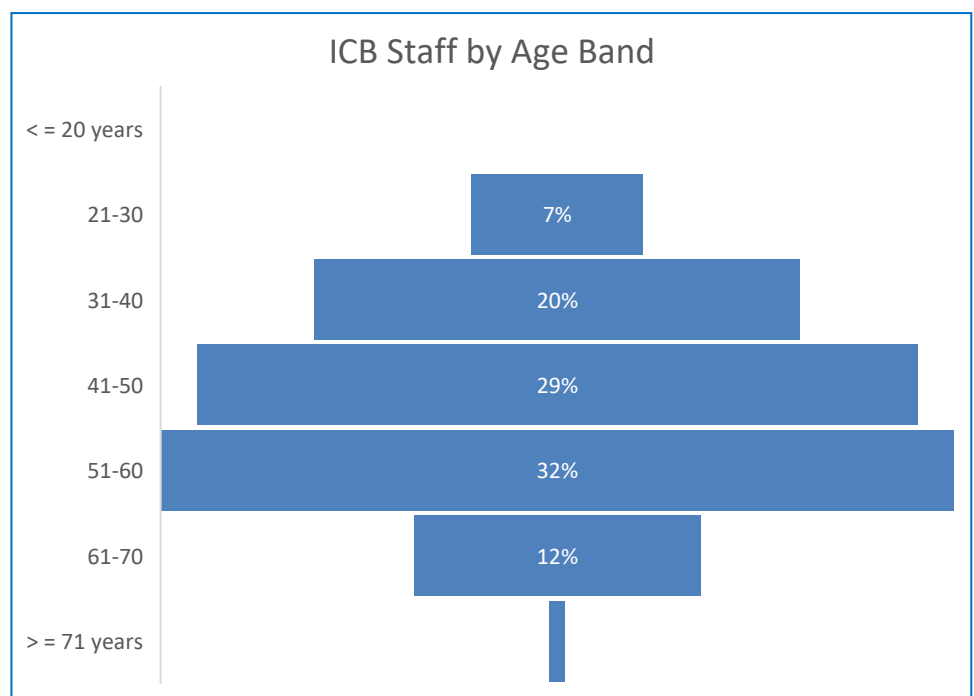
We have segmented the data by protected characteristic, drawing comparisons to last year's report to develop a narrative of our Organisational Change programme

Age

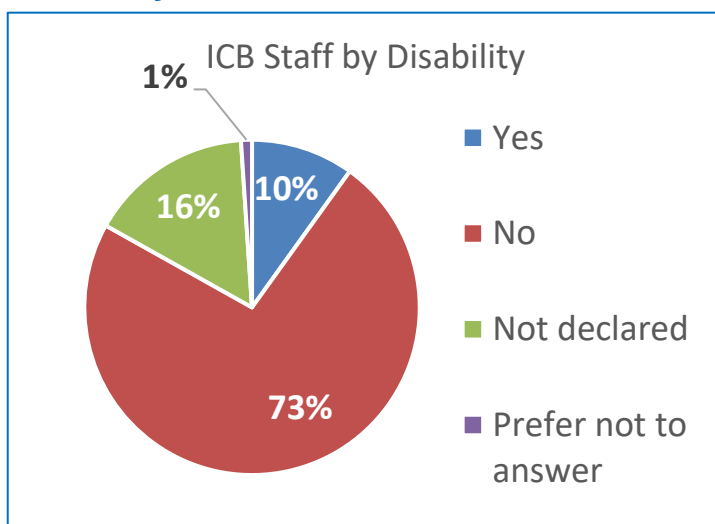
Similarly to last year's report, the majority of our workforce are between 31 and 61 years of age.

We have seen a decrease in the 61-70 age group from 12% to 9%. Note that last year we did not employ anybody aged 71 or older, but this year the group make up 1% of our workforce.

The 31-40 and 51-60 age groups have remained the same, and the 41-50 age group have decreased from 32% to 29%.



Disability



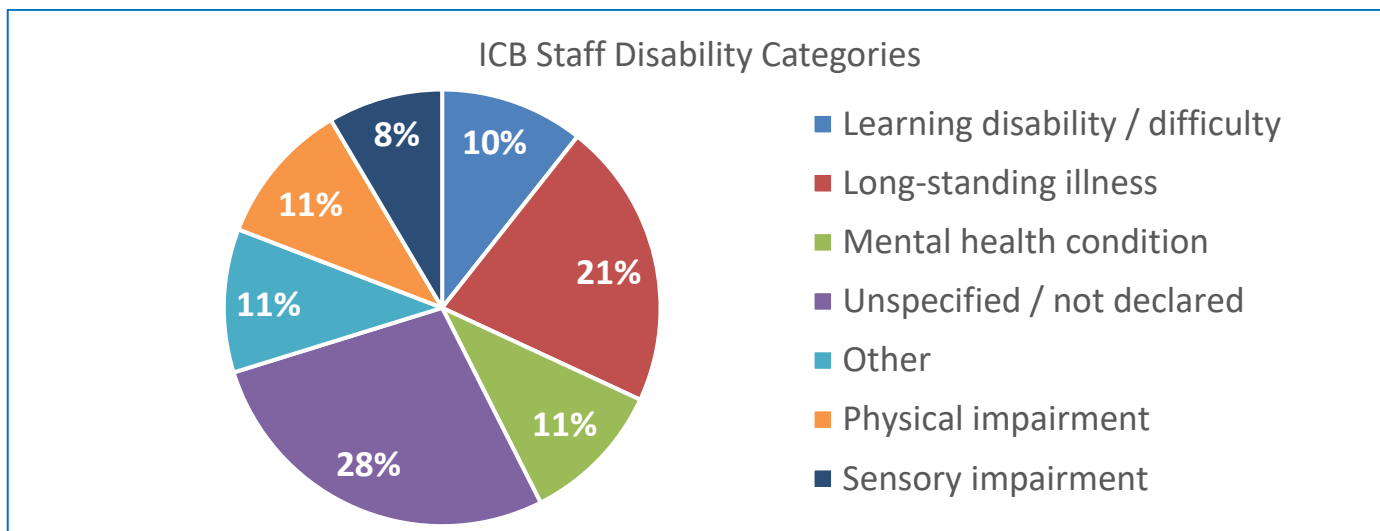
Nearly three quarters of our ICB workforce do not have a disability.

A further 16% have not declared whether they have a disability or not.

We have seen an increase from 7% to 10% of staff stating that they do have a disability.



We are unable to find the cause of this increase from our data. It is possible that new staff being recruited have disabilities. Of staff who remain from our previous report, some may have new diagnoses, while others may feel safer to declare due to ongoing work to raise awareness by our EDI Team and Disability Staff Network, which has included educational webinars and developing a staff passport.



More of the staff who declared disabilities have specified what this means for them. Our “unspecified” group has dropped from 38% to 28%. The only other group to have reduced is ‘Physical Impairment’ (orange on the chart) – which was 19% of our workforce last year.

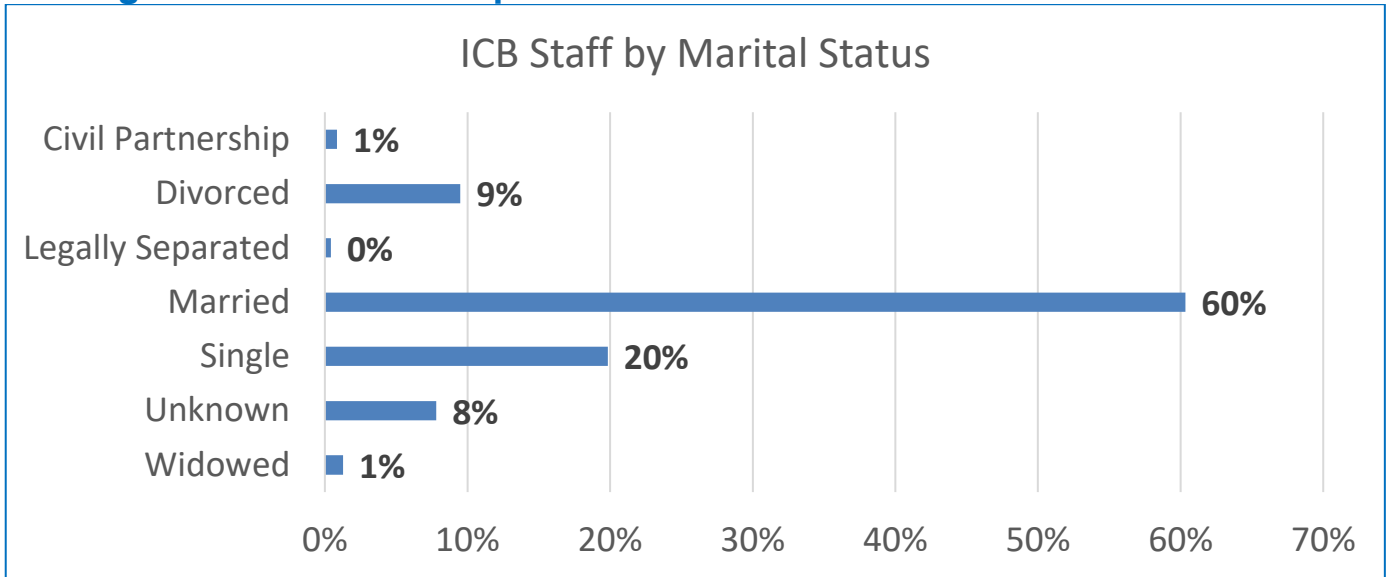
All other categories have increased since last year. The biggest increase is in ‘Long-standing illness’ from 16% last year to 21% this year. Another notable increase is in ‘Other’ which has increased from 6% last year to 11% this year. This could be as they are non-specific ways of giving information about a disability.

Gender Reassignment

The data collected in our Electronic Staff Record (ESR) continues not to report gender outside of the male/female binary. It prevents us from understanding the full makeup of our workforce. It also prevents us from understanding how we can attract talent from this protected characteristic group to come and work with us. This has been escalated to NHS England through EDI and National LGBTQ+ Staff Network channels.

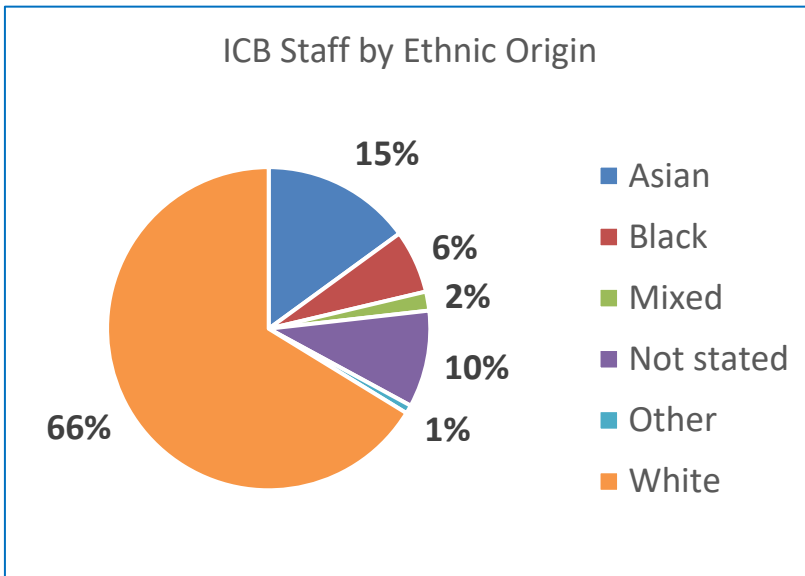


Marriage or Civil Partnership



The majority of our ICB staff are married, and around 30% of our staff are single, divorced or widowed. This is consistent with last year's data.

Race

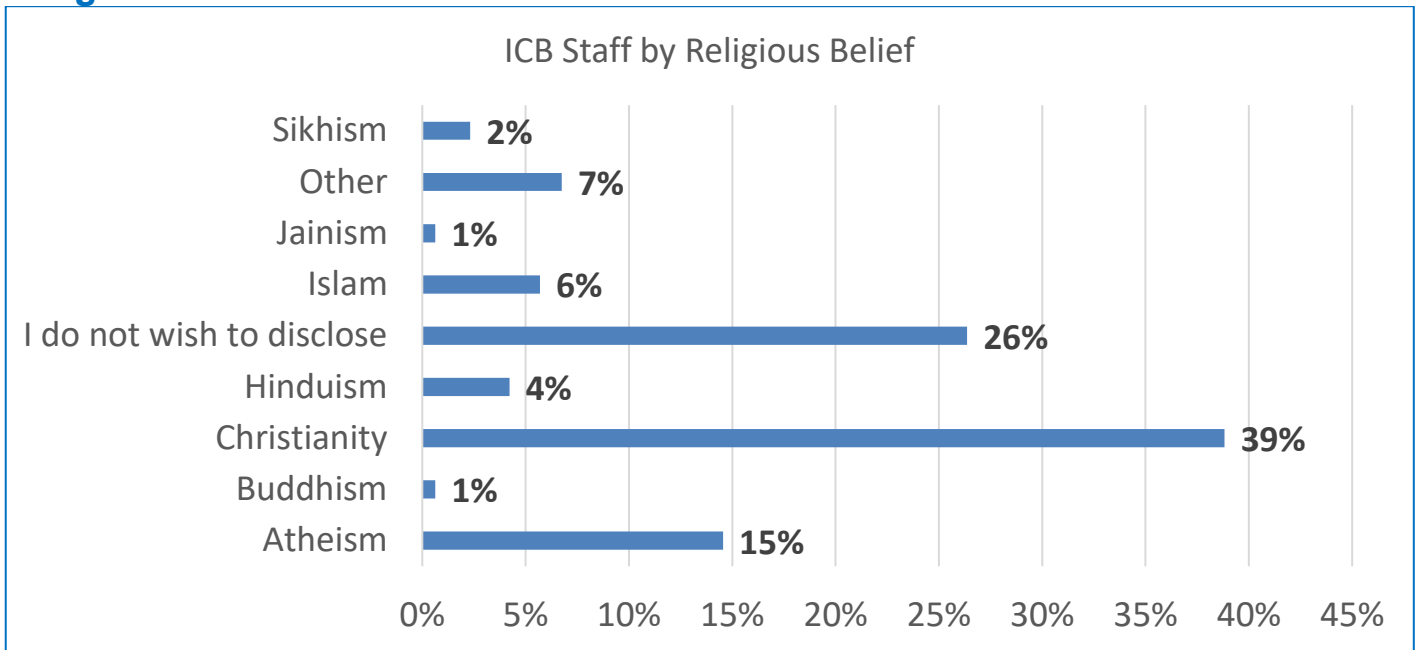


This year our data shows that 66% of our workforce are white. This is increased from 59% last year. We have also seen lesser increases in Asian (14% to 15%) and Black (5% to 6%) of our workforce.

Less staff are choosing 'Other' or 'Not stated' as options, which may infer more trust in how data is being used to inform the ICB's EDI strategy, aligned with our Anti-Racism Alliance work.

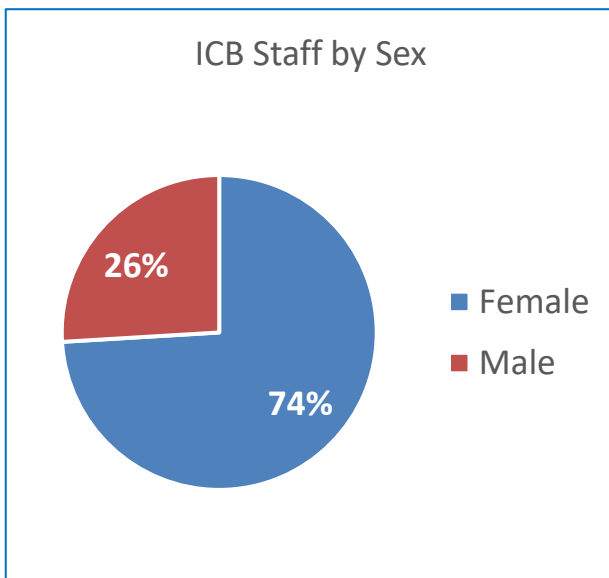


Religion or Belief



Similarly to last year, the majority of our staff are Christian. This group has increased from 31% to 39%. Our second highest group are those who prefer not to disclose. We have roughly the same amount of staff who are Muslim, Hindu, Jain, Sikh or Buddhist; they make up around 14% of our workforce. The percentages of staff who follow other religions, or who are Atheist, remain similar to last year.

Sex



The ICB continues to be a female dominated organisation, although the percentage of males has risen by 2% since last year.

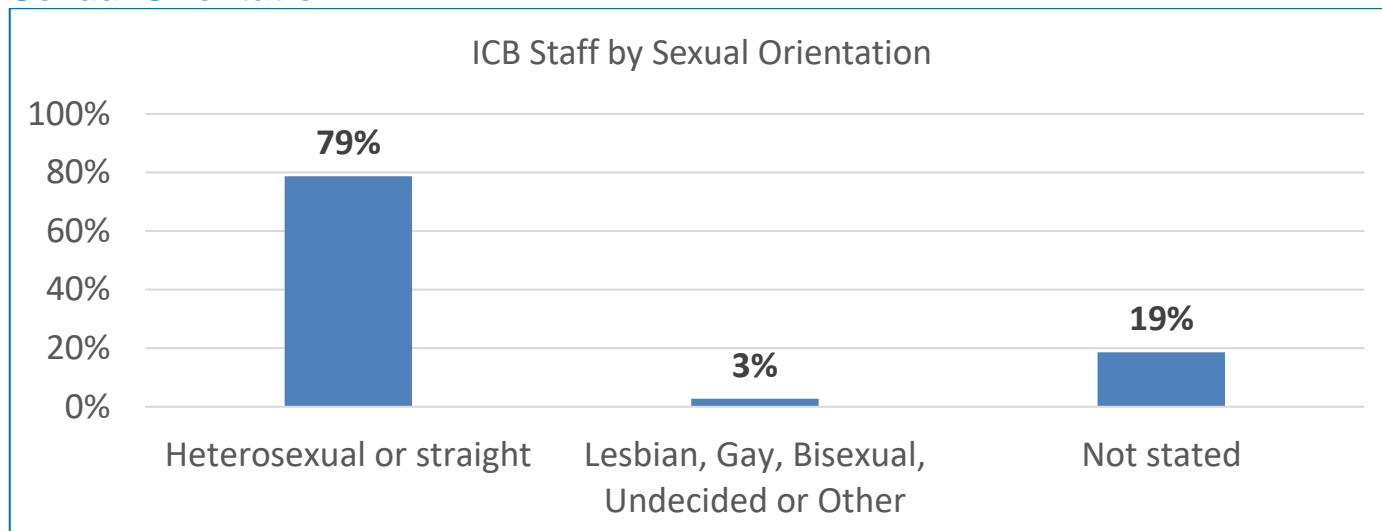
When looking at the split of gender and contract type in the table below, we can see that there is a slight increase in women working full time, with a decrease in working part time.

The percentage of men working part time has remained the same, while the amount of men working full time has increased slightly.

	2024			2025		
	Total	Part Time	Full Time	Total	Part Time	Full Time
Female	76%	28%	48%	74%	25%	49%
Male	24%	8%	16%	26%	8%	18%



Sexual Orientation



We have made positive improvements for this protected characteristic group. The percentage of ‘Not stated’ has dropped from 25% to 19%. Of those who have declared, we have seen an increase from 69% to 79% of heterosexual staff.

Our LGB+ community have increased from 1.7% to 3%. It is uncertain whether this is because existing staff have felt safer to disclose their orientation or if we have recruited new staff from this community. This is particularly noteworthy as we are now aligning with the 2021 Census data that states around 3% of the UK population are in this community.

Pregnancy & Maternity

At the point of our data collection, 2% of our ICB staff had their assignment status listed as “Maternity & Adoption”. This is consistent with last year’s report.

NHS FRIMLEY
WORKFORCE RACE EQUALITY STANDARD (WRES)
ACTION PLAN 2024



Contents

Introduction	4
NHS Frimley as an organisation	5
Workforce Data March 2022*	5
Workforce Data September 2023*	5
Frimley’s community	6
NHS Frimley Population by Ethnicity 2022	6
NHS Frimley Population by Ethnicity 2024	7
Comparing NHS Frimley’s workforce (2023) with our community (2024).....	8
Governance	8
Indicator 1	9
Non-Clinical Staff by %	9
Clinical Staff by %.....	10
Clinical Staff by %: Medical & Dental.....	11
Percentage differences between all ICB staff	11
Indicator 2	12
2022.....	12
2023.....	12
Indicator 3	13
Indicator 4	13
Indicator 5	14
2022.....	14
2023.....	14
Indicator 6	15
2022.....	15
2023.....	15
Indicator 7	17
2022.....	17
2023.....	17
Indicator 8	18
2022.....	18
2023.....	18
Indicator 9	19
Action Plan	20

Appendices.....

Introduction

The NHS Workforce Race Equality Standard (WRES) is a national standard for NHS Trusts and Integrated Care Boards (ICBs) to provide data against 9 indicators. As with all other protected characteristics, tackling inequality for NHS Frimley's Black, Asian and Minority Ethnic (B.A.M.E.) staff is essential to ensure that we support, nurture, and develop our people and enable the community within NHS Frimley to thrive in a safe and inclusive environment.

In its second year as an Integrated Care Board, NHS Frimley's Chief Executive, Chief Operating Officers and Directors remain committed to creating a safe and equitable environment that recognises the diversity of our staff and population.

This WRES Action Plan forms part of NHS Frimley's commitment, playing an integral part in our B.A.M.E. Staff Network, our Organisational Development and People Plan and our Equality, Diversity and Inclusion Strategy. The data reported here is from 1st April 2023 to 31st March 2024.

This Action Plan:

- Describes where we are now as an ICB, including:
 - Framing our workforce alongside our WRES and Staff Survey results,
 - Identifying our B.A.M.E. Network as an exemplar to other networks and parts of the organisation,
- Provides focus on our key areas of improvement, including:
 - Strengthening accountability for delivery of the WRES Action Plan in NHS Frimley,
 - Considering how we support, nurture and develop staff within protected characteristic groups,
 - Strengthening and increasing action on tackling workforce inequalities focussed on structural, institutional, and interpersonal change,
- Identifies which actions will be carried forward,
- Sets expectations of our achievements and details our success measurements by June 2025, and
- Details how we will achieve these actions.

This document uses the term "BME" (Black & Minority Ethnicities) where NHS England has returned reporting. It otherwise uses the term "B.A.M.E." (listed above) to mean any person of colour in line with our race-related staff network.

NHS Frimley as an organisation

Since writing the 2023 WRES action plan, our workforce composition has changed. As with all other Integrated Care Boards, NHS Frimley is undertaking a change programme to sustain financial impact. Alongside this, NHS Frimley now host the South-East Pharmacy Optometry and Dentistry (POD) Commissioning Hub and the Complaints Team. These teams work on behalf of all Integrated Care Boards (ICBs) across the South-East Region: Buckinghamshire, Oxfordshire & Berkshire West, Frimley, Hampshire & Isle of Wight, Kent & Medway, Surrey Heartlands and Sussex NHS Frimley.

While NHS Frimley has made positive steps in the EDI space, we know we still have work to do, and feedback from the NHS Staff Survey 2023 shows there are disparities for our B.A.M.E. staff. Short, medium and long-term action is needed to tackle inequalities in recruitment, career progression, representation at senior and Board level as well as the lived experience of our staff regarding the culture, values and behaviours at NHS Frimley.

The WRES Action Plan was shared with the B.A.M.E. Network and the NHS Frimley EDI Working Group for comments and approved by the Senior Leadership Team. The plan is built on significant feedback and data that has already been provided by our B.A.M.E. staff from our NHS Electronic Staff Records (ESR) and the NHS Frimley annual staff survey (2023).

Workforce Data March 2022*

Number of Staff – NHS Frimley CCG	260	100%
Number of white colleagues	173	67%
Number of B.A.M.E. colleagues	57	22%
Number of unknown	30	12%

The figures above are taken from the 2021-22 NHS Frimley CCG workforce. These WRES figures were not submitted to NHSE, as ICBs were not included for submission in 2022-23. They are included here for context and transparency of reporting but **do not represent NHS Frimley Integrated Care Board and cannot be directly compared with 2023 data.**

Workforce Data September 2023*

Number of Staff – NHS Frimley ICB	394	100%
Number of white colleagues	257	65%
Number of B.A.M.E. colleagues	80	20%
Number of unknown	57	15%

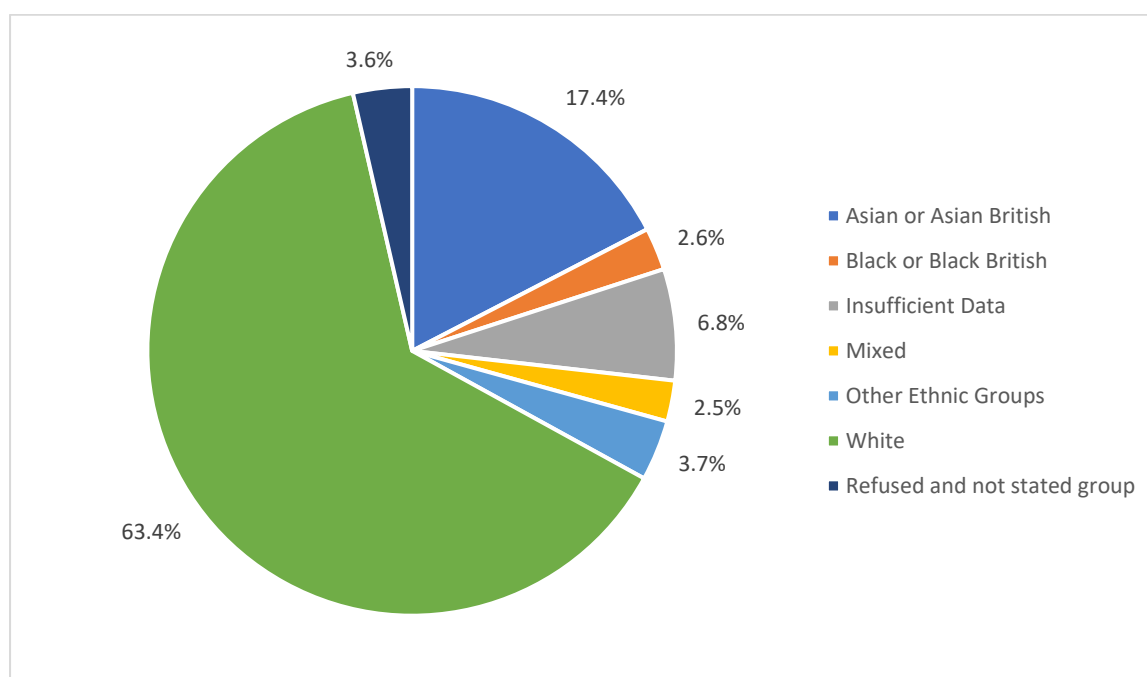
*This data is in line with the number of staff who completed the NHS Frimley staff survey for 2023. “Unknown” figures will include staff who prefer their identity to be anonymous, regardless of their racial group. It is also noteworthy that NHS Frimley is at the latter end of a change programme.

Frimley's community

The data presented in this section for 2022 and 2024 is taken from our Connected Care data system. It represents patients registered with General Practices in the Frimley ICS geography.

NHS Frimley Population by Ethnicity 2022

Ethnicity	#Population	% of Population
Asian or Asian British	143,655	17.4%
Black or Black British	21,928	2.6%
Insufficient Data	54,915	6.8%
Mixed	20,234	2.5%
Other Ethnic Groups	30,346	3.7%
White	522,943	63.4%
Refused and not stated group	30,070	3.6%
Total	824,091	100%

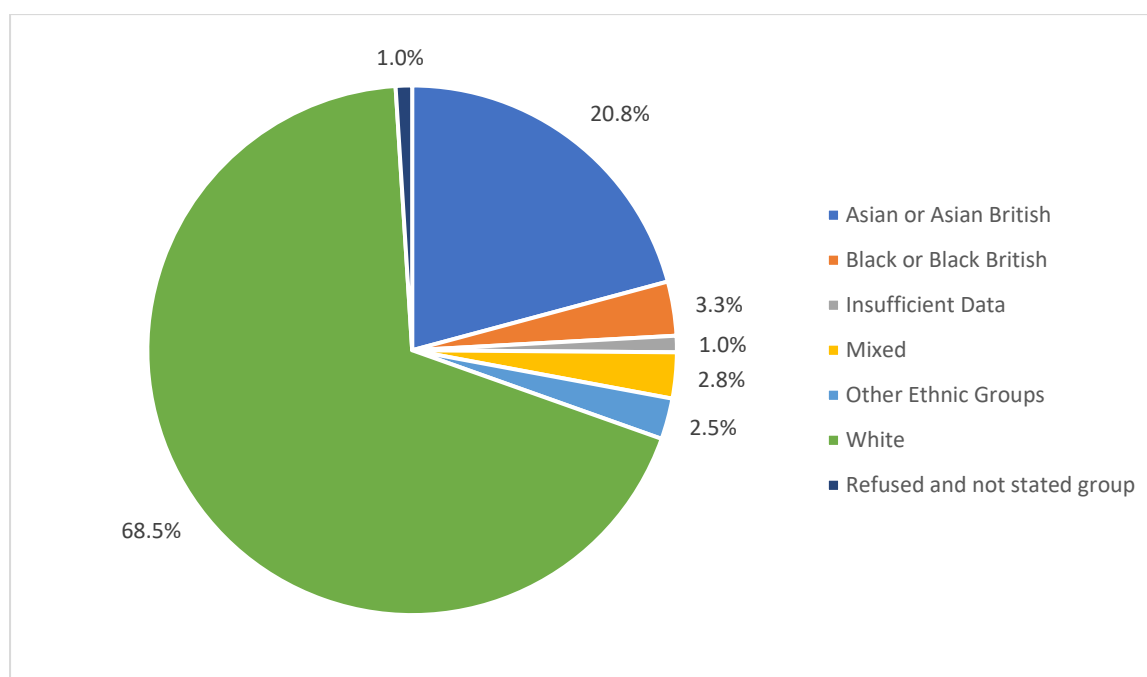


This population data shows:

- The B.A.M.E. population is 216,163 a representation of 26.2%
- The White population is 522,943 a representation of 63.4%
- A population of 54,915 with insufficient data which represents 6.8%
- A population of 30,070 which is a representation of 3.6% are those who have refused or not stated their ethnicity

NHS Frimley Population by Ethnicity 2024

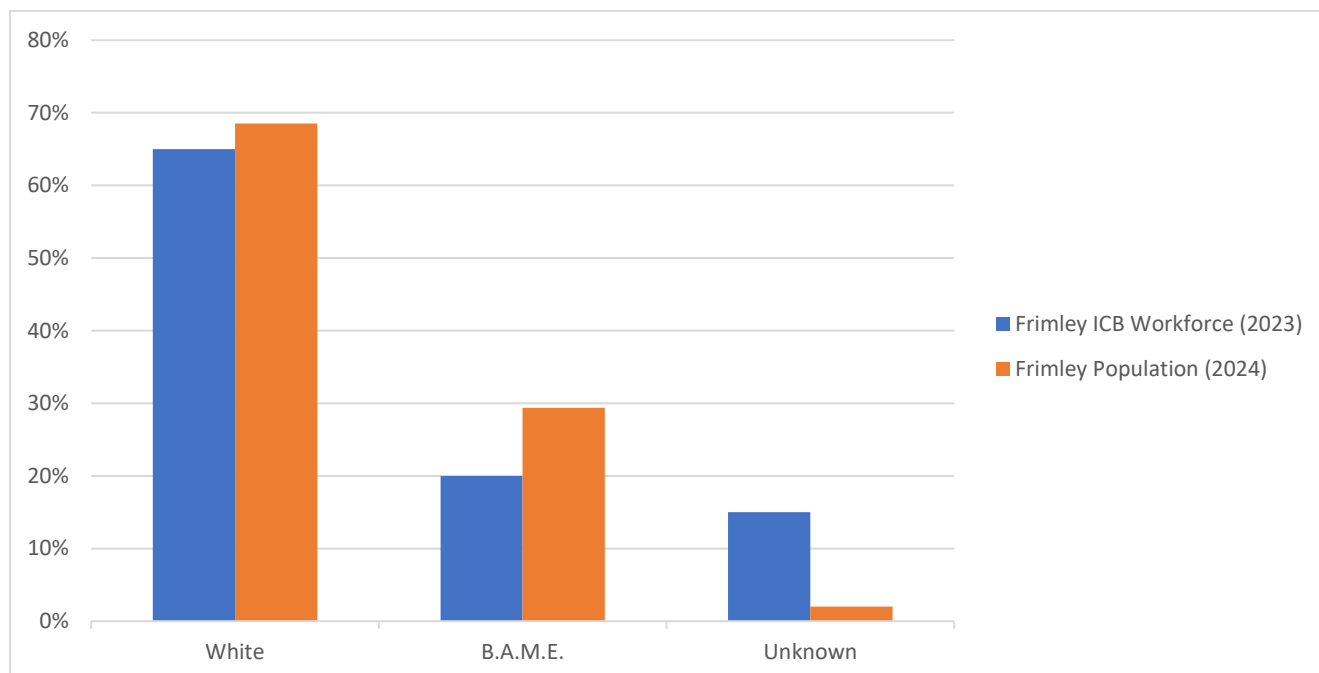
Ethnicity	# Population	% of Population
Asian or Asian British	176,660	20.8%
Black or Black British	28,248	3.3%
Insufficient Data	8,523	1.0%
Mixed	23,573	2.8%
Other Ethnic Groups	20,985	2.5%
White	581,013	68.5%
Refused and not stated group	8,786	1.0%
Total	847,728	100.0%



In comparison with 2022, this population data shows:

- NHS Frimley's population registered with GP practices have **grown by 23,637**
- The B.A.M.E. population is 249,466 a representation of 29.4% **an increase of 3.2%**
- The White population is 581,013 a representation of 68.5% **an increase of 5.1%**
- A population of 8,523 with insufficient data representing 1.0% of the population. **A decrease of -5.8% from data provided in 2023** resulting in more residents completing their data accurately.
- a population of 8,786 which is a representation of 1.0% of the population are those who have refused or not stated their ethnicity. **This is a decrease of -2.6% from data provided in 2023** resulting in more residents willing to share their data

Comparing NHS Frimley’s workforce (2023) with our community (2024)



When comparing data from our NHS Frimley workforce with our population there is an under-representation of B.A.M.E. staff (20%) compared to NHS Frimley community population (29%).

It is noteworthy that we do not know the ethnicity of 15% of our workforce, while in our community there is insufficient data of 1% of people and 1% do not wish their data to be used for secondary purposes. The large proportion of “unknown” workforce makes it difficult to establish exactly how we reflect the demographics of our wider community. Ongoing work will educate our staff on how this data is collected, stored, and used to inform our organisation, with a view to improving declarations.

It's important to understand that the staff and community populations are dynamic. When considering the data to hand, we have formed this action plan.

Governance

The progression of the WRES Action Plan will be overseen and monitored by the NHS Frimley EDI working group and reported to the Senior Leadership Team.

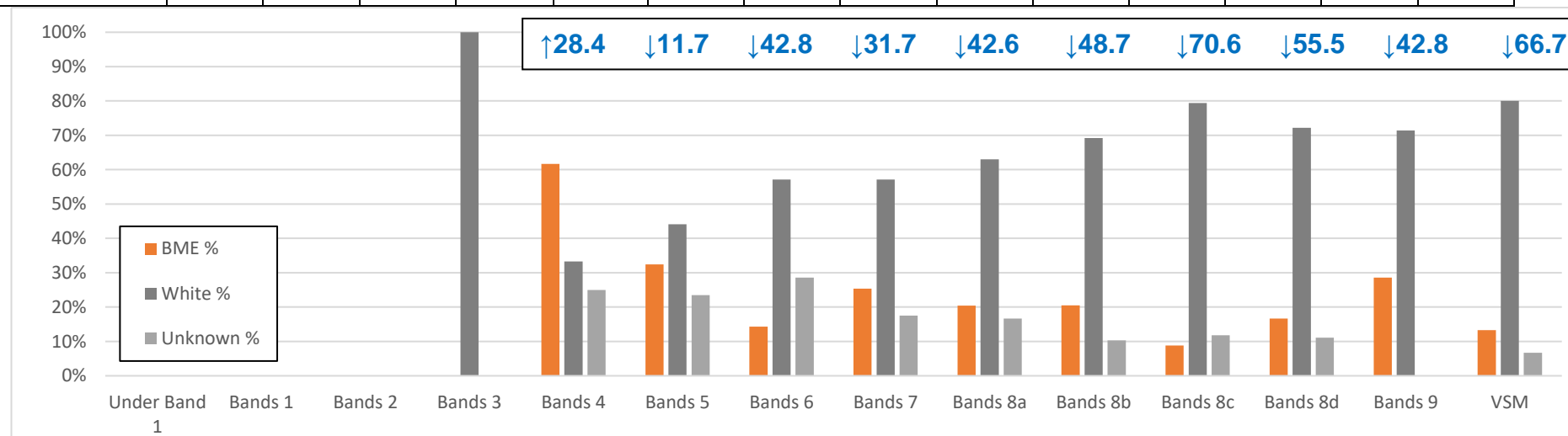
Note: Picker is the organisation that runs the NHS Frimley staff survey. The survey is run anonymously, and no identifiable information is passed on to any member of staff. Picker introduced a WRES report in 2023 which gave us a clear picture of discrepancies.

Indicator 1

Percentage of staff in each of the Agenda for Change Bands 1-9 VSM (including SLT members) compared with the percentage of staff in the overall workforce.

Non-Clinical Staff by %

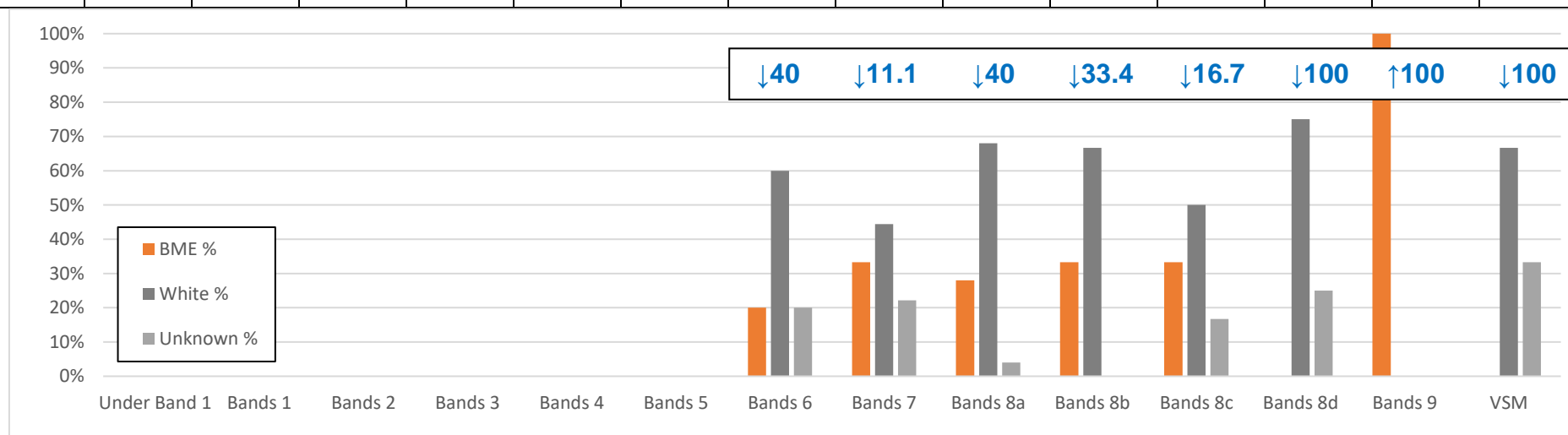
Staff by Ethnicity	Under Band 1	Bands 1	Bands 2	Bands 3	Bands 4	Bands 5	Bands 6	Bands 7	Bands 8a	Bands 8b	Bands 8c	Bands 8d	Bands 9	VSM
B.A.M.E.	0.0	0.0	0.0	0.0	61.7	32.4	14.3	25.4	20.4	20.5	8.8	16.7	28.6	13.3
White	0.0	0.0	0.0	100.0	33.3	44.1	57.1	57.1	63.0	69.2	79.4	72.2	71.4	80.0
Unknown	0.0	0.0	0.0	0.0	25.0	23.5	28.6	17.5	16.7	10.3	11.8	11.1	0.0	6.7



Opportunities for progress drop above Band 5 for B.A.M.E. colleagues. This is shown by the blue numbers on the graph, which show the percentage difference between percentage of B.A.M.E. and white colleagues at each Band.

Clinical Staff by %

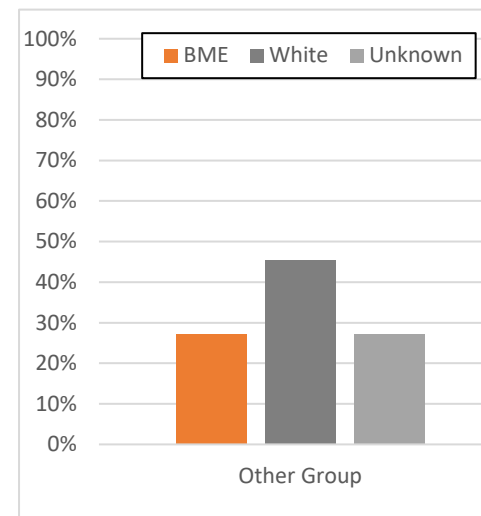
Staff by Ethnicity	Under Band 1	Bands 1	Bands 2	Bands 3	Bands 4	Bands 5	Bands 6	Bands 7	Bands 8a	Bands 8b	Bands 8c	Bands 8d	Bands 9	VSM
B.A.M.E.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	20.0%	33.3%	28.0%	33.3%	33.3%	0.0%	100.0%	0.0%
White	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	60.0%	44.4%	68.0%	66.7%	50.0%	75.0%	0.0%	66.7%
Unknown	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	20.0%	22.2%	4.0%	0.0%	16.7%	25.0%	0.0%	33.3%



Opportunities for progression drop between Bands 7 and 8d and at VSM for B.A.M.E. colleagues. This is shown by the blue numbers on the graph, which show the percentage difference between percentage of B.A.M.E. and white colleagues at each Band.

Clinical Staff by %: Medical & Dental

Staff by Ethnicity	Other Group	Trainee Grades (TG)	Non-consultant Career Grade (NCCG)	Consultants	Consultant Senior Medical Managers (CSMM)
B.A.M.E.	27.3%	0.0%	0.0%	0.0%	0.0%
White	45.5%	0.0%	0.0%	0.0%	0.0%
Unknown	27.3%	0.0%	0.0%	0.0%	0.0%

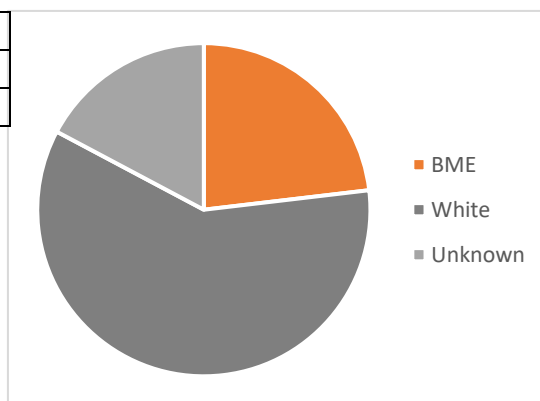


All of our Medical & Dental staff are in the “other” group. There are around 18% less BAME than white Medical & Dental staff in the ICB.

Percentage differences between all ICB staff

The overall percentages of B.A.M.E. vs white staff across all staff types in the ICB are:

B.A.M.E.	23%
White	60%
Unknown	17%



This shows that we employ slightly less B.A.M.E. staff (20%) than are living in our Frimley community (29%).

It suggests that we employ less white staff (65%) than are represented in our Frimley community (68%).

We do not know the demographics of 15% of our staff. This is a significant proportion and has the potential to influence our data, and thus organisational interventions by a large margin. We are looking at ongoing ways to encourage staff to feel safe to declare their protected characteristics on ESR so that our data and interventions are as accurate and impactful as possible.

Indicator 2

Relative likelihood of white candidates compared to B.M.E. candidates being appointed from shortlisting across all (internal and external) posts.

2022

Staff Ethnicity	Shortlisted applicants	Appointed from shortlisting
B.A.M.E.	43%	10.12%
White	55%	13.08%
Ethnicity Unkown	2%	28.57%
Relative likelihood of white staff being appointed from shortlisting compared to B.A.M.E. staff		1.29

Vs.

2023

Staff Ethnicity	Shortlisted applicants	Appointed from shortlisting
B.A.M.E.	67%	0%
White	28%	100%
Ethnicity Unknown	6%	0%
Relative likelihood of white staff being appointed from shortlisting compared to B.A.M.E. staff		

The data above indicates that more of our B.A.M.E. community were shortlisted than counterparts who are white or have not declared their ethnicity. We do not know whether this is because vastly more people from the B.A.M.E. community are applying for roles, or whether there is an influence or positive practice happening in the shortlisting process.

Despite the increased representation of B.A.M.E. colleagues at shortlisting, they are not successfully being appointed in the following stage. **The data shows that 100% of our appointments from shortlisting were white applicants.** This has moved in favour of a white colleague being appointed to a role in comparison to 2022 where it was 1.29% likelihood that a white colleague would be appointed over a BAME colleague.

Indicator 3

Relative likelihood of B.A.M.E. staff compared to white staff entering the formal disciplinary process, as measured by entry into formal disciplinary investigation (based on year-end data for the financial year).

Criteria	Measure	B.A.M.E.	White	Unknown
Number of staff entering the formal disciplinary process in the financial year	Headcount	0%	0%	0%
Likelihood of staff entering the formal disciplinary process	Auto-calculated	0%	0%	0%
Relative likelihood of BME staff entering the formal disciplinary process compared to white staff	Auto-calculated	N/A	N/A	N/A

This indicates that neither BAME nor White member of staff entered a formal disciplinary process year ending March 2023. These results are similar to those reported in March 2022

Indicator 4

Relative likelihood of white staff compared to BME staff accessing non-mandatory training and CPD (NMTCPD).

Criteria	B.A.M.E.	White	Unknown
Staff accessing NMTCPD in the financial year	21.9%	75%	3.1%

This information is collated by our Frimley Academy. It is not able to consider wider learning opportunities, for example web-based learning that colleagues may access and is not a true representation of any of our staff groups.

NHS Frimley will improve data captured from Line Managers and develop a system through the People and OD team to identify ways of capturing this data.

Indicator 5

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months.

2022

Criteria	Comparator (Organisation overall)	B.A.M.E.	White	Prefer not to say
Not experienced physical violence from patients / service users, their relatives or other members of the public	99.2%	100%	98.9%	0%
Not experienced harassment, bullying or abuse from patients / service users, their relatives or members of the public	96.2%	96.6%	96.0%	0%

2023

Criteria	Comparator (Organisation overall)	B.A.M.E.	White	Prefer not to say
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	4.4%	0.0%	4.6%	0%

The NHS Frimley staff survey results are showing that 4.6% white colleagues have experienced harassment, bullying or abuse from patients, relatives, or the public in comparison to 0.0% B.A.M.E. colleagues. The results show that 0.6% more White colleagues are experiencing bullying and harassment from the community than reported in 2022.

While these findings present as reassuring that our B.A.M.E. colleagues are not having negative experiences, we should be mindful that they may not feel able to report poor behaviours through the Staff Survey. This is particularly relevant when considering informally reported incidents of poor behaviour the ICB's Staff Networks and Freedom To Speak Up channels.

Indicator 6

Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.

2022

Criteria	Comparator (Organisation overall)	B.A.M.E.	White
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	16.5%	22.9%	11.4%

This question was answered by 35 Asian/Asian British staff. This data shows that 22.9% of staff answering this question in 2022 had experienced harassment, bullying or abuse from staff in the past 12 months. **In reality, this percentage is likely to be higher than reported.** This is because data from our colleagues in Black/African/Caribbean/Black British, Mixed/Multiple ethnic groups or other ethnic groups could not be reported as the number of staff is below 10 in each category.

Of the 177 white staff who answered this question, 11.4% have experienced harassment, bullying or abuse from staff.

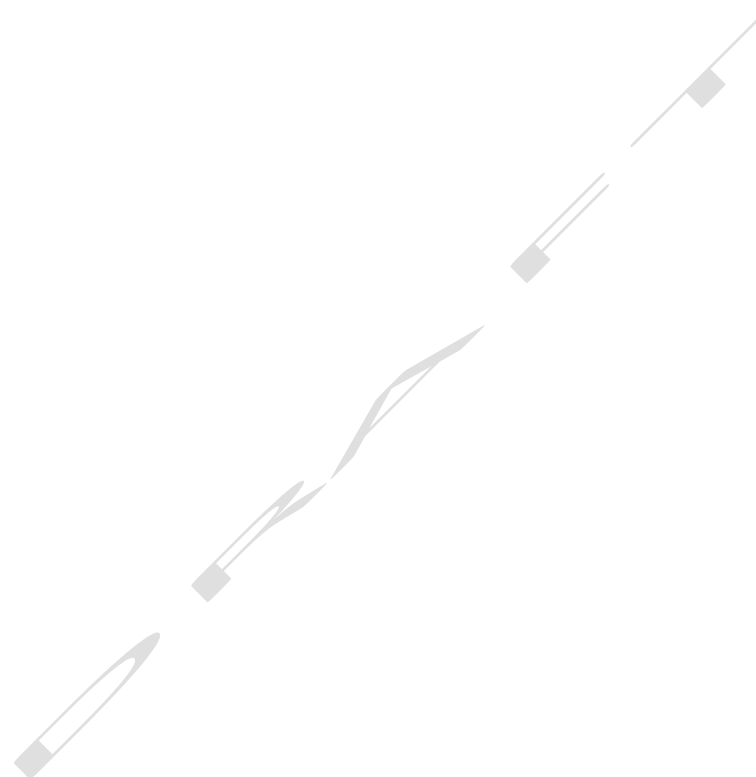
2023

Criteria	Comparator (Organisation overall)	B.A.M.E. 35 staff members	White 173 staff members
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	16.2%	62.8%	12.7%

This question was answered by 38 Asian/Asian British and Black African/Caribbean/Black British staff. This data shows that 32% of Asian/Asian British staff, and 30.8% of Black African/Caribbean/Black British staff who answered this question have experienced harassment, bullying or abuse from other colleagues. **This percentage may be higher than reported** because Mixed Multiple Ethnic Groups and Other Ethnic Groups are not represented here as the numbers are too small.

Of the 173 white staff who answered this question 12.7% have experienced harassment and abuse from colleagues.

This data indicates bullying harassment has gone up for both our B.A.M.E and white colleagues. The increase is disproportionately higher for our B.A.M.E. staff.



Indicator 7

Percentage of staff believing that NHS Frimley provides equal opportunities for career progression or promotion.

2022

Criteria	Comparator (Organisation overall)	B.A.M.E.	White
Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	58.2%	34.3%	64.8%

This data shows that 34.3% of B.A.M.E. staff members believe that NHS Frimley provides equal opportunities for career progression or promotion. **This percentage may be higher than reported** as data for Black/African/Caribbean/Black British, Mixed Multiple ethnic groups and other ethnic groups is too small to report. Comparatively, 64.8% of white staff who answered this question believe that NHS Frimley provide equal opportunities for career progression or promotion.

2023

Criteria	Comparator (Organisation overall)	B.A.M.E.	White
Percentage of staff believing that trust provides equal opportunities for career progression or promotion	52.9%	47.4%	59.1%

This data shows that 32% of Asian/Asian British staff and 15.4% of Black/African/Caribbean/Black British staff believe the organisation provide equal opportunities for career progression or promotion. The mixed multiple ethnic groups and other ethnic groups have too small a number to be represented here. Comparatively, 59.1% of white colleagues believe the organisation provides equal opportunities for career progression or promotion.

This data shows that the percentage of B.A.M.E. staff feeling opportunities are equal is rising Conversely, white staff are feeling that opportunities are less equal.

Indicator 8

Over last 12 months have you personally experienced discrimination at work from any of the following?

b) Manager/team leader or other colleagues.

2022

Criteria	Comparator (Organisation overall)	B.A.M.E.	White
In the last 12 months have you personally experienced discrimination at work from any of the following? Manager / team leader or other colleagues	6.3%	17.1%	2.3%

This question was answered by 35 members of staff representing Asian/Asian British. This data shows that 17.1% of these members of staff had personally experienced discrimination at work. The numbers of all other B.A.M.E subgroups were too small to publish.

2023

Criteria	Comparator (Organisation overall)	B.A.M.E.	White
In the last 12 months have you personally experienced discrimination at work from any of the following? Manager / team leader or other colleagues	8.4%	35.4%	4.1%

This question was answered by 38 members of staff derived from the Asian/Asian British and Black/African/Caribbean/Black British. This data shows that 20% of Asian/Asian British staff and 15.4% of Black/African/Caribbean/Black British have experienced discrimination at work from either colleagues or managers or team leaders. Comparatively, of the 173 white staff who answered this question 4.1% of white staff have experienced discrimination at work from either colleagues or managers or team leaders.

This data shows that the percentage of all staff personally experiencing discrimination at work from managers, team leaders or other colleagues is increasing. This is in part due to increased numbers of B.A.M.E. staff being declarable in 2023. It may also link to increasing awareness, and therefore reporting of, poor behaviours by colleagues due to ongoing work by the EDI Team. The increased reporting should not go unnoticed and is informing ongoing work needed in this Action Plan.

Indicator 9

Percentage difference between the organisation's Senior Leadership Team (SLT) voting membership and its organisation's overall workforce, disaggregated:

- By voting membership of the Board
- By Executive membership of the Board

Criteria	Measure	B.A.M.E.	White	Unknown
Total Board Members	Headcount	0.0%	77.78%	22.22%
<i>Of which: Voting Board Members</i>	Headcount	0.0%	44.78%	22.22%
<i>Non-Voting Board Members</i>	Auto calculated	0.0%	0.0%	0.0%
<i>Exec Board Members</i>	Headcount	0.0%	83.33%	16.67%
<i>Non-Executive Board Members</i>	Auto-calculated	0.0%	66.67%	33.3%

The above represents NHS Frimley's Senior Leadership Team (SLT). This data *is indicating* that there are no B.A.M.E. members at SLT level. All SLT members are Board members and have voting membership and executive membership for the overall workforce.

This indicates that NHS Frimley's ESR details have not been updated and therefore not collated at time of publication. The action plan represents an action to have this data completed by 2025.

Action Plan

The four outliers that the WRES action plan will take into consideration for 2024-25 are:

- **Representation at Board and Senior Leadership Team Level**
- **Career Progression**
- **Recruitment**
- **Bullying and Harassment**

Following are the overarching actions which form the action plan:

1. Representation at Board and Senior Leadership Team Level
 - Ensure that representation of the B.A.M.E. community at the Board and Senior Leadership Team levels reflect the Frimley ICS population (currently at 29%) by April 2027. There is currently no evidence of representation within the Board and Senior Leadership Team as this data is not recorded.
 - Mandate that every shortlisted and interview panel includes an Equality and Diversity representative, with all panel members holding equal decision-making authority.
 - Mandate completion of the 'BAME Candidate Feedback Form', where BAME candidates are unsuccessful. Ensure that the Inclusive Recruitment Toolkit and the relevant documents are made available on Consult HR.
2. Career Progression
 - Support for Developing BAME Colleagues: To support the development of BAME colleagues, NHS Frimley will implement several initiatives, including tailored leadership and talent development programmes, reverse mentoring schemes, and focused career conversations. These programmes will provide BAME staff with the skills, tools, and confidence needed to progress to higher bands. Specifically, we aim to achieve 29% representation to Band 8C by April 2027. Additionally, we will monitor the impact of these initiatives through regular feedback and data analysis to ensure they effectively address barriers to career progression. This will help us identify areas for improvement and make necessary adjustments to our strategies.
 - Increase Representation of BAME Staff at Band 8A: To increase the representation of BAME staff at Band 8A to 29% by April 2026, we will aim to increase the number of BAME staff in this band from the current 20% (80 staff members) to

approximately 114 staff members. This target will be achieved through targeted recruitment, development programmes, and mentorship opportunities designed to support BAME staff in their career progression.

- Implement representation of BAME staff through all bands with an emphasis on Bands 8A and 8C: To ensure that the representation of BAME staff through all bands reflects the Frimley ICS population (currently at 29%), NHS Frimley will implement several initiatives. These include targeted recruitment, tailored leadership and talent development programmes, reverse mentoring schemes, and focused career conversations. Specifically:
 - Band 8A: Increase the representation of BAME staff to 29% by April 2026. This means increasing the current representation from 20.4% to 29%.
 - Band 8C: Achieve 29% representation by April 2027. This means increasing the current representation from 8.8% to 29%, which would require approximately 10 additional BAME staff members.
- Capture non-mandatory training and continuing professional development for all staff members to have a clear picture of who is accessing training.

3. Recruitment

- Review recruitment and selection policies and procedures to reduce barriers and unconscious bias.
- Put diverse recruitment panels in place and offer B.A.M.E Network members the opportunity to train to sit on these panels.
- Produce a standard operating procedure for the interview process to ensure clear feedback is given to all candidates.
- Develop recruitment and selection training for all line managers and ensure EDI representation on recruitment panels.
- Improve exit interview process and feedback to anonymised data to the EDI Team and author of the WRES Action Plan.
- Increase transparency and accountability around decision-making at shortlisting and interview stages.

4. Bullying and Harassment

- Enforce a zero-tolerance policy on bullying and harassment, ensuring that perpetrators are held accountable and informed of the outcomes of any investigations.
- Conduct engagement workshops with all staff to embed equality, diversity, and inclusion objectives through the appraisal process.
- Chiefs to reiterate NHS Frimley's culture at Directorate meetings, giving people the confidence to call out inappropriate comments and behaviours.
- Share learning and good practice across the ICB and the system to support EDI objectives.

- Chiefs to reiterate and cascade the importance of completing the Freedom to Speak Up Training mandated by NHS Frimley within the Statutory and Mandatory Training.
5. Equality and Health Inequality Assessment (EHIA)
- EHIA Produced by People Team: The People Team will produce an Equality and Health Inequality Assessment (EHIA) to evaluate the potential impacts of our policies, programmes, and practices on different ethnic groups within the workforce. This assessment will help identify any disparities and ensure that our initiatives promote equality and address health inequalities effectively. The EHIA will be reviewed regularly to monitor progress and make necessary adjustments to our strategies.

The action plan below sets out actions to be taken by NHS Frimley ICB with time frames and expected outcomes.

Action	Target Date	Expected Outcomes	Key Milestones	By Whom	Date Completed
Recruitment – Indicators 1 and 2					
Review of recruitment and selection policies and procedures.	21 March 2025	<p>Sets out clear guidelines for recruitment for the organisation.</p> <p>A recruitment policy that reduces barriers and unconscious bias.</p>	All interviewees are invited to give feedback on interviews – form devised by EDI team.	<p>HR Partners (SCW CSU) & Policy Group.</p> <p>BAME Network colleagues.</p>	
Put diverse recruitment panels in place – mandatory.	30 June 2025	<p>Panels for shortlisting and decision-making elements to be diverse.</p> <p>The recruitment toolkit has been produced for the System by the EDI Team.</p>	BAME Network members offered the opportunity to train to sit on these recruitment panels.	EDI Team, People Team, People and OD, BAME Network Members.	

Action	Target Date	Expected Outcomes	Key Milestones	By Whom	Date Completed
Produce a standard operating procedure which reports on the interview process.	31 December 2024	Clear feedback given to all candidates.	All Line managers to get training on how to use the process and current feedback mechanisms / forms – HR to facilitate training at Line Managers Meetings.	EDI Team, EDI Working Group, People Team.	
Develop recruitment and selection training for all line managers and EDI representation on recruitment panels.	20 September 2025	Consistency across NHS Frimley. Reporting on recruitment should show a shift in equal opportunities for our BAME staff.		EDI Team, People & OD to include in the Line Managers meetings – People Team, EDI Team to deliver training.	
Improve exit interview process and feedback to anonymised data to EDI Team and author of the WRES Action Plan.	31 March 2025	Understanding of the reasons BAME staff are leaving the organisation.		People Team, Line Managers, EDI Team, People and OD	

Action	Target Date	Expected Outcomes	Key Milestones	By Whom	Date Completed
Transparency and accountability around how decisions are made at shortlisting and interview stage – ascertain why BAME staff are not being successful in securing roles within NHS Frimley.	31 December 2024				
Campaign to improve reporting and data capturing of ethnicity.	30 June 2025				

Action	Target Date	Expected Outcomes	Key Milestones	By Whom	Date Completed
Career Progression – Indicator 7					
Implement focussed career conversations with BAME staff.	31 March 2025	Focus on career opportunities for BAME staff. Wider opportunities and confidence building for BAME staff.		Line Managers	
Increase representation of BAME staff through all bands with an emphasis on Bands 8A and 8C.	31 March 2026	Detailed career conversation. Framework – Scope for Growth. Confident BAME staff who will have the tools to apply for jobs at higher bands.		Line Managers	

Action	Target Date	Expected Outcomes	Key Milestones	By Whom	Date Completed
Capturing non-mandatory training and continuing professional development for all staff members, so we have a picture of who is accessing training.	31 December 2024	Reporting will be more accurate and up to date.	All training to be logged on to Consult OD	HR, People & OD	
Bullying and Harassment – Indicator 5					
Engagement workshops with all staff to embed equality, diversity and inclusion objectives through appraisal process which links to this WRES action plan.	31 March 2025	Appraisals documents have EDI SMART objectives embedded within them which linked to the WRES Action Plan. Greater understanding of the EDI agenda for all staff.	To be discussed with all staff at appraisals by line managers and within team meetings.	People & OD, EDI Team, Chiefs, Directors, Line Managers	

Action	Target Date	Expected Outcomes	Key Milestones	By Whom	Date Completed
<p>Chiefs to reiterate NHS Frimley’s culture at Directorate meetings giving people the confidence to call out inappropriate comments and behaviours to report when behaviour falls below expected standards.</p>	<p>31 December 2024</p>	<p>Awareness of what is considered inappropriate and of expected behaviours.</p> <p>Fewer staff complaints of inappropriate comments.</p>		<p>Chiefs, EDI Team, People and OD</p>	
<p>Shared learning and good practices across the ICB and the system.</p>	<p>30 June 2025</p>	<p>Shared learning will support all the systems EDI Objectives.</p> <p>A system that shows that we are anti-racist in everything we do, i.e., being equal, equitable, inclusive and diverse.</p>		<p>Chiefs, Directors, All Staff, EDI Team, People and OD</p>	

Action	Target Date	Expected Outcomes	Key Milestones	By Whom	Date Completed
Increase Board and Senior Leadership Level Representation – Indicator 9					
Recruitment to Mirror Board – 2 nd cohort	31 December 2025	<p>Shared learning will support all the systems EDI Objectives.</p> <p>A system that shows that we are anti-racist in everything we do, i.e., being equal, equitable, inclusive and diverse.</p>		People & OD, EDI Team	
Shadow members of SLT for BAME staff	31 March 2025	<p>Shared learning will support all the systems EDI Objectives.</p> <p>Wider opportunities and confident BAME staff who will have the tools to apply for jobs at higher bands.</p>		Chiefs, Directors, Line Managers	

Appendices

Ethnicity and gender in detail 2024: NHS Frimley Staff Survey

NHS Frimley invited 381 staff to complete the NHS Staff Survey 2023 (results on 31st March 2024) carried out by Picker, an independent organisation.

NHS Frimley had a 60% completion rate, and the following is a breakdown of the staff who firmed their ethnicity (total of 224):

English/Welsh/Scottish/Northern Ireland	161
Irish	7
Any other white background	6
White & Asian	1
Indian	12
Pakistani	5
Bangladeshi	1
Any other Asian Background	6
African	10
Caribbean	3
Any other Black/African/Caribbean	1
Arab	2
Any other ethnic background	5
White and Black Caribbean	2
Chinese	2

NHS FRIMLEY
WORKFORCE DISABILITY WORKFORCE
STANDARDS (WRES)
ACTION PLAN 2024



Contents

Introduction	3
NHS Frimley as an organisation	4
Governance	5
Metric 1	6
Metrics 2 Recruitment	11
Metrics 3	13
Metrics 4	14
Metrics 5	16
Metrics 6	17
Metrics 7	18
Metrics 8	19
Metrics 9 - Staff Engagement Score	20
Action Plan.....	21

Introduction

The NHS Workforce Disability Equality Standard (WDES) is a national standard for NHS Trusts and Integrated Care Boards (ICBs) to provide data against 10 indicators. As with all other protected characteristics, tackling inequality for NHS Frimley's disabled staff is essential to ensure that we support, nurture, and develop our people and enable the community within NHS Frimley to thrive in a safe and inclusive environment.

In its second year as an Integrated Care Board, NHS Frimley's Chief Executive, Chief People Officer, Chief Operating Officers and Senior Directors remain committed to creating a safe and equitable environment that recognises the diversity of our staff and population.

Nationally, it is known, based on various sources of data and lived experiences, that disabled colleagues have a poorer experience of working within the NHS. At NHS Frimley workforce consists of people with varied disabilities and long-term health conditions. They include a whole range of hidden and often changing conditions that will affect different individuals in different ways, in terms of their ability to work, so we need to cater for all their bespoke needs.

This WDES Action Plan forms part of NHS Frimley's commitment, playing an integral part in our Disability and Wellness Staff Network (DAWN), our Organisational Development and People Plan and our Equality, Diversity and Inclusion Strategy.

The WDES is a set of ten specific measures (metrics) that enable NHS organisations to compare the experiences of Disabled and Non-disabled staff. This information informs the development of an action plan to demonstrate progress against the metrics to improve equality and inclusion for Disabled staff. The data reported here is from 1st April 2023 to 31st March 2024.

This Action Plan:

- Describes where we are now as an ICB, including:
 - Framing our workforce alongside our WDES and Staff Survey results,
- Identifying our Disability and Wellness Network (DAWN) as an exemplar to other networks and parts of the organisation, Provides focus on our key areas of improvement, including:
 - Strengthening accountability for delivery of the WDES Action Plan in NHS Frimley,
 - Considering how we support, nurture and develop staff within protected characteristic groups,
- Strengthening and increasing action on tackling workforce inequalities focussed on structural, institutional, and interpersonal change, Identifies which actions will be carried forward, Sets expectations of our achievements and details our success measurements by March 2026.
- Details how we will achieve these actions.

Our key goals for this WDES Action Plan include:

- Enhancing the representation of disabled staff across all pay bands.
- Improving the recruitment and retention of disabled staff.
- Ensuring a safe and supportive work environment free from harassment and bullying.
- Providing equal opportunities for career progression and professional development.
- Increasing staff engagement and satisfaction through targeted initiatives.

NHS Frimley as an organisation

As with all other Integrated Care Boards, NHS Frimley undertook a change programme to sustain financial impact. Alongside this, NHS Frimley now host the South-East Pharmacy Optometry and Dentistry (POD) Commissioning Hub and the Complaints Team. These teams work on behalf of all Integrated Care Boards (ICB)s across the South-East Region: Buckinghamshire, Oxfordshire & Berkshire West, Frimley, Hampshire & Isle of Wight, Kent & Medway, Surrey Heartlands and Sussex NHS Frimley.

Positive steps taken in the EDI space include:

- Launching the Disability and Wellness Network (DAWN) to support disabled staff.
- Implementing flexible working arrangements to accommodate staff needs.
- Conducting regular EDI training sessions for all employees.

While NHS Frimley has made positive steps in the EDI space, we know we still have work to do, and feedback from the NHS Staff Survey 2023 shows there are disparities for our disabled staff. Short, medium and long-term action is needed to tackle inequalities in recruitment, career progression, representation at senior and Board level as well as the lived experience of our staff regarding the culture, values and behaviours at NHS Frimley.

The WDES Action Plan was shared with the DAWN and the NHS Frimley EDI Working Group for comments and approved by the Senior Leadership Team. The plan is built on significant feedback and data that has already been provided by our Disabled staff from our NHS Electronic Staff Records (ESR) and the NHS Frimley annual staff survey (2023).

Feedback from the NHS Staff Survey 2023 highlighted key areas of concern, including:

- Disparities in career progression opportunities for disabled staff.
- Higher instances of harassment and bullying reported by disabled staff.
- A need for better support and reasonable adjustments for disabled employees.

Governance

The progression of the WDES Action Plan will be overseen and monitored by the NHS Frimley EDI Working Group and reported to the Senior Leadership Team on a quarterly basis.

Note: Picker is the organisation that runs the NHS Frimley staff survey. The survey is run anonymously, and no identifiable information is passed on to any member of staff. Picker introduced a WDES report in 2023 which gave us a clear picture of discrepancies.

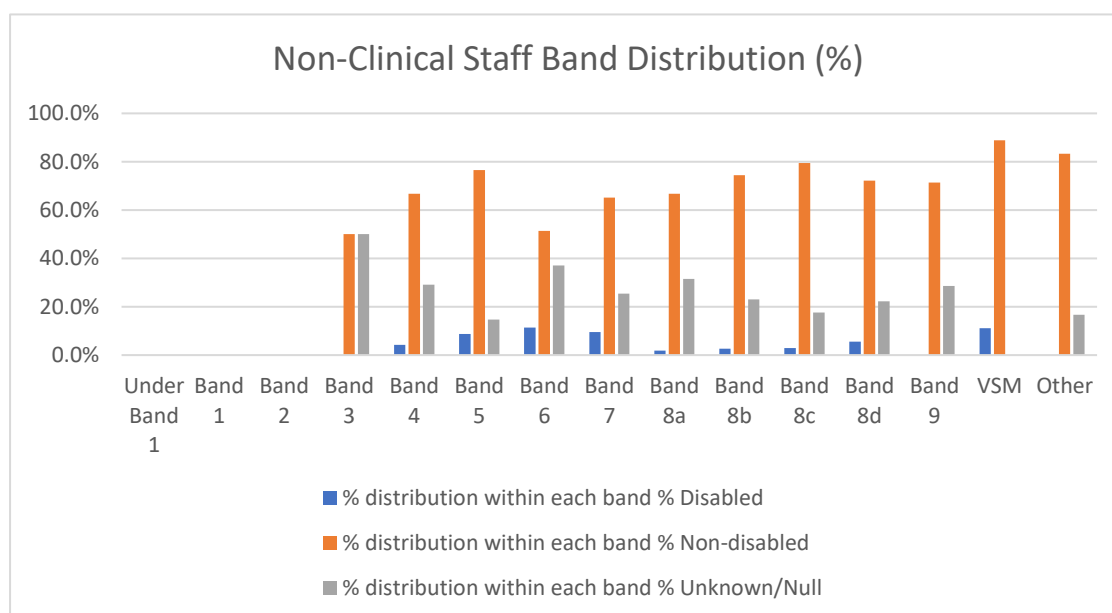
Metric 1

Workforce Representation

Non-Clinical Staff

Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including Executive Board Members) compared with the percentage of staff in the overall workforce.

Non Clinical Staff	% distribution within each band			% of total workforce		
	% Disabled	% Non-disabled	% Unknown/Null	% Disabled	% Non-disabled	% Unknown/Null
Under Band 1	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Band 1	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Band 2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Band 3	0.0%	50.0%	50.0%	0.0%	0.2%	0.2%
Band 4	4.2%	66.7%	29.2%	0.2%	3.6%	1.6%
Band 5	8.8%	76.5%	14.7%	0.7%	5.9%	1.1%
Band 6	11.4%	51.4%	37.1%	0.9%	4.1%	2.9%
Band 7	9.5%	65.1%	25.4%	1.4%	9.3%	3.6%
Band 8a	1.9%	66.7%	31.5%	0.2%	8.2%	3.9%
Band 8b	2.6%	74.4%	23.1%	0.2%	6.6%	2.0%
Band 8c	2.9%	79.4%	17.6%	0.2%	6.1%	1.4%
Band 8d	5.6%	72.2%	22.2%	0.2%	2.9%	0.9%
Band 9	0.0%	71.4%	28.6%	0.0%	1.1%	0.5%
VSM	11.1%	88.9%	0.0%	0.2%	1.8%	0.0%
Other	0.0%	83.3%	16.7%	0.0%	1.1%	0.2%
				4.31%	51.02%	18.37%



The data indicates potential gaps in reporting for lower bands and a decreasing representation of disabled staff in higher bands. This suggests a need for targeted efforts to improve data collection and support for disabled staff in senior roles.

Disability Status Distribution Across Bands

Lower Bands (Under Band 1 – Band 3) – There are no reported percentages for disabled, or unknown staff members in these bands, indicating potential gap in data or the organisation does not employ or have very low numbers for bands 1- 3.

Band 4 - Band 7: These bands show notable percentages of disabled and non-disabled staff. Disability representation is low but steadily increasing across bands (e.g., Band 6 has 11.4% disabled staff, while Band 7 has 9.5%).

Band 8 and above - The distribution of disabled employee generally decreases as you move up the bands, with VSM (Very Senior Manager) showing no disabled staff (likely due to lack of reporting or opportunity. There is a notable presence of non-disabled employees)

Disability Status Distribution Across Bands:

- Bands Under 1 - 4: These bands show no disability data reported, suggesting a lack of available information or absence of clinical staff in these bands.
- Band 5 - Band 7: Disability representation begins to appear here, with Band 6 showing 6.67% disabled employees, and Band 7 showing none.
- Band 8 and above: Disability representation decreases across these bands. For example, Band 8a has 4% disabled, while Band 8b, Band 9, and VSM show 0% disabled.
- VSM (Very Senior Manager): The only band where 100% of employees are reported as non-disabled is VSM. This highlights that clinical leadership roles might have challenges in recruiting or retaining disabled staff.

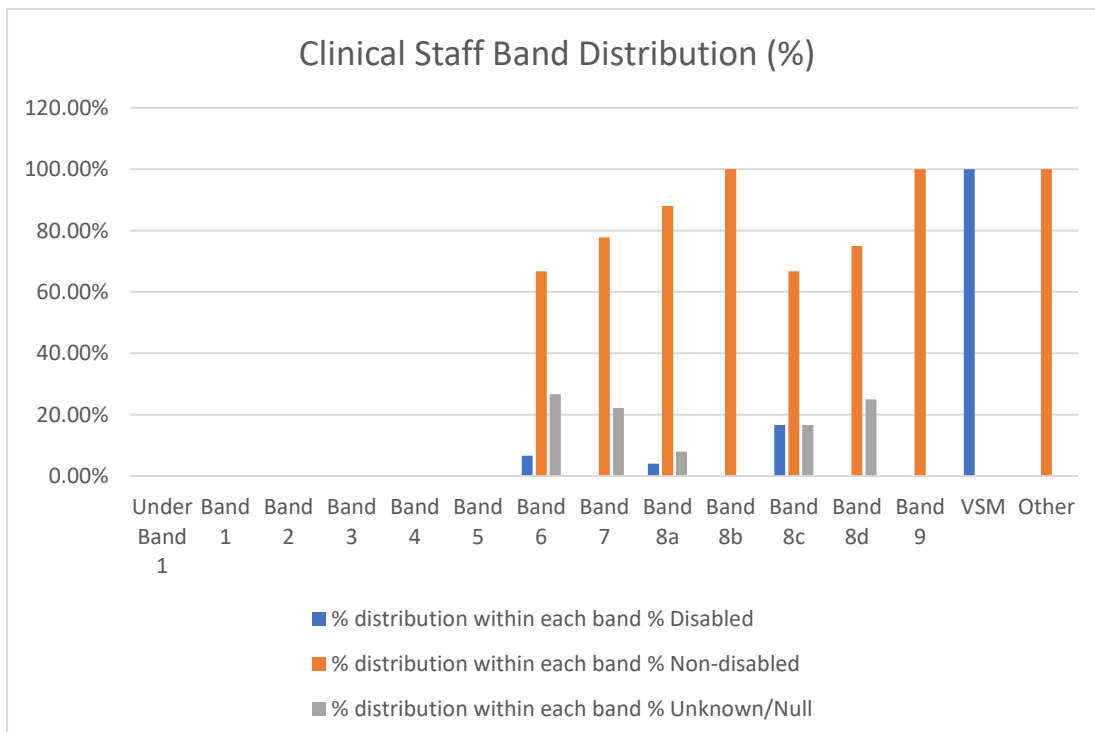
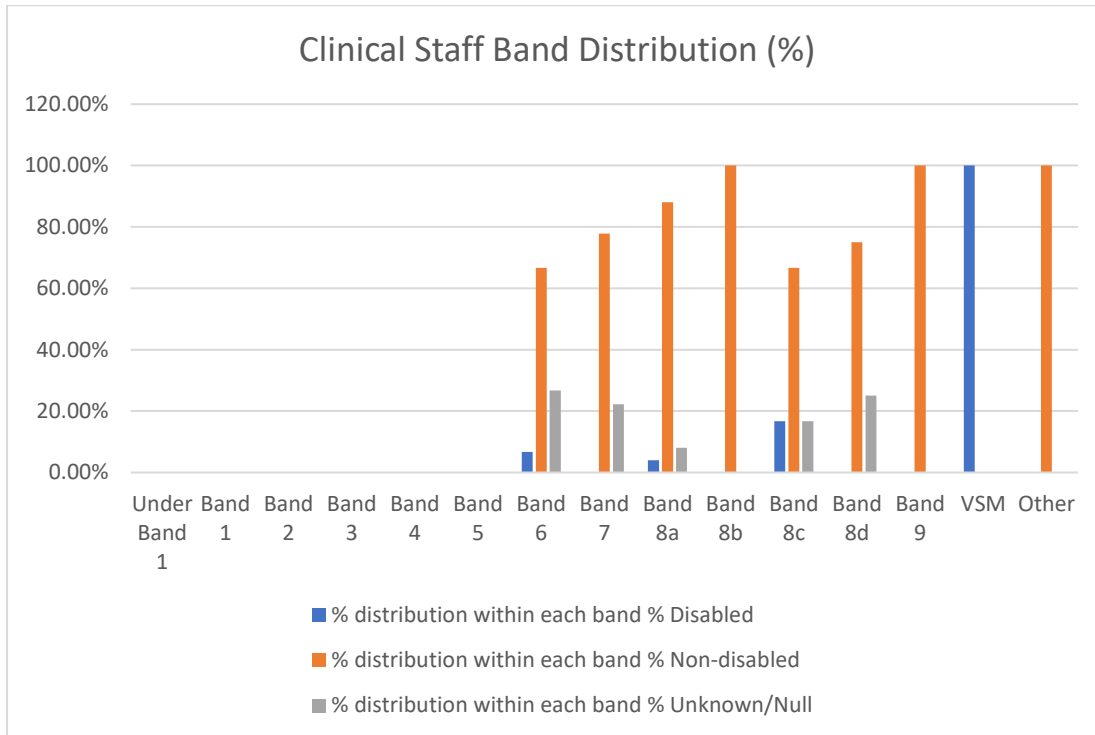
Non-disabled Workforce:

- Non-disabled employees dominate across all bands, particularly in Band 8b and Band 9, which show 100% non-disabled staff. This is a common trend in higher-ranking clinical roles, where disability representation might be absent or not reported.
- In Band 6 and Band 7, non-disabled staff make up a significant majority (66.67% and 77.78%, respectively).

Unknown/Null Data:

- A small percentage of employees in clinical staff bands have Unknown/Null disability status. The highest is seen in Band 7 and Band 8c, with 22.22% and 16.67% of staff, respectively.
- Overall, the Unknown/Null category is relatively low compared to non-disabled staff (except in VSM and other where this number drops to zero). **This indicates more complete reporting than in the non-clinical staff dataset.**

Clinical Staff



Overall Workforce Distribution for Clinical Staff

- 1.36% disabled staff across the clinical workforce, which is relatively low
- 17.69% non-disabled workforce in clinical roles.
- 3.17% unknown/NULL category, which is fairly low but still an area that could be improved for more transparent reporting.

Recommendations:

1. Increase Disability Representation:

Recruitment initiatives could target increasing the percentage of disabled individuals in clinical roles, particularly in bands that show lower representation (such as VSM and senior bands).

2. Support and Retention:

Workplace accommodations and policies could be looked into/ strengthened to ensure that disabled employees feel supported in clinical environments.

3. Enhance Reporting:

Increasing transparency and improving disability status reporting can help eliminate the Unknown/Null category.

4. Inclusion in Leadership:

Initiatives aimed at inclusive leadership could help promote disabled individuals to higher clinical positions. Support programs such as mentorship, leadership training, and job accommodations may help retain talent at senior levels. Ask for leadership to support initiatives to model /drive this.

Indicator 1 - Medical and Dental

• Disability Status Distribution Across Categories:

- Trainee Grades: This category shows that 25% of the data is marked as Unknown/Null, which indicates that a significant proportion of the workforce's disability status isn't reported. 75% of this category is non-2.

• Overall Distribution of Medical & Dental Staff:

- Disability Status: Across the three categories, the percentage distribution is 5.67% disabled, 76.19% non-disabled, and 24.04% unknown/null.
- The percentage of Unknown/Null status (24.04%) is quite high, which suggests a lack of complete reporting or that employees in these categories are not disclosing their disability status.

Analysis:

1. Disability Representation

The overall percentage of disabled individuals across the Medical & Dental workforce is relatively low, at 5.67%. This is a bit higher than the figures seen in clinical staff (1.36%) and non-clinical staff (4.31%), but still lower compared to the general population's disability representation.

2. Unknown/Null Category:

The Unknown/Null category is quite high, especially in the Trainee Grades, where 25% of employees are listed under this status. This suggests that the disability status for this group is either not recorded or employees are not willing to disclose this information.

The 24.04% unknown/null total across the workforce is a key area that needs attention to improve reporting accuracy.

3. Non-disabled Majority:

The workforce remains heavily non-disabled, with 76.19% in the non-disabled category, indicating a lack of diversity in terms of disability status within this specific part of the workforce.

Specifically, Trainee Grades show a 75% non-disabled population, with no disabled individuals reported, further highlighting a potential gap in inclusion.

Recommendations:

1. Encourage Disability Reporting:

Encouraging transparency and providing reassurance that disability status will not impact career progression could help reduce the Unknown/Null category. This would give a clearer view of the disability representation across the workforce.

2. Focus on Recruitment and Inclusion:

Consider implementing specific recruitment initiatives that target disabled individuals for both Medical & Dental roles and more senior positions.

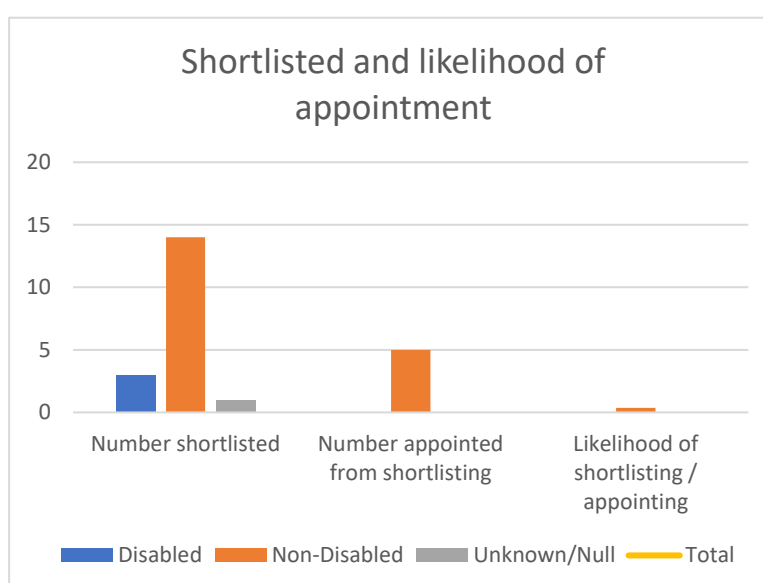
Introducing support programs, such as workplace accommodations or mentorship, could increase the participation and retention of disabled individuals, particularly in trainee and consultant roles.

3. Support for Trainee Grades:

The Trainee Grades category shows a concerning trend with no disabled employees recorded. Addressing this issue with specific outreach and accommodations in training environments could help foster a more inclusive medical workforce from the start of their careers.

Metrics 2 Recruitment

	Disabled	Non-Disabled	Unknown /Null	Total
Number shortlisted	3	14	1	18
Number appointed from shortlisting	0	5	0	5
Likelihood of shortlisting / appointing	0	0.357143	0	



To address the underrepresentation of disabled candidates, we will:

- Partner with disability organisations to increase outreach by Q2 2025.
- Ensure job listings are accessible and inclusive by Q2 2025.
- Implement diversity training for hiring managers by Q3 2025.

Insights:

Appointment Outcomes:

- No disabled candidates were appointed from the shortlist, which suggests a complete absence of disabled candidates in the appointments, even though they were shortlisted. This could be due to various factors such as lack of accommodations, biases during the interview process, or challenges in meeting role requirements.

- 5 non-disabled candidates were appointed, which accounts for 28% of the total appointments. This suggests that, while non-disabled candidates are the majority in shortlisting, they also have a higher rate of conversion to appointments (28% appointment rate for non-disabled).

Likelihood of Appointment and Shortlisting:

Likelihood of Shortlisting:

- Non-disabled candidates have a 36% likelihood of being shortlisted and appointed, suggesting that they are favoured in the process.
- Disabled candidates have a 0% likelihood of being shortlisted, which is a significant concern and may indicate biases in the recruitment process or lack of consideration for disabled candidates.

Likelihood of Appointment:

- The 0% likelihood of appointment for disabled candidates further highlights an issue in transitioning from shortlist to appointment for disabled candidates. This suggests that even when disabled candidates are considered, they are not being selected.
- Non-disabled candidates have a 36% likelihood of appointment from shortlisting, which is a relatively high conversion rate compared to the disabled group.

Recommendations

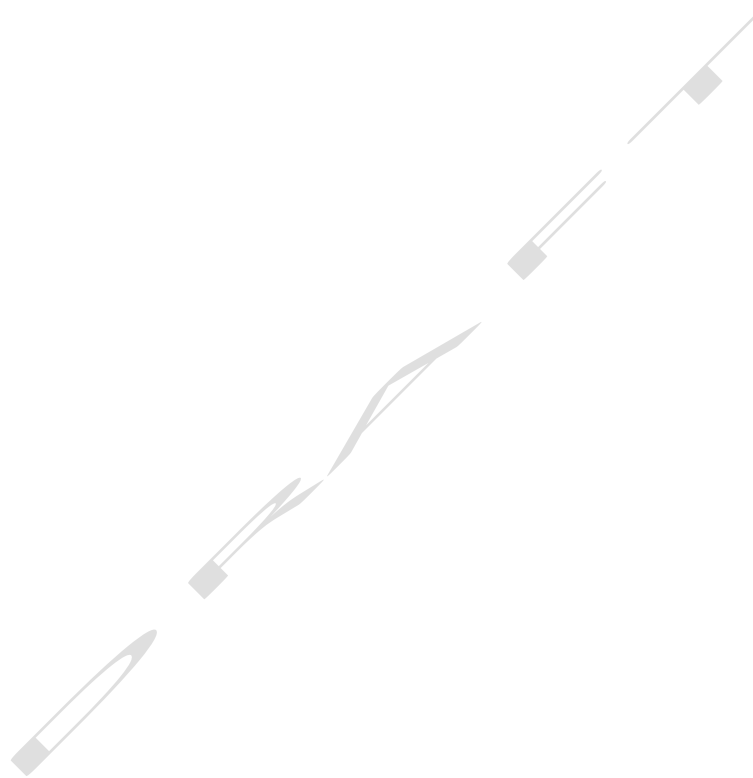
- Disabled candidates are underrepresented in the shortlisting process (only 16.7% of shortlisted candidates). This indicates a possible bias in the recruitment process or a lack of proactive outreach to disabled candidates.
- Increase efforts to encourage applications from disabled candidates, perhaps through outreach programs, targeted job advertisements, and creating a more inclusive application process.
- Implement diversity training for hiring managers.
- Review the Shortlisting Process: Make sure job listings are accessible, inclusive, and encourage disabled applicants. Ensure that the application process is accessible for all candidates.

Metrics 3

Capability - Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure – Data Source ESR

There have been no formal capability processes in 2024/25.

We will collect and analyse data on the relative likelihood of disabled staff entering the formal capability process. This data will be included in future reports to ensure transparency and accountability.

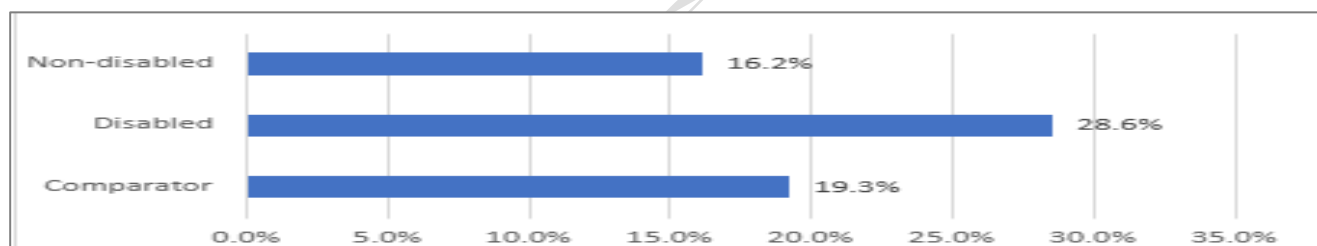


Metrics 4

4a. Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients, managers or colleagues

Indicator	Description	Comparator	Disabled	Non-disabled
4a	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients, managers or colleagues	19.3%	28.6%	16.2%

We have a higher percentage of disabled staff who experience harassment, bullying or abuse than the comparator



Recommendation:

- Implement anti-bullying and harassment policies with focus on protecting disabled staff.
- Increase awareness and training for staff to recognize and address bullying or harassment, particularly for disabled employees.

4b. Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it

Indicator	Description	Comparator	Disabled	Non-disabled
4b	Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	50.0%	33.3%	55.6%

Only a third of disabled staff who experience harassment, bullying or abuse reported it, compared to half for the comparator.

Recommendation:

Work on creating supportive environment where disabled staff feel more comfortable reporting incidents. This could include confidential reporting channels and clear policies for handling complaints. Freedom to speak up focus.

To implement anti-bullying policies, we will:

- Introduce mandatory anti-bullying training for all staff by Q3 2025.
- Increase awareness through workshops and seminars by Q4 2025.

Metrics 5

Percentage of disabled staff compared to non-disabled staff believing that their trust provides equal opportunities for career progression or promotion

Indicator	Description	Comparator	Disabled	Non-disabled
5	Percentage of disabled staff compared to non-disabled staff believing that their trust provides equal opportunities for career progression or promotion	52.9%	51.1%	51.8%

Around half of our disabled staff believe that the organisation provides equal opportunities for career progression and promotion, which is slightly lower than the comparator.

Recommendations

- Consider additional strategies such as mentorship programs or professional development tailored for disabled staff.

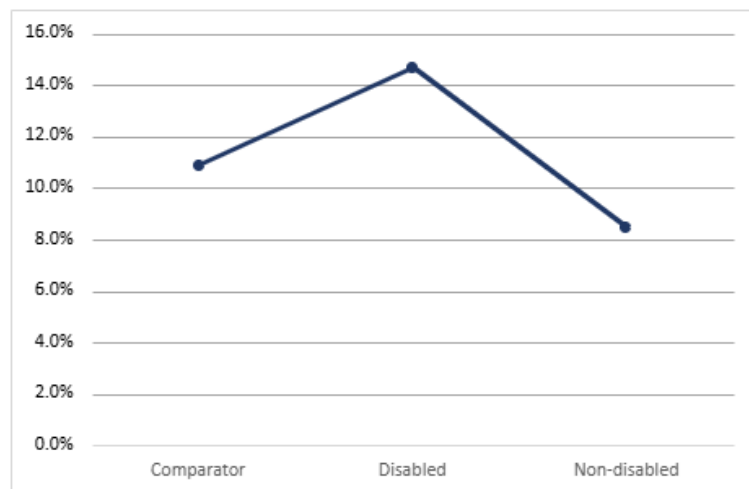
We will launch a mentorship programme for disabled staff by Q2 2025, providing tailored professional development opportunities and support.

Metrics 6

Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

Indicator	Description	Comparator	Disabled	Non-disabled
6	Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	10.9%	14.7%	8.5%

Our disabled staff feel more pressure to come to work while unwell than the comparator.



Recommendations

- Introduce or strengthen flexible working arrangements and sick leave policies, ensuring that all employees, particularly those with disabilities, feel supported in taking the time they need to recover when unwell. Including additional narrative for disabled staff specifically.

We will review and update our sick leave policy to ensure it supports disabled staff by Q1 2025. This includes introducing or strengthening flexible working arrangements.

Metrics 7

Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work

Indicator	Description	Comparator	Disabled	Non-disabled
7	Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	50.9%	46.8%	53.3%

Of all staff who feel satisfied with the extent that the organisation values their work, 46.8% are disabled.

Recommendations

- Could introduce recognition programs, feedback mechanisms, and initiatives that specifically target inclusion and support for disabled employees/showcase in an inclusive manner not specifically targeting but ensuring staff are included.

We will introduce a quarterly recognition programme to highlight the contributions of disabled staff by Q3 2025. This will include feedback mechanisms to ensure all staff feel valued.

Metrics 8

Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work.

Indicator	Description	Comparator	Disabled	Non-disabled
8	Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work	85.7%	85.7%	*

Examples of reasonable adjustments made include providing ergonomic workstations, flexible working hours, and assistive technologies. We will continue to identify and implement necessary adjustments to support our disabled staff.

Metrics 9 - Staff Engagement Score

Indicator	Description	Comparator	Disabled	Non-disabled
9a	Staff Engagement Score	7.00	6.6	7.1

Conclusions for Metrics 4 – 9

- Harassment and Bullying: There is a need for stronger anti-bullying policies and efforts to address harassment or bullying, particularly against disabled employees.
- Reporting and Support: The lower reporting rate for disabled staff suggests a need for more accessible reporting mechanisms and support systems to encourage reporting of harassment.
- Engagement and Satisfaction: While disabled staff report higher engagement and satisfaction, the overall goal should be to improve satisfaction for both disabled and non-disabled employees through recognition and valuing contributions.
- Reasonable Adjustments: Continue maintaining and improving reasonable adjustments to make sure disabled staff are supported effectively.

To improve engagement and satisfaction, we will:

- Conduct regular engagement surveys and focus groups to gather feedback from disabled staff by Q2 2025.
- Implement initiatives based on survey results to enhance the work environment.

Action Plan



Action	Target Date	Expected Outcomes	Key Milestones	By Whom	Date Completed
Increase outreach to disabled candidates	Q2 2025	Higher representation of disabled candidates in shortlisting	Partner with disability organisations, update job listings	Recruitment Team	
Implement anti-bullying training	Q3 2025	Reduced incidents of harassment and bullying	Develop training materials, schedule workshops	EDI Team	
Launch mentorship programme	Q2 2025	Improved career progression for disabled staff	Identify mentors, match with mentees	HR Team	
Review sick leave policy	Q1 2025	Better support for disabled staff	Draft policy changes, communicate to staff	HR Team	
Introduce recognition programme	Q3 2025	Increased staff satisfaction	Develop programme criteria, launch first recognition event	EDI Team	
Conduct engagement surveys	Q2 2025	Enhanced work environment	Design survey, analyse results, implement changes	EDI Team	

FRIMLEY INTEGRATED CARE BOARD

PUBLIC BOARD

Title of Paper	25/26 Financial Planning - Final Submission		
Agenda Item	6.1	Date of meeting	18 March 2025
Exec Lead	Rich Chapman, Chief Finance Officer		
Author(s)	Director of System Financial Sustainability		

Purpose	To Approve	<input type="checkbox"/>
	To Ratify	<input type="checkbox"/>
	To Discuss	<input type="checkbox"/>
	To Note	<input checked="" type="checkbox"/>

Link to Strategic Objective	6. <i>Outstanding Use of Resource</i>
------------------------------------	---------------------------------------

Executive Summary	
<p>The paper summarises the latest position on the financial planning requirements in terms of:</p> <ul style="list-style-type: none"> • Timelines • Governance requirements • Operational delivery • Financial delivery <p>The Board is asked to note that given the timings of the scheduled Board meeting on 18 March 2025 and the final deadline for submission on 27 March 2025, a further extra-ordinary meeting of the Board will need to be scheduled to agree the FINAL submission.</p>	
Recommendation	The Board is asked to NOTE the latest version of the submission to NHS England and furthermore to NOTE that an extra-ordinary meeting of the Board will need to be organised to approve the FINAL submission.

Please provide details on the impact of following aspects	
Risk and Assurance	
Equality and Quality Impact Assessment	
Patient and Stakeholder Engagement	
Financial Impact and Legal implications	
Please indicate which CQC Theme and Quality Statements this QIA supports. Interim guidance for assessing integrated care systems March 2023 (cqc.org.uk)	Choose a Quality Statement.

Reporting – has this paper been discussed at other meetings		
Committee Name	Date discussed	Outcome

1. Purpose of paper

1.1. Why is this paper being submitted and what input is required?

The Frimley System submitted draft headline plans on February 27th setting out our operational, financial and workforce plans for the new financial year. **Final plans are due for submission to NHS England on March 27th**, covering all aspects of our system. The following paper is produced to jointly brief the Boards of NHS Frimley and Frimley Health NHS Foundation Trust as the statutory Boards making up the Frimley System.

A specific requirement of the 2025/26 planning process is the formal agreement by our constituent Boards of a new “**Board Assurance Statement**”. A copy of this document is included as an appendix, and this paper has been produced to provide the Boards with initial assurances in order sign up to the statement prior to the submission on March 27th.

2. Executive Summary

2.1 Context

2025/26 plans are to be finalised by March 27th 2025. Every system must submit a plan which has been signed off by the Boards of every constituent organisation within the System (Frimley ICB & Frimley Health NHS Foundation Trust). Plans must show compliance with required operational deliverables, within the resource envelope which is available to the system.

Operational delivery

National priorities for the 2025/26 financial year are stated as follows:

- Reduce the time people wait for elective care. In Frimley, this means improving 18 week RTT compliance to 60% by March 2026. This is behind the national average standard which is 65% compliance by March, reflecting our current performance which is 51%.
- Improve ED wait times and ambulance response times with a minimum 78% compliance with the four hour wait target in March 2026 and cat 2 ambulance response times averaging no more than 30 minutes across 2025/26.
- Improve access to general practice, patient experience and access to urgent dental care with 700,000 additional dental appointments to be provided nationally.

- Improve patient flow through mental health and acute care pathways, reducing average length of stay in adult acute beds, and improve access to CYP mental health services.

Financial recovery

The NHS and every system within it are expected to reduce the cost base by 1% and to deliver a 4% improvement in productivity in order to deal with demand growth.

Every system is required to deliver a break-even plan, based on the allocations notified and delivering the operational requirements. NHSE guidance states that there will be no unallocated cost efficiency remaining by March 27th, and no unmitigated savings requirements to deliver that position.

The financial position for the Frimley system in 2025/26 indicates a challenging landscape, with an anticipated funding increase of 3.6% in absolute terms, which translates to a real-terms reduction of 0.5% when accounting for national inflationary uplifts.

Current plans show an expenditure increase of 10.3%, driven by inflationary uplifts (including pay awards and employer's NI), statutory commitments, and the opening of new facilities.

This results in a material consolidated deficit before savings. To address this, Frimley ICB and Frimley Health NHS Foundation Trust have set ambitious savings targets. These targets include a 2% national productivity requirement and additional stretch savings, highlighting the need for significant efficiency improvements and cost reductions.

To achieve these financial savings, the system must prioritise transformation initiatives across various portfolios. Key priorities include optimising demand management in urgent and emergency care, expanding mental health support teams, and improving general practice contract oversight. Additionally, the system aims to enhance outpatient transformation initiatives, maximise inpatient productivity, and apply 'discharge to assess' principles to improve patient flow from hospital to home. These transformation efforts will require robust multi-agency collaboration, the use of digital health solutions, and a focus on reducing unwarranted variation and health inequalities. By aligning these priorities with national goals and leveraging system-wide integration, the Frimley system can work towards financial sustainability while enhancing the quality and accessibility of care.

Approval of Plans

An extraordinary ICB Board is being scheduled for late March, ahead of the final submission on the 27th March. The Board will be presented on the latest position and asked to support agreement of the proposed plans ahead of the submission.

FRIMLEY INTEGRATED CARE BOARD

ICB Board in Public

Title of Paper	Delegation of Commissioning Responsibilities for Specialised Services		
Agenda Item	6.2.0	Date of meeting	18 March 2025
Exec Lead	Sam Burrows, Chief Transformation, Delivery and Digital Officer		
Author(s)			

Purpose	To Approve	<input checked="" type="checkbox"/>
	To Ratify	<input type="checkbox"/>
	To Discuss	<input checked="" type="checkbox"/>
	To Note	<input type="checkbox"/>

Link to Strategic Objective	All
------------------------------------	-----

Executive Summary

Following on from previous Board discussions, members are asked to note that from 1 April 2025 onwards, ICBs will be asked to assume delegated responsibility from NHS England for the commissioning of 59 Specialised Services which are listed in the Delegation Agreement.

NHS Frimley is working at scale with the other five ICBs in the South East Region to ensure a fully aligned population health management approach.

The Board should note that the other five ICBs in the South East Region are holding similar discussions during the month of March and that the decisions which the NHS Frimley Board are being asked to approve will only be able to come into effect should there be unanimous agreement from the six ICBs collectively.

Recommendation	<p>The ICB is asked to:</p> <p>APPROVE the Delegation Agreement Appendix 1</p> <p>APPROVE the Collaboration Agreement Appendix 2</p> <p>APPROVE the Proposed Interim Governance Arrangements (“The Backstop”) Appendix 3</p>
-----------------------	---

Please provide details on the impact of following aspects

Risk and Assurance	
Equality and Quality Impact Assessment	
Patient and Stakeholder Engagement	
Financial Impact and Legal implications	
Please indicate which CQC Theme and Quality Statements this QIA supports. Interim guidance for assessing integrated care systems March 2023 (cqc.org.uk)	Choose a Quality Statement.

Reporting – has this paper been discussed at other meetings		
Committee Name	Date discussed	Outcome
Finance and Performance Committee	13.03.25	

Dated: 1 April 2025.

(1) NHS ENGLAND

- and -

(2) NHS [INSERT NAME] INTEGRATED CARE BOARD

SE Region ICBs Delegation Agreement

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

DRAFT - NOT AVAILABLE FOR ACCEPTANCE

Table of contents

Clause heading and number

Page number:

Contents

1.	PARTICULARS	4
2.	INTERPRETATION	5
3.	BACKGROUND	5
4.	TERM.....	6
5.	PRINCIPLES	6
6.	DELEGATION	6
7.	EXERCISE OF DELEGATED FUNCTIONS	7
8.	REQUIREMENT FOR ICB COLLABORATION ARRANGEMENT.....	8
9.	PERFORMANCE OF THE RESERVED FUNCTIONS AND COMMISSIONING SUPPORT ARRANGEMENTS	9
10.	FINANCE	10
11.	INFORMATION, PLANNING AND REPORTING	13
12.	FURTHER ARRANGEMENTS	13
13.	STAFFING, WORKFORCE AND COMMISSIONING TEAMS.....	14
14.	BREACH.....	14
15.	ESCALATION RIGHTS	15
16.	LIABILITY AND INDEMNITY	16
17.	CLAIMS AND LITIGATION.....	16
18.	DATA PROTECTION, FREEDOM OF INFORMATION AND TRANSPARENCY	17
19.	IT INTER-OPERABILITY	52
20.	CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY.....	52
21.	PROHIBITED ACTS AND COUNTER-FRAUD	52
22.	CONFIDENTIAL INFORMATION OF THE PARTIES	53
23.	INTELLECTUAL PROPERTY	54
24.	NOTICES.....	54
25.	DISPUTES.....	54
26.	VARIATIONS	55
27.	TERMINATION	56
28.	CONSEQUENCE OF TERMINATION.....	57
29.	PROVISIONS SURVIVING TERMINATION	58
30.	COSTS	59
31.	SEVERABILITY	59
32.	GENERAL.....	59
	SCHEDULE 1: DEFINITIONS AND INTERPRETATION	60

SCHEDULE 2: DELEGATED SERVICES70

SCHEDULE 3: DELEGATED FUNCTIONS76

SCHEDULE 4: RESERVED FUNCTIONS86

SCHEDULE 5: RETAINED SERVICES.....93

SCHEDULE 6: FURTHER INFORMATION GOVERNANCE, SHARING AND PROCESSING PROVISIONS94

SCHEDULE 7: MANDATED GUIDANCE105

SCHEDULE 8: LOCAL TERMS.....106

SCHEDULE 9: DEVELOPMENTAL ARRANGEMENTS109

SCHEDULE 10: ADMINISTRATIVE AND MANAGEMENT SERVICES..... **ERROR! BOOKMARK NOT DEFINED.**

DRAFT

DELEGATION AGREEMENT FOR SPECIFIED FUNCTIONS

1. PARTICULARS

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

Integrated Care Board	[Insert Name]
Area	[Insert Area of the ICB as defined in its Constitution]
Date of Agreement	Date: 1 April 2025
ICB Representative	[Insert details of name of manager of this Agreement for the ICB]
ICB Email Address for Notices	[Insert Address]
NHS England Representative	[Insert details of name of manager of this Agreement for NHS England]
NHS England Email Address for Notices	[Insert Address]

1.2 This Agreement comprises:

- 1.2.1 the Particulars (Clause 1);
- 1.2.2 the Terms and Conditions (Clauses 2 to 32);
- 1.2.3 the Schedules; and
- 1.2.4 the Mandated Guidance

Signed by NHS England
 [Name]
 [Title]
 (for and on behalf of NHS England)

Signed by [Insert name] Integrated Care Board
 [Insert name of Authorised Signatory]
 [Insert title of Authorised Signatory]
 [for and on behalf of] [insert name] Integrated Care Board

TERMS AND CONDITIONS

2. INTERPRETATION

- 2.1 This Agreement is to be interpreted in accordance with SCHEDULE 1 (*Definitions and Interpretation*).
- 2.2 If there is any conflict or inconsistency between the provisions of this Agreement, that conflict or inconsistency must be resolved according to the following order of priority:
- 2.2.1 the Developmental Arrangements;
 - 2.2.2 the Particulars and Terms and Conditions (Clauses 1 to 32);
 - 2.2.3 Mandated Guidance;
 - 2.2.4 all Schedules excluding Developmental Arrangements and Local Terms; and
 - 2.2.5 Local Terms.
- 2.3 This Agreement constitutes the entire agreement and understanding between the Parties relating to the Delegation and supersedes all previous agreements, promises and understandings between them, whether written or oral, relating to its subject matter.
- 2.4 Where it is indicated that a provision in this Agreement is not used, that provision is not relevant and has no application in this Agreement.
- 2.5 Where a particular clause is included in this Agreement but is not relevant to the ICB because that clause relates to matters which do not apply the ICB (for example, if the clause only relates to functions that are not Delegated Functions in respect of the ICB), that clause is not relevant and has no application to this Agreement.

3. BACKGROUND

- 3.1 NHS England has statutory functions (duties and powers) conferred on it by legislation to make arrangements for the provision of prescribed services known as Specialised Services. These services support people with a range of rare and complex conditions. They are currently set out in the Prescribed Specialised Services Manual. The legislative basis for identifying these Specialised Services is Regulation 11 and Schedule 4 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996.
- 3.2 The ICBs have statutory functions to make arrangements for the provision of services for the purposes of the NHS in their Areas, apart from those commissioned by NHS England.
- 3.3 Pursuant to section 65Z5 of the NHS Act, NHS England is able to delegate responsibility for carrying out its Commissioning Functions to an ICB. NHS England will remain accountable to Parliament for ensuring that statutory requirements to commission all Specialised Services, and duties set out in the mandate, are being met.
- 3.4 By this Agreement, NHS England delegates the functions of commissioning certain Specialised Services (the “Delegated Functions”) to the ICB under section 65Z5 of the NHS Act.
- 3.5 This Agreement also sets out the elements of commissioning those Specialised Services for which NHS England will continue to have responsibility (the “Reserved Functions”).

-
- 6.5.1 The ICB must ensure that its officers or employees do not make statutory or financial decisions that allocate NHS England resources.
 - 6.5.2 NHS England must ensure that its officers or employees do not make statutory or financial decisions that allocate ICB resources, except as provided for in this agreement.
 - 6.6 Unless expressly provided for in this Agreement, the ICB is not authorised to take any step or make any decision in respect of Reserved Functions. Any such purported decision of the ICB is invalid and not binding on NHS England unless ratified in writing by NHS England in accordance with the NHS England Scheme of Delegation and Standing Financial Instructions.
 - 6.7 NHS England may, acting reasonably and solely to the extent that the decision relates to the Delegated Functions, substitute its own decision for any decision which the ICB purports to make where NHS England reasonably considers that the impact of the ICB decision could cause the ICB to be acting unlawfully, in breach of this Agreement including Mandated Guidance, or in breach of any Contract. The ICB must provide any information, assistance and support as NHS England requires to enable it to determine whether to make any such decision.
 - 6.8 The terms of Clauses 6.5, 6.6 and 6.7 are without prejudice to the ability of NHS England to enforce the terms of this Agreement or otherwise take action in respect of any failure by the ICB to comply with this Agreement.

7. EXERCISE OF DELEGATED FUNCTIONS

- 7.1 The ICB must establish effective, safe, efficient and economic arrangements for the discharge of the Delegated Functions.
- 7.2 The ICB agrees that it will exercise the Delegated Functions in accordance with:
 - 7.2.1 the terms of this Agreement;
 - 7.2.2 Mandated Guidance;
 - 7.2.3 any Contractual Notices;
 - 7.2.4 the Local Terms;
 - 7.2.5 any Developmental Arrangements;
 - 7.2.6 all applicable Law and Guidance;
 - 7.2.7 the ICB's constitution;
 - 7.2.8 the requirements of any assurance arrangements made by NHS England; and
 - 7.2.9 Good Practice.
- 7.3 The ICB must perform the Delegated Functions in such a manner:
 - 7.3.1 so as to ensure NHS England's compliance with NHS England's statutory duties in respect of the Reserved Functions and to enable NHS England to fulfil its Reserved Functions; and

-
- 7.3.2 having regard to NHS England's accountability to the Secretary of State and Parliament in respect of both the Delegated Functions and Reserved Functions; and
- 7.3.3 so as to ensure that the ICB complies with its statutory duties and requirements including those duties set out in Section 14Z32 to Section 14Z44 and the NICE Regulations.
- 7.4 In exercising the Delegated Functions, the ICB must comply with all Mandated Guidance as set out in this Agreement or as otherwise may be issued by NHS England from time to time including, but not limited to, ensuring compliance with National Standards and following National Specifications.
- 7.5 Where Developmental Arrangements conflict with any other term of this Agreement, the Developmental Arrangements shall take precedence until such time as NHS England agrees to the removal or amendment of the relevant Developmental Arrangements in accordance with Clause 26 (*Variations*).
- 7.6 The ICB must develop an operational scheme(s) of delegation defining those individuals or groups of individuals, including committees, who may discharge aspects of the Delegated Functions. For the purposes of this clause, the ICB may include the operational scheme(s) of delegation within its general organisational scheme of delegation.
- 7.7 NHS England may by Contractual Notice allocate Contracts to the ICB such that they are included as part of the Delegation. The Delegated Functions must be exercised both in respect of the relevant Contract and any related matters concerning any Specialised Service Provider that is a party to a Contract. NHS England may add or remove Contracts where this is associated with an extension or reduction of the scope of the Delegated Functions.
- 7.8 Subsequent to the Effective Date of Delegation and for the duration of this Agreement, unless otherwise agreed any new Contract entered into in respect of the Delegated Functions shall be managed by the ICB in accordance with the provisions of this Agreement.
- 7.9 Subject to the provisions of this Agreement, the ICB may determine the arrangements for the exercise of the Delegated Functions.

8. REQUIREMENT FOR ICB COLLABORATION ARRANGEMENT

- 8.1 Subject to the provisions of Clause 12 (*Further Arrangements*), the ICB must establish appropriate ICB Collaboration Arrangements with other ICBs in order to ensure that the commissioning of the Delegated Services can take place across an appropriate geographical footprint for the nature of each particular Delegated Service with consideration of population size, provider landscape and patient flow. Such ICB arrangements in respect of the Delegated Functions must be approved in advance by NHS England.
- 8.2 The ICB must establish, as part of or separate to the arrangements set out in Clause 8.1, an agreement that sets out the arrangements in respect of the Commissioning Team as required by Clause 13.
- 8.3 The ICB must participate in discussions, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view with the other ICBs within the ICB Collaboration Arrangement. The members of the ICB Collaboration Arrangement shall have a collective responsibility for the operation of the ICB Collaboration Arrangement.

-
- 8.4 The ICB shall ensure that any ICB Collaboration Arrangement is documented and such documentation must include (but is not limited to) the following:
- 8.4.1 membership which is limited solely to ICBs unless otherwise approved by NHS England;
 - 8.4.2 clear governance arrangements including reporting lines to the ICBs' Boards;
 - 8.4.3 provisions for independent scrutiny of decision making;
 - 8.4.4 the Delegated Functions or elements thereof which are the subject of the arrangements;
 - 8.4.5 the Delegated Services which are subject to the arrangements;
 - 8.4.6 financial arrangements and any pooled fund arrangements;
 - 8.4.7 data sharing arrangements including evidence of a Data Protection Impact Assessment;
 - 8.4.8 terms of reference for decision making; and
 - 8.4.9 limits on onward delegation.
- 8.5 The ICB must not terminate an ICB Collaboration Arrangement in respect of the Delegated Functions without the prior written approval of NHS England.

9. PERFORMANCE OF THE RESERVED FUNCTIONS AND COMMISSIONING SUPPORT ARRANGEMENTS

- 9.1 NHS England will remain responsible for the performance of the Reserved Functions.
- 9.2 For the avoidance of doubt, the Parties acknowledge that the Delegation may be amended, and additional functions may be delegated to the ICB, in which event consequential changes to this Agreement shall be agreed with the ICB pursuant to Clause 26 (*Variations*) of this Agreement.
- 9.3 Where it considers appropriate NHS England will work collaboratively with the ICB when exercising the Reserved Functions.
- 9.4 If there is any conflict or inconsistency between functions that are named as Delegated Functions and functions that are named as Reserved Functions, then such functions shall be interpreted as Reserved Functions unless and until NHS England confirms otherwise. If an ICB identifies such a conflict or inconsistency, it will inform NHS England as soon as is reasonably practicable.
- 9.5 The Parties acknowledge that they may agree for the ICB to provide Administrative and Management Services to NHS England in relation to certain Reserved Functions and Retained Services in order to assist in the efficient and effective exercise of such functions. Any such Commissioning Team Arrangements shall be set out in writing.
- 9.6 Notwithstanding any arrangement for or provision of Administrative and Management Services in respect of the Retained Services and Reserved Functions, NHS England shall retain statutory responsibility for, and be accountable for, the commissioning of the Retained Services.

-
- 9.7 The Parties acknowledge that they may agree for NHS England to provide Administrative and Management Services to ICBs in relation to certain Delegated Functions and Delegated Services in order to assist in the efficient and effective exercise of such Delegated Functions. Any such Administrative and Management Services shall be set out in writing.
- 9.8 Notwithstanding any arrangement for or provision of Administrative and Management Services in respect of the Delegated Services, the ICB shall retain delegated responsibility for the commissioning of the Delegated Services.
- 9.9 Any arrangement made between the ICB and NHS England under Clauses 9.5 or 9.7 must be made in accordance with: Clause 6.5, Clause 10.14 and Paragraph 4.2 of Schedule 4.

10. FINANCE

- 10.1 Without prejudice to any other provision in this Agreement, the ICB must comply with the Finance Guidance and any such financial processes as required by NHS England for the management, reporting and accounting of funds used for the purposes of the Delegated Functions.
- 10.2 The ICB acknowledges that it will receive funds from NHS England in respect of the Delegated Functions (the "Delegated Funds") and that these are in addition to the funds allocated to it within its Annual Allocation.
- 10.3 Subject to Clause 10.4 and any provisions in the Schedules or Mandated Guidance, the ICB may use:
- 10.3.1 its Annual Allocation and the Delegated Funds in the exercise of the Delegated Functions; and
 - 10.3.2 the Delegated Funds and its Annual Allocation in the exercise of the ICB's Functions other than the Delegated Functions.
- 10.4 The ICB's expenditure on the Delegated Functions must be sufficient to:
- 10.4.1 ensure that NHS England is able to fulfil its functions, including without limitation the Reserved Functions, effectively and efficiently;
 - 10.4.2 meet all liabilities arising under or in connection with all Contracts in so far as they relate to the exercise of the Delegated Functions;
 - 10.4.3 appropriately commission the Delegated Services in accordance with Mandatory Guidance, National Specifications, National Standards and Guidance; and
 - 10.4.4 meet national commitments from time to time on expenditure on specific Delegated Functions.
- 10.5 NHS England may increase or reduce the Delegated Funds in any Financial Year, by sending a notice to the ICB of such increase or decrease:
- 10.5.1 in order to take into account any monthly adjustments or corrections to the Delegated Funds that NHS England considers appropriate, including without limitation, adjustments following any changes to the Delegated Functions, changes in allocations, changes in Contracts, to implement Mandated Guidance or otherwise;

-
- 10.5.2 in order to comply with a change in the amount allocated to NHS England by the Secretary of State pursuant to section 223B of the NHS Act;
 - 10.5.3 to take into account any Losses of NHS England for which the ICB is required to indemnify NHS England under Clause 17 (*Claims and Litigation*);
 - 10.5.4 to take into account any adjustments that NHS England considers appropriate (including without limitation in order to make corrections or otherwise to reflect notional budgets) to reflect funds transferred (or that should have been transferred) to the ICB in respect of the Delegated Functions or funds transferred (or that should have been transferred) to the ICB in respect of Administrative and Management Services; and
 - 10.5.5 in order to ensure compliance by NHS England with its obligations under the NHS Act (including, Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State in respect of NHS England under the NHS Act.
- 10.6 NHS England acknowledges that the intention of Clause 10.5 is to reflect genuine corrections and adjustments to the Delegated Funds and may not be used to change the allocation of the Delegated Funds unless there are significant or exceptional circumstances that would require such corrections or adjustments.
- 10.7 The ICB acknowledges that it must comply with its statutory financial duties, including those under Part 11 of the NHS Act to the extent that these sections apply in relation to the receipt of the Delegated Funds.
- 10.8 NHS England may in respect of the Delegated Funds:
- 10.8.1 notify the ICB regarding the required payment of sums by the ICB to NHS England in respect of charges referable to the valuation or disposal of assets and such conditions as to records, certificates or otherwise;
 - 10.8.2 by notice, require the ICB to take such action or step in respect of the Delegated Funds, in order to ensure compliance by NHS England of its duties or functions under the NHS (including Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State under the NHS Act.
- 10.9 The Schedules to this Agreement may identify further financial provisions in respect of the exercise of the Delegated Functions.
- 10.10 NHS England may issue Mandated Guidance in respect of the financial arrangements in respect of the Delegated Functions.
- 10.11 NHS England will pay the Delegated Funds to the ICB using the revenue transfer process as used for the Annual Allocation or such other process as notified to the ICB from time to time.
- 10.12 Without prejudice to any other obligation upon the ICB, for the purposes of the Delegated Functions the ICB agrees that it must use its resources in accordance with:
- 10.12.1 the terms and conditions of this Agreement including any Mandated Guidance issued by NHS England from time to time in relation to the use of resources for the purposes of the Delegated Functions (including in relation to the form or contents of any accounts);
 - 10.12.2 any NHS payment scheme published by NHS England;
 - 10.12.3 the business rules as set out in NHS England's planning guidance or such other documents issued by NHS England from time to time;

-
- 10.12.4 any Capital Investment Guidance;
 - 10.12.5 the HM Treasury Guidance *Managing Public Money* (dated September 2022) as replaced or updated from time to time; and
 - 10.12.6 any other Guidance published by NHS England with respect to the financial management of Delegated Functions.
- 10.13 Without prejudice to any other obligation upon the ICB, the ICB agrees that it must provide:
- 10.13.1 all information, assistance and support to NHS England in relation to the audit and/or investigation (whether internal or external and whether under Law or otherwise) in relation to the use of or payment of resources for the purposes of the Delegated Functions and the discharge of those functions;
 - 10.13.2 such reports in relation to the expenditure on the Delegated Functions as set out in Mandated Guidance, the Schedules to this Agreement or as otherwise required by NHS England.

Ledger access and use of financial data

- 10.14 NHS England and the ICB agree that they shall not access a financial ledger or other finance system that is operated by another organisation, or use data directly obtained from such a financial ledger or other finance system.
- 10.15 Clause 10.14 applies unless that access or use has been approved in advance by the organisation that operates that financial ledger or other finance system, or as is otherwise expressly provided for in this Agreement.

Pooled Funds

- 10.16 Subject to the provisions of this Agreement, the ICB may, for the purposes of exercising the Delegated Functions under this Agreement, establish and maintain a pooled fund(s) in respect of any part of the Delegated Funds with:
 - 10.16.1 NHS England in accordance with sections 13V or 65Z6 of the NHS Act;
 - 10.16.2 one or more ICBs in accordance with section 65Z6 of the NHS Act as part of a Further Arrangement; or
 - 10.16.3 NHS England and one or more ICBs in accordance with section 13V of the NHS Act; and
 - 10.16.4 NHS England and one or more ICBs in accordance with section 65Z6 of the NHS Act.
- 10.17 Where the ICB has decided to enter into arrangements under Clause 10.16 the agreement must be in writing and must specify:
 - 10.17.1 the agreed aims and outcomes of the arrangements;
 - 10.17.2 the payments to be made by each partner and how those payments may be varied;
 - 10.17.3 the specific Delegated Functions which are the subject of the arrangements;
 - 10.17.4 the Delegated Services which are subject to the arrangements;
 - 10.17.5 the duration of the arrangements and provision for the review or variation or termination of the arrangements;

- 10.17.6 the arrangements in place for governance of the pooled fund; and
 - 10.17.7 the arrangements in place for assuring, oversight and monitoring of the ICB's exercise of the functions referred to in 10.15.3.
- 10.18 At the date of this Agreement, details of the pooled funds (including any terms as to the governance and payments out of such pooled fund) of NHS England and the ICB are set out in the Local Terms.

11. INFORMATION, PLANNING AND REPORTING

- 11.1 The ICB must provide to NHS England:
- 11.1.1 such information or explanations in relation to the exercise of the Delegated Functions; as required by NHS England from time to time; and
 - 11.1.2 all such information (and in such form), that may be relevant to NHS England in relation to the exercise by NHS England of its other duties or functions including, without limitation, the Reserved Functions.
- 11.2 The provisions of this Clause 11 are without prejudice to the ability of NHS England to exercise its other powers and duties in obtaining information from and assessing the performance of the ICB.

Forward Plan and Annual Report

- 11.3 Before the start of each Financial Year, the ICB must describe in its joint forward plan prepared in accordance with section 14Z52 of the NHS Act how it intends to exercise the Delegated Functions.
- 11.4 The ICB must report on its exercise of the Delegated Functions in its annual report prepared in accordance with section 14Z58 of the NHS Act.

Risk Register

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

12. FURTHER ARRANGEMENTS

- 12.1 In addition to any ICB Collaboration Arrangement agreed in accordance with Clause 8 (*ICB Collaboration Arrangements*) the ICB must give due consideration to whether any of the Delegated Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act ("Further Arrangements").
- 12.2 The ICB may only make Further Arrangements with another person (a "Sub-Delegate") with the prior written approval of NHS England.
- 12.3 The approval of any Further Arrangements may:
- 12.3.1 include approval of the terms of the proposed Further Arrangements; and
 - 12.3.2 require conditions to be met by the ICB and the Sub-Delegate in respect of that arrangement.

-
- 12.4 All Further Arrangements must be made in writing.
 - 12.5 The ICB must not terminate Further Arrangements without the prior written approval of NHS England.
 - 12.6 If the ICB enters into a Further Arrangement it must ensure that the Sub-Delegate does not make onward arrangements for the exercise of any or all of the Delegated Functions without the prior written approval of NHS England.
 - 12.7 The terms of this Clause 12 do not prevent the ICB from making arrangements for assistance and support in the exercise of the Delegated Functions with any person, where such arrangements reserve the consideration and making of any decision in respect of a Delegated Function to the ICB.
 - 12.8 Where Further Arrangements are made, and unless NHS England has otherwise given specific prior written agreement, any obligations or duties on the part of the ICB under this Agreement that are relevant to those Further Arrangements shall also require the ICB to ensure that all Sub-Delegates comply with such obligations or duties and support the ICB in doing so.

13. STAFFING, WORKFORCE AND COMMISSIONING TEAMS

- 13.1 Where there is an arrangement for NHS England to provide Administrative and Management Services to the ICB, the ICB shall provide full co-operation with NHS England and enter into any necessary arrangements with NHS England and, where appropriate, other ICBs in respect of the Specialised Services Staff.
- 13.2 The ICB shall, if and where required by NHS England, enter into appropriate arrangements with NHS England in respect of the transfer of Specialised Services Staff.
- 13.3 The ICB shall, where appropriate, enter into an agreement with other ICBs, in order to establish arrangements in respect of the Commissioning Team. Where appropriate, this agreement may be included as part of the ICB Collaboration Arrangement entered into in accordance with Clause 8.

14. BREACH

- 14.1 If the ICB does not comply with the terms of this Agreement, then NHS England may:
 - 14.1.1 exercise its rights under this Agreement; and
 - 14.1.2 take such steps as it considers appropriate in the exercise of its other functions concerning the ICB.
- 14.2 Without prejudice to Clause 14.1, if the ICB does not comply with the terms of this Agreement (including if the ICB exceeds its delegated authority under the Delegation), NHS England may (at its sole discretion):
 - 14.2.1 waive its rights in relation to such non-compliance in accordance with Clause 14.3;
 - 14.2.2 ratify any decision in accordance with Clause 6.6;
 - 14.2.3 substitute a decision in accordance with Clause 6.7;

- 14.2.4 amend Developmental Arrangements or impose new Developmental Arrangements;
 - 14.2.5 revoke the whole or part of the Delegation and terminate this Agreement in accordance with Clause 27 (*Termination*) below;
 - 14.2.6 exercise the Escalation Rights in accordance with Clause 155 (*Escalation Rights*); and/or
 - 14.2.7 exercise its rights under common law.
- 14.3 NHS England may waive any non-compliance by the ICB with the terms of this Agreement provided that the ICB provides a written report to NHS England as required by Clause 14.4 and, after considering the ICB's written report, NHS England is satisfied that the waiver is justified.
- 14.4 If:
- 14.4.1 the ICB does not comply with this Agreement;
 - 14.4.2 the ICB considers that it may not be able to comply with this Agreement;
 - 14.4.3 NHS England notifies the ICB that it considers the ICB has not complied with this Agreement; or
 - 14.4.4 NHS England notifies the ICB that it considers that the ICB may not be able to comply with this Agreement,
- then the ICB must provide a written report to NHS England within ten (10) Operational Days of the non-compliance (or the date on which the ICB identifies that it may not be able to comply with this Agreement) setting out:
- 14.4.5 details of and reasons for the non-compliance (or likely non-compliance) with the Agreement and/or the Delegation; and
 - 14.4.6 a plan for how the ICB proposes to remedy the non-compliance.

15. ESCALATION RIGHTS

- 15.1 If the ICB does not comply with this Agreement, NHS England may exercise the following Escalation Rights:
- 15.1.1 NHS England may require a suitably senior representative of the ICB to attend a review meeting within ten (10) Operational Days of NHS England becoming aware of the non-compliance; and
 - 15.1.2 NHS England may require the ICB to prepare an action plan and report within twenty (20) Operational Days of the review meeting (to include details of the non-compliance and a plan for how the ICB proposes to remedy the non-compliance).
- 15.2 If NHS England does not comply with this Agreement, the ICB may require a suitably senior representative of NHS England to attend a review meeting within ten (10) Operational Days of the ICB making NHS England aware of the non-compliance.
- 15.3 Nothing in Clause 15 (*Escalation Rights*) will affect NHS England's right to substitute a decision in accordance with Clause 6.87, revoke the Delegation or terminate this Agreement in accordance with Clause 27 (*Termination*) below.

16. LIABILITY AND INDEMNITY

- 16.1 NHS England is liable in respect of any Losses arising in respect of NHS England's negligence, fraud, recklessness or deliberate breach in respect of the Delegated Functions and occurring after the Effective Date of Delegation and, if the ICB suffers any Losses in respect of such actions by NHS England, NHS England shall make such adjustments to the Annual Allocation (or other amounts payable to the ICB) in order to reflect any Losses suffered by the ICB (except to the extent that the ICB is liable for such Losses pursuant to Clause 16.3).
- 16.2 For the avoidance of doubt, NHS England remains liable for a Claim relating to facts, events or circumstances concerning the Delegated Functions before the Effective Date of Delegation.
- 16.3 The ICB is liable to (and shall pay) NHS England for any Losses suffered by NHS England that result from or arise out of the ICB's negligence, fraud, recklessness or breach of the Delegation (including any actions that are taken that exceed the authority conferred by the Delegation) or this Agreement. In respect of such Losses, NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB or make such adjustments to the Delegated Funds pursuant to Clause 10.5. The ICB shall not be liable to the extent that the Losses arose prior to the Effective Date of Delegation.
- 16.4 Each Party acknowledges and agrees that any rights acquired, or liabilities (including liabilities in tort) incurred, in respect of the exercise by the ICB of any Delegated Function are enforceable by or against the ICB only, in accordance with section 65Z5(6) of the NHS Act.
- 16.5 Each Party will at all times take all reasonable steps to minimise and mitigate any Losses or other matters for which one Party is entitled to be indemnified by or to bring a claim against the other under this Agreement.

17. CLAIMS AND LITIGATION

- 17.1 Nothing in this Clause 17 (*Claims and Litigation*) shall be interpreted as affecting the reservation to NHS England of the Reserved Functions.
- 17.2 Except in the circumstances set out in Clause **Error! Reference source not found.** 17.5 and subject always to compliance with this Clause 17 (*Claims and Litigation*), the ICB shall be responsible for and shall retain the conduct of any Claim.
- 17.3 The ICB must:
- 17.3.1 comply with any policy issued by NHS England from time to time in relation to the conduct of or avoidance of Claims and the pro-active management of Claims;
 - 17.3.2 if it receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim, immediately notify NHS England and send to NHS England all copies of such correspondence;
 - 17.3.3 co-operate fully with NHS England in relation to such Claim and the conduct of such Claim;
 - 17.3.4 provide, at its own cost, to NHS England all documentation and other correspondence that NHS England requires for the purposes of considering and/or resisting such Claim; and

- 17.3.5 at the request of NHS England, take such actions or step or provide such assistance as may in NHS England's discretion be necessary or desirable having regard to the nature of the Claim and the existence of any time limit in relation to avoiding, disputing, defending, resisting, appealing, seeking a review or compromising such Claim or to comply with the requirements of the provider of an Indemnity Arrangement in relation to such Claim.
- 17.4 Subject to Clauses 17.3 and 17.5 the ICB is entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit.

NHS England Stepping into Claims

- 17.5 NHS England may, at any time following discussion with the ICB, send a notice to the ICB stating that NHS England will take over the conduct of the Claim and the ICB must immediately take all steps necessary to transfer the conduct of such Claim to NHS England unless and until NHS England transfers conduct back to the ICB. In such cases:
- 17.5.1 NHS England shall be entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit, provided that if NHS England wishes to invoke Clause 17.5.3 it agrees to seek the ICB's views on any proposal to pay or settle that Claim prior to finalising such payment or settlement; and
- 17.5.2 the Delegation shall be treated as being revoked to the extent that and for so long as NHS England has assumed responsibility for exercising those of the Delegated Functions that are necessary for the purposes of having conduct of the Claim; and
- 17.5.3 NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or make an adjustment to the Delegated Funds pursuant to Clause 10.5.3 for the purposes of meeting any Claim Losses associated with that Claim.

Claim Losses

- 17.6 The ICB and NHS England shall notify each other as soon as reasonably practicable of becoming aware of any Claim Losses.
- 17.7 The ICB acknowledges that NHS England will pay to the ICB the funds that are attributable to the Delegated Functions. Accordingly, the ICB acknowledges that it must pay any Claim Losses out of either the Delegated Funds or its Annual Allocation. NHS England may, in respect of any Claim Losses, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or pursuant to Clause 10.5.3 make such adjustments to the Delegated Funds to take into account the amount of any Claim Losses (other than any Claim Losses in respect of which NHS England has retained any funds, provisions or other resources to discharge such Claim Losses). For the avoidance of doubt, in circumstances where NHS England suffers any Claim Losses, then NHS England shall be entitled to recoup such Claim Losses pursuant to Clause 10.5.3. If and to the extent that NHS England has retained any funds, provisions or other resources to discharge such Claim Losses, then NHS England may either use such funds to discharge the Claim Loss or make an upward adjustment to the amounts paid to the ICB pursuant to Clause 10.5.3.

18. DATA PROTECTION, FREEDOM OF INFORMATION AND TRANSPARENCY

- 18.1 The Parties must ensure that all Personal Data processed by or on behalf of them while carrying out the Delegated Functions and Reserved Functions is processed in

accordance with the relevant Party's obligations under Data Protection Legislation and Data Guidance and the Parties must assist each other as necessary to enable each other to comply with these obligations.

- 18.2 The ICB must respond to any information governance breach in accordance with Information Governance Guidance for Serious Incidents. If the ICB is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach then as soon as reasonably practical and in any event on or before the first such notification is made the ICB must fully inform NHS England of the information governance breach. This clause does not require the ICB to provide NHS England with information which identifies any individual affected by the information governance breach where doing so would breach Data Protection Legislation.
- 18.3 Whether or not a Party is a Data Controller or Data Processor will be determined in accordance with Data Protection Legislation and any Data Guidance from a Regulatory or Supervisory Body. The Parties acknowledge that a Party may act as both a Data Controller and a Data Processor.
- 18.4 NHS England may, from time to time, issue a data sharing protocol or update a protocol previously issued relating to the data sharing in relation to the Delegated Functions and/or Reserved Functions. The ICB shall comply with such data sharing protocols.
- 18.5 Each Party acknowledges that the other is a public authority for the purposes of the Freedom of Information Act 2000 ("FOIA") and the Environmental Information Regulations 2004 ("EIR").
- 18.6 Each Party may be required by statute to disclose further information about the Agreement and the Relevant Information in response to a specific request under FOIA or EIR, in which case:
- 18.6.1 each Party shall provide the other with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR;
- 18.6.2 each Party shall consult the other regarding the possible application of exemptions in relation to the information requested; and
- 18.6.3 subject only to Clause 17 (*Claims and Litigation*), each Party acknowledges that the final decision as to the form or content of the response to any request is a matter for the Party to whom the request is addressed.
- 18.7 NHS England may, from time to time, issue a FOIA or EIR protocol or update a protocol previously issued relating to the handling and responding to of FOIA or EIR requests in relation to the Delegated Functions. The ICB shall comply with such FOIA or EIR protocols.

18.8 Delegated Services

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

The list of Delegated Services set out in Schedule 2 of this Agreement contains two categories of service: the first is drawn from the Prescribed Specialised Services (PSS) Manual and aligns to Schedule 4 of the 2012 Standing Rules Regulations; the second is the sub-service line codes that NHS England has introduced over time to assist in the commissioning of specialised services. From time-to-time, NHS England will amend the list of sub-service line codes, either to repurpose, remove or add a code.

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
	Adult specialist neurosciences services (continued)	08S	Neurosurgery (adults)
		08T	Mechanical Thrombectomy
		58A	Neurosurgery LVHC national: surgical removal of clival chordoma and chondrosarcoma
		58B	Neurosurgery LVHC national: EC-IC bypass (complex/high flow)
		58C	Neurosurgery LVHC national: transoral excision of dens
		58D	Neurosurgery LVHC regional: anterior skull based tumours
		58E	Neurosurgery LVHC regional: lateral skull based tumours
		58F	Neurosurgery LVHC regional: surgical removal of brainstem lesions
		58G	Neurosurgery LVHC regional: deep brain stimulation
		58H	Neurosurgery LVHC regional: pineal tumour surgeries - resection
		58I	Neurosurgery LVHC regional: removal of arteriovenous malformations of the nervous system
		58J	Neurosurgery LVHC regional: epilepsy
		58K	Neurosurgery LVHC regional: insula glioma's/complex low grade glioma's
		58L	Neurosurgery LVHC local: anterior lumbar fusion
		58M	Neurosurgery LVHC local: removal of intramedullary spinal tumours
		58N	Neurosurgery LVHC local: intraventricular tumours resection
		58O	Neurosurgery LVHC local: surgical repair of aneurysms (surgical clipping)
		58P	Neurosurgery LVHC local: thoracic discectomy
	58Q	Neurosurgery LVHC local: microvascular decompression for trigeminal neuralgia	
	58R	Neurosurgery LVHC local: awake surgery for removal of brain tumours	
	58S	Neurosurgery LVHC local: removal of pituitary tumours including for Cushing's and acromegaly	
12	Adult specialist ophthalmology services	37C	Artificial Eye Service
		37Z	Adult specialist ophthalmology services
13	Adult specialist orthopaedic services	34A	Orthopaedic surgery (adults)
		34R	Orthopaedic revision (adults)
15	Adult specialist renal services	11B	Renal dialysis
		11C	Access for renal dialysis
		11T	Renal Transplantation
16	Adult specialist services for people living with HIV	14A	Adult specialised services for people living with HIV
17	Adult specialist vascular services	30Z	Adult specialist vascular services
18	Adult thoracic surgery services	29B	Complex thoracic surgery (adults)
		29Z	Adult thoracic surgery services: outpatients
29	Haematopoietic stem cell transplantation services (adults and children)	02Z	Haematopoietic stem cell transplantation services (adults and children)
		ECP	Extracorporeal photopheresis service (adults and children)
30	Bone conduction hearing implant services (adults and children)	32B	Bone anchored hearing aids service
		32D	Middle ear implantable hearing aids service
32	Children and young people's inpatient mental health service	23K	Tier 4 CAMHS (general adolescent in eating disorders) MHLDA PC
		23L	Tier 4 CAMHS (low secure) MHLDA PC

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
121	Specialist orthopaedic services for children	23Q	Specialist orthopaedic services for children
122	Paediatric critical care services	PIC	Specialist paediatric intensive care services
124	Specialist perinatal mental health services (adults and adolescents)	22P	Specialist perinatal mental health services (adults and adolescents) MHLDA PC
125	Specialist plastic surgery services for children	23R	Specialist plastic surgery services for children
126	Specialist rehabilitation services for patients with highly complex needs (adults and children)	07Z	Specialist rehabilitation services for patients with highly complex needs (adults and children)
127	Specialist renal services for children	23S	Specialist renal services for children
128	Specialist respiratory services for children	23T	Specialist respiratory services for children
129	Specialist rheumatology services for children	23W	Specialist rheumatology services for children
130	Specialist services for children with infectious diseases	18C	Specialist services for children with infectious diseases
131	Specialist services for complex liver, biliary and pancreatic diseases in adults	19L	Specialist services for complex liver diseases in adults
		19P	Specialist services for complex pancreatic diseases in adults
		19Z	Specialist services for complex liver, biliary and pancreatic diseases in adults
		19B	Specialist services for complex biliary diseases in adults
132	Specialist services for haemophilia and other related bleeding disorders (adults and children)	03X	Specialist services for haemophilia and other related bleeding disorders (Adults)
		03Y	Specialist services for haemophilia and other related bleeding disorders (Children)
134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	05C	Specialist augmentative and alternative communication aids (adults and children)
		05E	Specialist environmental controls (adults and children)
		05P	Prosthetics (adults and children)
135	Specialist paediatric surgery services	23X	Specialist paediatric surgery services - general surgery
136	Specialist paediatric urology services	23Z	Specialist paediatric urology services
139A	Specialist morbid obesity services for children	35Z	Specialist morbid obesity services for children
139AA	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital	04P	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital
ACC	Adult Critical Care	ACC	Adult critical care

SCHEDULE 3: Delegated Functions

1 Introduction

- 1.1 Subject to the reservations set out in Schedule 4 (*Reserved Functions*) and the provisions of any Developmental Arrangements, NHS England delegates to the ICB the statutory function for commissioning the Delegated Services. This Schedule 3 sets out the key powers and duties that the ICB will be required to carry out in exercise of the Delegated Functions being, in summary:
- 1.1.1 decisions in relation to the commissioning and management of Delegated Services;
 - 1.1.2 planning Delegated Services for the Population, including carrying out needs assessments;
 - 1.1.3 undertaking reviews of Delegated Services in respect of the Population;
 - 1.1.4 supporting the management of the Specialised Commissioning Budget;
 - 1.1.5 co-ordinating a common approach to the commissioning and delivery of Delegated Services with other health and social care bodies in respect of the Population where appropriate; and
 - 1.1.6 such other ancillary activities that are necessary to exercise the Specialised Commissioning Functions.
- 1.2 When exercising the Delegated Functions, ICBs are not acting on behalf of NHS England but acquire rights and incur any liabilities in exercising the functions.

2 General Obligations

- 2.1 The ICB is responsible for planning the commissioning of the Delegated Services in accordance with this Agreement. This includes ensuring at all times that the Delegated Services are commissioned in accordance with the National Standards.
- 2.2 The ICB shall put in place arrangements for collaborative working with other ICBs in accordance with Clause 8 (*Requirement for ICB Collaboration Arrangement*).
- 2.3 The Developmental Arrangements set out in Schedule 9 shall apply.

Specific Obligations

3 Assurance and Oversight

- 3.1 The ICB must at all times operate in accordance with:
- 3.1.1 the Oversight Framework published by NHS England;
 - 3.1.2 any national oversight and/or assurance guidance in respect of Specialised Services and/or joint working arrangements; and
 - 3.1.3 any other relevant NHS oversight and assurance guidance;
- collectively known as the "Assurance Processes".

-
- 3.2 The ICB must:
- 3.2.1 develop and operate in accordance with mutually agreed ways of working in line with the Assurance Processes;
 - 3.2.2 oversee the provision of Delegated Services and the outcomes being delivered for its Population in accordance with the Assurance Processes;
 - 3.2.3 assure that Specialised Service Providers are meeting, or have an improvement plan in place to meet, National Standards;
 - 3.2.4 provide any information and comply with specific actions in relation to the Delegated Services, as required by NHS England, including metrics and detailed reporting.

4 Attendance at governance meetings

- 4.1 The ICB must ensure that there is appropriate representation at forums established through the ICB Collaboration Arrangement.
- 4.2 The ICB must ensure that an individual(s) has been nominated to represent the ICB at the Delegated Commissioning Group (DCG) and regularly attends that group. This could be a single representative on behalf of the members of an ICB Collaboration Arrangement. Where that representative is not an employee of the ICB, the ICB must have in place appropriate arrangements to enable the representative to feedback to the ICB.
- 4.3 The ICB should also ensure that they have a nominated representative with appropriate subject matter expertise to attend National Standards development forums as requested by NHS England. This could be a single representative on behalf of the members of an ICB Collaboration Arrangement. Where that representative is not an employee of the ICB, the ICB must have in place appropriate arrangements to enable the representative to feedback to the ICB.

5 Clinical Leadership and Clinical Reference Groups

- 5.1 The ICB shall support the development of clinical leadership and expertise at a local level in respect of Specialised Services.
- 5.2 The ICB shall support local and national groups including Relevant Clinical Networks and Clinical Reference Groups that are involved in developing Clinical Commissioning Policies, National Specifications, National Standards and knowledge around Specialised Services.

6 Clinical Networks

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

-
- 6.3 The ICB shall monitor the implementation of the annual plan and receive an annual report from the Relevant Clinical Network that considers delivery against the annual plan.
- 6.4 The ICB shall actively support and participate in dialogue with Relevant Clinical Networks and shall ensure that there is a clear and effective mechanism in place for giving and receiving information with the Relevant Clinical Networks including network reports.
- 6.5 The ICB shall support NHS England in the management of Relevant Clinical Networks.
- 6.6 The ICB shall actively engage and promote Specialised Service Provider engagement in appropriate Relevant Clinical Networks.
- 6.7 Where a Relevant Clinical Network identifies any concern, the ICB shall seek to consider and review that concern as soon as is reasonably practicable and take such action, if any, as it deems appropriate.
- 6.8 The ICB shall ensure that network reports are considered where relevant as part of exercising the Delegated Functions.

7 Complaints

- 7.1 This part (*Complaints*) applies from the Effective Date of Delegation or the date on which the Commissioning Team is transferred to the relevant Host ICB (whichever is the later) (the applicable date).
- 7.2 The ICB will be responsible for all complaints in respect of the Delegated Services that are received from the applicable date, regardless of whether the circumstances to which the complaint relates occurred prior to the applicable date.
- 7.3 For the avoidance of doubt, NHS England will retain responsibility for all complaints in respect of the Delegated Services that were received prior to the applicable date.
- 7.4 At all times the ICB shall operate in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and shall co-operate with other ICBs to ensure that complaints are managed effectively.
- 7.5 Where NHS England has provided the ICB with a protocol for sharing complaints in respect of any or all Specialised Services then those provisions shall apply and are deemed to be part of this Agreement (the "Complaints Sharing Protocol").
- 7.6 The ICB shall:
- 7.6.1 work with local organisations, including other ICBs that are party to the ICB Collaboration Arrangement or Commissioning Team, to ensure that arrangements are in place for the management of complaints in respect of the Delegated Services.
 - 7.6.2 consider, in the context of the ICB Collaboration Arrangement for the commissioning of the Delegated Services and employment arrangements for the Commissioning Team, whether it is best placed to manage the complaint, or whether it should be transferred to another ICB that is better placed to affect change.
 - 7.6.3 provide the relevant individuals at NHS England with appropriate access to complaints data held by the ICB that is necessary to carry out the complaints function as set out in the Complaints Sharing Protocol.

- 7.6.4 Provide such information relating to key performance indicators (“KPIs”) as is requested by NHS England.
- 7.6.5 co-operate with NHS England in respect of the review of complaints related to the Delegated Services and shall, on request, share any learning identified in carrying out the complaints function.
- 7.6.6 take part in any peer review process put in place in respect of the complaints function.

8 Commissioning and optimisation of High Cost Drugs

- 8.1 The ICB must support the effective and efficient commissioning of High Cost Drugs for Delegated Services.
- 8.2 The ICB must support NHS England in its responsibility for the financial management and reimbursement of High Cost Drugs for Specialised Services. The ICB and NHS England must agree the support to be provided. The support must be set out in writing and may include staffing, processes, reporting, prescribing analysis and oversight arrangements, but is not limited to these matters.
- 8.3 The ICB must ensure equitable access to High Cost Drugs used within the Delegated Services that may be impacted by health inequalities and develop a strategy for delivering equitable access.
- 8.4 The ICB must develop and implement Shared Care Arrangements across the Area of the ICB.
- 8.5 The ICB must provide clinical and commissioning leadership in the commissioning and management of High Cost Drugs.
- 8.6 The ICB must ensure:
 - 8.6.1 safe and effective use of High Cost Drugs in line with national Clinical Commissioning Policies, NICE technology appraisal or highly specialised technologies guidance;
 - 8.6.2 effective introduction of new medicines;
 - 8.6.3 compliance with all NHS England commercial processes and frameworks for High Cost Drugs;
 - 8.6.4 Specialised Services Providers adhere to all NHS England commercial processes and frameworks for High Cost Drugs;
 - 8.6.5 appropriate use of Shared Care Arrangements, ensuring that they are safe and well monitored; and
 - 8.6.6 consistency of prescribing and unwarranted prescribing variation are addressed.
- 8.7 The ICB must engage in the development, implementation and monitoring of initiatives that enable use of better value medicines. Such schemes include those at a local, regional or national level.
- 8.8 Where the relevant pharmacy teams have transferred to the ICB or Host ICB, the ICB must provide:

- 8.8.1 support to prescribing networks and forums, including but not limited to, Immunoglobulin Assessment panels, prescribing networks and medicines optimisation networks;
- 8.8.2 expert medicines advice and input into the Individual Funding Request process for Delegated Services;
- 8.8.3 advice and input to national procurement and other commercial processes relating to medicines and High Cost Drugs (for example, arrangements for Homecare);
- 8.8.4 advice and input to NHS England policy development relating to medicines and High Cost Drugs.

9 Contracting

- 9.1 The ICB shall be responsible for ensuring appropriate arrangements are in place for the commissioning of the Delegated Services which for the avoidance of doubt includes:
 - 9.1.1 co-ordinating or collaborating in the award of appropriate Specialised Service Contracts;
 - 9.1.2 drafting of the contract schedules so that it reflects Mandatory Guidance, National Specifications and any specific instructions from NHS England; and
 - 9.1.3 management of Specialised Services Contracts.
- 9.2 The ICB must comply with the Contracting Standard Operating Procedure issued by NHS England.
- 9.3 In relation to the contracting for NHS England Retained Services where the ICB has agreed to act as the co-ordinating commissioner, to implement NHS England's instructions in relation to those Retained Services and, where appropriate, put in place a Collaborative Commissioning Agreement with NHS England as a party.

10 Data Management and Analytics

- 10.1 The ICB shall:
 - 10.1.1 lead on standardised collection, processing, and sharing of data for Delegated Services in line with broader NHS England, Department of Health and Social Care and government data strategies;
 - 10.1.2 lead on the provision of data and analytical services to support commissioning of Delegated Services;
 - 10.1.3 ensure collaborative working across partners on agreed programmes of work focusing on provision of pathway analytics;
 - 10.1.4 share expertise and existing reporting tools with partner ICBs in the ICB Collaboration Arrangement;
 - 10.1.5 ensure interpretation of data is made available to NHS England and other ICBs within the ICB Collaboration Arrangement;

-
- 10.1.6 ensure data and analytics teams within ICBs and NHS England work collaboratively on jointly agreed programmes of work focusing on provision of pathway analytics;
- 10.2 The ICB must ensure that the data reporting and analytical frameworks, as set out in Mandated Guidance or as otherwise required by NHS England, are in place to support the commissioning of the Delegated Services.
- 11 Finance**
- 11.1 The provisions of Clause 10 (*Finance*) of this Agreement set out the financial requirements in respect of the Delegated Functions.
- 12 Freedom of Information and Parliamentary Requests**
- 12.1 The ICB shall lead on the handling, management and response to all Freedom of Information and parliamentary correspondence relating to Delegated Services.
- 13 Incident Response and Management**
- 13.1 The ICB shall:
- 13.1.1 lead on local incident management for Delegated Services as appropriate to the stated incident level;
 - 13.1.2 support national and regional incident management relating to Specialised Services; and
 - 13.1.3 ensure surge events and actions relating to Specialised Services are included in ICB escalation plans.
- 13.2 In the event that an incident is identified that has an impact on the Delegated Services (such as potential failure of a Specialised Services Provider), the ICB shall fully support the implementation of any requirements set by NHS England around the management of such incident and shall provide full co-operation to NHS England to enable a co-ordinated national approach to incident management. NHS England retains the right to take decisions at a national level where it determines this is necessary for the proper management and resolution of any such incident and the ICB shall be bound by any such decision.
- 14 Individual Funding Requests**
- 14.1 The ICB shall provide any support required by NHS England in respect of determining an Individual Funding Request and shall implement the decision of the Individual Funding Request panel.
- 15 Innovation and New Treatments**
- 15.1 The ICB shall support local implementation of innovative treatments for Delegated Services.
- 16 Mental Health, Learning Disability and Autism Specialised Services**
- 16.1 The ICB will oversee the lead provider contract(s) relating to mental health, learning disability and autism (MHLDA) provider collaboratives that are transferred to the ICB on 1 April 2025 by NHS England. This includes complying with all terms and conditions of the contract(s), including in respect of notice periods and extensions.

-
- 16.2 If the ICB proposes to terminate a MHLDA lead provider contract before the end of its term, it must seek written approval from NHS England in advance.
- 16.3 In the performance of its commissioning responsibilities for MHLDA Specialised Services, the ICB shall:
- 16.3.1 Have regard to any commissioning guidance relating to MHLDA Specialised Services issued by NHS England;
 - 16.3.2 Comply with the requirements of the Mental Health Investment Standard and related guidance issued by NHS England;
 - 16.3.3 Generally have regard to the need to commission MHLDA Specialised Services for the ICB's Population in such a manner as to ensure safe, efficient and effective services, across appropriate geographies, and which may require partnership working across other ICB or other organisational boundaries.
 - 16.3.4 Ensure that its case management function will work collaboratively across Delegated Services and Retained Services to support the oversight and progression of individual patient care, including the movement across elements of the care pathway.

17 Provider Selection and Procurement

- 17.1 The ICB shall:
- 17.1.1 run appropriate local provider selection and procurement processes for Delegated Services;
 - 17.1.2 align all procurement processes with any changes to national procurement policy (for example new legislation) for Delegated Services;
 - 17.1.3 support NHS England with national procurements where required with subject matter expertise on provider engagement and provider landscape; and
 - 17.1.4 monitor and provide advice, guidance and expertise to NHS England on the overall provider market and provider landscape.
- 17.2 In discharging these responsibilities, the ICB must comply at all times with Law and any relevant Guidance including but not limited to Mandated Guidance; any applicable procurement law and Guidance on the selection of, and award of contracts to, providers of healthcare services.
- 17.3 When the ICB makes decisions in connection with the awarding of Specialised Services Contracts, it should ensure that it can demonstrate compliance with requirements for the award of such Contracts, including that the decision was:
- 17.3.1 made in the best interest of patients, taxpayers and the Population;
 - 17.3.2 robust and defensible, with conflicts of interests appropriately managed;
 - 17.3.3 made transparently; and
 - 17.3.4 compliant with relevant Guidance and legislation.

18 Quality

-
- 18.1 The ICB must ensure that appropriate arrangements for quality oversight are in place. This must include:
- 18.1.1 clearly defined roles and responsibilities for ensuring governance and oversight of Delegated Services;
 - 18.1.2 defined roles and responsibilities for ensuring robust communication and appropriate feedback, particularly where Delegated Services are commissioned through an arrangement with one or more other ICBs;
 - 18.1.3 working with providers and partner organisations to address any issues relating to Delegated Services and escalate appropriately if such issues cannot be resolved;
 - 18.1.4 developing and standardising processes that align with regional systems to ensure oversight of the quality of Delegated Services, and participating in local System Quality Groups and Regional Quality Groups, or their equivalent;
 - 18.1.5 ensuring processes are robust and concerns are identified, mitigated and escalated as necessary;
 - 18.1.6 ensuring providers are held to account for delivery of safe, patient-focused and quality care for Delegated Services, including mechanisms for monitoring patient complaints, concerns and feedback; and
 - 18.1.7 the implementation of the Patient Safety Incident Response Framework for the management of incidents and serious events, appropriate reporting of any incidents, undertaking any appropriate patient safety incident investigation and obtaining support as required.
- 18.2 The ICB must establish a plan to ensure that the quality of the Delegated Services is measured consistently, using nationally and locally agreed metrics triangulated with professional insight and soft intelligence.
- 18.3 The ICB must ensure that the oversight of the quality of the Delegated Services is integrated with wider quality governance in the local system and aligns with the NHS England National Quality Board's recommended quality escalation processes.
- 18.4 The ICB must ensure that there is a System Quality Group (or equivalent) to identify and manage concerns across the local system.
- 18.5 The ICB must ensure that there is appropriate representation at any Regional Quality Groups or their equivalent.
- 18.6 The ICB must have in place all appropriate arrangements in respect of child and adult safeguarding and comply with all relevant Guidance.

19 Service Planning and Strategic Priorities

- 19.1 The ICB is responsible for setting local commissioning strategy, policy and priorities and planning for and carrying out needs assessments for the Delegated Services.
- 19.2 In planning, commissioning and managing the Delegated Services, the ICB must have processes in place to assess and monitor equitable patient access, in accordance with the access criteria set out in Clinical Commissioning Policies and National Specifications, taking action to address any apparent anomalies.

-
- 19.3 The ICB must ensure that it works with Specialised Service Providers and Provider Collaboratives to translate local strategic priorities into operational outputs for Delegated Services.
- 19.4 The ICB shall provide input into any consideration by NHS England as to whether the commissioning responsibility in respect of any of the Retained Services should be delegated.

20 National Standards, National Specifications and Clinical Commissioning Policies

- 20.1 The ICB shall provide input into national decisions on National Standards and national transformation regarding Delegated Services through attendance at governance meetings.
- 20.2 The ICB shall facilitate engagement with local communities on National Specification development.
- 20.3 The ICB must comply with the National Specifications and relevant Clinical Commissioning Policies and ensure that all clinical Specialised Services Contracts accurately reflect Clinical Commissioning Policies and include the relevant National Specification, where one exists in relation to the relevant Delegated Service.
- 20.4 The ICB must co-operate with any NHS England activities relating to the assessment of compliance against National Standards, including through the Assurance Processes.
- 20.5 The ICB must have appropriate mechanisms in place to ensure National Standards and National Specifications are being adhered to.
- 20.6 Where the ICB has identified that a Specialised Services Provider may not be complying with the National Standards set out in the relevant National Specification, the ICB shall consider the action to take to address this in line with the Assurance Processes.

21 Transformation

- 21.1 The ICB shall:
- 21.1.1 prioritise pathways and services for transformation according to the needs of its Population and opportunities for improvement in ICB commissioned services and for Delegated Services;
 - 21.1.2 lead ICB and ICB Collaboration Arrangement driven transformation programmes across pathways for Delegated Services;
 - 21.1.3 lead the delivery locally of transformation in areas of national priority (such as Cancer, Mental Health and Learning Disability and Autism), including supporting delivery of commitments in the NHS Long Term Plan;
 - 21.1.4 support NHS England with agreed transformational programmes for Retained Services;
 - 21.1.5 support NHS England with agreed transformational programmes and identify future transformation programmes for consideration and prioritisation for Delegated Services where national co-ordination and enablement may support transformation;

- 21.1.6 work collaboratively with NHS England on the co-production and co-design of transformation and improvement interventions and solutions in those areas prioritised; and
- 21.1.7 ensure Relevant Clinical Networks and other clinical networks use levers to facilitate and embed transformation at a local level for Delegated Services.

DRAFT

SCHEDULE 4: Reserved Functions

Introduction

1. Reserved Functions in Relation to the Delegated Services

- 1.1. In accordance with Clause 6.2 of this Agreement, all functions of NHS England other than those defined as Delegated Functions, are Reserved Functions.
- 1.2. This Schedule sets out further provision regarding the carrying out of the Reserved Functions as they relate to the Delegated Functions.
- 1.3. The ICB will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions.
- 1.4. The following functions and related activities shall continue to be exercised by NHS England.

2. Retained Services

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

3. Reserved Specialised Service Functions

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

Reserved Functions

4. Assurance and Oversight

- 4.1. NHS England shall:
 - 4.1.1. have oversight of what ICBs are delivering (inclusive of Delegated Services) for their Populations and all patients;
 - 4.1.2. design and implement appropriate assurance of ICBs' exercise of Delegated Functions including the Assurance Processes;
 - 4.1.3. help the ICB to coordinate and escalate improvement and resolution interventions where challenges are identified (as appropriate);
 - 4.1.4. ensure that the NHS England Board is assured that Delegated Functions are being discharged appropriately;
 - 4.1.5. ensure specialised commissioning considerations are appropriately included in NHS England frameworks that guide oversight and assurance of service delivery; and
 - 4.1.6. host a Delegated Commissioning Group ("DCG") that will undertake an assurance role in line with the Assurance Processes. This assurance role shall include assessing and monitoring the overall coherence, stability and sustainability of the commissioning model of Specialised Services at a

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

- 4.2. Where an officer or employee of NHS England is performing its Reserved Functions in respect of assurance and oversight, NHS England must ensure that those officers or employees do not hold responsibility for, or undertake any, decision making in respect of the ICB's Delegated Functions.

5. Attendance at governance meetings

- 5.1. NHS England shall ensure that there is appropriate representation in respect of Reserved Functions and Retained Services at local governance forums (for example, the Regional Leadership Team) and at NCG.
- 5.2. NHS England shall:
- 5.2.1. ensure that there is appropriate representation by NHS England subject matter expert(s) at National Standards development forums;
 - 5.2.2. ensure there is appropriate attendance by NHS England representatives at nationally led clinical governance meetings; and
 - 5.2.3. co-ordinate, and support key national governance groups.

6. Clinical Leadership and Clinical Reference Groups

- 6.1. NHS England shall be responsible for the following:
- 6.1.1. developing local leadership and support for the ICB relating to Specialised Services;
 - 6.1.2. providing clinical leadership, advice and guidance to the ICB in relation to the Delegated Services;
 - 6.1.3. providing point-of-contact and ongoing engagement with key external bodies, such as interest groups, charities, NICE, DHSC, and Royal Colleges; and enabling access to clinical trials for new treatments and medicines.
- 6.2. NHS England will host Clinical Reference Groups, which will lead on the development and publication of the following for Specialised Services:
- 6.2.1. Clinical Commissioning Policies;
 - 6.2.2. National Specifications, including National Standards for each of the Specialised Services.

7. Clinical Networks

- 7.1. Unless otherwise agreed between the Parties, NHS England shall put in place contractual arrangements and funding mechanisms for the commissioning of the Relevant Clinical Networks.
- 7.2. NHS England shall ensure development of multi-ICB, and multi-region (where necessary) governance and oversight arrangements for Relevant Clinical Networks that give line of sight between all clinical networks and all ICBs whose Population they serve.
- 7.3. NHS England shall be responsible for:
- 7.3.1. developing national policy for the Relevant Clinical Networks;

- 7.3.2. developing and approving the specifications for the Relevant Clinical Networks;
- 7.3.3. maintaining links with other NHS England national leads for clinical networks not focused on Specialised Services;
- 7.3.4. convening or supporting national networks of the Relevant Clinical Networks;
- 7.3.5. agreeing the annual plan for each Relevant Clinical Network with the involvement of the ICB and Relevant Clinical Network, ensuring these reflect national and regional priorities;
- 7.3.6. managing Relevant Clinical Networks jointly with the ICB; and
- 7.3.7. agreeing and commissioning the hosting arrangements of the Relevant Clinical Networks.

8. Complaints

- 8.1. NHS England shall manage all complaints in respect of the Delegated Services that are received prior to the Effective Date of Delegation or the date on which the Commissioning Team is transferred to the Host ICB (whichever is the later).
- 8.2. NHS England shall provide the relevant individuals at the ICB with appropriate access to complaints data held by NHS England that is necessary to carry out the complaints function as set out in the Complaints Sharing Protocol.
- 8.3. NHS England shall manage all complaints in respect of the Retained Services.
- 8.4. NHS England shall set out what information the ICB is required to provide when reporting on the key performance indicators. NHS England should notify the ICB in advance and provide sufficient time to allow compliance.

9. Commissioning and optimisation of High Cost Drugs

- 9.1. Unless otherwise agreed with the ICB, NHS England shall manage a central process for reimbursement of High Costs Drugs for Specialised Services. This may include making reimbursements directly to Specialised Services Providers.
- 9.2. In respect of pharmacy and optimisation of High Cost Drugs, NHS England shall:
 - 9.2.1. where appropriate, ensure that only validated drugs spend is reimbursed, there is timely drugs data and drugs data quality meets the standards set nationally;
 - 9.2.2. support the ICB on strategy for access to medicines used within Delegated Services, minimising barriers to health inequalities;
 - 9.2.3. provide support, as reasonably required, to the ICB to assist it in the commissioning of High Cost Drugs for Delegated Services including shared care agreements;
 - 9.2.4. seek to address consistency of prescribing in line with national commissioning policies, introduction of new medicines, and addressing unwarranted prescribing variation;
 - 9.2.5. develop medicines commissioning policies and criteria for access to medicines within Specialised Services;

- 9.2.6. develop support tools, including prior approval criteria, and frameworks to support the delivery of cost-effective and high quality commissioning of High Cost Drugs;
- 9.2.7. co-ordinate the development, implementation and monitoring of initiatives that enable the use of better value medicines;
- 9.2.8. where appropriate, co-ordinate national procurement or other commercial processes to secure medicines or High Cost Drugs for Specialised Services.

10. Contracting

- 10.1. NHS England shall retain the following obligations in relation to contracting for Delegated Services:
 - 10.1.1. ensure Specialised Services are included in national NHS England contracting and payment strategy (for example, Aligned Payment Incentives);
 - 10.1.2. provide advice for ICBs on schedules to support the Delegated Services;
 - 10.1.3. set, publish or make otherwise available the Contracting Standard Operating Procedure and Mandated Guidance detailing contracting strategy and policy for Specialised Services; and
 - 10.1.4. provide and distribute contracting support tools and templates to the ICB.
- 10.2. In respect of the Retained Services, NHS England shall:
 - 10.2.1. where appropriate, ensure a Collaborative Commissioning Agreement is in place between NHS England and the ICB(s); and
 - 10.2.2. where appropriate, construct model template schedules for Retained Services and issue to ICBs.

11. Data Management and Analytics

- 11.1. NHS England shall:
 - 11.1.1. support the ICB by collaborating with the wider data and analytics network (nationally) to support development and local deployment or utilisation of support tools;
 - 11.1.2. support the ICB to address data quality and coverage needs, accuracy of reporting Specialised Services activity and spend on a Population basis to support commissioning of Specialised Services;
 - 11.1.3. ensure inclusion of Specialised Services data strategy in broader NHS England, DHSC and government data strategies;
 - 11.1.4. lead on defining relevant contractual content of the information schedule (Schedule 6) of the NHS Standard Contract for Clinical Services;
 - 11.1.5. work collaboratively with the ICB to drive continual improvement of the quality and coverage of data used to support commissioning of Specialised Services;
 - 11.1.6. provide a national analytical service to support oversight and assurance of Specialised Services, and support (where required) the national Specialised

SCHEDULE 5: Retained Services

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

SCHEDULE 6: Further Information Governance, Sharing and Processing Provisions

PART 1

1. Introduction

- 1.1. This Schedule sets out the scope for the secure and confidential sharing of information between the Parties on a Need To Know basis, or where a Party acts as a Data Processor on behalf of the other Party in order to enable the Parties to exercise their functions in pursuance of this Agreement.
- 1.2. References in this Schedule (*Further Information Governance and Sharing Provisions*) to the Need to Know basis or requirement (as the context requires) should be taken to mean that each Party's Staff will only have access to Personal Data or Special Category Personal Data if it is lawful for such Staff to have access to such data for the Specified Purpose in paragraph 2.1 and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Special Category Personal Data specified.
- 1.3. This Schedule (including the details at Part 2 and 3 of this Schedule) and any Data Sharing Agreement and/or Data Processing Agreements entered into under this Schedule are designed to:
 - 1.3.1. provide information about the reasons why Relevant Information may need to be shared and/or processed on behalf of another Party and how this will be managed and controlled by the Parties;
 - 1.3.2. describe the purposes for which the Parties have agreed to share and/or the basis on which a Party is instructed to act as a Data Processor in relation to the Relevant Information;
 - 1.3.3. set out the lawful basis for the processing of Relevant Information and sharing of information between the Parties, and the principles that underpin the exchange of Relevant Information;
 - 1.3.4. describe roles and structures to support the exchange of Relevant Information between the Parties;
 - 1.3.5. apply to the sharing and processing of Relevant Information relating to Specialised Services Providers and their Staff;
 - 1.3.6. apply to the sharing and processing of Relevant Information whatever the medium in which it is held and however it is transmitted;
 - 1.3.7. ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and processed and how this sharing and processing will be managed;
 - 1.3.8. apply to the activities of the Parties' Staff; and

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

2. Purpose

- 2.1. The Specified Purpose of the data sharing and associated processing is to facilitate the exercise of the Delegated Functions and NHS England's Reserved Functions.
- 2.2. Each Party must ensure that they have in place appropriate data sharing or data processing arrangements to enable data to be received from any third party organisations from which the Parties must obtain data in order to achieve the Specified Purpose.
- 2.3. Where necessary specific and detailed purposes must be set out in a Data Sharing Agreement or Data Processing Agreement that complies with all relevant legislation and Guidance.

3. Benefits of information sharing

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

4. Lawful basis for sharing

- 4.1. The Parties shall comply with all relevant Data Protection Legislation requirements and Good Practice in relation to the processing of Relevant Information shared further to this Agreement.
- 4.2. The Parties shall ensure that there is a Data Protection Impact Assessment ("DPIA") that covers processing undertaken in pursuance of the Specified Purpose. The DPIA shall identify the lawful basis for sharing Relevant Information for each purpose and data flow.
- 4.3. Further details regarding the Relevant Information to be shared shall be set out in a Data Sharing Agreement and/or Data Processing Agreement.

5. Restrictions on use of the Shared Information

- 5.1. Each Party shall only process the Relevant Information as is necessary to achieve the Specified Purpose and, in particular, shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.
- 5.2. Access to, and processing of, the Relevant Information provided by a Party must be the minimum necessary to achieve the Specified Purpose. Information and Special Category Personal Data will be handled at all times on a restricted basis, in compliance with Data Protection Legislation requirements, and the Parties' Staff should only have access to Personal Data on a justifiable Need to Know basis.
- 5.3. Neither the provisions of this Schedule nor any associated Data Sharing Agreement and/or Data Processing Agreement should be taken to permit unrestricted access to data held by any of the Parties.

- 5.4. Neither Party shall subcontract any processing of the Relevant Information without the prior consent of the other Party. Where a Party subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor which imposes the same obligations as are imposed on that Party under this Agreement, and shall remain liable for the performance of the subcontractor's obligations.
- 5.5. The Parties shall not cause or allow Relevant Information to be transferred to any territory outside the United Kingdom without the prior written permission of the responsible Data Controller.
- 5.6. Any particular restrictions on use of certain Relevant Information should be included in a Data Sharing Agreement and/or Data Processing Agreement.

6. Ensuring fairness to the Data Subject

- 6.1. In addition to having a lawful basis for sharing information, the UK GDPR generally requires that the sharing must be fair and transparent. In order to achieve fairness and transparency to the Data Subjects, the Parties will take the following measures as reasonably required:
 - 6.1.1. amendment of internal guidance to improve awareness and understanding among Staff;
 - 6.1.2. amendment of respective privacy notices and policies to reflect the processing of data carried out further to this Agreement, including covering the requirements of articles 13 and 14 UK GDPR and providing these (or making them available to) Data Subjects;
 - 6.1.3. ensuring that information and communications relating to the processing of data is clear and easily accessible; and
 - 6.1.4. giving consideration to carrying out activities to promote public understanding of how data is processed where appropriate.
- 6.2. Each Party shall procure that its notification to the Information Commissioner's Office, and record of processing maintained for the purposes of Article 30 UK GDPR, reflects the flows of information under this Agreement.
- 6.3. The Parties shall reasonably co-operate in undertaking any DPIA associated with the processing of data further to this Agreement, and in doing so engage with their respective Data Protection Officers in the performance by them of their duties pursuant to Article 39 UK GDPR.
- 6.4. Further provision in relation to specific data flows may be included in a Data Sharing Agreement and/or Data Processing Agreement between the Parties.

7. Governance: Staff

- 7.1. The Parties must take reasonable steps to ensure the suitability, reliability, training and competence, of any Staff who have access to Personal Data, and Special Category Personal Data, including ensuring reasonable background checks and evidence of completeness are available on request.
- 7.2. The Parties agree to treat all Relevant Information as confidential and imparted in confidence and must safeguard it accordingly. Where any of the Parties' Staff are not healthcare professionals (for the purposes of the Data Protection Act 2018), the employing Parties must procure that Staff operate under a duty of confidentiality which is equivalent to that which would arise if that person were a healthcare professional.

- 7.3. The Parties shall ensure that all Staff required to access Personal Data (including Special Category Personal Data) are informed of the confidential nature of the Personal Data. The Parties shall include appropriate confidentiality clauses in employment/service contracts of all Staff that have any access whatsoever to the Relevant Information, including details of sanctions for acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure provisions of Data Protection Legislation requirements, or cause damage to or loss of the Relevant Information.
- 7.4. Each Party shall provide evidence (further to any reasonable request) that all Staff that have any access to the Relevant Information whatsoever are adequately and appropriately trained to comply with their responsibilities under Data Protection Legislation and this Agreement.
- 7.5. The Parties shall ensure that:
- 7.5.1. only those Staff involved in delivery of the Agreement use or have access to the Relevant Information;
 - 7.5.2. that such access is granted on a strict Need to Know basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited. Evidence of audit should be made freely available on request by the originating Data Controller; and
 - 7.5.3. specific limitations on the Staff who may have access to the Relevant Information are set out in any Data Sharing Agreement and/or Data Processing Agreement entered into in accordance with this Schedule.

8. Governance: Protection of Personal Data

- 8.1. At all times, the Parties shall have regard to the requirements of Data Protection Legislation and the rights of Data Subjects.
- 8.2. Wherever possible (in descending order of preference), only anonymised information, or, strongly or weakly pseudonymised information will be shared and processed by the Parties. The Parties shall co-operate in exploring alternative strategies to avoid the use of Personal Data in order to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data or Special Category Personal Data.
- 8.3. Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need to Know basis.
- 8.4. If any Party becomes aware of:
- 8.4.1. any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or
 - 8.4.2. any security vulnerability or breach in respect of the Relevant Information, it shall promptly, within 48 hours, notify the other Parties. The Parties shall fully co-operate with one another to remedy the issue as soon as reasonably practicable, and in making information about the incident available to the Information Commissioner and Data Subjects where required by Data Protection Legislation.

- 8.5. In processing any Relevant Information further to this Agreement, the Parties shall process the Personal Data and Special Category Personal Data only:
- 8.5.1. in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only in accordance with written instructions from the originating Data Controller in respect of its Relevant Information including any instructions set out in a Data Processing Agreement entered into under this Schedule, unless required by law (in which case, the processor shall inform the relevant Data Controller of that legal requirement before processing, unless that law prohibits such information on important grounds of public interest);
 - 8.5.2. to the extent as is necessary for the provision of the Specified Purpose or as is required by law or any regulatory body; and
 - 8.5.3. in accordance with Data Protection Legislation requirements, in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) UK GDPR; and not in such a way as to cause any other Data Controller to breach any of their applicable obligations under Data Protection Legislation.
- 8.6. The Parties shall act generally in accordance with Data Protection Legislation requirements. This includes implementing, maintaining and keeping under review appropriate technical and organisational measures to ensure and demonstrate that the processing of Personal Data is undertaken in accordance with Data Protection Legislation, and in particular to protect Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing, and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:
- 8.6.1. take account of the nature, scope, context and purposes of processing as well as the risks, of varying likelihood and severity for the rights and freedoms of Data Subjects; and
 - 8.6.2. be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data and Special Category Personal Data, and having the nature of the Personal Data and Special Category Personal Data which is to be protected.
- 8.7. In particular, each Party shall:
- 8.7.1. ensure that only Staff as provided under this Schedule have access to the Personal Data and Special Category Personal Data;
 - 8.7.2. ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display or distribution, of the Relevant Information;
 - 8.7.3. obtain prior written consent from the originating Party in order to transfer the Relevant Information to any third party;
 - 8.7.4. permit any other party or their representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors or assigns) and comply with all reasonable requests or directions to enable each Party to verify and/or procure that the other is in full compliance with its obligations under this Agreement; and

- 8.7.5. if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.
- 8.8. The Parties shall adhere to the specific requirements as to information security set out in any Data Sharing Agreement and/or Data Processing Agreement entered into in accordance with this Schedule.
- 8.9. The Parties shall use best endeavours to achieve and adhere to the requirements of the NHS Digital Data Security and Protection Toolkit.
- 8.10. The Parties' Single Points of Contact set out in paragraph **Error! Reference source not found.** will be the persons who, in the first instance, will have oversight of third party security measures.

9. Governance: Transmission of Information between the Parties

- 9.1. This paragraph supplements paragraph 8 of this Schedule.
- 9.2. Transfer of Personal Data between the Parties shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net or gcsx) e-mail.
- 9.3. Wherever possible, Personal Data should be transmitted and held in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, so as to ensure that the correct patient record and/or data is identified.
- 9.4. Any other special measures relating to security of transfer should be specified in a Data Sharing Agreement and/or Data Processing Agreement entered into in accordance with this Schedule.
- 9.5. Each Party shall keep an audit log of Relevant Information transmitted and received in the course of this Agreement.
- 9.6. The Parties' Single Point of Contact notified pursuant to paragraph 13 will be the persons who, in the first instance, will have oversight of the transmission of information between the Parties.

10. Governance: Quality of Information

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

11. Governance: Retention and Disposal of Shared Information

- 11.1. A non-originating Party shall securely destroy or return the Relevant Information once the need to use it has passed or, if later, upon the termination of this Agreement, howsoever determined. Where Relevant Information is held electronically, the Relevant Information will be deleted and formal notice of the deletion sent to the Party that shared the Relevant Information. Once paper information is no longer required, paper records will be securely destroyed or securely returned to the Party they came from.
- 11.2. Each Party shall provide an explanation of the processes used to securely destroy or return the information, or verify such destruction or return, upon request and shall comply with any request of the Data Controllers to dispose of data in accordance with specified standards or criteria.

- 11.3. If a Party is required by any law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy in accordance with this Schedule, it shall notify the other Parties in writing of that retention, giving details of the documents or materials that it must retain.
- 11.4. Retention of any data shall comply with the requirements of Article 5(1)(e) GDPR and with all Good Practice including the Records Management NHS Code of Practice, as updated or amended from time to time.
- 11.5. The Parties shall set out any special retention periods in a Data Sharing Agreement where appropriate.
- 11.6. The Parties shall ensure that Relevant Information held in paper form is held in secure files, and, when it is no-longer needed, destroyed using a cross cut shredder or subcontracted to a confidential waste company that complies with European Standard EN15713.
- 11.7. Each Party shall ensure that, when no longer required, electronic storage media used to hold or process Personal Data are destroyed or overwritten to current policy requirements.
- 11.8. Electronic records will be considered for deletion once the relevant retention period has ended.
- 11.9. In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Party shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

12. Governance: Complaints and Access to Personal Data

- 12.1. The Parties shall assist each other in responding to any requests made under Data Protection Legislation made by persons who wish to access copies of information held about them ("Subject Access Requests"), as well as any other exercise of a Data Subject's rights under Data Protection Legislation or complaint to or investigation undertaken by the Information Commissioner.
- 12.2. Complaints about processing shall be reported to the Single Points of Contact and the ICB. Complaints about information sharing shall be routed through each Parties' own complaints procedure unless otherwise provided for in the Agreement or determined by the ICB. Where the complaint relates to processing undertaken by a Party acting as a Data Processor on behalf of the other Party, complaints shall be routed through the relevant Data Controller's own complaints procedure unless otherwise provided for in the Agreement.
- 12.3. The Parties shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Schedule or any data processing carried out further to it.
- 12.4. Basic details of the Agreement shall be included in the appropriate log under each Party's publication scheme.

13. Governance: Single Points of Contact

- 13.1. The Parties each shall appoint a Single Point of Contact to whom all queries relating to the particular information sharing should be directed in the first instance.

14. Monitoring and review

- 14.1. The Parties shall monitor and review on an ongoing basis the sharing and wider processing of Relevant Information to ensure compliance with Data Protection Legislation and best practice. Specific monitoring requirements must be set out in the relevant Data Sharing Agreement and/or Data Processing Agreement.

DRAFT

SCHEDULE 6: Further Information Governance, Sharing and Processing Provisions

PART 2

Data Sharing Agreement

Description	Details
Subject matter of the processing	<p>Due to the complexities of Specialised Services and the distinctions between Delegated Functions and Reserved Functions, both the ICB Commissioning Teams (employed by the Host ICB) delivering Delegated Functions and the NHS England teams delivering Reserved Functions will need access to Relevant Information, which contains Personal Data.</p> <p>As set out in Schedule 6, Part 1, Paragraph 2.1, the specified purpose for sharing data is: <i>'...to facilitate the exercise of the Delegated Functions and NHS England's Reserved Functions.'</i> In order to achieve this purpose in the most effective, efficient and cost effective manner, the data will be hosted by NHS England in a collaborative working space which ICBs will have access to.</p> <p>NHS England will be responsible for ensuring that Commissioning Team staff have sufficient and appropriate access to Relevant Information to enable those staff to fulfil their commissioning functions in respect of the Delegated Services, including those described in Schedule 3 (Delegated Functions) to this agreement.</p> <p>In addition, NHS England may process the data for the following purposes:</p> <ul style="list-style-type: none"> • development, oversight, and the quality improvement of Specialised Commissioning Functions; • undertaking work to evaluate the effectiveness of innovation and changes in delivery models and advising other bodies and organisations about these functions; • arranging the provision of services to support commissioning activities, to enable reporting and evaluations; • undertaking analysis, audits, and inspections to assess and assure the quality of Commissioning Functions; • supporting healthcare organisations to interpret population health data and evidence, and to undertake reviews of the likely effectiveness and cost-effectiveness of a range of interventions; • development a of strategies on population health outcomes and to identify gaps or deficiencies in current care and to produce recommendations for improvements, including in relation to specific pathways of care; • using and supporting health organisations to use health economic tools to support decision-making and interpreting data about the surveillance or assessment of a population's health to improve health outcomes and reduce health inequalities; • the development of population health policies and strategies, and their implementation
Duration of the processing	Unless otherwise specified in this Data Sharing Agreement, the processing shall commence on the Effective Date of Delegation and, as per paragraph

	11.1 of this Schedule, shall continue until the need to use it has passed or, if later, upon the termination of this Agreement.
Nature and purpose of the processing	<p>Personal Data is shared between the in relation to the delivery of the Delegated Functions. Such processing should ensure continued:</p> <ul style="list-style-type: none"> • Provision of live services and associated reporting. • Quality improvement and assurance of services. • Dissemination of data for health and research purposes.
Type of Personal Data being Processed	<p>There will be data shared between NHSE and the ICB hub, either directly, via the shared SharePoint workspaces (hosted by NHS England) or via CSU/DSCRO (commissioning Support Unit/Data Services Commissioning Regional Offer) in respect of both the delegated and retained services, as needed in order to successfully deliver the specialised commissioned services.</p> <p>Wherever possible this data will be anonymised or pseudonymised, there will also at times be the need to share identifiable and special category data (this is mapped out in the associated DPIA and data flow mapping document).</p>
Categories of Data Subject	<p>Examples include: Staff (including volunteers, agents, and temporary workers), customers/clients, suppliers, patients, members of the public.</p>

SCHEDULE 6: Further Information Governance, Sharing and Processing Provisions

PART 3

Data Processing Agreement

Description	Details
Identity of the Controller and Processor	The ICB is the Data Controller and NHS England is the Data Processor.
Subject matter of the processing	<p>Both the ICB Commissioning Teams (employed by the Host ICB) delivering Delegated Functions and the NHS England teams delivering Reserved Functions will need access to Relevant Information. In order to achieve this purpose in the most effective, efficient and cost effective manner, the data will be hosted by NHS England in a collaborative working space which ICBs will have access to.</p> <p>Consequently, NHS England will act as a Data Processor on behalf of the ICB in relation to the Relevant Information required to commission the Delegated Services and fulfil the Delegated Functions.</p>
Duration of the processing	Unless otherwise specified in this Data Processing Agreement the processing shall commence on the Effective Date of Delegation and, as per paragraph 11.1 of this Schedule, shall continue until the need to use it has passed or, if later, upon the termination of this Agreement.
Plan for return and destruction of the data once the processing is complete	As set out in paragraph 11.1 of this Schedule
Nature and purpose of the processing	<p>This Data Processing Agreement considers processing of any data by NHS England on behalf of the ICB Commissioning Teams in relation to the delivery of the Delegated Functions. Such processing should ensure continued:</p> <ul style="list-style-type: none"> • Provision of live services and associated reporting. • Quality improvement and assurance of services. • Dissemination of data for health and research purposes.
Type of Personal Data being Processed	In the shared workspace, hosted on NHS England tenancy, on behalf of the ICBs, will hold any relevant data required to deliver both the delegated and retained specialised commissioning services. This will predominantly be anonymised and contract/commissioning data but in some instances, there may also be identifiable/special category data, this will however continue to be restricted to the relevant staff members. (this is detailed in the associated DPIA and data flow mapping document)
Categories of Data Subject	Examples include: Staff (including volunteers, agents, and temporary workers), customers/clients, suppliers, patients, members of the public.

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

19. IT INTER-OPERABILITY

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

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

20. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

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

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

21. PROHIBITED ACTS AND COUNTER-FRAUD

21.1 The ICB must not commit any Prohibited Act.

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

21.2.1 to revoke the Delegation;

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

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

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

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

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

21.6 The ICB must, on becoming aware of:

- 21.6.1 any suspected or actual bribery, corruption or fraud involving public funds;
or
- 21.6.2 any suspected or actual security incident or security breach involving Staff
or involving NHS resources;

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

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

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

- 21.7.2 all Staff who may have information to provide.

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

22. CONFIDENTIAL INFORMATION OF THE PARTIES

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

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

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

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

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

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

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

- 22.3.2 in connection with any litigation between the Parties;

- 22.3.3 to comply with the Law;

- 22.3.4 to any appropriate Regulatory or Supervisory Body;

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

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

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

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

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

- 22.4.1 is in, or comes into, the public domain other than by breach of this Agreement;
 - 22.4.2 the receiving Party can show by its records was in its possession before it received it from the disclosing Party; or
 - 22.4.3 the receiving Party can prove it obtained or was able to obtain from a source other than the disclosing Party without breaching any obligation of confidence.
- 22.5 This Clause 22 does not prevent NHS England making use of or disclosing any Confidential Information disclosed by the ICB where necessary for the purposes of exercising its functions in relation to the ICB.
- 22.6 The Parties acknowledge that damages would not be an adequate remedy for any breach of this Clause 22 by the receiving Party, and in addition to any right to damages the disclosing Party will be entitled to the remedies of injunction, specific performance and other equitable relief for any threatened or actual breach of this Clause 22.
- 22.7 This Clause 22 will survive the termination of this Agreement for any reason for a period of five (5) years.
- 22.8 This Clause 22 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

23. INTELLECTUAL PROPERTY

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

24. NOTICES

- 24.1 Any notices given under this Agreement must be sent by e-mail to the other Party's address set out in the Particulars or as otherwise notified by one Party to another as the appropriate address for this Clause 24.1.
- 24.2 Notices by e-mail will be effective when sent in legible form, but only if, following transmission, the sender does not receive a non-delivery message.

25. DISPUTES

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

- 25.2 If a Dispute arises out of, or in connection with, this Agreement then the Parties must follow the procedure set out in this clause:
- 25.2.1 either Party must give to the other written notice of the Dispute, setting out its nature and full particulars (“Dispute Notice”), together with relevant supporting documents. On service of the Dispute Notice, the Agreement Representatives must attempt in good faith to resolve the Dispute;
 - 25.2.2 if the Agreement Representatives are, for any reason, unable to resolve the Dispute within twenty (20) Operational Days of service of the Dispute Notice, the Dispute must be referred to the Chief Executive Officer (or equivalent person) of the ICB and a director of or other person nominated by NHS England (and who has authority from NHS England to settle the Dispute) who must attempt in good faith to resolve it; and
 - 25.2.3 if the people referred to in Clause 25.2.2 are for any reason unable to resolve the Dispute within twenty (20) Operational Days of it being referred to them, the Parties may attempt to settle it by mediation in accordance with the CEDR model mediation procedure. Unless otherwise agreed between the Parties, the mediator must be nominated by CEDR. To initiate the mediation, a Party must serve notice in writing (‘Alternative Dispute Resolution’ (“ADR” notice”) to the other Party to the Dispute, requesting a mediation. A copy of the ADR notice should be sent to CEDR. The mediation will start no later than ten (10) Operational Days after the date of the ADR notice.
- 25.3 If the Dispute is not resolved within thirty (30) Operational Days after service of the ADR notice, or either Party fails to participate or to continue to participate in the mediation before the expiration of the period of thirty (30) Operational Days, or the mediation terminates before the expiration of the period of thirty (30) Operational Days, the Dispute must be referred to the NHS England Board, who shall resolve the matter and whose decision shall be binding upon the Parties.

26. VARIATIONS

- 26.1 The Parties acknowledge that the scope of the Delegated Functions may be reviewed and amended from time to time including by revoking this Agreement and making alternative arrangements.
- 26.2 NHS England may vary this Agreement without the ICB’s consent where:
- 26.2.1 it is reasonably satisfied that the variation is necessary in order to comply with Legislation, NHS England’s statutory duties, or any requirements or direction given by the Secretary of State;
 - 26.2.2 where variation is as a result of amendment to or additional Mandated Guidance;
 - 26.2.3 it is satisfied that any Developmental Arrangements are no longer required;
 - 26.2.4 it reasonably considers that Developmental Arrangements are required under Clause 14 (*Breach*); or
 - 26.2.5 it is satisfied that such amendment or Developmental Arrangement is required in order to ensure the effective commissioning of the Delegated Services or other Specialised Services.
- 26.3 Where NHS England wishes to vary the Agreement in accordance with Clause 26.2 it must notice in writing to the ICB of the wording of the proposed variation and the date

on which that variation is to take effect which must, unless it is not reasonably practicable, be a date which falls at least thirty (30) Operational Days after the date on which the notice under that clause is given to the ICB.

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

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

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

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

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

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

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

26.7.1 that it accepts the Variation Proposal; or

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

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

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

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

27. TERMINATION

27.1 The ICB may:

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

27.1.2 terminate this Agreement;

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

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

- 28.1 Termination of this Agreement, or termination of the ICB's exercise of any of the Delegated Functions, will not affect any rights or liabilities of the Parties that have accrued before the date of that termination or which later accrue in respect of the term of this Agreement. For the avoidance of doubt, the ICB shall be responsible for any Claims or other costs or liabilities incurred in the exercise of the Delegated Functions during the period of this Agreement unless expressly agreed otherwise by NHS England.
- 28.2 Subject to Clause 28.4, on or pending termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, NHS England, the ICB and, if appropriate, any successor delegate will:
- 28.2.1 agree a plan for the transition of the Delegated Functions from the ICB to the successor delegate, including details of the transition, the Parties' responsibilities in relation to the transition, the Parties' arrangements in respect of the Staff engaged in the Delegated Functions and the date on which the successor delegate will take responsibility for the Delegated Functions;
 - 28.2.2 implement and comply with their respective obligations under the plan for transition agreed in accordance with Clause 28.2.1; and
 - 28.2.3 act with a view to minimising any inconvenience or disruption to the commissioning of healthcare in the Area.
- 28.3 For a reasonable period before and after termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, the ICB must:
- 28.3.1 co-operate with NHS England and any successor delegate to ensure continuity and a smooth transfer of the Delegated Functions; and
 - 28.3.2 at the reasonable request of NHS England:
 - 28.3.2.1 promptly provide all reasonable assistance and information to the extent necessary for an efficient assumption of the Delegated Functions by a successor delegate;
 - 28.3.2.2 deliver to NHS England all materials and documents used by the ICB in the exercise of any of the Delegated Functions; and
 - 28.3.2.3 use all reasonable efforts to obtain the consent of third parties to the assignment, novation or termination of existing contracts between the ICB and any third party which relate to or are associated with the Delegated Functions.
- 28.4 Where any or all of the Delegated Functions or Reserved Functions are to be directly conferred on the ICB, the Parties will co-operate with a view to ensuring continuity and a smooth transfer to the ICB.

29. PROVISIONS SURVIVING TERMINATION

- 29.1 Any rights, duties or obligations of any of the Parties which are expressed to survive, including those referred to in Clause 29.2, or which otherwise by necessary implication survive the termination for any reason of this Agreement, together with all indemnities, will continue after termination, subject to any limitations of time expressed in this Agreement.
- 29.2 The surviving provisions include the following clauses together with such other provisions as are required to interpret and give effect to them:

- 29.2.1 Clause 10 (*Finance*);
- 29.2.2 Clause 13 (*Staffing, Workforce and Commissioning Teams*);
- 29.2.3 Clause 16 (*Liability and Indemnity*);
- 29.2.4 Clause 17 (*Claims and Litigation*);
- 29.2.5 Clause 18 (*Data Protection, Freedom of Information and Transparency*);
- 29.2.6 Clause 25 (*Disputes*);
- 29.2.7 Clause 27 (*Termination*);
- 29.2.8 Schedule 6 (*Further Information Governance, Sharing and Processing Provisions*).

30. COSTS

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

31. SEVERABILITY

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

32. GENERAL

- 32.1 Nothing in this Agreement will create a partnership or joint venture or relationship of principal and agent between NHS England and the ICB.
- 32.2 A delay or failure to exercise any right or remedy in whole or in part shall not waive that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy.
- 32.3 This Agreement does not give rise to any rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this Agreement.

SCHEDULE 1: Definitions and Interpretation

1. The headings in this Agreement will not affect its interpretation.
2. Reference to any statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance, includes a reference to that statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance as from time to time updated, amended, extended, supplemented, re-enacted or replaced in whole or in part.
3. Reference to a statutory provision includes any subordinate legislation made from time to time under that provision.
4. References to clauses and schedules are to the clauses and schedules of this Agreement, unless expressly stated otherwise.
5. References to any body, organisation or office include reference to its applicable successor from time to time.
6. Any references to this Agreement or any other documents or resources includes reference to this Agreement or those other documents or resources as varied, amended, supplemented, extended, restated and/or replaced from time to time and any reference to a website address for a resource includes reference to any replacement website address for that resource.
7. Use of the singular includes the plural and vice versa.
8. Use of the masculine includes the feminine and all other genders.
9. Use of the term “including” or “includes” will be interpreted as being without limitation.
10. The following words and phrases have the following meanings:

“Administrative and Management Services”

means administrative and management support provided in accordance with Clause 9.5 or 9.7;

“Agreement”

means this agreement between NHS England and the ICB comprising the Particulars, the Terms and Conditions, the Schedules and the Mandated Guidance;

“Agreement Representatives”

means the ICB Representative and the NHS England Representative as set out in the Particulars or such person identified to the other Party from time to time as the relevant representative;

“Annual Allocation”

means the funds allocated to the ICB annually under section 223G of the NHS Act;

“Area”

means the geographical area covered by the ICB;

“Assurance Processes”

has the definition given in paragraph 3.1 of Schedule 3;

“Best Practice”

means any methodologies, pathway designs and processes relating to this Agreement or the Delegated Functions developed by the ICB or its Staff for the purposes of delivering the Delegated Functions and which are capable of wider use in the delivery of healthcare services for the purposes of the NHS, but not including inventions that are capable of patent protection

and for which patent protection is being sought or has been obtained, registered designs, or copyright in software;

“Capital Investment Guidance”

means any Mandated Guidance issued by NHS England from time to time in relation to the development, assurance and approvals process for proposals in relation to:

- the expenditure of Capital, or investment in property, infrastructure or information and technology; and
- the revenue consequences for commissioners or third parties making such investment;

“CEDR”

means the Centre for Effective Dispute Resolution;

“Claims”

means, for or in relation to the Delegated Functions (i) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or the Secretary of State, any governmental, regulatory or similar body, or any department, board or agency or (ii) any dispute with, or any investigation, inquiry or enforcement proceedings by, any governmental, regulatory or similar body or agency;

“Claim Losses”

means all Losses arising in relation to any Claim;

“Clinical Commissioning Policies”

means a nationally determined clinical policy setting out the commissioning position on a particular clinical treatment issue and defines accessibility (including a not for routine commissioning position) of a medicine, medical device, diagnostic technique, surgical procedure or intervention for patients with a condition requiring a specialised service;

“Clinical Reference Groups”

means a group consisting of clinicians, commissioners, public health experts, patient and public voice representatives and professional associations, which offers specific knowledge and expertise on the best ways that Specialised Services should be provided;

“Collaborative Commissioning Agreement”

means an agreement under which NHS Commissioners set out collaboration arrangements in respect of commissioning Specialised Services Contracts;

“Commissioning Functions”

means the respective statutory functions of the Parties in arranging for the provision of services as part of the health service;

“Commissioning Team”

means those Specialised Services Staff that support the commissioning of Delegated Services immediately prior to this Agreement and, at the point that Staff transfer from NHS England to an identified ICB, it shall mean those NHS England Staff and such other Staff appointed by that ICB to carry out a role in respect of commissioning the Delegated Services;

“Commissioning Team Arrangements”

means the arrangements through which the services of a Commissioning Team are made available to another NHS body for the purposes of commissioning the Delegated Services;

“Complaints Sharing Protocol”	has the definition given in paragraph 7.6 of Schedule 3;
“Confidential Information”	means any information or data in whatever form disclosed, which by its nature is confidential or which the disclosing Party acting reasonably states in writing to the receiving Party is to be regarded as confidential, or which the disclosing Party acting reasonably has marked ‘confidential’ (including, financial information, strategy documents, tenders, employee confidential information, development or workforce plans and information, and information relating to services) but which is not information which is disclosed in response to an FOIA request, or information which is published as a result of NHS England or government policy in relation to transparency;
“Contracts”	means any contract or arrangement in respect of the commissioning of any of the Delegated Services;
“Contracting Standard Operating Procedure”	means the Contracting Standard Operating Procedure produced by NHS England in respect of the Delegated Services;
“Contractual Notice”	means a contractual notice issued by NHS England to the ICB, from time to time and relating to allocation of contracts for the purposes of the Delegated Functions;
“CQC”	means the Care Quality Commission;
“Data Controller”	shall have the same meaning as set out in the UK GDPR;
“Data Guidance”	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency and the Information Commissioner;
“Data Protection Impact Assessment”	means an assessment to identify and minimise the data protection risks in relation to any data sharing proposals;
“Data Protection Officer”	shall have the same meaning as set out in the Data Protection Legislation;
“Data Processing Agreement”	means a data processing agreement which should be in substantially the same form as a Data Processing Agreement template approved by NHS England;
“Data Protection Legislation”	means the UK GDPR, the Data Protection Act 2018 and all applicable Law concerning privacy, confidentiality or the processing of personal data including but not limited to the

Human Rights Act 1998, the Health and Social Care (Safety and Quality) Act 2015, the common law duty of confidentiality and the Privacy and Electronic Communications (EC Directive) Regulations 2003;

“Data Sharing Agreement”	means a data sharing agreement which should be in substantially the same form as a Data Sharing Agreement template approved by NHS England;
“Data Subject”	shall have the same meaning as set out in the UK GDPR;
“Delegated Commissioning Group (DCG)”	means the advisory forum in respect of Delegated Services set up by NHS England currently known as the Delegated Commissioning Group for Specialised Services;
“Delegated Functions”	means the statutory functions delegated by NHS England to the ICB under the Delegation and as set out in detail in this Agreement;
“Delegated Funds”	means the funds defined in Clause 10.2;
“Delegated Services”	means the services set out in Schedule 2 of this Agreement and which may be updated from time to time by NHS England;
“Delegation”	means the delegation of the Delegated Functions from NHS England to the ICB as described at Clause 6.1;
“Developmental Arrangements”	means the arrangements set out in Schedule 9 as amended or replaced;
“Dispute”	a dispute, conflict or other disagreement between the Parties arising out of or in connection with this Agreement;
“Effective Date of Delegation”	means for the Specialised Services set out in Schedule 2, the date set out in Schedule 2 as the date delegation will take effect in respect of that particular Specialised Service and for any future delegations means the date agreed by the parties as the date that the delegation will take effect;
“EIR”	means the Environmental Information Regulations 2004;
“Escalation Rights”	means the escalation rights as defined in Clause 15 (<i>Escalation Rights</i>);
“Finance Guidance”	means the guidance, rules and operating procedures produced by NHS England that relate to these delegated arrangements, including but not limited to the following: <ul style="list-style-type: none">- Commissioning Change Management Business Rules;- Contracting Standard Operating Procedure;- Cashflow Standard Operating Procedure;- Finance and Accounting Standard Operating Procedure;

- Service Level Framework Guidance;

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

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

“NHS Counter Fraud Authority”	means the Special Health Authority established by and in accordance with the NHS Counter Fraud Authority (Establishment, Constitution, and Staff and Other Transfer Provisions) Order 2017/958;
“NHS Digital Data Security and Protection Toolkit”	means the toolkit published by NHS Digital and available on the NHS Digital website at: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/data-security-and-protection-toolkit ;
“NHS England”	means the body established by section 1H of the NHS Act;
“NHS England Deliverables”	means all documents, products and materials NHS England in which NHS England holds IPRs which are relevant to this Agreement, the Delegated Functions or the Reserved Functions in any form and made available by NHS England to the ICB under this Agreement, including data, reports, policies, plans and specifications;
“NHS England Functions”	means all functions of NHS England as set out in legislation excluding any functions that have been expressly delegated;
“Non-Personal Data”	means data which is not Personal Data;
“Operational Days”	a day other than a Saturday, Sunday, Christmas Day, Good Friday or a bank holiday in England;
“Oversight Framework”	means the NHS Oversight Framework, as may be amended or replaced from time to time, and any relevant associated Guidance published by NHS England;
“Party/Parties”	means a party or both parties to this Agreement;
“Patient Safety Incident Response Framework”	means the framework published by NHS England and made available on the NHS England website at: https://www.england.nhs.uk/patient-safety/incident-response-framework/ ;
“Personal Data”	shall have the same meaning as set out in the UK GDPR and shall include references to Special Category Personal Data where appropriate;
“Population”	means, in relation to any particular delegated service, the group of people for which the ICB would have the duty to arrange for the provision of that service under section 3 of the NHS Act (hospital and other services), if it was not a service which NHS England had a duty to arrange under its Specialised Commissioning Functions;

For guidance on the persons for whom an ICB is responsible for arranging services see *Who Pays? Determining which NHS commissioner is responsible for commissioning healthcare services and making payments to providers*;

“Prescribed Specialised Services Manual”	means the document which may be amended or replaced from time to time which is currently known as the prescribed specialised services manual which describes how NHS England and ICBs commission specialised services and sets out the identification rules which describe how NHS England and ICBs identify Specialised Services activity within data flows;
“Provider Collaborative”	means a group of Specialised Service Providers who have agreed to work together to improve the care pathway for one or more Specialised Services;
“Provider Collaborative Guidance”	means the guidance published by NHS England in respect of Provider Collaboratives;
“Prohibited Act”	means the ICB: <ul style="list-style-type: none"> (i) offering, giving, or agreeing to give NHS England (or an of their officers, employees or agents) any gift or consideration of any kind as an inducement or reward for doing or not doing or for having done or not having done any act in relation to the obtaining of performance of this Agreement, the Reserved Functions, the Delegation or any other arrangement with the ICB, or for showing or not showing favour or disfavour to any person in relation to this Agreement or any other arrangement with the ICB; and (ii) in connection with this Agreement, paying or agreeing to pay any commission, other than a payment, particulars of which (including the terms and conditions of the agreement for its payment) have been disclosed in writing to NHS England; or (iii) committing an offence under the Bribery Act 2010;
“Regional Quality Group”	means a group set up to act as a strategic forum at which regional partners from across health and social care can share, identify and mitigate wider regional quality risks and concerns as well as share learning so that quality improvement and best practice can be replicated;
“Regulatory or Supervisory Body”	means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: <ul style="list-style-type: none"> (i) CQC; (ii) NHS England; (iii) the Department of Health and Social Care; (iv) the National Institute for Health and Care Excellence; (v) Healthwatch England and Local Healthwatch; (vi) the General Medical Council;

- (vii) the General Dental Council;
- (viii) the General Optical Council;
- (ix) the General Pharmaceutical Council;
- (x) the Healthcare Safety Investigation Branch; and
- (xi) the Information Commissioner;

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

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

SCHEDULE 2: Delegated Services

Delegated Services

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

The list of Delegated Services set out in Schedule 2 of this Agreement contains two categories of service: the first is drawn from the Prescribed Specialised Services (PSS) Manual and aligns to Schedule 4 of the 2012 Standing Rules Regulations; the second is the sub-service line codes that NHS England has introduced over time to assist in the commissioning of specialised services. From time-to-time, NHS England will amend the list of sub-service line codes, either to repurpose, remove or add a code.

This is done to support in the management of finances, activity or for other administrative reasons; or to support transformational work that may be ongoing in the service area that requires a sub-service line code to track and manage funding and activity. The intention is that any changes will be supportive of ICBs' commissioning responsibilities, and that there will be a small number of changes in the delegated services sub-service line codes in any one year.

All future changes to sub-service line codes relating to Delegated Services will be developed with ICBs. ICBs will be engaged and have the opportunity to provide comment on the proposed change before it is made. Changes to the sub-service line codes will be discussed at and agreed by the Delegated Commissioning Group, hosted by NHS England and attended by ICB representatives. If changes are agreed, the latest lists will be made available on the NHS England website here [\[NHS England » NHS England service codes by year 2024/25\]](#) and a more detailed version on the NHSFutures site here [\[Service Portfolio Analysis - Integrating specialised services within Integrated Care Systems - FutureNHS Collaboration Platform\]](#).

The PSS Manual Lines in Schedule 2 of the Agreement, which derive from the 2012 Standing Rules Regulations, will not be altered unless there is a decision of the NHS England Board, which will necessitate wider engagement with ICBs and stakeholders.

The following Specialised Services will be delegated to the ICB on 1 April 2025:

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
2	Adult congenital heart disease services	13X	Adult congenital heart disease services (non-surgical)
		13Y	Adult congenital heart disease services (surgical)
3	Adult specialist pain management services	31Z	Adult specialist pain management services
4	Adult specialist respiratory services	29M	Interstitial lung disease (adults)
		29S	Severe asthma (adults)
		29L	Lung volume reduction (adults)
		29V	Complex home ventilation (adults)
5	Adult specialist rheumatology services	26Z	Adult specialist rheumatology services
6	Adult secure mental health services	22S(a)	Secure and specialised mental health services (adult) (medium and low) – excluding LD/ASD/WEMS/ABI/DEAF
		22S(c)	Secure and specialised mental health services (adult) (Medium and low) – ASD MHLDA PC

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
		22S(d)	Secure and specialised mental health services (adult) (Medium and low) – LD MHLDA PC
7	Adult Specialist Cardiac Services	13A	Complex device therapy
		13B	Cardiac electrophysiology & ablation
		13C	Inherited cardiac conditions
		13E	Cardiac surgery (inpatient)
		13F	PPCI for ST- elevation myocardial infarction
		13H	Cardiac magnetic resonance imaging
		13T	Complex interventional cardiology
		13Z	Cardiac surgery (outpatient)
8	Adult specialist eating disorder services	22E	Adult specialist eating disorder services MHLDA PC
9	Adult specialist endocrinology services	27E	Adrenal Cancer (adults)
		27Z	Adult specialist endocrinology services
11	Adult specialist neurosciences services	08O	Neurology (adults)
		08P	Neurophysiology (adults)
		08R	Neuroradiology (adults)
		08S	Neurosurgery (adults)
		08T	Mechanical Thrombectomy
		58A	Neurosurgery LVHC national: surgical removal of clival chordoma and chondrosarcoma
		58B	Neurosurgery LVHC national: EC-IC bypass (complex/high flow)
		58C	Neurosurgery LVHC national: transoral excision of dens
		58D	Neurosurgery LVHC regional: anterior skull based tumours
		58E	Neurosurgery LVHC regional: lateral skull based tumours
		58F	Neurosurgery LVHC regional: surgical removal of brainstem lesions
		58G	Neurosurgery LVHC regional: deep brain stimulation
		58H	Neurosurgery LVHC regional: pineal tumour surgeries - resection
		58I	Neurosurgery LVHC regional: removal of arteriovenous malformations of the nervous system
		58J	Neurosurgery LVHC regional: epilepsy
		58K	Neurosurgery LVHC regional: insula glioma's/complex low grade glioma's
		58L	Neurosurgery LVHC local: anterior lumbar fusion
	Adult specialist neurosciences services (continued)	58M	Neurosurgery LVHC local: removal of intramedullary spinal tumours
		58N	Neurosurgery LVHC local: intraventricular tumours resection
		58O	Neurosurgery LVHC local: surgical repair of aneurysms (surgical clipping)
	58P	Neurosurgery LVHC local: thoracic discectomy	
	58Q	Neurosurgery LVHC local: microvascular decompression for trigeminal neuralgia	
	58R	Neurosurgery LVHC local: awake surgery for removal of brain tumours	
	58S	Neurosurgery LVHC local: removal of pituitary tumours including for Cushing's and acromegaly	
12	Adult specialist ophthalmology services	37C	Artificial Eye Service
		37Z	Adult specialist ophthalmology services
13	Adult specialist orthopaedic services	34A	Orthopaedic surgery (adults)
		34R	Orthopaedic revision (adults)
15	Adult specialist renal services	11B	Renal dialysis
		11C	Access for renal dialysis

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
		11T	Renal Transplantation
16	Adult specialist services for people living with HIV	14A	Adult specialised services for people living with HIV
17	Adult specialist vascular services	30Z	Adult specialist vascular services
18	Adult thoracic surgery services	29B	Complex thoracic surgery (adults)
		29Z	Adult thoracic surgery services: outpatients
29	Haematopoietic stem cell transplantation services (adults and children)	02Z	Haematopoietic stem cell transplantation services (adults and children)
		ECP	Extracorporeal photopheresis service (adults and children)
30	Bone conduction hearing implant services (adults and children)	32B	Bone anchored hearing aids service
		32D	Middle ear implantable hearing aids service
32	Children and young people's inpatient mental health service	23K	Tier 4 CAMHS (general adolescent inc eating disorders) MHLDA PC
		23L	Tier 4 CAMHS (low secure) MHLDA PC
		23O	Tier 4 CAMHS (PICU) MHLDA PC
		23U	Tier 4 CAMHS (LD) MHLDA PC
		23V	Tier 4 CAMHS (ASD) MHLDA PC
35	Cleft lip and palate services (adults and children)	15Z	Cleft lip and palate services (adults and children)
36	Cochlear implantation services (adults and children)	32A	Cochlear implantation services (adults and children)
40	Complex spinal surgery services (adults and children)	06Z	Complex spinal surgery services (adults and children)
		08Z	Complex neuro-spinal surgery services (adults and children)
45	Cystic fibrosis services (adults and children)	10Z	Cystic fibrosis services (adults and children)
54	Fetal medicine services (adults and adolescents)	04C	Fetal medicine services (adults and adolescents)
58	Specialist adult gynaecological surgery and urinary surgery services for females	04A	Severe Endometriosis
		04D	Complex urinary incontinence and genital prolapse
58A	Specialist adult urological surgery services for men	41P	Penile implants
		41S	Surgical sperm removal
		41U	Urethral reconstruction
59	Specialist allergy services (adults and children)	17Z	Specialist allergy services (adults and children)
61	Specialist dermatology services (adults and children)	24Z	Specialist dermatology services (adults and children)
62	Specialist metabolic disorder services (adults and children)	36Z	Specialist metabolic disorder services (adults and children)
63	Specialist pain management services for children	23Y	Specialist pain management services for children
64	Specialist palliative care services for children and young adults	E23	Specialist palliative care services for children and young adults
65	Specialist services for adults with infectious diseases	18A	Specialist services for adults with infectious diseases
		18E	Specialist Bone and Joint Infection (adults)
72	Major trauma services (adults and children)	34T	Major trauma services (adults and children)

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
78	Neuropsychiatry services (adults and children)	08Y	Neuropsychiatry services (adults and children)
83	Paediatric cardiac services	23B	Paediatric cardiac services
94	Radiotherapy services (adults and children)	01R	Radiotherapy services (Adults)
		51R	Radiotherapy services (Children)
		01S	Stereotactic Radiosurgery / radiotherapy
98	Specialist secure forensic mental health services for young people	24C	FCAMHS MHLDA PC
103A	Specialist adult haematology services	03C	Castleman disease
105	Specialist cancer services (adults)	01C	Chemotherapy
		01J	Anal cancer (adults)
		01K	Malignant mesothelioma (adults)
		01M	Head and neck cancer (adults)
		01N	Kidney, bladder and prostate cancer (adults)
		01Q	Rare brain and CNS cancer (adults)
		01U	Oesophageal and gastric cancer (adults)
		01V	Biliary tract cancer (adults)
		01W	Liver cancer (adults)
		01X	Penile cancer (adults)
		01Y	Cancer Outpatients (adults)
		01Z	Testicular cancer (adults)
		04F	Gynaecological cancer (adults)
		19V	Pancreatic cancer (adults)
		19C	Biliary tract cancer surgery (adults)
		19M	Liver cancer surgery (adults)
		19Q	Pancreatic cancer surgery (adults)
		24Y	Skin cancer (adults)
		29E	Management of central airway obstruction (adults)
		51A	Interventional oncology (adults)
		51B	Brachytherapy (adults)
		51C	Molecular oncology (adults)
		61M	Head and neck cancer surgery (adults)
		61Q	Ophthalmic cancer surgery (adults)
		61U	Oesophageal and gastric cancer surgery (adults)
		61Z	Testicular cancer surgery (adults)
		33C	Transanal endoscopic microsurgery (adults)
		33D	Distal sacrectomy for advanced and recurrent rectal cancer (adults)
		106	Specialist cancer services for children and young adults
23A	Children's cancer		
106A	Specialist colorectal surgery services (adults)	33A	Complex surgery for faecal incontinence (adults)
		33B	Complex inflammatory bowel disease (adults)
107	Specialist dentistry services for children	23P	Specialist dentistry services for children
108	Specialist ear, nose and throat services for children	23D	Specialist ear, nose and throat services for children
109	Specialist endocrinology services for children	23E	Specialist endocrinology and diabetes services for children
110	Specialist gastroenterology, hepatology and nutritional support services for children	23F	Specialist gastroenterology, hepatology and nutritional support services for children
112	Specialist gynaecology services for children	73X	Specialist paediatric surgery services - gynaecology

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
113	Specialist haematology services for children	23H	Specialist haematology services for children
114	Specialist haemoglobinopathy services (adults and children)	38S	Sickle cell anaemia (adults and children)
		38T	Thalassemia (adults and children)
115	Specialist immunology services for adults with deficient immune systems	16X	Specialist immunology services for adults with deficient immune systems
115A	Specialist immunology services for children with deficient immune systems	16Y	Specialist immunology services for children with deficient immune systems
115B	Specialist maternity care for adults diagnosed with abnormally invasive placenta	04G	Specialist maternity care for women diagnosed with abnormally invasive placenta
118	Neonatal critical care services	NIC	Specialist neonatal care services
119	Specialist neuroscience services for children	23M	Specialist neuroscience services for children
		07Y	Paediatric neurorehabilitation
		08J	Selective dorsal rhizotomy
120	Specialist ophthalmology services for children	23N	Specialist ophthalmology services for children
121	Specialist orthopaedic services for children	23Q	Specialist orthopaedic services for children
122	Paediatric critical care services	PIC	Specialist paediatric intensive care services
124	Specialist perinatal mental health services (adults and adolescents)	22P	Specialist perinatal mental health services (adults and adolescents) MHLDA PC
125	Specialist plastic surgery services for children	23R	Specialist plastic surgery services for children
126	Specialist rehabilitation services for patients with highly complex needs (adults and children)	07Z	Specialist rehabilitation services for patients with highly complex needs (adults and children)
127	Specialist renal services for children	23S	Specialist renal services for children
128	Specialist respiratory services for children	23T	Specialist respiratory services for children
129	Specialist rheumatology services for children	23W	Specialist rheumatology services for children
130	Specialist services for children with infectious diseases	18C	Specialist services for children with infectious diseases
131	Specialist services for complex liver, biliary and pancreatic diseases in adults	19L	Specialist services for complex liver diseases in adults
		19P	Specialist services for complex pancreatic diseases in adults
		19Z	Specialist services for complex liver, biliary and pancreatic diseases in adults
		19B	Specialist services for complex biliary diseases in adults
132	Specialist services for haemophilia and other related bleeding disorders (adults and children)	03X	Specialist services for haemophilia and other related bleeding disorders (Adults)
		03Y	Specialist services for haemophilia and other related bleeding disorders (Children)
134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	05C	Specialist augmentative and alternative communication aids (adults and children)
		05E	Specialist environmental controls (adults and children)
		05P	Prosthetics (adults and children)
135	Specialist paediatric surgery services	23X	Specialist paediatric surgery services - general surgery
136	Specialist paediatric urology services	23Z	Specialist paediatric urology services

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
139A	Specialist morbid obesity services for children	35Z	Specialist morbid obesity services for children
139AA	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital	04P	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital
ACC	Adult Critical Care	ACC	Adult critical care

DRAFT

SCHEDULE 3: Delegated Functions

22 Introduction

- 22.1 Subject to the reservations set out in Schedule 4 (*Reserved Functions*) and the provisions of any Developmental Arrangements, NHS England delegates to the ICB the statutory function for commissioning the Delegated Services. This Schedule 3 sets out the key powers and duties that the ICB will be required to carry out in exercise of the Delegated Functions being, in summary:
- 22.1.1 decisions in relation to the commissioning and management of Delegated Services;
 - 22.1.2 planning Delegated Services for the Population, including carrying out needs assessments;
 - 22.1.3 undertaking reviews of Delegated Services in respect of the Population;
 - 22.1.4 supporting the management of the Specialised Commissioning Budget;
 - 22.1.5 co-ordinating a common approach to the commissioning and delivery of Delegated Services with other health and social care bodies in respect of the Population where appropriate; and
 - 22.1.6 such other ancillary activities that are necessary to exercise the Specialised Commissioning Functions.
- 22.2 When exercising the Delegated Functions, ICBs are not acting on behalf of NHS England but acquire rights and incur any liabilities in exercising the functions.

23 General Obligations

- 23.1 The ICB is responsible for planning the commissioning of the Delegated Services in accordance with this Agreement. This includes ensuring at all times that the Delegated Services are commissioned in accordance with the National Standards.
- 23.2 The ICB shall put in place arrangements for collaborative working with other ICBs in accordance with Clause 8 (*Requirement for ICB Collaboration Arrangement*).
- 23.3 The Developmental Arrangements set out in Schedule 9 shall apply.

Specific Obligations

24 Assurance and Oversight

- 24.1 The ICB must at all times operate in accordance with:
- 24.1.1 the Oversight Framework published by NHS England;
 - 24.1.2 any national oversight and/or assurance guidance in respect of Specialised Services and/or joint working arrangements; and
 - 24.1.3 any other relevant NHS oversight and assurance guidance;
- collectively known as the “Assurance Processes”.

24.2 The ICB must:

- 24.2.1 develop and operate in accordance with mutually agreed ways of working in line with the Assurance Processes;
- 24.2.2 oversee the provision of Delegated Services and the outcomes being delivered for its Population in accordance with the Assurance Processes;
- 24.2.3 assure that Specialised Service Providers are meeting, or have an improvement plan in place to meet, National Standards;
- 24.2.4 provide any information and comply with specific actions in relation to the Delegated Services, as required by NHS England, including metrics and detailed reporting.

25 Attendance at governance meetings

- 25.1 The ICB must ensure that there is appropriate representation at forums established through the ICB Collaboration Arrangement.
- 25.2 The ICB must ensure that an individual(s) has been nominated to represent the ICB at the Delegated Commissioning Group (DCG) and regularly attends that group. This could be a single representative on behalf of the members of an ICB Collaboration Arrangement. Where that representative is not an employee of the ICB, the ICB must have in place appropriate arrangements to enable the representative to feedback to the ICB.
- 25.3 The ICB should also ensure that they have a nominated representative with appropriate subject matter expertise to attend National Standards development forums as requested by NHS England. This could be a single representative on behalf of the members of an ICB Collaboration Arrangement. Where that representative is not an employee of the ICB, the ICB must have in place appropriate arrangements to enable the representative to feedback to the ICB.

26 Clinical Leadership and Clinical Reference Groups

- 26.1 The ICB shall support the development of clinical leadership and expertise at a local level in respect of Specialised Services.
- 26.2 The ICB shall support local and national groups including Relevant Clinical Networks and Clinical Reference Groups that are involved in developing Clinical Commissioning Policies, National Specifications, National Standards and knowledge around Specialised Services.

27 Clinical Networks

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

- 27.3 The ICB shall monitor the implementation of the annual plan and receive an annual report from the Relevant Clinical Network that considers delivery against the annual plan.
- 27.4 The ICB shall actively support and participate in dialogue with Relevant Clinical Networks and shall ensure that there is a clear and effective mechanism in place for giving and receiving information with the Relevant Clinical Networks including network reports.
- 27.5 The ICB shall support NHS England in the management of Relevant Clinical Networks.
- 27.6 The ICB shall actively engage and promote Specialised Service Provider engagement in appropriate Relevant Clinical Networks.
- 27.7 Where a Relevant Clinical Network identifies any concern, the ICB shall seek to consider and review that concern as soon as is reasonably practicable and take such action, if any, as it deems appropriate.
- 27.8 The ICB shall ensure that network reports are considered where relevant as part of exercising the Delegated Functions.

28 Complaints

- 28.1 This part (*Complaints*) applies from the Effective Date of Delegation or the date on which the Commissioning Team is transferred to the relevant Host ICB (whichever is the later) (the applicable date).
- 28.2 The ICB will be responsible for all complaints in respect of the Delegated Services that are received from the applicable date, regardless of whether the circumstances to which the complaint relates occurred prior to the applicable date.
- 28.3 For the avoidance of doubt, NHS England will retain responsibility for all complaints in respect of the Delegated Services that were received prior to the applicable date.
- 28.4 At all times the ICB shall operate in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and shall co-operate with other ICBs to ensure that complaints are managed effectively.
- 28.5 Where NHS England has provided the ICB with a protocol for sharing complaints in respect of any or all Specialised Services then those provisions shall apply and are deemed to be part of this Agreement (the "Complaints Sharing Protocol").
- 28.6 The ICB shall:
- 28.6.1 work with local organisations, including other ICBs that are party to the ICB Collaboration Arrangement or Commissioning Team, to ensure that arrangements are in place for the management of complaints in respect of the Delegated Services.
 - 28.6.2 consider, in the context of the ICB Collaboration Arrangement for the commissioning of the Delegated Services and employment arrangements for the Commissioning Team, whether it is best placed to manage the complaint, or whether it should be transferred to another ICB that is better placed to affect change.
 - 28.6.3 provide the relevant individuals at NHS England with appropriate access to complaints data held by the ICB that is necessary to carry out the complaints function as set out in the Complaints Sharing Protocol.

- 28.6.4 Provide such information relating to key performance indicators (“KPIs”) as is requested by NHS England.
- 28.6.5 co-operate with NHS England in respect of the review of complaints related to the Delegated Services and shall, on request, share any learning identified in carrying out the complaints function.
- 28.6.6 take part in any peer review process put in place in respect of the complaints function.

29 Commissioning and optimisation of High Cost Drugs

- 29.1 The ICB must support the effective and efficient commissioning of High Cost Drugs for Delegated Services.
- 29.2 The ICB must support NHS England in its responsibility for the financial management and reimbursement of High Cost Drugs for Specialised Services. The ICB and NHS England must agree the support to be provided. The support must be set out in writing and may include staffing, processes, reporting, prescribing analysis and oversight arrangements, but is not limited to these matters.
- 29.3 The ICB must ensure equitable access to High Cost Drugs used within the Delegated Services that may be impacted by health inequalities and develop a strategy for delivering equitable access.
- 29.4 The ICB must develop and implement Shared Care Arrangements across the Area of the ICB.
- 29.5 The ICB must provide clinical and commissioning leadership in the commissioning and management of High Cost Drugs.
- 29.6 The ICB must ensure:
 - 29.6.1 safe and effective use of High Cost Drugs in line with national Clinical Commissioning Policies, NICE technology appraisal or highly specialised technologies guidance;
 - 29.6.2 effective introduction of new medicines;
 - 29.6.3 compliance with all NHS England commercial processes and frameworks for High Cost Drugs;
 - 29.6.4 Specialised Services Providers adhere to all NHS England commercial processes and frameworks for High Cost Drugs;
 - 29.6.5 appropriate use of Shared Care Arrangements, ensuring that they are safe and well monitored; and
 - 29.6.6 consistency of prescribing and unwarranted prescribing variation are addressed.
- 29.7 The ICB must engage in the development, implementation and monitoring of initiatives that enable use of better value medicines. Such schemes include those at a local, regional or national level.
- 29.8 Where the relevant pharmacy teams have transferred to the ICB or Host ICB, the ICB must provide:

- 29.8.1 support to prescribing networks and forums, including but not limited to, Immunoglobulin Assessment panels, prescribing networks and medicines optimisation networks;
- 29.8.2 expert medicines advice and input into the Individual Funding Request process for Delegated Services;
- 29.8.3 advice and input to national procurement and other commercial processes relating to medicines and High Cost Drugs (for example, arrangements for Homecare);
- 29.8.4 advice and input to NHS England policy development relating to medicines and High Cost Drugs.

30 Contracting

- 30.1 The ICB shall be responsible for ensuring appropriate arrangements are in place for the commissioning of the Delegated Services which for the avoidance of doubt includes:
 - 30.1.1 co-ordinating or collaborating in the award of appropriate Specialised Service Contracts;
 - 30.1.2 drafting of the contract schedules so that it reflects Mandatory Guidance, National Specifications and any specific instructions from NHS England; and
 - 30.1.3 management of Specialised Services Contracts.
- 30.2 The ICB must comply with the Contracting Standard Operating Procedure issued by NHS England.
- 30.3 In relation to the contracting for NHS England Retained Services where the ICB has agreed to act as the co-ordinating commissioner, to implement NHS England's instructions in relation to those Retained Services and, where appropriate, put in place a Collaborative Commissioning Agreement with NHS England as a party.

31 Data Management and Analytics

- 31.1 The ICB shall:
 - 31.1.1 lead on standardised collection, processing, and sharing of data for Delegated Services in line with broader NHS England, Department of Health and Social Care and government data strategies;
 - 31.1.2 lead on the provision of data and analytical services to support commissioning of Delegated Services;
 - 31.1.3 ensure collaborative working across partners on agreed programmes of work focusing on provision of pathway analytics;
 - 31.1.4 share expertise and existing reporting tools with partner ICBs in the ICB Collaboration Arrangement;
 - 31.1.5 ensure interpretation of data is made available to NHS England and other ICBs within the ICB Collaboration Arrangement;

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

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

32 Finance

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

33 Freedom of Information and Parliamentary Requests

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

34 Incident Response and Management

34.1 The ICB shall:

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

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

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

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

35 Individual Funding Requests

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

36 Innovation and New Treatments

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

37 Mental Health, Learning Disability and Autism Specialised Services

37.1 The ICB will oversee the lead provider contract(s) relating to mental health, learning disability and autism (MHLDA) provider collaboratives that are transferred to the ICB on 1 April 2025 by NHS England. This includes complying with all terms and conditions of the contract(s), including in respect of notice periods and extensions.

- 37.2 If the ICB proposes to terminate a MHLDA lead provider contract before the end of its term, it must seek written approval from NHS England in advance.
- 37.3 In the performance of its commissioning responsibilities for MHLDA Specialised Services, the ICB shall:
 - 37.3.1 Have regard to any commissioning guidance relating to MHLDA Specialised Services issued by NHS England;
 - 37.3.2 Comply with the requirements of the Mental Health Investment Standard and related guidance issued by NHS England;
 - 37.3.3 Generally have regard to the need to commission MHLDA Specialised Services for the ICB's Population in such a manner as to ensure safe, efficient and effective services, across appropriate geographies, and which may require partnership working across other ICB or other organisational boundaries.
 - 37.3.4 Ensure that its case management function will work collaboratively across Delegated Services and Retained Services to support the oversight and progression of individual patient care, including the movement across elements of the care pathway.

38 Provider Selection and Procurement

- 38.1 The ICB shall:
 - 38.1.1 run appropriate local provider selection and procurement processes for Delegated Services;
 - 38.1.2 align all procurement processes with any changes to national procurement policy (for example new legislation) for Delegated Services;
 - 38.1.3 support NHS England with national procurements where required with subject matter expertise on provider engagement and provider landscape; and
 - 38.1.4 monitor and provide advice, guidance and expertise to NHS England on the overall provider market and provider landscape.
- 38.2 In discharging these responsibilities, the ICB must comply at all times with Law and any relevant Guidance including but not limited to Mandated Guidance; any applicable procurement law and Guidance on the selection of, and award of contracts to, providers of healthcare services.
- 38.3 When the ICB makes decisions in connection with the awarding of Specialised Services Contracts, it should ensure that it can demonstrate compliance with requirements for the award of such Contracts, including that the decision was:
 - 38.3.1 made in the best interest of patients, taxpayers and the Population;
 - 38.3.2 robust and defensible, with conflicts of interests appropriately managed;
 - 38.3.3 made transparently; and
 - 38.3.4 compliant with relevant Guidance and legislation.

39 Quality

- 39.1 The ICB must ensure that appropriate arrangements for quality oversight are in place. This must include:
- 39.1.1 clearly defined roles and responsibilities for ensuring governance and oversight of Delegated Services;
 - 39.1.2 defined roles and responsibilities for ensuring robust communication and appropriate feedback, particularly where Delegated Services are commissioned through an arrangement with one or more other ICBs;
 - 39.1.3 working with providers and partner organisations to address any issues relating to Delegated Services and escalate appropriately if such issues cannot be resolved;
 - 39.1.4 developing and standardising processes that align with regional systems to ensure oversight of the quality of Delegated Services, and participating in local System Quality Groups and Regional Quality Groups, or their equivalent;
 - 39.1.5 ensuring processes are robust and concerns are identified, mitigated and escalated as necessary;
 - 39.1.6 ensuring providers are held to account for delivery of safe, patient-focused and quality care for Delegated Services, including mechanisms for monitoring patient complaints, concerns and feedback; and
 - 39.1.7 the implementation of the Patient Safety Incident Response Framework for the management of incidents and serious events, appropriate reporting of any incidents, undertaking any appropriate patient safety incident investigation and obtaining support as required.
- 39.2 The ICB must establish a plan to ensure that the quality of the Delegated Services is measured consistently, using nationally and locally agreed metrics triangulated with professional insight and soft intelligence.
- 39.3 The ICB must ensure that the oversight of the quality of the Delegated Services is integrated with wider quality governance in the local system and aligns with the NHS England National Quality Board's recommended quality escalation processes.
- 39.4 The ICB must ensure that there is a System Quality Group (or equivalent) to identify and manage concerns across the local system.
- 39.5 The ICB must ensure that there is appropriate representation at any Regional Quality Groups or their equivalent.
- 39.6 The ICB must have in place all appropriate arrangements in respect of child and adult safeguarding and comply with all relevant Guidance.

40 Service Planning and Strategic Priorities

- 40.1 The ICB is responsible for setting local commissioning strategy, policy and priorities and planning for and carrying out needs assessments for the Delegated Services.
- 40.2 In planning, commissioning and managing the Delegated Services, the ICB must have processes in place to assess and monitor equitable patient access, in accordance with the access criteria set out in Clinical Commissioning Policies and National Specifications, taking action to address any apparent anomalies.

- 40.3 The ICB must ensure that it works with Specialised Service Providers and Provider Collaboratives to translate local strategic priorities into operational outputs for Delegated Services.
- 40.4 The ICB shall provide input into any consideration by NHS England as to whether the commissioning responsibility in respect of any of the Retained Services should be delegated.

41 National Standards, National Specifications and Clinical Commissioning Policies

- 41.1 The ICB shall provide input into national decisions on National Standards and national transformation regarding Delegated Services through attendance at governance meetings.
- 41.2 The ICB shall facilitate engagement with local communities on National Specification development.
- 41.3 The ICB must comply with the National Specifications and relevant Clinical Commissioning Policies and ensure that all clinical Specialised Services Contracts accurately reflect Clinical Commissioning Policies and include the relevant National Specification, where one exists in relation to the relevant Delegated Service.
- 41.4 The ICB must co-operate with any NHS England activities relating to the assessment of compliance against National Standards, including through the Assurance Processes.
- 41.5 The ICB must have appropriate mechanisms in place to ensure National Standards and National Specifications are being adhered to.
- 41.6 Where the ICB has identified that a Specialised Services Provider may not be complying with the National Standards set out in the relevant National Specification, the ICB shall consider the action to take to address this in line with the Assurance Processes.

42 Transformation

- 42.1 The ICB shall:
- 42.1.1 prioritise pathways and services for transformation according to the needs of its Population and opportunities for improvement in ICB commissioned services and for Delegated Services;
 - 42.1.2 lead ICB and ICB Collaboration Arrangement driven transformation programmes across pathways for Delegated Services;
 - 42.1.3 lead the delivery locally of transformation in areas of national priority (such as Cancer, Mental Health and Learning Disability and Autism), including supporting delivery of commitments in the NHS Long Term Plan;
 - 42.1.4 support NHS England with agreed transformational programmes for Retained Services;
 - 42.1.5 support NHS England with agreed transformational programmes and identify future transformation programmes for consideration and prioritisation for Delegated Services where national co-ordination and enablement may support transformation;

- 42.1.6 work collaboratively with NHS England on the co-production and co-design of transformation and improvement interventions and solutions in those areas prioritised; and
- 42.1.7 ensure Relevant Clinical Networks and other clinical networks use levers to facilitate and embed transformation at a local level for Delegated Services.

DRAFT

SCHEDULE 4: Reserved Functions

Introduction

22. Reserved Functions in Relation to the Delegated Services

- 22.1. In accordance with Clause 6.2 of this Agreement, all functions of NHS England other than those defined as Delegated Functions, are Reserved Functions.
- 22.2. This Schedule sets out further provision regarding the carrying out of the Reserved Functions as they relate to the Delegated Functions.
- 22.3. The ICB will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions.
- 22.4. The following functions and related activities shall continue to be exercised by NHS England.

23. Retained Services

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

24. Reserved Specialised Service Functions

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

Reserved Functions

25. Assurance and Oversight

- 25.1. NHS England shall:
 - 25.1.1. have oversight of what ICBs are delivering (inclusive of Delegated Services) for their Populations and all patients;
 - 25.1.2. design and implement appropriate assurance of ICBs' exercise of Delegated Functions including the Assurance Processes;
 - 25.1.3. help the ICB to coordinate and escalate improvement and resolution interventions where challenges are identified (as appropriate);
 - 25.1.4. ensure that the NHS England Board is assured that Delegated Functions are being discharged appropriately;
 - 25.1.5. ensure specialised commissioning considerations are appropriately included in NHS England frameworks that guide oversight and assurance of service delivery; and
 - 25.1.6. host a Delegated Commissioning Group ("DCG") that will undertake an assurance role in line with the Assurance Processes. This assurance role shall include assessing and monitoring the overall coherence, stability and sustainability of the commissioning model of Specialised Services at a

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

- 25.2. Where an officer or employee of NHS England is performing its Reserved Functions in respect of assurance and oversight, NHS England must ensure that those officers or employees do not hold responsibility for, or undertake any, decision making in respect of the ICB's Delegated Functions.

26. Attendance at governance meetings

- 26.1. NHS England shall ensure that there is appropriate representation in respect of Reserved Functions and Retained Services at local governance forums (for example, the Regional Leadership Team) and at NCG.
- 26.2. NHS England shall:
 - 26.2.1. ensure that there is appropriate representation by NHS England subject matter expert(s) at National Standards development forums;
 - 26.2.2. ensure there is appropriate attendance by NHS England representatives at nationally led clinical governance meetings; and
 - 26.2.3. co-ordinate, and support key national governance groups.

27. Clinical Leadership and Clinical Reference Groups

- 27.1. NHS England shall be responsible for the following:
 - 27.1.1. developing local leadership and support for the ICB relating to Specialised Services;
 - 27.1.2. providing clinical leadership, advice and guidance to the ICB in relation to the Delegated Services;
 - 27.1.3. providing point-of-contact and ongoing engagement with key external bodies, such as interest groups, charities, NICE, DHSC, and Royal Colleges; and enabling access to clinical trials for new treatments and medicines.
- 27.2. NHS England will host Clinical Reference Groups, which will lead on the development and publication of the following for Specialised Services:
 - 27.2.1. Clinical Commissioning Policies;
 - 27.2.2. National Specifications, including National Standards for each of the Specialised Services.

28. Clinical Networks

- 28.1. Unless otherwise agreed between the Parties, NHS England shall put in place contractual arrangements and funding mechanisms for the commissioning of the Relevant Clinical Networks.
- 28.2. NHS England shall ensure development of multi-ICB, and multi-region (where necessary) governance and oversight arrangements for Relevant Clinical Networks that give line of sight between all clinical networks and all ICBs whose Population they serve.
- 28.3. NHS England shall be responsible for:
 - 28.3.1. developing national policy for the Relevant Clinical Networks;

- 28.3.2. developing and approving the specifications for the Relevant Clinical Networks;
- 28.3.3. maintaining links with other NHS England national leads for clinical networks not focused on Specialised Services;
- 28.3.4. convening or supporting national networks of the Relevant Clinical Networks;
- 28.3.5. agreeing the annual plan for each Relevant Clinical Network with the involvement of the ICB and Relevant Clinical Network, ensuring these reflect national and regional priorities;
- 28.3.6. managing Relevant Clinical Networks jointly with the ICB; and
- 28.3.7. agreeing and commissioning the hosting arrangements of the Relevant Clinical Networks.

29. Complaints

- 29.1. NHS England shall manage all complaints in respect of the Delegated Services that are received prior to the Effective Date of Delegation or the date on which the Commissioning Team is transferred to the Host ICB (whichever is the later).
- 29.2. NHS England shall provide the relevant individuals at the ICB with appropriate access to complaints data held by NHS England that is necessary to carry out the complaints function as set out in the Complaints Sharing Protocol.
- 29.3. NHS England shall manage all complaints in respect of the Retained Services.
- 29.4. NHS England shall set out what information the ICB is required to provide when reporting on the key performance indicators. NHS England should notify the ICB in advance and provide sufficient time to allow compliance.

30. Commissioning and optimisation of High Cost Drugs

- 30.1. Unless otherwise agreed with the ICB, NHS England shall manage a central process for reimbursement of High Costs Drugs for Specialised Services. This may include making reimbursements directly to Specialised Services Providers.
- 30.2. In respect of pharmacy and optimisation of High Cost Drugs, NHS England shall:
 - 30.2.1. where appropriate, ensure that only validated drugs spend is reimbursed, there is timely drugs data and drugs data quality meets the standards set nationally;
 - 30.2.2. support the ICB on strategy for access to medicines used within Delegated Services, minimising barriers to health inequalities;
 - 30.2.3. provide support, as reasonably required, to the ICB to assist it in the commissioning of High Cost Drugs for Delegated Services including shared care agreements;
 - 30.2.4. seek to address consistency of prescribing in line with national commissioning policies, introduction of new medicines, and addressing unwarranted prescribing variation;
 - 30.2.5. develop medicines commissioning policies and criteria for access to medicines within Specialised Services;

- 30.2.6. develop support tools, including prior approval criteria, and frameworks to support the delivery of cost-effective and high quality commissioning of High Cost Drugs;
- 30.2.7. co-ordinate the development, implementation and monitoring of initiatives that enable the use of better value medicines;
- 30.2.8. where appropriate, co-ordinate national procurement or other commercial processes to secure medicines or High Cost Drugs for Specialised Services.

31. Contracting

- 31.1. NHS England shall retain the following obligations in relation to contracting for Delegated Services:
 - 31.1.1. ensure Specialised Services are included in national NHS England contracting and payment strategy (for example, Aligned Payment Incentives);
 - 31.1.2. provide advice for ICBs on schedules to support the Delegated Services;
 - 31.1.3. set, publish or make otherwise available the Contracting Standard Operating Procedure and Mandated Guidance detailing contracting strategy and policy for Specialised Services; and
 - 31.1.4. provide and distribute contracting support tools and templates to the ICB.
- 31.2. In respect of the Retained Services, NHS England shall:
 - 31.2.1. where appropriate, ensure a Collaborative Commissioning Agreement is in place between NHS England and the ICB(s); and
 - 31.2.2. where appropriate, construct model template schedules for Retained Services and issue to ICBs.

32. Data Management and Analytics

- 32.1. NHS England shall:
 - 32.1.1. support the ICB by collaborating with the wider data and analytics network (nationally) to support development and local deployment or utilisation of support tools;
 - 32.1.2. support the ICB to address data quality and coverage needs, accuracy of reporting Specialised Services activity and spend on a Population basis to support commissioning of Specialised Services;
 - 32.1.3. ensure inclusion of Specialised Services data strategy in broader NHS England, DHSC and government data strategies;
 - 32.1.4. lead on defining relevant contractual content of the information schedule (Schedule 6) of the NHS Standard Contract for Clinical Services;
 - 32.1.5. work collaboratively with the ICB to drive continual improvement of the quality and coverage of data used to support commissioning of Specialised Services;
 - 32.1.6. provide a national analytical service to support oversight and assurance of Specialised Services, and support (where required) the national Specialised

Commissioning team, Programmes of Care and Clinical Reference Groups;
and

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

33. Finance

- 33.1. The provisions of Clause 10 shall apply in respect of the financial arrangements in respect of the Delegated Functions.
- 33.2. NHS England shall:
 - 33.2.1. hold the budgets for prescribed specialised services top-up payments for specialist centres;
 - 33.2.2. administer the top-up payments schemes; and
 - 33.2.3. make top-up payments to the Specialised Services Providers.
- 33.3. For the avoidance of doubt, the functions set out in 12.2 include top-up payments for the Delegated Services and Retained Services.

34. Freedom of Information and Parliamentary Requests

- 34.1. NHS England shall:
 - 34.1.1. lead on handling, managing and responding to all national FOIA and parliamentary correspondence relating to Retained Services; and
 - 34.1.2. co-ordinate a response when a single national response is required in respect of Delegated Services.

35. Incident Response and Management

- 35.1. NHS England shall:
 - 35.1.1. provide guidance and support to the ICB in the event of a complex incident;
 - 35.1.2. lead on national incident management for Specialised Services as appropriate to stated incident level and where nationally commissioned services are impacted;
 - 35.1.3. lead on monitoring, planning and support for service and operational resilience at a national level and provide support to the ICB; and
 - 35.1.4. respond to specific service interruptions where appropriate; for example, supplier and workforce challenges and provide support to the ICB in any response to interruptions.

36. Individual Funding Requests

- 36.1. NHS England shall be responsible for:
 - 36.1.1. leading on Individual Funding Requests (IFR) policy, IFR governance and managing the IFR process for Delegated Services and Retained Services;
 - 36.1.2. taking decisions in respect of IFRs at IFR Panels for both Delegated Services and Retained Services; and

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

37. Innovation and New Treatments

- 37.1. NHS England shall support the local implementation of innovative treatments for Delegated Services.
- 37.2. NHS England shall ensure services are in place for innovative treatments such as advanced medicinal therapy products recommended by NICE technology appraisals within statutory requirements.
- 37.3. NHS England shall provide national leadership for innovative treatments with significant service impacts including liaison with NICE.

38. Mental Health, Learning Disability and Autism Specialised Services

- 38.1. NHS England shall issue commissioning guidance for MHLDA Specialised Services in relation to the Delegated Services and Retained Services.
- 38.2. NHS England shall prepare and issue service specifications and clinical commissioning policies for MHLDA Specialised Services.
- 38.3. NHS England will monitor the ICB's compliance with the Mental Health Investment Standard in respect of MHLDA Delegated Services.
- 38.4. NHS England shall ensure that its case management function will work collaboratively across Delegated Services and Retained Services to support the oversight and progression of individual patient care, including the movement across elements of the care pathway.

39. Provider Selection and Procurement

- 39.1. In relation to procurement, NHS England shall be responsible for:
 - 39.1.1. setting standards and agreeing frameworks and processes for provider selections and procurements for Specialised Services;
 - 39.1.2. monitoring and providing advice, guidance and expertise on the overall provider market in relation to Specialised Services; and
 - 39.1.3. where appropriate, running provider selection and procurement processes for Specialised Services.

40. Quality

- 40.1. In respect of quality, NHS England shall:
 - 40.1.1. work with the ICB to ensure oversight of Specialised Services through quality surveillance and risk management and escalate as required;
 - 40.1.2. work with the ICB to seek to ensure that quality and safety issues and risks are managed effectively and escalated to the National Specialised Commissioning Quality and Governance Group (QGG), or other appropriate forums, as necessary;
 - 40.1.3. work with the ICB to seek to ensure that the quality governance and processes for Delegated Services are aligned and integrated with broader clinical quality governance and processes in accordance with National Quality Board Guidance;

- 40.1.4. facilitate improvement when quality issues impact nationally and regionally, through programme support, and mobilising intensive support when required on specific quality issues;
- 40.1.5. provide guidance on quality and clinical governance matters and benchmark available data;
- 40.1.6. support the ICB to identify key themes and trends and utilise data and intelligence to respond and monitor as necessary;
- 40.1.7. report on quality to both NCG and DCG as well as QGG and Executive Quality Group as required;
- 40.1.8. facilitate and support the national quality governance infrastructure (for example, the QGG); and
- 40.1.9. identify and act upon issues and concerns that cross multiple ICBs, coordinating response and management as necessary.

41. National Standards, National Specifications and Clinical Commissioning Policies

- 41.1. NHS England shall carry out:
 - 41.1.1. development, engagement and approval of National Standards for Specialised Services (including National Specifications, Clinical Commissioning Policies, quality and data standards);
 - 41.1.2. production of national commissioning products and tools to support commissioning of Specialised Services;
 - 41.1.3. maintenance and publication of the Prescribed Specialised Services Manual and engagement with the DHSC on policy matters; and
 - 41.1.4. determination of content for national clinical registries.

42. Transformation

- 42.1. NHS England shall be responsible for:
 - 42.1.1. co-ordinating and enabling ICB-led specialised service transformation programmes for Delegated Services where necessary;
 - 42.1.2. supporting the ICB to implement national policy and guidance across its Populations for Retained Services;
 - 42.1.3. supporting the ICB with agreed transformational programmes where national transformation support has been agreed for Delegated Services;
 - 42.1.4. providing leadership for transformation programmes and projects that have been identified as priorities for national coordination and support, or are national priorities for the NHS, including supporting delivery of commitments in the NHS Long Term Plan;
 - 42.1.5. co-production and co-design of transformation programmes with the ICB and wider stakeholders; and
 - 42.1.6. providing access to subject matter expertise including Clinical Reference Groups, national clinical directors, Programme of Care leads for the ICB where it needs support, including in relation to local priority transformation.

SCHEDULE 5: Retained Services

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

DRAFT

SCHEDULE 6: Further Information Governance, Sharing and Processing Provisions

PART 1

15. Introduction

- 15.1. This Schedule sets out the scope for the secure and confidential sharing of information between the Parties on a Need To Know basis, or where a Party acts as a Data Processor on behalf of the other Party in order to enable the Parties to exercise their functions in pursuance of this Agreement.
- 15.2. References in this Schedule (*Further Information Governance and Sharing Provisions*) to the Need to Know basis or requirement (as the context requires) should be taken to mean that each Party's Staff will only have access to Personal Data or Special Category Personal Data if it is lawful for such Staff to have access to such data for the Specified Purpose in paragraph 2.1 and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Special Category Personal Data specified.
- 15.3. This Schedule (including the details at Part 2 and 3 of this Schedule) and any Data Sharing Agreement and/or Data Processing Agreements entered into under this Schedule are designed to:
 - 15.3.1. provide information about the reasons why Relevant Information may need to be shared and/or processed on behalf of another Party and how this will be managed and controlled by the Parties;
 - 15.3.2. describe the purposes for which the Parties have agreed to share and/or the basis on which a Party is instructed to act as a Data Processor in relation to the Relevant Information;
 - 15.3.3. set out the lawful basis for the processing of Relevant Information and sharing of information between the Parties, and the principles that underpin the exchange of Relevant Information;
 - 15.3.4. describe roles and structures to support the exchange of Relevant Information between the Parties;
 - 15.3.5. apply to the sharing and processing of Relevant Information relating to Specialised Services Providers and their Staff;
 - 15.3.6. apply to the sharing and processing of Relevant Information whatever the medium in which it is held and however it is transmitted;
 - 15.3.7. ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and processed and how this sharing and processing will be managed;
 - 15.3.8. apply to the activities of the Parties' Staff; and
 - 15.3.9. describe how complaints relating to Personal Data sharing between the Parties and wider processing will be investigated and resolved, and how the information sharing and processing will be monitored and reviewed.

16. Purpose

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

- 16.2. Each Party must ensure that they have in place appropriate data sharing or data processing arrangements to enable data to be received from any third party organisations from which the Parties must obtain data in order to achieve the Specified Purpose.
- 16.3. Where necessary specific and detailed purposes must be set out in a Data Sharing Agreement or Data Processing Agreement that complies with all relevant legislation and Guidance.

17. Benefits of information sharing

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

18. Lawful basis for sharing

- 18.1. The Parties shall comply with all relevant Data Protection Legislation requirements and Good Practice in relation to the processing of Relevant Information shared further to this Agreement.
- 18.2. The Parties shall ensure that there is a Data Protection Impact Assessment (“DPIA”) that covers processing undertaken in pursuance of the Specified Purpose. The DPIA shall identify the lawful basis for sharing Relevant Information for each purpose and data flow.
- 18.3. Further details regarding the Relevant Information to be shared shall be set out in a Data Sharing Agreement and/or Data Processing Agreement.

19. Restrictions on use of the Shared Information

- 19.1. Each Party shall only process the Relevant Information as is necessary to achieve the Specified Purpose and, in particular, shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.
- 19.2. Access to, and processing of, the Relevant Information provided by a Party must be the minimum necessary to achieve the Specified Purpose. Information and Special Category Personal Data will be handled at all times on a restricted basis, in compliance with Data Protection Legislation requirements, and the Parties’ Staff should only have access to Personal Data on a justifiable Need to Know basis.
- 19.3. Neither the provisions of this Schedule nor any associated Data Sharing Agreement and/or Data Processing Agreement should be taken to permit unrestricted access to data held by any of the Parties.
- 19.4. Neither Party shall subcontract any processing of the Relevant Information without the prior consent of the other Party. Where a Party subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor which imposes the same obligations as are imposed on that Party under this Agreement, and shall remain liable for the performance of the subcontractor’s obligations.
- 19.5. The Parties shall not cause or allow Relevant Information to be transferred to any territory outside the United Kingdom without the prior written permission of the responsible Data Controller.

- 19.6. Any particular restrictions on use of certain Relevant Information should be included in a Data Sharing Agreement and/or Data Processing Agreement.

20. Ensuring fairness to the Data Subject

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

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

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

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

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

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

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

- 20.4. Further provision in relation to specific data flows may be included in a Data Sharing Agreement and/or Data Processing Agreement between the Parties.

21. Governance: Staff

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

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

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

- 21.4. Each Party shall provide evidence (further to any reasonable request) that all Staff that have any access to the Relevant Information whatsoever are adequately and appropriately trained to comply with their responsibilities under Data Protection Legislation and this Agreement.
- 21.5. The Parties shall ensure that:
- 21.5.1. only those Staff involved in delivery of the Agreement use or have access to the Relevant Information;
- 21.5.2. that such access is granted on a strict Need to Know basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited. Evidence of audit should be made freely available on request by the originating Data Controller; and
- 21.5.3. specific limitations on the Staff who may have access to the Relevant Information are set out in any Data Sharing Agreement and/or Data Processing Agreement entered into in accordance with this Schedule.

22. Governance: Protection of Personal Data

- 22.1. At all times, the Parties shall have regard to the requirements of Data Protection Legislation and the rights of Data Subjects.
- 22.2. Wherever possible (in descending order of preference), only anonymised information, or, strongly or weakly pseudonymised information will be shared and processed by the Parties. The Parties shall co-operate in exploring alternative strategies to avoid the use of Personal Data in order to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data or Special Category Personal Data.
- 22.3. Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need to Know basis.
- 22.4. If any Party becomes aware of:
- 22.4.1. any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or
- 22.4.2. any security vulnerability or breach in respect of the Relevant Information, it shall promptly, within 48 hours, notify the other Parties. The Parties shall fully co-operate with one another to remedy the issue as soon as reasonably practicable, and in making information about the incident available to the Information Commissioner and Data Subjects where required by Data Protection Legislation.
- 22.5. In processing any Relevant Information further to this Agreement, the Parties shall process the Personal Data and Special Category Personal Data only:
- 22.5.1. in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only in accordance with written instructions from the originating Data Controller in respect of its Relevant Information including any instructions set out in a Data Processing Agreement entered into under this Schedule, unless required by law (in which case, the processor shall inform the relevant Data

- Controller of that legal requirement before processing, unless that law prohibits such information on important grounds of public interest);
- 22.5.2. to the extent as is necessary for the provision of the Specified Purpose or as is required by law or any regulatory body; and
- 22.5.3. in accordance with Data Protection Legislation requirements, in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) UK GDPR; and not in such a way as to cause any other Data Controller to breach any of their applicable obligations under Data Protection Legislation.
- 22.6. The Parties shall act generally in accordance with Data Protection Legislation requirements. This includes implementing, maintaining and keeping under review appropriate technical and organisational measures to ensure and demonstrate that the processing of Personal Data is undertaken in accordance with Data Protection Legislation, and in particular to protect Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing, and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:
- 22.6.1. take account of the nature, scope, context and purposes of processing as well as the risks, of varying likelihood and severity for the rights and freedoms of Data Subjects; and
- 22.6.2. be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data and Special Category Personal Data, and having the nature of the Personal Data and Special Category Personal Data which is to be protected.
- 22.7. In particular, each Party shall:
- 22.7.1. ensure that only Staff as provided under this Schedule have access to the Personal Data and Special Category Personal Data;
- 22.7.2. ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display or distribution, of the Relevant Information;
- 22.7.3. obtain prior written consent from the originating Party in order to transfer the Relevant Information to any third party;
- 22.7.4. permit any other party or their representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors or assigns) and comply with all reasonable requests or directions to enable each Party to verify and/or procure that the other is in full compliance with its obligations under this Agreement; and
- 22.7.5. if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.
- 22.8. The Parties shall adhere to the specific requirements as to information security set out in any Data Sharing Agreement and/or Data Processing Agreement entered into in accordance with this Schedule.

- 22.9. The Parties shall use best endeavours to achieve and adhere to the requirements of the NHS Digital Data Security and Protection Toolkit.
- 22.10. The Parties' Single Points of Contact set out in paragraph **Error! Reference source not found.** will be the persons who, in the first instance, will have oversight of third party security measures.

23. Governance: Transmission of Information between the Parties

- 23.1. This paragraph supplements paragraph 8 of this Schedule.
- 23.2. Transfer of Personal Data between the Parties shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net or gcsx) e-mail.
- 23.3. Wherever possible, Personal Data should be transmitted and held in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, so as to ensure that the correct patient record and/or data is identified.
- 23.4. Any other special measures relating to security of transfer should be specified in a Data Sharing Agreement and/or Data Processing Agreement entered into in accordance with this Schedule.
- 23.5. Each Party shall keep an audit log of Relevant Information transmitted and received in the course of this Agreement.
- 23.6. The Parties' Single Point of Contact notified pursuant to paragraph 13 will be the persons who, in the first instance, will have oversight of the transmission of information between the Parties.

24. Governance: Quality of Information

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

25. Governance: Retention and Disposal of Shared Information

- 25.1. A non-originating Party shall securely destroy or return the Relevant Information once the need to use it has passed or, if later, upon the termination of this Agreement, howsoever determined. Where Relevant Information is held electronically, the Relevant Information will be deleted and formal notice of the deletion sent to the Party that shared the Relevant Information. Once paper information is no longer required, paper records will be securely destroyed or securely returned to the Party they came from.
- 25.2. Each Party shall provide an explanation of the processes used to securely destroy or return the information, or verify such destruction or return, upon request and shall comply with any request of the Data Controllers to dispose of data in accordance with specified standards or criteria.
- 25.3. If a Party is required by any law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy in accordance with this Schedule, it shall notify the other Parties in writing of that retention, giving details of the documents or materials that it must retain.

- 25.4. Retention of any data shall comply with the requirements of Article 5(1)(e) GDPR and with all Good Practice including the Records Management NHS Code of Practice, as updated or amended from time to time.
- 25.5. The Parties shall set out any special retention periods in a Data Sharing Agreement where appropriate.
- 25.6. The Parties shall ensure that Relevant Information held in paper form is held in secure files, and, when it is no-longer needed, destroyed using a cross cut shredder or subcontracted to a confidential waste company that complies with European Standard EN15713.
- 25.7. Each Party shall ensure that, when no longer required, electronic storage media used to hold or process Personal Data are destroyed or overwritten to current policy requirements.
- 25.8. Electronic records will be considered for deletion once the relevant retention period has ended.
- 25.9. In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Party shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

26. Governance: Complaints and Access to Personal Data

- 26.1. The Parties shall assist each other in responding to any requests made under Data Protection Legislation made by persons who wish to access copies of information held about them ("Subject Access Requests"), as well as any other exercise of a Data Subject's rights under Data Protection Legislation or complaint to or investigation undertaken by the Information Commissioner.
- 26.2. Complaints about processing shall be reported to the Single Points of Contact and the ICB. Complaints about information sharing shall be routed through each Parties' own complaints procedure unless otherwise provided for in the Agreement or determined by the ICB. Where the complaint relates to processing undertaken by a Party acting as a Data Processor on behalf of the other Party, complaints shall be routed through the relevant Data Controller's own complaints procedure unless otherwise provided for in the Agreement.
- 26.3. The Parties shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Schedule or any data processing carried out further to it.
- 26.4. Basic details of the Agreement shall be included in the appropriate log under each Party's publication scheme.

27. Governance: Single Points of Contact

- 27.1. The Parties each shall appoint a Single Point of Contact to whom all queries relating to the particular information sharing should be directed in the first instance.

28. Monitoring and review

- 28.1. The Parties shall monitor and review on an ongoing basis the sharing and wider processing of Relevant Information to ensure compliance with Data Protection Legislation and best practice. Specific monitoring requirements must be set out in the relevant Data Sharing Agreement and/or Data Processing Agreement.

SCHEDULE 6: Further Information Governance, Sharing and Processing Provisions

PART 2

Data Sharing Agreement

Description	Details
Subject matter of the processing	<p>Due to the complexities of Specialised Services and the distinctions between Delegated Functions and Reserved Functions, both the ICB Commissioning Teams (employed by the Host ICB) delivering Delegated Functions and the NHS England teams delivering Reserved Functions will need access to Relevant Information, which contains Personal Data.</p> <p>As set out in Schedule 6, Part 1, Paragraph 2.1, the specified purpose for sharing data is: <i>'...to facilitate the exercise of the Delegated Functions and NHS England's Reserved Functions.'</i> In order to achieve this purpose in the most effective, efficient and cost effective manner, the data will be hosted by NHS England in a collaborative working space which ICBs will have access to.</p> <p>NHS England will be responsible for ensuring that Commissioning Team staff have sufficient and appropriate access to Relevant Information to enable those staff to fulfil their commissioning functions in respect of the Delegated Services, including those described in Schedule 3 (Delegated Functions) to this agreement.</p> <p>In addition, NHS England may process the data for the following purposes:</p> <ul style="list-style-type: none">• development, oversight, and the quality improvement of Specialised Commissioning Functions;• undertaking work to evaluate the effectiveness of innovation and changes in delivery models and advising other bodies and organisations about these functions;• arranging the provision of services to support commissioning activities, to enable reporting and evaluations;• undertaking analysis, audits, and inspections to assess and assure the quality of Commissioning Functions;• supporting healthcare organisations to interpret population health data and evidence, and to undertake reviews of the likely effectiveness and cost-effectiveness of a range of interventions;• development a of strategies on population health outcomes and to identify gaps or deficiencies in current care and to produce recommendations for improvements, including in relation to specific pathways of care;• using and supporting health organisations to use health economic tools to support decision-making and interpreting data about the surveillance or assessment of a population's health to improve health outcomes and reduce health inequalities;• the development of population health policies and strategies, and their implementation
Duration of the processing	Unless otherwise specified in this Data Sharing Agreement, the processing shall commence on the Effective Date of Delegation and, as per paragraph

	11.1 of this Schedule, shall continue until the need to use it has passed or, if later, upon the termination of this Agreement.
Nature and purpose of the processing	<p>Personal Data is shared between the in relation to the delivery of the Delegated Functions. Such processing should ensure continued:</p> <ul style="list-style-type: none">• Provision of live services and associated reporting.• Quality improvement and assurance of services.• Dissemination of data for health and research purposes.
Type of Personal Data being Processed	<p>There will be data shared between NHSE and the ICB hub, either directly, via the shared SharePoint workspaces (hosted by NHS England) or via CSU/DSCRO (commissioning Support Unit/Data Services Commissioning Regional Offer) in respect of both the delegated and retained services, as needed in order to successfully deliver the specialised commissioned services.</p> <p>Wherever possible this data will be anonymised or pseudonymised, there will also at times be the need to share identifiable and special category data (this is mapped out in the associated DPIA and data flow mapping document).</p>
Categories of Data Subject	<p>Examples include: Staff (including volunteers, agents, and temporary workers), customers/clients, suppliers, patients, members of the public.</p>

SCHEDULE 6: Further Information Governance, Sharing and Processing Provisions

PART 3

Data Processing Agreement

Description	Details
Identity of the Controller and Processor	The ICB is the Data Controller and NHS England is the Data Processor.
Subject matter of the processing	<p>Both the ICB Commissioning Teams (employed by the Host ICB) delivering Delegated Functions and the NHS England teams delivering Reserved Functions will need access to Relevant Information. In order to achieve this purpose in the most effective, efficient and cost effective manner, the data will be hosted by NHS England in a collaborative working space which ICBs will have access to.</p> <p>Consequently, NHS England will act as a Data Processor on behalf of the ICB in relation to the Relevant Information required to commission the Delegated Services and fulfil the Delegated Functions.</p>
Duration of the processing	Unless otherwise specified in this Data Processing Agreement the processing shall commence on the Effective Date of Delegation and, as per paragraph 11.1 of this Schedule, shall continue until the need to use it has passed or, if later, upon the termination of this Agreement.
Plan for return and destruction of the data once the processing is complete	As set out in paragraph 11.1 of this Schedule
Nature and purpose of the processing	<p>This Data Processing Agreement considers processing of any data by NHS England on behalf of the ICB Commissioning Teams in relation to the delivery of the Delegated Functions. Such processing should ensure continued:</p> <ul style="list-style-type: none"> • Provision of live services and associated reporting. • Quality improvement and assurance of services. • Dissemination of data for health and research purposes.
Type of Personal Data being Processed	In the shared workspace, hosted on NHS England tenancy, on behalf of the ICBs, will hold any relevant data required to deliver both the delegated and retained specialised commissioning services. This will predominantly be anonymised and contract/commissioning data but in some instances, there may also be identifiable/special category data, this will however continue to be restricted to the relevant staff members. (this is detailed in the associated DPIA and data flow mapping document)
Categories of Data Subject	Examples include: Staff (including volunteers, agents, and temporary workers), customers/clients, suppliers, patients, members of the public.

DRAFT

SCHEDULE 7: Mandated Guidance

ICBs are required to follow the following the Nationally Mandated Guidance for the Commissioning of Specialised Services:

- [National Guidance on System Quality Groups.](#)
- [Managing Conflicts of Interest in the NHS.](#)
- Arrangements for Delegation and Joint Exercise of Statutory Functions.
- Guidance relating to procurement and provider selection.
- Information Governance Guidance relating to serious incidents.
- All other applicable IG and Data Protection Guidance.
- Any applicable Freedom of Information protocols.
- Any applicable Guidance on Counter Fraud, including from The NHS Counter Fraud Authority.
- Any applicable Guidance relating to the use of data and data sets for reporting.
- Guidance relating to the processes for making and handling individual funding requests, including:
 - [Commissioning policy: Individual funding requests;](#)
 - [Standard operating procedures: Individual funding requests.](#)

Workforce

- [Guidance on the Employment Commitment.](#)

Finance

- [Guidance on NHS System Capital Envelopes.](#)
- [Managing Public Money \(HM Treasury\).](#)

Specialised Services Mandated Guidance

- Commissioning Change Management Business Rules.
- Cashflow Standard Operating Procedure.
- Finance and Accounting Standard Operating Procedure.
- Provider Collaborative Guidance.
- Clinical Commissioning Policies.
- National Specifications.
- National Standards.
- The Prescribed Specialised Services Manual

SCHEDULE 8: Local Terms

General

The SE ICB, along with the other five ICBs in the South East England and NHS England, will sign a Collaboration Agreement to accompany this Delegation Agreement. This will set out the detail needed to ensure that delegated specialised commissioned services are delivered safely and effectively. The Collaboration Agreement sets out how the 6 SE ICBs will work together to discharge their commissioning responsibilities for specialised services.

This Schedule 8 (Local Terms) makes reference to appropriate clauses or schedules within the Collaboration Agreement, where necessary.

Following signature of the Delegation Agreement, this Schedule can be amended by the Parties using the Variations procedure at Clause 26.

NHS England can amend this Schedule without the ICB's consent by using the variation procedure set out in Clause 26.2 but the expectation is that variations should be by consent.

Where there is a Dispute as to the content of this Schedule, the Parties should follow the Disputes procedure set out at Clause 25.

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

All Delegated Services outlined in Schedule 2 of this document will be collectively commissioned by all six ICBs.

Given patient flow patterns and the ways in which care is accessed, no single specialised service can be commissioned solely within the footprint of any individual South East ICB. Additionally, in line with the delegation conditions set by NHSE for the region (see Schedule 9), the South East ICBs will collaborate to fulfil their specialised commissioning responsibilities through a statutory joint committee. This arrangement ensures that decisions are made collectively across all six South East ICBs, rather than independently by individual ICBs. The joint committee will also serve as a formal link to the Boards of ICBs, which hold statutory responsibility for the populations they serve.

Exceptions to this approach, along with any associated recommendations, will be submitted to the joint committee for consideration as they arise or may be reconsidered in response to changes in NHSE national policy.

Part 2 – the services to be planned or commissioned by an ICB Collaboration Arrangement

All Delegated Services outlined in Schedule 2 of this document will be collectively commissioned by all six ICBs.

Given patient flow patterns and the ways in which care is accessed, no single specialised service can be commissioned solely within the footprint of any individual South East ICB. Additionally, in line with the delegation conditions set by NHSE for the region (see Schedule 9), the South East ICBs will collaborate to fulfil their specialised commissioning responsibilities through a statutory joint committee. This arrangement ensures that decisions are made collectively across all six South East ICBs, rather than independently by individual ICBs. The joint committee will also serve as a formal link to the Boards of ICBs, which hold statutory responsibility for the populations they serve.

Exceptions to this approach, along with any associated recommendations, will be submitted to the joint committee for consideration as they arise or may be reconsidered in response to changes in NHSE national policy.

Part 3 – Funding arrangements

The SE ICBs must adhere to two key delegation conditions related to the future financial framework:

- **Establishment of a Risk Share Arrangement:** By 2025/26, ICBs must implement a Risk Share arrangement for Specialised Commissioning. This is a critical measure to address broader financial challenges and mitigate the impact of the long-term convergence rate.
- **Financial Contingency Requirement:** ICBs are required to maintain a 0.5% contingency within their specialised commissioning financial allocations for 2025/26.

Further details on these funding arrangements, including the financial framework and risk share agreements, are provided in Schedule 3 of the Collaboration Agreement (Financial Arrangements).

Part 4 – Workforce and Commissioning Team Arrangements

Workforce and commissioning team arrangements are set out in the Collaboration Agreement, Schedule 7 (Commissioning Team Arrangements).

Part 5 – ICB Collaboration Arrangements

These are detailed in the Collaboration Agreement signed by the six ICBs in the South East England region and NHS England.

Part 6 – Pooled Funds and Non-Pooled Funds

The ICBs have determined that they will not seek to create Pooled or Non-Pooled Funds. Financial arrangements are set out in the Collaboration Agreement, Schedule 3 (Financial Arrangements).

Part 7 – Provider Collaboratives

Mental Health Provider Collaboratives (MHPCs) are part of the delegated services listed in schedule 2 of this agreement. Further collaborative structures or models across different providers will need to be discussed and agreed by the ICBs impacted and then discussed and agreed with the Joint Committee and relevant Sub Committee as necessary.

Any collaborative arrangements in addition to the MHPCs will need to be raised with the Joint Committee in due course.

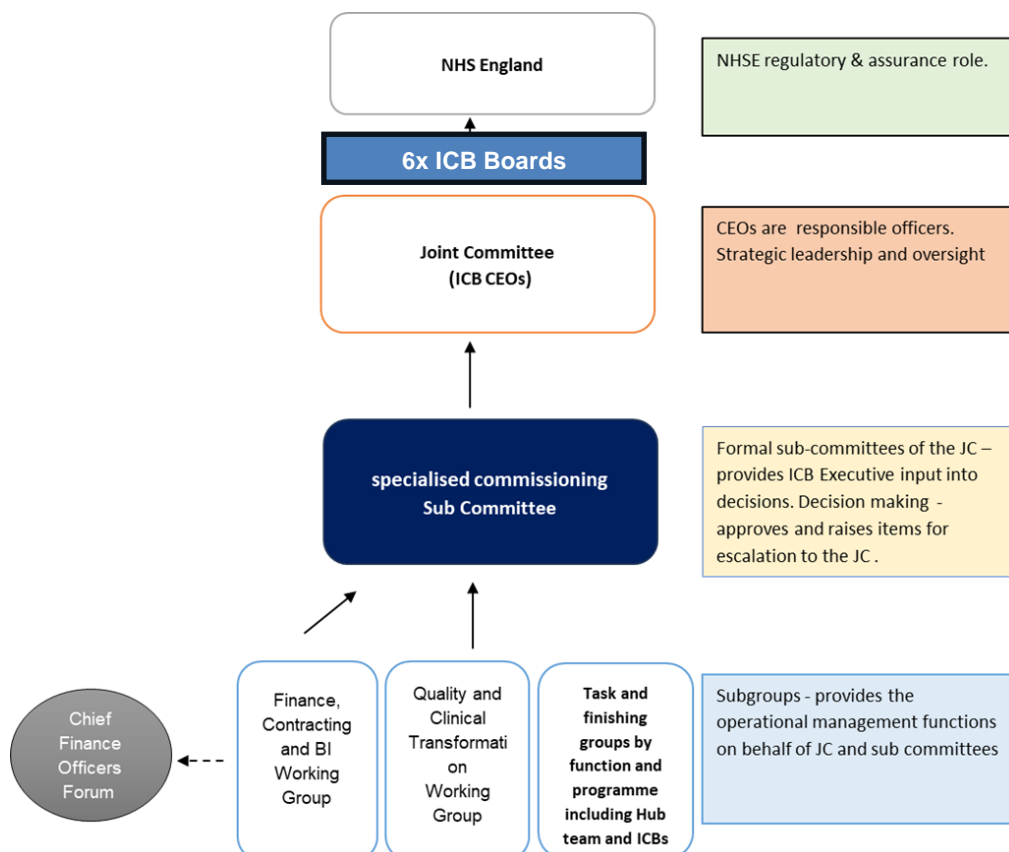
Part 8 – Further Governance Arrangements

The Partners have established a three-tiered governance model to support the commissioning of Specialised Services in South East Region, effective from April 2025. The three tiers comprises of:

- **NHS England (NHSE):**
 - Acts as the regulatory body, providing oversight and assurance for the collaborative commissioning framework.
- **Joint Committee:**

- The Delegation Agreement for Specialised Commissioning will explicitly delegate all functions to the Joint Committee under the authority granted by Section 65Z5 of the NHS Act 2006.
 - Composed of ICB Chief Executive Officers (CEOs) who serve as responsible officers.
 - Provides strategic leadership and oversight for decision-making across the collaborative arrangement.
- **Specialised Commissioning Subcommittee:**
 - Functions as a single, multi-ICB subcommittee operating under the Joint Committee.
 - The Joint Committee can delegate the relevant functions to this sub-committee and through to individuals/groups for operational management, as may be needed from time to time.
 - Responsible for operational management, decision-making, and raising escalated matters to the Joint Committee.
 - Includes formal subcommittees and working groups for specific operational and functional tasks.

Figure 1: Three- tiered governance model for ICB collaboration



Further details are set out in the Collaboration Agreement, Schedule 2 (Governance Arrangements).

SCHEDULE 9: Developmental Arrangements

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

The Developmental Arrangements

The following Developmental Arrangements apply to this Agreement:

1. To establish a Statutory Joint Multi-ICB Committee SE ICBs will be required to discharge their new specialised commissioning responsibilities through a statutory joint committee arrangement to ensure that decisions are made collectively across the six South East ICBs, rather than taken independently. The multi-ICB joint committee will provide a formal link back to the Boards of ICBs as statutory bodies with statutory responsibility for local populations they serve.
2. The Developmental Arrangements relating to the NHS Oversight Framework and ICB decision making.

The following extract is taken from Guidance Note 5 – ‘Managing the Developmental Arrangements for ICBs in NOF3/4 or equivalent status.’ Issued: 10 February 2025:

1. ***With reference to the Oversight Framework and the ICB’s assessed status within the Oversight Framework, the ICB and NHS England agree that:***
 - a. ***Any decision that impacts on the overall spend of the specialised service allocation (the Delegated Funds) must have NHS England (regional) approval before the commissioning change is made or any change process is begun.***
2. ***This Developmental Arrangement:***
 - a. ***applies if the ICB is assessed as within NOF3 or NOF4 of the Oversight Framework at the time of signing the agreement or, an equivalent score at the time the annual ICB capability assessment is undertaken.***
 - b. ***should not act as barrier to innovation and change but does reflect NHS England’s continued accountability for Delegated Services, its role in oversight and assurance and the need to work together to support those systems facing the greatest challenges.***

3. NHS England may issue further Guidance on this Developmental Arrangement to ensure it aligns with any amended Oversight Framework.

3. Two delegation conditions around the future financial framework:
 - a) Establish an ICB Risk Share arrangement for Specialised Commissioning. South East ICBs will need to create a financial risk-sharing agreement for 25/26. This is essential to address broader financial challenges and the impact of the long-term convergence rate.
 - b) Financial Reserves: ICBs will be required to hold a 0.5 % contingency in their specialised commissioning financial allocations in 25/26.

DRAFT

SCHEDULE 10: Administrative and Management Services

Administrative and management services are set out in the Collaboration Agreement, Schedule 5 (Commissioning Team Arrangements).

1. General Scope of Arrangements

1.1. Resource Allocation

NHS England shall allocate the resources currently supporting delegated specialised services to the administration and management of such services in accordance with this Agreement.

1.2. Provision of Services During Transition

Pursuant to the Delegation Agreements, NHS England agrees to provide Administrative and Management Services to the Integrated Care Boards ("ICBs") as specified in this Agreement for the period commencing April 1, 2025, and ending June 30, 2025

1.3. Transfer of Staff

Effective July 1, 2025, the majority of staff responsible for the commissioning of Delegated Services ("the Staff") shall transfer to Frimley ICB, the designated Host ICB. Notwithstanding the foregoing, certain staff who also support the commissioning of Retained Services shall remain employed by NHS England but shall continue to provide support to the ICBs in relation to Delegated Services. Together, these staff members shall constitute the Specialised Commissioning Hub Team.

1.4. Leadership Appointments

NHS England shall appoint additional Executive Senior Managers ("ESMs") and/or Directors as joint appointments between NHS England and the South East ICBs. These appointments shall provide senior leadership for the Specialised Commissioning Hub Team and shall oversee the commissioning of Delegated Specialised Services alongside Commissioning activities retained by NHSE (eg Health and Justice Commissioning). The shared leadership posts will support the administrative and day-to-day management functions of the Specialised Commissioning Hub Team.

1.5. Financial Administration

Frimley ICB, in its capacity as Host ICB, shall act as the financial administrator for the Specialised Commissioning Hub Team. The Host ICB's responsibilities shall include processing and disbursing salaries and facilitating payments. The Host ICB shall have no authority to make decisions regarding the allocation of funds.

1.6. Cost Allocation

The Partners agree that costs associated with the Administrative and Management Services provided by the Specialised Commissioning Hub Team shall be transferred from NHS England to the ICBs on a proportional basis, reflecting each ICB's population. Each ICB shall be responsible for facilitating inter-ICB transfers to appropriately fund any agreed-upon local hosting and operational arrangements.

1.7. Work Programme Development and Review

The Specialised Commissioning Hub Team shall support the commissioning of Delegated Services and perform specific functions related to Retained Services, where necessary. To ensure statutory obligations are met, all Partners, including the ICBs, NHS England, and the Hub Team, shall collaborate to jointly develop and regularly review the work programme of the Specialised Commissioning Hub Team.

1.8. Changes to Team Capacity or Capability

Any proposed changes to the capacity or capabilities of the Specialised Commissioning Hub Team shall be subject to a detailed evaluation, including the preparation of a case for change and an impact assessment. NHS England’s South East Regional Team shall be consulted to ensure strategic alignment and service continuity prior to implementing any such changes.

1.9. Notice of Restructuring

In the event that an ICB intends to propose a restructuring of the Specialised Commissioning Hub Team, it shall provide NHS England with no less than 12 months formal written notice. Such notice must also include prior agreement from NHS England Regional Director of the South East - given the activities the Hub team will continue to provide for NHSE with regards to residual regional commissioning activities (eg retained specialised commissioned services and health & justice services)

1.10. Conditions for Restructuring

No restructuring of the Specialised Commissioning Hub Team shall proceed unless and until alternative arrangements for the delivery of services and functions of the Hub Team and/or Retained Services have been established and approved by the Partners.

1.11. Avoidance of Role Duplication

The Partners agree that no ICB shall appoint ESM or Director-level staff whose roles would duplicate that of the leadership roles that will be ‘Shared Posts’ between NHSE and the SE ICBs. This provision is intended to ensure operational efficiency, avoid redundancy, foster collaborative working relationships, streamline decision-making processes, and clearly define the roles and responsibilities of all entities within the Specialised Commissioning framework.

2. Services provided by Specialised Commissioning Hub Team

- 2.1. The Specialised Commissioning Hub Team, hosted by Frimley ICB, along with the jointly appointed ESMs, will deliver the Administrative and Management Services outlined in Appendix 5 or as otherwise agreed in writing by the Partners and the Joint Committee.
- 2.2. The 2025/26 financial year will serve as a transitional period, during which minimal changes will be made to the existing service provisions. The current team responsible for these functions will continue to perform their roles during this time.
- 2.3. Any adjustments to the team structure, roles, or service delivery model during the transitional year must be agreed upon by all Partners and approved by the Joint Committee to ensure alignment with strategic priorities and service continuity.

3. Availability of NHS England staff and Shared Posts

- 3.1. In addition to any Staff transferred to the Host ICB, NHS England will deploy additional Staff as Shared Posts between the NHSE and Frimley to the Specialised Commissioning Hub Team to perform Management Services.
- 3.2. NHS England will take all reasonable steps to ensure that the NHS England Staff deployed for the purposes of carrying out the Delegated Functions shall:
 - faithfully and diligently perform duties and exercise such powers as may from time to time be reasonably assigned to or vested in them, and
 - perform all duties assigned to them pursuant to this Schedule 6 (Commissioning Team Arrangements).
- 3.3. The host ICB shall notify NHS England if the host ICB becomes aware of any act or omission by any NHS England staff which may have a material adverse impact on the provision of the Services or constitute a material breach of the terms and conditions of employment of the NHS England staff.
- 3.4. The following Director posts have been identified as Shared Posts between NHS and the SE ICBs:
 - Regional Director of Commissioning
 - Director of Specialised Commissioning and Health & Justice
 - Director of Commissioning Finance
 - Director of Commissioning Nursing
 - Regional Medical Director of Commissioning
 - Head of PC/PH Commissioning
- 3.5. A separate MOU which describes the activities of these Shared Posts will be varied into this Delegation Agreement at a later date.

4. HOST ICB

- 4.1. Frimley ICB is the host for the regional Specialised Commissioning Hub Team and will fulfil the following functions.
- 4.2. Work with the Regional Director of Commissioning, Director of Specialised Commissioning, Director of Commissioning Finance, Director of Nursing and Quality and Specialised Commissioning Medical Director to whom the Specialised Commissioning Hub Team will report into.
- 4.3. Ensure the Specialised Commissioning Hub Team effectively delivers the commissioning functions on behalf of the six ICBs in the South East of England and NHS England (NHSE).
- 4.4. Ensure professional leadership is provided to senior managers and commissioning functions within the team.
- 4.5. Employ and manage the Specialised Commissioning Hub Team following the transfer of staff.

5. GOVERNANCE AND DECISION- MAKING ARRANGEMENTS

- 5.1. The responsibility for commissioning the Delegated Services will transfer to ICBs from 1 April 2025. The Specialised Commissioning Hub Team will undertake services on behalf of the ICBs with the following guidance:
 - The Hub will have autonomy to undertake operational commissioning decisions on

behalf of all 6 ICB and report into the Joint Committee.

- The Joint Committee will set the clinical vision and strategy for specialised services across the 6 ICBs in the South East Region and will set the direction for the Hub team as to how those commissioning activities should be undertaken.

6. FUNDING OF COMMISSIONING SUPPORT SERVICES FOR THE HOST ICB

- 6.1. Each individual ICB (including the Host ICB) will receive an allocation and must transfer their allocation to the Host ICB, ensuring it has sufficient funds to cover all expenses, including staff salaries, pay, and non-pay costs.
- 6.2. The allocation to transfer to the Host ICB will need to cover the full pay and non-pay cost of the staff who transfer to the Host ICB from NHS England under the TUPE transfer arrangement. The total allocation will cover staff costs, and associated travel expenses.
- 6.3. The Host ICB is responsible for reporting to ICBs on administrative costs and any underspend. It will return the direct proportion of any underspend to all ICBs (including the Host ICB).

Dated: 1 April 2025

Collaboration Agreement is agreed between the following parties:

- (1) KENT & MEDWAY INTEGRATED CARE BOARD.**
- (2) SURREY HEARTLANDS INTEGRATED CARE BOARD.**
- (3) SUSSEX INTEGRATED CARE BOARD**
- (4) HAMPSHIRE & IOW INTEGRATED CARE BOARD.**
- (5) FRIMLEY INTEGRATED CARE BOARD.**
- (6) BUCKINGHAMSHIRE OXFORDSHIRE & BERKSHIRE
WEST INTEGRATED CARE BOARD.**
- (7) NHS ENGLAND – SOUTH EAST REGION**

Table of contents Clause heading and number Page number

1. COMMENCEMENT AND DURATION 4

2. PRINCIPLES AND AIMS..... 4

3. SCOPE OF THE ARRANGEMENTS 4

4. FUNCTIONS 5

5. COMMISSIONING HUB 5

6. STAFFING **Error! Bookmark not defined.**

7. JOINT COMMITTEE 6

8. GOVERNANCE 6

9. RISK SHARING 6

10. REVIEW 6

11. COMPLAINTS 7

12. FINANCES 7

13. VARIATION..... 7

14. DATA PROTECTION..... 8

15. IT INTER-OPERABILITY 8

16. FURTHER ARRANGEMENTS..... 8

17. FREEDOM OF INFORMATION..... 9

18. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY..... 9

19. CONFIDENTIALITY 9

20. LIABILITIES 11

21. DISPUTE RESOLUTION 12

22. BREACHES OF THE AGREEMENT 12

23. TERMINATION & DEFAULT..... 13

24. CONSEQUENCES OF TERMINATION..... 13

25. PUBLICITY 14

26. EXCLUSION OF PARTNERSHIP OR AGENCY 14

27. THIRD PARTY RIGHTS 14

28. NOTICES 14

29. ASSIGNMENT AND SUBCONTRACTING 14

30. SEVERABILITY 14

31. WAIVER 14

32. STATUS	14
33. ENTIRE AGREEMENT	15
34. GOVERNING LAW AND JURISDICTION.....	15
35. FAIR DEALINGS	15
36. COUNTERPARTS	15
SCHEDULE 1: DEFINITIONS AND INTERPRETATIONS	16
SCHEDULE 2: GOVERNANCE ARRANGEMENTS FPR SPECIALISED SERVICES	25
SCHEDULE 3: FINANCIAL ARRANGEMENTS FOR DELEGATED SPECIALISED SERVICES.....	28
SCHEDULE 4: FURTHER INFORMATION GOVERNANCE AND SHARING PROVISIONS.....	31
SCHEDULE 5: COMMISSIONING HUB ARRANGEMENTS FOR DELEGATED SPECIALISED SERVICES.....	36

THIS AGREEMENT is made on the **1st of April 2025** BETWEEN:

- (1) **Kent & Medway INTEGRATED CARE BOARD.**
- (2) **Surrey Heartlands INTEGRATED CARE BOARD.**
- (3) **Sussex INTEGRATED CARE BOARD.**
- (4) **Hampshire & IOW INTEGRATED CARE BOARD.**
- (5) **Frimley INTEGRATED CARE BOARD.**
- (6) **Buckinghamshire Oxfordshire & Berkshire West INTEGRATED CARE BOARD.**

And specifically in respect of the Delegated Specialised Service Functions only:

- (7) **NHS England SE Region.**

Individually each ICB will be referred to as a "ICB Partner" and together form the "SE ICB Partners".

BACKGROUND

- (A) NHS England has statutory functions to make arrangements for the provision of prescribed services for the purposes of the NHS.
- (B) The ICBs have statutory functions to make arrangements for the provision of services for the purposes of the NHS in their areas, apart from those commissioned by NHS England.
- (C) Pursuant to section 65Z5 of the NHS Act, NHS England and the ICBs are able to establish and maintain joint arrangements in respect of the discharge of their commissioning functions.
- (D) The ICBs have agreed that they will exercise certain functions, as specified in Clause 4, jointly and for that purpose have created a joint committee of their Chief Executive Officers (CEOs) in accordance with sections 65Z5 and 65Z6 of the NHS Act.
- (E) Under the Delegation Agreement made pursuant to section 65Z5 NHS England has delegated the Delegated Functions to the ICB. NHS England has retained responsibility for the NHS England Reserved Functions and commissioning of the Retained Services.

- (F) It is agreed that in order to exercise the Delegated Functions in the most efficient and effective manner that Delegated Specialised Services would be best commissioned on a multi-ICB footprint.
- (G) This Agreement sets out the arrangements that will apply between the ICBs in relation to the joint commissioning of such functions as they determine to exercise jointly through the joint committee and the Specialised Services for the ICBs' Populations.
- (H) This Agreement is intended to govern the relationship between the ICBs and NHSE in respect of the commissioning of Specialised Services (and not the wider ICB functions) on a multi ICB footprint.

NOW IT IS HEREBY AGREED as follows:

1. COMMENCEMENT AND DURATION

1.1 This Agreement has effect from the date of this Agreement and will remain in force for the Initial Term unless terminated in accordance with Clause 22 (Termination & Default) below.

2. PRINCIPLES AND AIMS

2.1 The SE ICB Partners acknowledge that, in exercising their obligations under this Agreement, each ICB Partner must comply with the statutory duties set out in the NHS Act and must:

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

2.1.2 consider how, in performing its obligations, it can address health inequalities.

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

2.1.4 act at all times in good faith towards each other.

2.1.5 Improving access to treatment, especially for those with the worst health outcomes (e.g. relating to inequalities others who currently struggle to access treatment).

2.1.6 Potential to shift resource towards more early intervention and prevention and facilitate transformational changes generating efficiencies.

2.1.7 Build closer relationships and alliances with commissioners and providers of services outside the South East England who service our population.

2.1.8 Enable SE ICB Partners to review and discuss NHSE's Reserved Functions and Retained Services, specifically in respect of the delegated specialised services functions.

3. SCOPE OF THE ARRANGEMENTS

3.1 This Agreement sets out the arrangements through which the SE ICB Partners will work together to Commission Services jointly and in respect of the Delegation Agreement for specialised services. This includes the following commissioning mechanisms.

3.2 In respect of functions held by SE ICB Partners which they determine should be exercised jointly the following will apply:

3.2.1 Establishment of a Joint Committee as described in Schedule 2 – Governance Arrangements.

- 3.2.2 The designation of NHS Frimley ICB to act as the host body for staffing arrangements on behalf of the other SE ICB Partners which relate to the joint exercise of functions.
- 3.2.3 The purpose and scope of the Joint Committee, any sub-committees and/or working groups will need to be confirmed by the Joint Committee at its first meeting and subsequently on establishment of sub-committees and working groups thereafter.
- 3.3 In respect of functions delegated to SE ICB Partners under the Specialised Services Delegation Agreement the following will apply:
- 3.3.1 Delegation by NHS England of the Delegated Specialised Services Functions to each individual ICB Partner in accordance with the relevant Delegation Agreement.
- 3.3.2 Delegation by each ICB Partner of its Delegated Specialised Services Functions to the Joint Committee established by clause 3.2.1 and subsequently to a Specialised Commissioning sub-committee as described in Schedule 2 – Governance Arrangements.
- 3.3.3 Development of a Specialised Commissioning Hub Team, which will be hosted for all SE ICB Partners by NHS Frimley ICB, through which these Specialised Services will be commissioned as set out in Schedule 6 – Specialised Commissioning Team Arrangements.
- 3.3.4 The establishment of Shared Director posts between NHS England and the SE ICB Partners, solely in relation to the Delegated Specialised Services Functions, to enable the SE ICB Partners and NHS England to act at all times in accordance with the scope of their statutory powers.
- 3.4 At the commencement Date the SE ICB Partners and, where relevant, NHS England agree that the following shall be in place:
- 3.4.1 The purpose and scope of the Joint Committee and the Specialised Commissioning sub-committee.
- 3.4.2 The Delegation for Specialised Services Functions to each ICB Partner in accordance with the relevant Delegation Agreement.
- 3.4.3 The development of a Specialised Commissioning Hub Team in accordance with clause 3.3.3.

ICB Partner ICB ICB Partners ICB Partner ICB ICB Partners 4. FUNCTIONS

- 4.1 The purpose of this Agreement is to establish a framework through which the SE ICB Partners can secure the commissioning of health services in accordance with the terms of this Agreement, which includes the Delegation of Specialised Services Functions from NHS England.
- 4.2 This Agreement shall include such Commissioning Functions as shall be agreed from time to time by the SE ICB Partners and set out in this agreement.

5. COMMISSIONING HUB FOR SPECIALISED SERVICES FUNCTIONS

- 5.1 The SE ICB Partners and NHS England agree to use the existing Specialised Commissioning Hub Team as set out in Schedule 5 (Commissioning Hub Arrangements) for the purpose of exercising the Delegated Specialised Services Functions.
- 5.2 The staffing arrangements shall be as set out in the Schedule 5 (the Commissioning Hub Agreement).

6. JOINT COMMITTEE

6.1 The SE ICB Partners will form a statutory Joint Committee of their Chief Executive Officers (CEOs), which will offer strategic leadership and oversight of all functions exercised through it, and ensure that decisions are made collectively across the SE ICB Partners, rather than taken independently. The arrangements are set out in Schedule 2.

6.2 The Joint Committee or a sub-committee of it will exercise functions which each ICB Partner has delegated to it.

6.3 In addition, the Joint Committee shall establish a Specialised Commissioning sub-committee which will be responsible for operational management and decision-making of Delegated Specialised Services.

7. GOVERNANCE

7.1 Overall strategic oversight of partnership working between the ICB Partners shall be as set out in Schedule 2 (Governance Arrangements).

7.2 Each ICB Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each ICB Partner's own statutory duties and organisation are complied with.

7.3 ICB Partners will have overall oversight and approval of variations to each delegated specialised commissioned service through the Joint Committee.

8. RISK SHARING

8.1 The SE ICB Partners will establish and implement a risk sharing agreement in 2025/26 in respect of such functions as they all delegate to the Joint Committee.

8.2 Separate to the risk sharing agreement in clause 9.1 the SE ICB Partners must adhere to two key delegation conditions related to the future financial framework which are:

8.2.1 Establishment of a Risk Share Arrangement: By 2025/26, ICBs must implement a Risk Share arrangement for Specialised Commissioning. This is a critical measure to address broader financial challenges and mitigate the impact of the long-term convergence rate.

8.2.2 Financial Contingency Requirement: ICBs are required to maintain a 0.5% contingency within their specialised commissioning financial allocations for 2025/26.

8.3 For Delegated Specialised Services Functions the SE ICB Partners have agreed Risk Sharing in accordance with Schedule 3 - Financial Arrangements for the Delegated Specialised Services Functions, which will be updated from time to time to align with national planning and other guidance as necessary.

9. REVIEW

9.1 Save where the ICBs agree alternative arrangements (including alternative frequencies) the ICBs shall undertake a review after six months of the operation of this Agreement.

9.2 After that, unless ICBs agree on other arrangements, including alternative frequencies, the ICBs shall undertake an annual review of the operation of this Agreement..

9.3 Reviews shall be conducted in good faith.

10. COMPLAINTS

10.1 Complaints received shall be processed in accordance with the Local Authority, Social Services and National Health Service Complaints Regulations 2009 and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and reported back to the respective ICB, and as set out within the Delegation Agreement. This shall be set out in Schedule 5 (Commissioning Team Arrangements).

10.2 Any complaints related to the Delegated Specialised Services Functions shall be dealt with in accordance with Schedule 5.

11. FINANCES

11.1 The financial arrangements shall be as agreed between the ICB Partners and summarised in Schedule 3A - Financial Arrangements for the Delegated ICB Functions.

11.2 Unless expressly provided otherwise in this Agreement or otherwise agreed in advance in writing by the SE ICB Partners, each ICB Partner and, where relevant, NHS England shall bear its own costs as they are incurred.

12. VARIATION

12.1 The SE ICB Partners acknowledge that the scope of the Arrangements may be reviewed and amended from time to time.

12.2 This Agreement may be varied by the agreement of the SE ICB Partners at any time in writing in accordance with their internal decision-making processes.

12.3 No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the ICB Partners and approved at the Joint Committee.

12.4 The following approach shall, unless otherwise agreed, be followed by the SE ICB Partners:

12.4.1 on receipt of a request from one ICB Partner to vary the Agreement, the SE ICB Partners will first undertake an impact assessment and identify the likely impact of the variation on all parties.

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

- (a) whether any Service Contracts affected by the proposed variation should continue, be varied or terminated, taking note of the Service Contract terms and conditions and ensuring that the ICB Partner holding the Service Contract/s is not put in breach of contract; its statutory obligations or financially disadvantaged; and/or
- (b) whether the proposed variation could have an impact on the Commissioning Hub and/or impacts on the ability of the Hub team to provide commissioning support services back to NHSE for the retained (Spec comm) and residual services (H&J & Public Health).

12.4.3 wherever possible agreement will be reached to reduce the level of funding in the Service Contract(s) in line with any reduction in budget; and

12.4.4 should this not be possible and one ICB Partner is left financially disadvantaged as a result of the proposed variation, then the financial risk will, unless otherwise agreed, be shared equally between the ICBs¹.

12.4.5 NHS England may seek a variation of the Agreement, in accordance with the above clauses, in respect of the clauses and Schedules relating to the Delegated Specialised Services Functions.

¹ Risk sharing arrangements will be for local agreement between the SE ICB Partners.

13. DATA PROTECTION

13.1 The SE ICB Partners must ensure that all Personal Data processed by or on behalf of them is processed in accordance with the relevant ICB Partner's obligations under Data Protection Legislation and Data Guidance, and the SE ICB Partners must assist each other as necessary to enable each other to comply with these obligations.

13.2 Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need-to-Know basis. If any ICB Partner:

13.2.1 becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or

becomes aware of any security breach, in respect of the Relevant Information it shall promptly notify the Joint Committee and NHS England. The SE ICB Partners shall fully cooperate with one another to remedy the issue as soon as reasonably practicable.

13.3 In processing any Relevant Information further to this Agreement, each ICB Partner shall at all times comply with their own policies and any NHS England policies and guidance on the handling of data.

13.4 Any information governance breach must be responded to in accordance with Data Security and the Protection Incident Reporting tool. If any ICB Partner is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach, then, as soon as reasonably practical and in any event on or before the first such notification is made, the relevant ICB Partner must fully inform NHS England and the Joint Committee of the information governance breach. This clause does not require the relevant ICB Partner to provide information which identifies any individual affected by the information governance breach where doing so would breach Data Protection Legislation.

13.5 Whether or not a ICB Partner is a Data Controller or Data Processor will be determined in accordance with Data Protection Legislation and any Data Guidance from a Regulatory or Supervisory Body. The SE ICB Partners acknowledge that a ICB Partner may act as both a Data Controller and a Data Processor.

13.6 The SE ICB Partners will share information to enable joint service planning, commissioning, and financial management subject to the requirements of law, including in particular the Data Protection Legislation in respect of any Personal Data.

13.7 Other than in compliance with judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise required by any Law, no information will be shared with any other ICB Partner save as agreed by the SE ICB Partners in writing.

13.8 Schedule 6 makes further provision about information sharing and information governance.

14. IT INTER-OPERABILITY

14.1 The SE ICB Partners will work together to ensure that all relevant IT systems operated by the SE ICB Partners in respect of the Joint Functions are inter-operable and that data may be transferred between systems securely, easily and efficiently.

14.2 The SE ICB Partners will use their respective reasonable endeavours to help develop initiatives to further this aim.

15. FURTHER ARRANGEMENTS

15.1 The SE ICB Partners must give due consideration to whether any of the Joint Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act. The SE ICB Partners must comply with any Guidance around the commissioning of Joint Specialised Services by means of arrangements under section 65Z5 or 75 of the NHS Act.

16. FREEDOM OF INFORMATION

16.1 Each ICB Partner acknowledges that the others are a public authority for the purposes of the Freedom of Information Act 2000 (“**FOIA**”) and the Environmental Information Regulations 2004 (“**EIR**”).

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

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

16.2.2 each ICB Partner shall consult the other regarding the possible application of exemptions in relation to the information requested; and

16.2.3 each ICB Partner acknowledges that the final decision as to the form or content of the response to any request is a matter for the ICB Partner to whom the request is addressed.

16.3 Each ICB Partner is aware and recognises that NHS England may, from time to time, issue a FOIA or EIR protocol or update a protocol previously issued relating to the dealing with and responding to of FOIA or EIR requests in relation to the Delegated Functions and that the SE ICB Partners shall comply with such FOIA or EIR protocols.

17. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

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

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

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

18. CONFIDENTIALITY

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

18.2 Subject to Clause 18.3, the receiving ICB Partner agrees:

18.2.1 to use the disclosing ICB Partner’s Confidential Information only in connection with the receiving ICB Partner’s performance under this Agreement.

18.2.2 not to disclose the disclosing ICB Partner’s Confidential Information to any third party or to use it to the detriment of the disclosing ICB Partner; and

18.2.3 to maintain the confidentiality of the disclosing ICB Partner’s Confidential Information.

18.3 The receiving ICB Partner may disclose the disclosing ICB Partner’s Confidential Information:

18.3.1 in connection with any Dispute Resolution Procedure.

18.3.2 to comply with the Law.

18.3.3 to any appropriate Regulatory or Supervisory Body.

18.3.4 to its staff, who in respect of that Confidential Information will be under a duty no less onerous than the Receiving ICB Partner's duty under Clause 18.2;

18.3.5 to NHS Bodies for the purposes of carrying out their functions.

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

18.4 The obligations in Clause 18 will not apply to any Confidential Information which:

18.4.1 is in or comes into the public domain other than by breach of this Agreement.

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

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

18.5 This Clause 18 does not prevent NHS England making use of or disclosing any Confidential Information disclosed by an ICB where necessary for the purposes of exercising its functions in relation to that ICB.

18.6 This Clause 18 will survive the termination of this Agreement for any reason for a period of 5 years.

18.7 This Clause 18 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

18.8 The above shall also apply to such confidential information as is created and shared between the ICB Partners and NHS England in respect of the Delegated Specialised Services Functions, with each ICB Partner noting the application of clause 18.5.

19. LIABILITIES

19.1 Subject to Clause 19.2, and 19.3, if an ICB Partner or Partners (“First ICB(s)”) incurs a Loss arising out of or in connection with this Agreement as a consequence of any act or omission of another ICB Partner or Partners (“Other ICB(s)”) which constitutes negligence, fraud or a breach of contract in relation to this Agreement or any Services Contract then the Other ICB(s) shall be liable to the First ICB(s) for that Loss.

19.2 Clause 19.1 shall only apply to the extent that the acts or omissions of the Other ICB(s) contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other ICB(s) acting in accordance with the instructions or requests of the First ICB(s) or the Joint Committee.

19.3 If any third party makes a claim or intimates an intention to make a claim against any ICB Partner, which may reasonably be considered as likely to give rise to liability under this Clause 19, the First ICB(s) that may claim against the Other ICB(s) will:

19.3.1 as soon as reasonably practicable give written notice of that matter to the Other ICB(s) specifying in reasonable detail the nature of the relevant claim.

19.3.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Other ICB(s) (such consent not to be unreasonably conditioned, withheld or delayed);

19.3.3 give the Other ICB(s) and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Indemnifying ICB Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

19.4 Each ICB Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement.

19.5 Unless expressly agreed otherwise, nothing in this Agreement shall affect:

19.5.1 the liability of NHS England to any person in respect of NHS England's Commissioning Functions; or

19.5.2 the liability of any of the ICBs to any person in respect of that ICB's Commissioning Functions.

19.6 In respect of the Delegated Specialised Services Functions and the Delegation Agreement with NHS England then each ICB Partner must:

- 19.6.1 comply with any requirements set out in the Delegation Agreements and any policy issued by NHS England from time to time in relation to the conduct of or avoidance of Claims or the pro-active management of Claims.
- 19.6.2 if it receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim, immediately notify the other SE ICB Partners and NHS England and send to NHS England all copies of such correspondence.
- 19.6.3 co-operate fully with each ICB Partner and NHS England in relation to such Claim and the conduct of such Claim.
- 19.6.4 at the request of NHS England, take such action or step or provide such assistance as may in NHS England's discretion be necessary or desirable having regard to the nature of the Claim and the existence of any time limit in relation to avoiding, disputing, defending, resisting, appealing, seeking a review or compromising such Claim or to comply with the requirements of the provider of an Indemnity Arrangement in relation to such Claim.

20. DISPUTE RESOLUTION

- 21.1 Where any dispute arises between the SE ICB Partners in connection with this Agreement, they must use their best endeavours to resolve that dispute.
- 21.2 Where any dispute is not resolved under clause 21.1 on an informal basis then the dispute will be referred to a meeting of the relevant ICB Partner Chief Executive Officers to attempt to resolve the dispute.
- 21.3 Where any dispute is not resolved under clause 21.2 then any ICB may refer the matter to the Joint Committee for resolution.
- 21.4 Should the dispute relate to the Delegated Specialised Services Functions then the matter may be referred to the South East Regional Leadership Team of NHS England for resolution should clauses 21.1 and 21.2 not lead to a resolution of the dispute.
- .

21. BREACHES OF THE AGREEMENT

- 21.1 If any ICB Partner ("Relevant ICB Partner") fails to meet any of its obligations under this Agreement, the other ICB Partners (acting jointly) may by notice require the Relevant ICB Partner to take such reasonable action within a reasonable timescale as the other ICB Partners may specify to rectify such failure. Should the Relevant ICB Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 20 ("Dispute Resolution").
- 21.2 Without prejudice to Clause 21.1, if any ICB Partner does not comply with the terms of this Agreement (including if any ICB Partner exceeds its authority under this Agreement), the other ICB Partners may at their discretion agree to:
- 21.2.1 waive their rights in relation to such non-compliance.
- 21.2.2 terminate this Agreement in accordance with Clause 22 (*Termination and Default*) below.
- 21.2.3 exercise the dispute resolution procedure in accordance with Clause 20, (*Dispute Resolution*).
- 21.2.4 agree to put in place a variation, under Clause 12, including ratifying a decision with remaining ICB Partners.
- 21.3 For the avoidance of doubt, there is no provision in this Clause 21 that enables the agreement to be terminated upon breach by any ICB.

- 21.4 This clause shall also apply as between the ICB Partners, the SE ICB Partners and NHS England in respect of any breaches of the Agreement that arise from the exercise of the Delegated Specialised Services Functions,

22. TERMINATION & DEFAULT²

- 22.1 If an ICB wishes to end its participation in this Agreement, the relevant ICB must provide at least 12 months' formal and written notice to the other ICB Partners of its intention to end its participation in this Agreement. Such notification shall only take effect from the end of 31 March in any calendar year.
- 22.2 Should clause 22.1 be activated by an ICB Partner and will end their joint exercise of the Delegated Specialised Services Functions with other ICB Partners then the relevant ICB Partner must obtain the prior agreement of NHS England and make arrangements for their exercise of the Delegated Specialised Services Functions that are acceptable to NHS England.
- 22.3 The termination shall only take effect where alternative arrangements for the provision of the Delegated Services and effective exercise of the Delegated Functions are in place for the period immediately following termination. This will enable the ICB Partners and NHS England to work together to ensure that there are suitable alternative arrangements in place in relation to the exercise of the Delegated Functions.
- 22.4 If the termination will impact the Specialised Commissioning Hub team or Retained Services, the termination shall only take effect where alternative arrangements for the provision of the Hub team and/or Retained Services and Functions are in place for the period immediately following termination.

23. CONSEQUENCES OF TERMINATION

- 23.1 Upon termination of this Agreement (in whole or in part), for any reason whatsoever, the following shall apply:
- 23.1.1 the SE ICB Partners agree that they will work together and co-operate to ensure that the winding down of these arrangements is carried out smoothly and with as little disruption as possible to patients, employees, the ICB Partners and third parties, so as to minimise costs and liabilities of each ICB Partner in doing so.
- 23.1.2 where a ICB Partner has entered into a Service Contract in exercise of the Functions of any other ICB Partner which continues after the termination of this Agreement, any ICB Partner for whom that contract shall continue shall contribute to the Contract Price in accordance with the agreed contribution for that Service prior to termination and will enter into all appropriate legal documentation required in respect of this.
- 23.1.3 termination of this Agreement shall have no effect on the liability of any rights or remedies of any ICB Partner already accrued, prior to the date upon which such termination takes effect.
- 23.2 The provisions of Clauses 13 (Data Protection), 16 (Freedom of Information), 18 (Confidentiality), 19 (Liabilities) and 23 (Consequences of Termination) shall survive termination or expiry of this Agreement.
- 23.3 Where there are Commissioning Hub arrangements in place the ICB Partners shall discuss and agree arrangements for the Staff and any financial arrangements. NHS Frimley ICB must take the lead on relevant arrangements. These conversations must include NHS England as the Hub team provide commissioning support services back to NHSE for the retained (Spec comm) and residual services (H&J & Public Health).

23.4 The termination provisions relating to the Delegated Specialised Services Functions are as set out in clause 22.3 and 22.4.

24. PUBLICITY

24.1 The ICB Partners shall use reasonable endeavours to consult one another before making any public announcements concerning the subject matter of this Agreement.

•

25. EXCLUSION OF PARTNERSHIP OR AGENCY

25.1 Nothing in this Agreement shall create or be deemed to create a legal partnership under the Partnership Act 1890 or the relationship of employer and employee between the Partners or render any Partner directly liable to any third party for the debts, liabilities or obligations of any Partner.

25.2 Save as specifically authorised under the terms of this Agreement, no Partner shall hold itself out as the agent of any other Partner.

26. THIRD PARTY RIGHTS

26.1 The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Agreement and accordingly the ICB Partners to this Agreement do not intend that any third party should have any rights in respect of this Agreement by virtue of that Act.

27. NOTICES

27.1 Any notices given under this Agreement must be sent by e-mail to the relevant Authorised Officers or their nominated deputies.

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

28. ASSIGNMENT AND SUBCONTRACTING

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

29. SEVERABILITY

29.1 If any term, condition or provision contained in this Agreement shall be held to be invalid, unlawful or unenforceable to any extent, such term, condition or provision shall not affect the validity, legality or enforceability of the remaining parts of this Agreement.

30. WAIVER

30.1 No failure or delay by a ICB Partner to exercise any right or remedy provided under this Agreement or by law shall constitute a waiver of that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy. No single or partial exercise of such right or remedy shall prevent or restrict the further exercise of that or any other right or remedy.

31. STATUS

31.1 The SE ICB Partners and NHS England acknowledge that they are health service bodies for the purposes of section 9 of the NHS Act. Accordingly, this Agreement shall be treated as an NHS contract and shall not be legally enforceable.

•

32. ENTIRE AGREEMENT

32.1 This Agreement constitutes the entire agreement and understanding of the ICB Partners and NHS England, and supersedes any previous agreement between the ICB Partners and NHS England relating to the subject matter of this Agreement.

33. GOVERNING LAW AND JURISDICTION

33.1 Subject to the provisions of Clause 20 (Dispute Resolution) and Clause 31(Status), this Agreement shall be governed by and construed in accordance with English Law, and the SE ICB Partners and NHS England irrevocably agree that the courts of England shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this Agreement.

34. FAIR DEALINGS

34.1 The ICB Partners and NHS England recognise that it is impracticable to make provision for every contingency which may arise during the life of this Agreement and they declare it to be their intention that this Agreement shall operate between them with fairness and without detriment to the interests of either of them and that, if in the course of the performance of this Agreement, unfairness to either of them does or may result, then the other shall use its reasonable endeavours to agree upon such action as may be necessary to remove the cause or causes of such unfairness.

35. COUNTERPARTS

35.1 This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all ICB Partners and NHS England shall constitute a full original of this Agreement for all purposes.

This Agreement has been entered into on the date stated at the beginning of it.

SIGNED by

for and on behalf of **NHS England SE Region** (Signature)

.....
(Date)

SIGNED by

for and on behalf of **Kent & Medway** Integrated Care Board (Signature)

.....
(Date)

SIGNED by

for and on behalf of **Surrey Heartlands** Integrated Care Board (Signature)

.....
(Date)

SIGNED by
for and on behalf of **Hampshire & IOW** Integrated Care Board (Signature)

.....
(Date)

SIGNED byfor and on behalf of
Sussex Integrated Care Board (Signature)

.....
(Date)

SIGNED by for and on behalf of
Frimley Integrated Care Board (Signature)

.....
(Date)

SIGNED by
for and on behalf of **Buckinghamshire Oxfordshire & Berkshire West**
Integrated Care Board (Signature)

.....
(Date)

SCHEDULE 1: DEFINITIONS AND INTERPRETATIONS

DEFINITIONS AND INTERPRETATION

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

- “Agreement”** this agreement between the ICB Partners comprising these terms and conditions together with all schedules attached to it;
- “Aligned Commissioning”** means a mechanism by which the ICB Partners agree to commission a Service in a co-ordinated and collaborative manner. For the avoidance of doubt, an aligned commissioning arrangement does not involve the delegation of any functions between ICBs;
- “Annual Review”** Means the annual review of the arrangements under this Agreement by the Partners;
- “Area”** means the geographical area covered by the ICBs;
- “Arrangements”** means the joint working and delegation arrangements set out in this Agreement;
- “Assurance Processes”** has the meaning in Paragraph 8 of Schedule 3 (Oversight and Assurance);

"Authorised Officer"	the individual(s) appointed as Authorised Officer in accordance with the agreed Terms of Reference;
"Change in Law"	a change in Law that is relevant to the arrangements made under this Agreement, which comes into force after the Commencement Date;
"Claim"	means for or in relation to the Commissioning Functions (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or the Secretary of State, any governmental, regulatory or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by any governmental, regulatory or similar body or agency;
"Clinical Commissioning Policies"	a nationally determined clinical policy sets out the commissioning position on a particular clinical treatment issue and defines accessibility (including a not for routine commissioning position) of a medicine, medical device, diagnostic technique, surgical procedure or intervention for patients with a condition requiring a specialised service;
"Clinical Reference Groups"	means a group consisting of clinicians, commissioners, public health experts, patient and public voice representatives and professional associations, which offers specific knowledge and expertise on the best ways that Specialised Services should be provided;
"Collaborative Commissioning Agreement"	means an agreement under which NHS Commissioners set out collaboration arrangements in respect of commissioning Specialised Services Contracts;
"Commencement Date"	means 1 April 2025;
"Commissioning Functions"	the respective statutory functions of the ICB Partners in arranging for the provision of services as part of the health service;
"Commissioning Hub"	
"Commissioning Hub Arrangements"	Means the arrangements in respect of the Commissioning Hub;
"Commissioning Hub Agreement"	Means the agreement that sets out the arrangements for the Commissioning Hub between [] and NHS England;
"Confidential Information"	means information, data and/or material of any nature which any ICB Partner may receive or obtain in connection with the operation of this Agreement, or arrangements made pursuant to it and: <ul style="list-style-type: none"> (a) which comprises Personal Data or which relates to any patient or his treatment or medical history. (b) the release of which is likely to prejudice the commercial interests of a ICB Partner; or (c) which is a trade secret;
"Contracting Standard Operating Procedure"	means the Contracting Standard Operating Procedure produced by NHS England in respect of the Joint Specialised Services;
"Core Membership"	means the voting membership of the Joint Committee as set out in the Terms of Reference;

“Data Controller”	shall have the same meaning as set out in the Data Protection Legislation;
“Data Processor”	shall have the same meaning as set out in the Data Protection Legislation;
“Data Guidance”	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency and the Information Commissioner;
"Data Protection Legislation"	means the UK General Data Protection Regulation, the Data Protection Act 2018, the Regulation of Investigatory Powers Act 2000, the Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000 (SI 2000/2699), the Privacy and Electronic Communications (EC Directive) Regulations 2003 (SI 2426/2003), the common law duty of confidentiality and all applicable laws and regulations relating to the processing of personal data and privacy, including where applicable the guidance and codes of practice issued by the Information Commissioner;
“Data Protection Officer”	shall have the same meaning as set out in the Data Protection Legislation;
“Data Security and Protection Incident Reporting tool”	the incident reporting tool for data security and protection incidents, which forms part of the Data Security and Protection Toolkit available at https://www.dsptoolkit.nhs.uk/ ;
“Delegated Commissioning Group” “DCG”	means a group hosted by NHS England whose terms shall include providing an assurance role in compliance with the Assurance Processes;
“Delegation Agreement(s)”	Means the Delegation Agreements under which NHS England delegate NHS England Commissioning Functions to each ICB;
“Delegated Functions”	Means Commissioning Functions of NHS England delegated to each ICB under a Delegation Agreement;
“Delegated Services”	Means those services commissioned in exercise of the Delegated Functions
"Dispute Resolution Procedure"	the procedure set out in Clause 20 (Dispute Resolution);

“Finance Guidance”	guidance, rules and operating procedures produced by NHS England that relate to these Joint Working Arrangements, including but not limited to the following:
	<ul style="list-style-type: none"> - Commissioning Change Management Business Rules. - Contracting Standard Operating Procedure. - Cashflow Standard Operating Procedure. - Finance and Accounting Standard Operating Procedure. - Service Level Framework Guidance;
“Flexibilities”	Mean the flexibilities that the ICB Partners may use to work in a coordinated manner as set out at Clause []
"FOIA"	the Freedom of Information Act 2000 and any subordinate legislation made under it from time to time, together with any guidance or codes of practice issued by the Information Commissioner or relevant government department concerning this legislation;
“Guidance”	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the ICB Partners have a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified by any relevant Regulatory or Supervisory Body;
“Governance Arrangements”	Means the governance arrangements in respect of the Arrangements agreed by the ICB Partners and as set out in Schedule [4]
“High-Cost Drugs”	Means medicines not reimbursed though national prices and identified on the NHS England high-cost drugs list;
“ICB Functions”	the Commissioning Functions of an ICB;
“ICB Functions”	Reserved Where there is any delegation of ICB Functions or further delegation of Delegated Functions, those functions that remain reserved to each ICB
“Individual Scheme”	Means a scheme which has been agreed by the ICB Partners to be included within this Agreement;
"Information"	has the meaning given under section 84 of FOIA;
“Indemnity Arrangement”	mean either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);
"Information Sharing Agreement"	any information sharing agreement entered into in accordance with Schedule 5 (Further Information Governance and Sharing Provisions).
“Indemnity Arrangement”	means either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);
“Initial Term”	Means [INSERT AGREED INITIAL TERM]

“Joint Committee”	means the joint committee(s) established under this Agreement on the terms set out in the Terms of Reference;
“Joint Functions”	any Functions that are delegated to a Joint Committee
"Law"	means: <ul style="list-style-type: none"> (a) any statute or proclamation or any delegated or subordinate legislation. (b) any guidance, direction or determination with which the ICB Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the ICB Partner(s) or relevant third party (as applicable); and (c) any judgment of a relevant court of law which is a binding precedent in England;
“Lead Commissioning Arrangements”	means the arrangements by which one ICB Partner commissions Services in relation to an Individual Scheme on behalf of another ICB Partner or ICB Partners in exercise of the Commissioning Functions of the ICB Partners;
“Lead ICB Partner”	means the ICB Partner responsible for commissioning an Individual Service under a Lead Commissioning Arrangement;
“Mandated Guidance”	means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of Delegated Functions and issued by NHS England from time to time as mandatory;
“National Standards”	means the service standards for each Specialised Service, as set by NHS England and included in Clinical Commissioning Policies or National Specifications;
“National Specifications”	the service specifications published by NHS England in respect of Specialised Services;
“Need to Know”	has the meaning set out in Schedule 5;
“NHS Act”	the National Health Service Act 2006;
“NHS England Functions”	NHS England’s statutory functions exercisable under or by virtue of the NHS Act;
“NHS England Reserved Functions”	those aspects of the Specialised Commissioning Functions for which NHS England retains commissioning responsibility;
“Non-Personal Data”	means data which is not Personal Data;
“Non-Pooled Funds”	means the budget detailing the financial contributions of the ICB Partner/ICB ICB Partners which are not included in a Pooled Fund in respect of a particular Service as set out in the relevant Scheme Specification
“Oversight Framework”	means the NHS Oversight Framework, as may be amended or replaced from time to time, and any relevant associated Guidance published by NHS England;

“ICB Partners”	the parties to this Agreement;
"Personal Data"	has the meaning set out in the Data Protection Legislation;
“Pooled Funds”	means any pooled fund established and maintained by the ICB Partners as a pooled fund
“Population”	means the population for which an ICB or all of the ICBs have the responsibility for commissioning health services;
“Provider Collaborative”	a group of Providers who have agreed to work together to improve the care pathway for one or more Services;
“Provider Collaborative Arrangements”	Means the contracting arrangements entered into in respect of a Provider Collaborative;
“Provider Collaborative Guidance”	Means any guidance published by NHS England in respect of Provider Collaboratives;
“Regional Quality Group”	A group set up to act as a strategic forum at which regional ICB Partners from across health and social care can share, identify and mitigate wider regional quality risks and concerns as well as share learning so that quality improvement and best practice can be replicated;
“Regulatory or Supervisory Body”	means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: <ul style="list-style-type: none"> (i) CQC. (ii) NHS England. (iii) the Department of Health and Social Care. (iv) NICE. (v) Healthwatch England and Local Healthwatch. (vi) the General Medical Council. (vii) the General Dental Council. (viii) the General Optical Council. (ix) the General Pharmaceutical Council. (x) the Healthcare Safety Investigation Branch; and (xi) the Information Commissioner;
“Relevant Information”	means the Personal Data and Non-Personal Data processed under this Agreement, and includes, where appropriate, “confidential patient information” (as defined under section 251 of the NHS Act), and “patient confidential information” as defined in the 2013 Report, The Information Governance Review – “ <i>To Share or Not to Share?</i> ”);
"Request for Information"	has the meaning set out in the FOIA;

“Reserved Functions”	Means NHS England Reserved Functions or ICB Reserved Functions
“Relevant Clinical Networks”	means those clinical networks identified by NHS England as required to support the commissioning of Specialised Services for the Population;
“Retained Services”	means those Specialised Services for which NHS England shall retain commissioning responsibility, as set out the Delegation Agreement;
“Risk Sharing”	means an agreed arrangement for risk and benefit sharing between the ICB Partners;
“Shared Care Arrangements”	these arrangements support patients receiving elements of their care closer to home, whilst still ensuring that they have access to the expertise of a specialised centre and that care is delivered in line with the expectation of the relevant National Specification;
“Single Point of Contact”	the member of Staff appointed by each relevant ICB Partner in accordance with Paragraph 14 of Schedule 5;
“Special Category Personal Data”	has the meaning set out in the Data Protection Legislation;
“Specialised Commissioning Budget”	means the budget identified by NHS England in respect of each ICB for the purpose of exercising the Delegated Functions;
“Specialised Commissioning Functions”	means the statutory functions conferred on NHS England under Section 3B of the NHS Act 2006 and Regulation 11 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996 (as amended or replaced);
“Specified Purpose”	means the purpose for which the Relevant Information is shared and processed to facilitate the exercise of the Joint Functions and Reserved Functions as specified in Schedule [] (<i>Further Information Governance and Sharing Provisions</i>) to this Agreement;
“Specialised Services”	means the services commissioned in exercise of the Specialised Commissioning Functions;
“Specialised Services Contract”	a contract for the provision of Specialised Services entered into in the exercise of the Specialised Commissioning Functions;
“Specialised Services Provider”	a provider party to a Specialised Services Contract;
“Specialised Services Staff”	means the Staff carrying out the Specialised Services Functions;
“Staff”	means the ICB Partners’ employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of any ICB Partner (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors’ and their sub-contractors’ personnel;

“System quality group” means a group set up to identify and manage concerns across the local system. The system quality group shall act as a strategic forum at which ICB Partners from across the local health and social care footprint can share issues and risk information to inform response and management, identify and mitigate quality risks and concerns as well as share learning and best practice;

"Term" the Initial Term, as may be varied by:

- (a) any extensions to this Agreement that are agreed under Clause 1.1 (Commencement and Duration); or
- (b) the earlier termination of this Agreement in accordance with its terms;

“Terms of Reference” means the Terms of Reference for the Joint Committee agreed between the ICB Partners at the first meeting of the Joint Committee, a draft of which is included at Schedule 2 (Joint Committee);

“Triple Aim” the duty on each of the ICB ICB Partners in making decisions about the exercise of their functions, to have regard to all likely effects of the decision in relation to:

- (a) the health and well-being of the people of England.
- (b) the quality of services provided to individuals by the NHS.
- (c) efficiency and sustainability in relation to the use of resources by the NHS;

“UK GDPR” means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018;

"Working Day" any day other than Saturday, Sunday, a public or bank holiday in England.

1. References to statutory provisions shall be construed as references to those provisions as respectively amended or re-enacted (whether before or after the Commencement Date) from time to time.
2. The headings of the Clauses in this Agreement are for reference purposes only and shall not be construed as part of this Agreement or deemed to indicate the meaning of the relevant Clauses to which they relate. Reference to Clauses is Clauses in this Agreement.
3. References to Schedules are references to the schedules to this Agreement and a reference to a Paragraph is a reference to the paragraph in the Schedule containing such reference.
4. References to a person or body shall not be restricted to natural persons and shall include a company, corporation or organisation.
5. Words importing the singular number only shall include the plural.
6. Use of the masculine includes the feminine and all other genders.
7. Where anything in this Agreement requires the mutual agreement of the ICB Partners, then unless the context otherwise provides, such agreement must be in writing.

8. Any reference to the ICB Partners shall include their respective statutory successors, employees and agents.
9. In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.
10. Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

SCHEDULE 2: GOVERNANCE ARRANGEMENTS FOR THE DELEGATED SPECIALISED SERVICES FUNCTIONS

1 GENERAL

1.1 The ICB Partners have established a three-tiered governance model to support the commissioning of Specialised Services in South East Region, effective from April 2025, as described in Figure 1 below. The three tiers are comprised of:

1.1.1. NHS England (NHSE):

- Acts as the regulatory body, providing oversight and assurance for the collaborative commissioning framework.

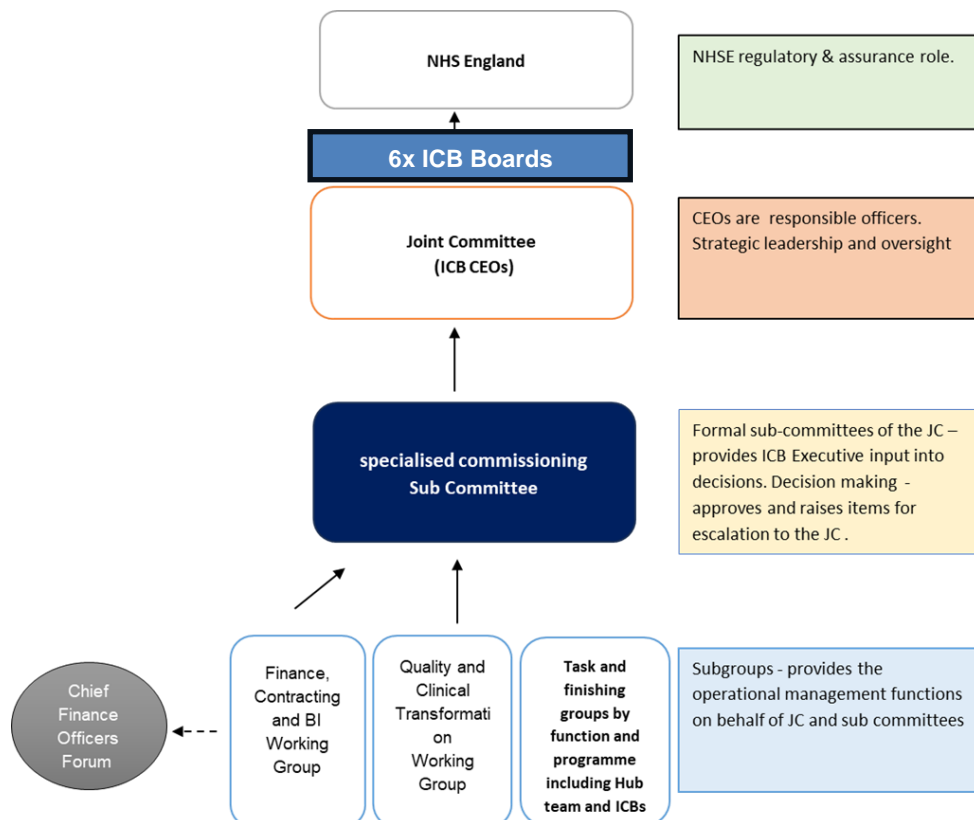
1.1.2. Joint Committee:

- The Delegation Agreement for Specialised Commissioning will explicitly delegate all functions to the Joint Committee under the authority granted by Section 65Z5 of the NHS Act 2006.
- Composed of ICB Chief Executive Officers (CEOs) who serve as responsible officers.
- Provides strategic leadership and oversight for decision-making across the collaborative arrangement.

1.1.3. Specialised Commissioning Subcommittee:

- Functions as a multi-ICB subcommittee operating under the Joint Committee.
- The Joint Committee can delegate the relevant functions to this sub-committee and through to individuals/groups for operational management, as may be needed from time to time.
- Responsible for operational management, decision-making forum for delegated specialised commissioning across the South East – it will escalate matters to the ICB CEO Joint Committee by determination of the Chair of the Specialised Commissioning Subcommittee as set out in the TOR.
- Includes formal subcommittees and working groups for specific operational and functional tasks as per their TOR.

Figure 1: Three- tiered governance model for ICB collaboration



- 1.2 The Joint Committee, supported by the Specialised Commissioning Subcommittee, will oversee and make decisions regarding the delegated Specialised Services.
- 1.3 For all ICBs in NOF3 or NOF4, any decision that impacts on the overall spend of the specialised service allocation must have NHSE Regional approval before the commissioning change is made or any change process is begun. To support this, NHS England will act as a ICB Partner within the Joint Committee (and or any subcommittee as needed) to provide advice to the ICBs on delegated specialised services, particularly those within NOF levels 3 and 4, and to facilitate the ICBs in advising NHS England on its retained commissioning responsibilities. The NHS England representative present at all meetings will be given power to approve decisions that require NHS England's approval. The Terms of Reference for the Joint Committee will be established as a separate document. A separate guidance document for further information entitled, "Approach to Managing the Developmental Arrangements for ICBs in NOF3/4" will be shared with ICBs.
- 1.4 The Joint Committee will be a formal committee of the board for any of the ICB Partner ICBs. ICB Boards will enable the Joint Committee to make decisions on their behalf for delegated specialised services. The Authorised Officer from each ICB Partner at the Joint Committee will represent and make decisions on behalf on their organisation, as set out in their respective Schemes of Reservation and Delegation (SoRDs).
- 1.5 Where decisions fall outside of the arrangements suggested in section 1.4 above, then the Authorised Officer will ensure that they have sufficient authority from their organisation for decision making, for example, obtaining approval from the relevant committees or board.
- 1.6 It is the responsibility of each ICB Partner to determine the route by which it receives assurance from, and contributes to, the decision making of the Joint Committee. It is the responsibility of each Authorised Officer of the Committee to operate within the governance structure of their organisation in order to provide such assurance using the route agreed by their organisation.

2 JOINT COMMITTEE FOR THE DELEGATED SPECIALISED SERVICES FUNCTIONS

- 2.1 The Joint Committee (and each member of the committee) will act at all times in accordance with the Terms of Reference.

- 2.2 The ICB Partners shall nominate one Authorised Officer and substitutes/deputies to the Joint Committee in accordance with the Terms of Reference.
- 2.3 The ICB Partners shall ensure that their Authorised Officer and substitutes/deputies have appropriate delegated authority, in accordance with their organisational governance arrangements, to represent the interests of their organisation in the Joint Committee and any other sub-groups established by the Joint Committee.
- 2.5 The ICB Partners recognise the need to ensure that any potential conflicts of interest on the part of any ICB Partner, including its representatives, in respect of this Agreement and the establishment or operation of the Joint Committee and any sub-group of the Joint Committee must be appropriately identified, recorded and managed.
- 2.6 The Joint Committee must establish effective, safe, efficient and economic arrangements for the discharge of ICB functions.
- 2.7 The members of the Joint Committee must act in accordance with:
- the terms of this Agreement,
 - all applicable Law,
 - guidance,
 - the Schemes of Reservation and Delegation of ICB Partners
 - the Terms of Reference of the Joint Committee, and
 - the Delegation Agreement signed by each ICB and NHS England
- 2.8 NHS England South East Region will update and inform members of the Committee in respect of those specialised services it is retaining to support continuity of decision making on patient pathways.
- 2.9 Where the Joint Committee addresses business relating to the delegated specialised services for ICBs in NOF 3/4, then
- The Joint Committee will send minutes of the decision made to NHS England's regional team within 2 working days of the decision being made.
 - NHS England's Regional team shall have 5 working days to indicate whether they are content with the decision or whether they need to look at it more thoroughly.
 - Should the Joint Committee receive no notification from the NHS England's Regional team within 5 working days of submitting the decision then it will be deemed approved.
- 2.10 Further details on the roles and responsibility of the Specialised Commissioning Subcommittee will be detailed in the terms of reference of the committee.

3 SPECIALISED COMMISSIONING SUBCOMMITTEE

- 3.1 The Specialised Commissioning Subcommittee is a formal establish sub-committee of the Joint Committee. The terms of reference of this committee will be reviewed annually and members of the subcommittee will act at all times in accordance with the Terms of Reference.
- 3.2 The ICB Partners shall nominate one Authorised Officer and substitutes/deputies to the Specialised Commissioning Subcommittee in accordance with the Terms of Reference.
- 3.3 The ICB Partners shall ensure that their Authorised Officer and substitutes/deputies have appropriate delegated authority, in accordance with their organisational governance arrangements, to represent the interests of their organisation on the subcommittee and make appropriate decisions on their behalf.

- 3.4 The ICB Partners recognise the need to ensure that any potential conflicts of interest on the part of any ICB Partner, including its representatives, in respect of this Agreement and the establishment or operation of the Joint Committee and any sub-group of the Joint Committee must be appropriately identified, recorded and managed.
- 3.5 The Specialised Commissioning Subcommittee must establish effective, safe, efficient and economic arrangements for the discharge of ICB functions and its members must act in accordance with the terms noted section 2.7 of the Joint Committee.
- 3.6 NHS England South East Region will be formal members of the Committee in respect of those specialised services it is retaining. Where the Joint Committee addresses business relating to the delegated specialised services, then NHSE will be observers.
- 3.7 The operational management of the commissioning functions will be dealt with through the working groups at a level below the sub-committee.
- 3.8 Further details on the roles and responsibility of the Specialised Commissioning Subcommittee and the working groups below it will be detailed in the terms of reference of the committee.

SCHEDULE 3: FINANCIAL ARRANGEMENTS FOR THE DELEGATED SPECIALISED SERVICES FUNCTIONS

1 Financial Delegation Conditions

- 1.1 The SE ICBs must adhere to two key delegation conditions related to the future financial framework:
- During 2025/26, ICBs must implement a Risk Share arrangement for Specialised Commissioning. This is a critical measure to address broader financial challenges and mitigate the impact of the long-term convergence rate.
 - ICBs are required to maintain a 0.5% contingency within their specialised commissioning financial allocations for 2025/26.
- 1.2 These conditions shall be subject to review in accordance with Clause 9 (Review).

2 Financial allocations

- 2.1 The ICBs have agreed **not** to establish and maintain pooled funds for revenue expenditure.
- 2.2 The financial allocation for 2025/26 shall be as set out by the NHSE national specialised team in the agreed schedules with each ICB. Growth funding will be applied in accordance with national guidance for baseline levels. Any discretionary growth funding allocated nationally will be agreed by ICBs for consistent application into risk and investment reserves held by each ICB.
- 2.3 Given the complexity of the derivation of the Specialised Commissioning opening baselines for 2025/26, it may be necessary to agree a redistribution of allocations where discrepancies come to light during the setting of 2025/26 plans or by exception in year.
- 2.4 A running costs allowance (RCA) adjustment to individual ICB allocations is expected in 2025/26 (part year effect) and a full year effect in 2026/27 financial year, to enable the staff transfer in July 2025. This RCA adjustment to support specialised commissioning delegation will be ringfenced to resource the Specialised Commissioning Hub Team.

3 Risk share arrangements, Overspends and Underspends

- 3.1 The ICB Partners have agreed to financial risk share arrangements as set out in Appendix 1 of this Schedule 3, which provide details for risk share arrangements arising within the commissioning of services.
- 3.2 The risk share arrangement relates exclusively to the 70 Specialised Commissioning services transferred to ICBs with effect from April 2025.
- 3.3 The introduction of ICB risk share arrangements into the NHS replaced the competitive approach of the internal market with principles of collaboration, openness and transparency.
- 3.4 Organisations will resolve any financial issues between them through the South East Specialised Commissioning Finance Working Group, that will continue to be in place and if required through the ICB CFOs. In the last resort where resolution proves unobtainable issues may be referred through the escalation procedure outlined in Section 11 of the Risk Share Agreement in Appendix 1 and Dispute Resolution Process of this Agreement (Clause 20).
- 3.5 The risk share in place for 2025/26 will be a full risk share to ensure there is a safe transfer of services and to minimise any financial risk. The arrangement covers: -
- 3.5.1 The variable elements of NHS provider contracts, for delegated specialised services commissioned by South East ICBs as per national guidance.
 - 3.5.2 Variable non-NHS provider contracts (including providers in devolved nations) for delegated specialised services commissioned by South East ICBs.
 - 3.5.3 Other unplanned cost pressures, for delegated specialised services, which could not reasonably have been known about, and planned for, during the annual planning cycle.
 - 3.5.4 Once in year mitigations (inc. performance reserves and contingency) have been fully considered and implemented remaining issues will be managed through applying risk management arrangements. The risk share will apply either where the bottom-line position is in surplus, balance, or where there is a deficit.
 - 3.5.5 Bottom-line deficits will be shared pro rata to the ICB 2025/26 opening budget position. This will be within the overall specialised commissioning budgets, and not based on non-specialised system allocations.
 - 3.5.6 For budgetary surpluses deficits will be cleared and the net surplus distributed pro rata to original surpluses.
 - 3.5.7 A worked example of surplus, balanced, and deficit positions is shown in Appendix 1.
 - 3.5.8 There should be options to amend ICB risk share percentages annually by consensus of all ICBs. This may include adjustments for service change covering both the impact of additional pathways within delegated service arrangements or delivered pathway change outside of delegated service arrangements but impacting delegated spend. In the latter scenario it will be based on evidence of quantifiable, sustained, and recurrent delivery not production of a business case.
- 3.6 Cost mitigation always precedes any application of risk sharing. Risk sharing may only be considered once the Finance Working Group has satisfied itself that the appropriate mitigations have been implemented.
- 3.7 Quarterly position statements of agreed risk sharing should be produced including a forecast at each quarter. These will form the basis of recommended adjustments, and at Q3 a forecast and recommendation will be made for the year end to support delivery of year end positions. This may be supplemented by a Month 11 update and recommendation. If the national timetables suggest a different timescale for locking in year-end forecast outputs that date will be used instead.
- 3.8 Enacting the risk share will be a recommendation from the Finance Working Group to the Joint Committee. The risk share will apply region wide i.e., across all 6 ICBs. All services that are part of the delegation will be included in the risk share. Currently there are no specific risk shares for individual specialties.

4 Capital Expenditure

4.1 Unless agreed by the ICBs, no funds shall normally be applied towards any one-off expenditure on goods and/or services, which would historically have been funded from the capital budgets of one of the ICBs. If a need for capital expenditure is identified for specialised services, this must be agreed by the ICB Partners.

5 Finance Operating Model

5.1 The finance operating model is set out in Appendix 3 which details the support that the finance team initially within NHSE prior to 1 July and then from within the Specialised Commissioning Hub finance team, thereafter, will provide to the Integrated Care Boards (ICBs) to enable them to discharge their responsibility for delegated Specialised Commissioning finance functions from April 2025.

Appendix 1 - Risk Share Agreement

Appendix 2 - Financial Framework Planning

Appendix 3 – Finance operating model - to follow

SCHEDULE 4: FURTHER INFORMATION GOVERNANCE AND SHARING PROVISIONS

1. Introduction

- 1.1. This Schedule sets out the scope for the secure and confidential sharing of information between the ICB Partners on a Need-to-Know basis, in order to enable the ICB Partners to exercise their functions in pursuance of this Agreement.
- 1.2. References in this Schedule (*Further Information Governance and Sharing Provisions*) to the Need to Know basis or requirement (as the context requires) should be taken to mean that the Data Controllers' Staff will only have access to Personal Data or Special Category Personal Data if it is lawful for such Staff to have access to such data for the Specified Purpose in paragraph 2.1 and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Special Category Personal Data specified.
- 1.3. This Schedule and the Data Sharing Agreements entered into under this Schedule are designed to:
 - 1.3.1. provide information about the reasons why Relevant Information may need to be shared and how this will be managed and controlled by the ICB Partners;
 - 1.3.2. describe the purposes for which the ICB Partners have agreed to share Relevant Information;
 - 1.3.3. set out the lawful basis for the sharing of information between the ICB ICB Partners, and the principles that underpin the exchange of Relevant Information;
 - 1.3.4. describe roles and structures to support the exchange of Relevant Information between the ICB ICB Partners;
 - 1.3.5. apply to the sharing of Relevant Information relating to Specialised Services Providers and their Staff;
 - 1.3.6. apply to the sharing of Relevant Information whatever the medium in which it is held and however it is transmitted;
 - 1.3.7. ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and how this sharing will be managed;
 - 1.3.8. apply to the activities of the ICB Partners' Staff; and
 - 1.3.9. describe how complaints relating to Personal Data sharing between the ICB Partners will be investigated and resolved, and how the information sharing will be monitored and reviewed.

2. Purpose

- 2.1. The Specified Purpose of the data sharing is to facilitate the exercise of the Joint Functions and NHS England's Reserved Functions.
- 2.2. Each ICB Partner must ensure that they have in place appropriate Data Sharing Agreements to enable data to be received from any third-party organisations from which the ICB Partners must obtain data in order to achieve the Specified Purpose. Where necessary specific and detailed purposes must be set out in a Data Sharing Agreement that complies with all relevant Legislation and Guidance.

3. Benefits of information sharing

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

4. Lawful basis for sharing

- 4.1. The ICB Partners shall comply with all relevant Data Protection Legislation requirements and good practice in relation to the processing of Relevant Information shared further to this Agreement.
- 4.2. The ICB Partners shall ensure that there is a Data Protection Impact Assessment (“DPIA”) that covers processing undertaken in pursuance of the Specified Purpose. The DPIA shall identify the lawful basis for sharing Relevant Information for each purpose and data flow.
- 4.3. Where appropriate, the Relevant Information to be shared shall be set out in a Data Sharing Agreement.

5. Restrictions on use of the Shared Information

- 5.1. Each ICB Partner shall only process the Relevant Information as is necessary to achieve the Specified Purpose and, in particular, shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.
- 5.2. Access to, and processing of, the Relevant Information provided by a ICB Partner must be the minimum necessary to achieve the Specified Purpose. Information and Special Category Personal Data will be handled at all times on a restricted basis, in compliance with Data Protection Legislation requirements, and the ICB Partners’ Staff should only have access to Personal Data on a justifiable Need to Know basis.
- 5.3. Neither the provisions of this Schedule nor any associated Data Sharing Agreements should be taken to permit unrestricted access to data held by any of the ICB Partners.
- 5.4. Neither ICB Partner shall subcontract any processing of the Relevant Information without the prior consent of the other ICB Partner. Where a ICB Partner subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor which imposes the same obligations as are imposed on the Data Controllers under this Agreement.
- 5.5. The ICB ICB Partners shall not cause or allow Data to be transferred to any territory outside the United Kingdom without the prior written permission of the responsible Data Controller.
- 5.6. Any particular restrictions on use of certain Relevant Information should be included in a Personal Data Agreement.

6. Ensuring fairness to the Data Subject

- 6.1. In addition to having a lawful basis for sharing information, the UK GDPR generally requires that the sharing must be fair and transparent. In order to achieve fairness and transparency to the Data Subjects, the ICB Partners will take the following measures as reasonably required:
 - 6.1.1. amendment of internal guidance to improve awareness and understanding among Staff;
 - 6.1.2. amendment of respective privacy notices and policies to reflect the processing of data carried out further to this Agreement, including covering the requirements of articles 13 and 14 UK GDPR and providing these (or making them available to) Data Subjects;
 - 6.1.3. ensuring that information and communications relating to the processing of data is clear and easily accessible; and
 - 6.1.4. giving consideration to carrying out activities to promote public understanding of how data is processed where appropriate.

- 6.2. Each ICB Partner shall procure that its notification to the Information Commissioner's Office, and record of processing maintained for the purposes of Article 30 UK GDPR, reflects the flows of information under this Agreement.
- 6.3. The ICB ICB Partners shall reasonably cooperate in undertaking any DPIA associated with the processing of data further to this Agreement, and in doing so engage with their respective Data Protection Officers in the performance by them of their duties pursuant to Article 39 UK GDPR.
- 6.4. Further provision in relation to specific data flows may be included in a Personal Data Agreement between the ICB Partners.

7. Governance: Staff

- 7.1. The ICB Partners must take reasonable steps to ensure the suitability, reliability, training and competence, of any Staff who have access to Personal Data, and Special Category Personal Data, including ensuring reasonable background checks and evidence of completeness are available on request.
- 7.2. The ICB Partners agree to treat all Relevant Information as confidential and imparted in confidence and must safeguard it accordingly. Where any of the ICB Partners' Staff are not healthcare professionals (for the purposes of the Data Protection Act 2018) the employing ICB Partners must procure that Staff operate under a duty of confidentiality which is equivalent to that which would arise if that person were a healthcare professional.
- 7.3. The ICB Partners shall ensure that all Staff required to access Personal Data (including Special Category Personal Data) are informed of the confidential nature of the Personal Data. The ICB Partners shall include appropriate confidentiality clauses in employment/service contracts of all Staff that have any access whatsoever to the Relevant Information, including details of sanctions for acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure provisions of Data Protection Legislation requirements, or cause damage to or loss of the Relevant Information.

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

- 7.4. The ICB ICB Partners shall ensure that:

- 7.4.1. only those Staff involved in delivery of the Agreement use or have access to the Relevant Information; and
- 7.4.2. that such access is granted on a strict Need to Know basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited. Evidence of audit should be made freely available on request by the originating Data Controller; and
- 7.4.3. specific limitations on the Staff who may have access to the Information are set out in any Data Sharing Agreement entered into in accordance with this Schedule.

8. Governance: Protection of Personal Data

- 8.1. At all times, the ICB Partners shall have regard to the requirements of Data Protection Legislation and the rights of Data Subjects.
- 8.2. Wherever possible (in descending order of preference), only anonymised information, or strongly or weakly pseudonymised information will be shared and processed by the ICB Partners. The ICB Partners shall cooperate in exploring alternative strategies to avoid the use of Personal Data in order to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data or Special Category Personal Data.

- 8.3. Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need-to-Know basis.
- 8.4. If any ICB Partner
- 8.4.1. becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or
 - 8.4.2. becomes aware of any security vulnerability or breach in respect of the Relevant Information, it shall promptly, within 48 hours, notify the other ICB Partners. The ICB Partners shall fully cooperate with one another to remedy the issue as soon as reasonably practicable, and in making information about the incident available to the Information Commissioner and Data Subjects where required by Data Protection Legislation.
- 8.5. In processing any Relevant Information further to this Agreement, the ICB Partners shall process the Personal Data and Special Category Personal Data only:
- 8.5.1. in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only in accordance with written instructions from the originating Data Controller in respect of its Relevant Information;
 - 8.5.2. to the extent as is necessary for the provision of the Specified Purpose or as is required by law or any regulatory body;
 - 8.5.3. in accordance with Data Protection Legislation requirements, in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) UK GDPR; and not in such a way as to cause any other Data Controller to breach any of their applicable obligations under Data Protection Legislation.
- 8.6. The ICB Partners shall act generally in accordance with Data Protection Legislation requirements. This includes implementing, maintaining and keeping under review appropriate technical and organisational measures to ensure and demonstrate that the processing of Personal Data is undertaken in accordance with Data Protection Legislation, and in particular to protect the Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing, and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:
- 8.6.1. take account of the nature, scope, context and purposes of processing as well as the risks, of varying likelihood and severity for the rights and freedoms of Data Subjects; and
 - 8.6.2. be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data and Special Category Personal Data and having the nature of the Personal Data (and Special Category Personal Data) which is to be protected.
- 8.7. In particular, each ICB Partner shall:
- 8.7.1. ensure that only Staff as provided under this Schedule have access to the Personal Data and Special Category Personal Data;
 - 8.7.2. ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display or distribution, of the Relevant Information;
 - 8.7.3. obtain prior written consent from the originating ICB Partner in order to transfer the Relevant Information to any third party;

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

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

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

8.8. The ICB Partners shall use best endeavours to achieve and adhere to the requirements of the NHS Digital Data Security and Protection Toolkit.

8.9. The ICB Partners' Single Points of Contact set out in paragraph 13 will be the persons who, in the first instance, will have oversight of third-party security measures.

9. Governance: Transmission of Information between the ICB Partners

9.1. This paragraph supplements paragraph 8 of this Schedule.

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

9.3. Wherever possible, Personal Data should be transmitted and held in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, so as to ensure that the correct patient record / data is identified.

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

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

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

10. Governance: Quality of Information

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

11. Governance: Retention and Disposal of Shared Information

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

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

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

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

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

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

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

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

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

12. Governance: Complaints and Access to Personal Data

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

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

12.3. The ICB Partners shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Schedule or any data processing carried out further to it.

12.4. Basic details of the Agreement shall be included in the appropriate log under each ICB Partner's Publication Scheme.

13. Governance: Single Points of Contact

13.1. The ICB Partners each shall appoint a Single Point of Contact to whom all queries relating to the particular information sharing should be directed in the first instance.

14. Monitoring and review

14.1. The ICB Partners shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Data Protection Legislation and best practice. Specific monitoring requirements must be set out in the relevant Data Sharing Agreement.

SCHEDULE 5: COMMISSIONING HUB ARRANGEMENTS FOR SPECIALISED SERVICES

1. General Scope of Arrangements

1.1. Resource Allocation

NHS England shall allocate the resources currently supporting delegated specialised services to the administration and management of such services in accordance with this Agreement.

1.2. Provision of Services During Transition

Pursuant to the Delegation Agreements, NHS England agrees to provide Administrative and Management Services to the Integrated Care Boards ("ICBs") as specified in this Agreement for the period commencing April 1, 2025, and ending June 30, 2025.

1.3. Transfer of Staff

Effective July 1, 2025, the majority of staff responsible for the commissioning of Delegated Services ("the Staff") shall transfer to Frimley ICB, the designated Host ICB. Notwithstanding the foregoing, certain staff who also support the commissioning of Retained Services shall remain employed by NHS England but shall continue to provide support to the ICBs in relation to Delegated Services. Together, these staff members shall constitute the Specialised Commissioning Hub Team.

1.4. Leadership Appointments

NHS England shall appoint additional Executive Senior Managers ("ESMs") and/or Directors as joint appointments between NHS England and the South East ICBs. These appointments shall provide senior leadership for the Specialised Commissioning Hub Team and shall oversee the commissioning of Delegated Specialised Services alongside Commissioning activities retained by NHSE (e.g. Health and Justice Commissioning). The shared leadership posts will support the administrative and day-to-day management functions of the Specialised Commissioning Hub Team.

1.5. Financial Administration

Frimley ICB, in its capacity as Host ICB, shall act as the financial administrator for the Specialised Commissioning Hub Team. The Host ICB's responsibilities shall include processing and disbursing salaries and facilitating payments. The Host ICB shall have no authority to make decisions regarding the allocation of funds.

1.6. Cost Allocation

The ICB Partners agree that costs associated with the Administrative and Management Services provided by the Specialised Commissioning Hub Team shall be transferred from NHS England to the ICBs on a proportional basis, reflecting each ICB's population. Each ICB shall be responsible for facilitating inter-ICB transfers to appropriately fund any agreed-upon local hosting and operational arrangements.

1.7. Work Programme Development and Review

The Specialised Commissioning Hub Team shall support the commissioning of Delegated Services and perform specific functions related to Retained Services, where necessary. To ensure statutory obligations are met, all ICB Partners, including the ICBs, NHS England, and the Hub Team, shall collaborate to jointly develop and regularly review the work programme of the Specialised Commissioning Hub Team.

1.8. Changes to Team Capacity or Capability

Any proposed changes to the capacity or capabilities of the Specialised Commissioning Hub Team shall be subject to a detailed evaluation, including the preparation of a case for change and an impact assessment. NHS England's South East Regional Team shall be consulted to ensure strategic alignment and service continuity prior to implementing any such changes.

1.9. Notice of Restructuring

In the event that an ICB intends to propose a restructuring of the Specialised Commissioning Hub Team, it shall provide NHS England with no less than 12 months formal written notice. Such notice must also include prior agreement from NHS England Regional Director of the South East - given the activities the Hub team will continue to provide for NHSE with regards to residual regional commissioning activities (e.g. retained specialised commissioned services and health & justice services)

1.10. Conditions for Restructuring

No restructuring of the Specialised Commissioning Hub Team shall proceed unless and until alternative arrangements for the delivery of services and functions of the Hub Team and/or Retained Services have been established and approved by the ICB Partners.

1.11. Avoidance of Role Duplication

The ICB Partners agree that no ICB shall appoint ESM or Director-level staff whose roles would duplicate that of the leadership roles that will be 'Shared Posts' between NHSE and the SE ICBs. This provision is intended to ensure operational efficiency, avoid redundancy, foster collaborative working relationships, streamline decision-making processes, and clearly define the roles and responsibilities of all entities within the Specialised Commissioning framework.

2. Services provided by Specialised Commissioning Hub Team

- 2.1. The Specialised Commissioning Hub Team, hosted by Frimley ICB, along with the jointly appointed ESMs, will deliver the Administrative and Management Services outlined in Appendix 5 or as otherwise agreed in writing by the ICB Partners and the Joint Committee.
- 2.2. The 2025/26 financial year will serve as a transitional period, during which minimal changes will be made to the existing service provisions. The current team responsible for these functions will continue to perform their roles during this time.
- 2.3. Any adjustments to the team structure, roles, or service delivery model during the transitional year must be agreed upon by all ICB Partners and approved by the Joint Committee to ensure alignment with strategic priorities and service continuity.
- 2.4. The Host ICB and the Hub Team will deliver services as agreed with the ICBs to support them in fulfilling their statutory functions outlined in the Delegation Agreement (Schedule 3). These services will include, but are not limited to, the provisions detailed below.

2.4.1. Contract Management

- The Specialised Commissioning Hub Team shall provide contract management and support in respect of the Delegated Services. Such support shall be in compliance with the agreed regional contracting strategy and relevant National Contracting Standard Operating Procedures.

2.4.2. Finance

- The financial arrangements in respect of the provision of the services by the Host ICB to the ICBs shall be as set out in Schedule 3 (Financial Arrangements) of this Agreement.

2.4.3. Data Management and Analytics

- The Specialised Commissioning Hub Team shall provide such data management and analytic services as the Joint Committee considers necessary to ensure that the ICB meets its obligations under Schedule 3 (Delegated Functions) of the Delegation Agreement.

2.4.4. Freedom of Information and Parliamentary Requests

- The Specialised Commissioning Hub Team shall provide such reasonable support as required by an ICB to ensure the appropriate handling, management and response to all freedom of information and parliamentary correspondence relating to Delegated Services.

2.4.5. Incident Response and Management

- The Commissioning Team shall provide such reasonable support as required by an ICB in relation to local incident management for Delegated Services.

2.4.6. Provider Selection and Procurement

- The Commissioning Team shall act on instructions from the ICBs in relation to provider selection and procurement processes for the Delegated Services.

2.4.7. Pharmacy

- The Commissioning Team shall ensure appropriate arrangements for commissioning of high-cost drugs and devices are in place in for Delegated and Retained services.

2.4.8. Quality

- The Commissioning Team shall ensure appropriate arrangements for quality oversight are in place in respect of the provision of services.

2.4.9. Strategy, planning and transformation

- The Specialised Commissioning Hub Team will support the development of strategies and plans for Specialised Services, liaising and coordinating with ICB staff who are leading on the development of strategies and plans for non-specialised services. This will include development of a joint resource prioritisation approach and work programmes for both Delegated and Retained Services.
- The transformation team will provide transformation project, programme, and portfolio management support for Specialised Services on a multi-ICB footprint.

2.4.10. Complaints

- For complaints via the commissioner, patients will contact their local ICB or their local Complaints Hub as appropriate. The Commissioning Team will support each ICB or Complaints Hub (as appropriate) in provision of appropriate responses, advice and guidance relating to Delegated Services.

3. Availability of NHS England staff and Shared Posts

- 3.1. In addition to any Staff transferred to the Host ICB, NHS England will deploy additional Staff as Shared Posts between the NHSE and Frimley to the Specialised Commissioning Hub Team to perform Management Services.
- 3.2. NHS England will take all reasonable steps to ensure that the NHS England Staff deployed for the purposes of carrying out the Delegated Functions shall:
 - faithfully and diligently perform duties and exercise such powers as may from time to time be reasonably assigned to or vested in them, and
 - perform all duties assigned to them pursuant to this Schedule 6 (Commissioning Team Arrangements).

- 3.3. The host ICB shall notify NHS England if the host ICB becomes aware of any act or omission by any NHS England staff which may have a material adverse impact on the provision of the Services or constitute a material breach of the terms and conditions of employment of the NHS England staff.
- 3.4. The following Director posts have been identified as Shared Posts between NHS and the SE ICBs:
- Regional Director of Commissioning
 - Director of Specialised Commissioning and Health & Justice
 - Director of Commissioning Finance
 - Director of Commissioning Nursing
 - Regional Medical Director of Commissioning
 - Head of PC/PH Commissioning
- 3.5. A separate MOU which describes the activities of these Shared Posts will be varied into this Delegation Agreement at a later date.

4. HOST ICB

- 4.1. Frimley ICB is the host for the regional Specialised Commissioning Hub Team and will fulfil the following functions.
- 4.2. Work with the Director of Specialised Commissioning, Director of Commissioning Finance, Director of Commissioning Nursing and Regional Medical Director of Commissioning, to whom the Specialised Commissioning Hub Team will report into.
- 4.3. Ensure the Specialised Commissioning Hub Team effectively delivers the commissioning functions on behalf of the six ICBs in the South East of England and NHS England (NHSE).
- 4.4. Ensure professional leadership is provided to senior managers and commissioning functions within the team.
- 4.5. Employ and manage the Specialised Commissioning Hub Team following the transfer of staff.

5. GOVERNANCE AND DECISION- MAKING ARRANGEMENTS

- 5.1. The responsibility for commissioning the Delegated Services will transfer to ICBs from 1 April 2025. The Specialised Commissioning Hub Team will undertake services on behalf of the ICBs with the following guidance:
- The Hub will have autonomy to undertake operational commissioning decisions on behalf of all 6 ICB and report into the Joint Committee via the Specialised Services Subcommittee.
 - The Joint Committee will set the clinical vision and strategy for specialised services across the 6 ICBs in the South East Region and will set the direction for the Hub team as to how those commissioning activities should be undertaken.
- 5.2. This gives autonomy for the Hub to undertake operational commissioning decisions on behalf of all the ICBs, with the Joint Committee to set the clinical vision and strategy. It will be important to have a clear decision making framework in place for the Hub to use and so the Joint Committee can be assured that it is exercising the delegated functions in accordance with the Agreement.

6. FUNDING OF COMMISSIONING SUPPORT SERVICES FOR THE HOST ICB

- 6.1. Each individual ICB (including the Host ICB) will receive an allocation and must transfer their allocation to the Host ICB, ensuring it has sufficient funds to cover all expenses, including staff salaries, pay, and nonpay costs.

- 6.2. The allocation to transfer to the Host ICB will need to cover the full pay and non-pay cost of the staff who transfer to the Host ICB from NHS England under the TUPE transfer arrangement. The total allocation will cover staff costs and associated travel expenses.
- 6.3. The Host ICB is responsible for reporting to ICBs on administrative costs and any underspend. It will return the direct proportion of any underspend to all ICBs (including the Host ICB).

ICB CEOs - Proposal for consideration – March 2025.

Interim Specialised Commissioning Governance Arrangements from 1 April – 31 May 2025.

SE ICBs are due to take on delegated specialised commissioning responsibilities for 70/154 services from NHSE on 1st April. ICB Boards are required to return a signed Delegation and Collaboration Agreement by 31st March.

As part of the new arrangements – SE ICBs are required to establish a joint committee. However, the TOR for the Joint Committee has yet to be agreed. Therefore, if the TOR are not established by the 31st of March, it is proposed there will need to be Exceptional Interim Governance arrangements for some Specialised Commissioning decisions for Quarter 1 25/26.

The Delegation Agreement and Collaboration Agreement set out the following levels of governance:

- a. ICB CEO Joint Committee – which will cover broad areas of collaboration between the ICBs – including Spec Comm (TOR required and agreed between 6 ICBs).
- b. Spec Comm Sub Committee - which will bring together Executive/Board level representatives of the ICBs to agree and oversee the work plan/mandate of the Spec Comm Hub team and escalate commissioning decisions to the JC, where required (TOR required and agreed between 6 ICBs)
- c. Spec Comm Hub team – will take operational day-to-day commissioning decisions on behalf of all 6 ICB – as per the workplan/mandate agreed with the Sub Committee. Examples of these commissioning decisions could be:
 - a. Progressing mutual aid requests between specialised centres due to workforce, capacity, capability or other concerns.
 - b. Processing performance notices where we find compliance issues in specialised services.
 - c. Site visits and rectification and improvement plans where we see trends in serious incidents at specialised centres.
 - d. Negotiation of specialised contract services/schedules with providers.

1. Background:

- a. TOR for the SE ICB Joint Committee are being developed, and this is being led by Frimley ICB. Legal advice has been engaged from Browne Jacobson to work alongside ICB governance leads.
- b. TOR for the ICB Joint and Specialised Commissioning Subcommittees are being iterated with ICB governance leads during March 2025, and will iterate during 2025 as these are tested during 2025/26 which will be a transitional year.
- c. A decision will need to be taken to sign off TOR for the Specialised Commissioning Sub-committee by the CEO Joint Committee by 31 May at the latest to enable quarter two preparations.
- d. In the absence of an agreed TOR (during quarter one 2025/26), there may be occasion to have sign off of decisions to complete pieces of work that have been in train for some time. E.g. completion of procurement process. Whilst the current Spec Comm Partnership Board will have been briefed and informed during the past 24 months on progress, this will need completion of the Regional Teams work to hand over a completed product to the new ICB governance structure, in line with their new responsibility.

- e. The principle involved here is similar to complaints, where new complaints from April 2025 will be the responsibility of the ICBs and old items need to be completed before formal handover, as a reasonable approach to ‘ramping’ ICBs knowledge base and responsibilities.
- f. This will not in any way negate the ICBs responsibilities under the terms of the Delegation Agreement – more of a pragmatic and reasonable, interim arrangement to support the ICBs, and completion of tasks by the Specialised Team where actions/items overhang the April 2025 timeline.

2. Proposal and actions:

- a. Caroline Reid and David Barron oversee any final sign off for ‘overhanging items’ for completion during Quarter one 2025 should the need arise. This is in the absence of a ‘steady state’ TOR & governance process that will become established in Q1 2025/26. This need may arise, as the Specialised Subcommittee of the SE Joint Committee may not be in an operational ‘steady state’ at the time that decision and sign off is required. Any risks that are realised in Quarter one will be raised with the CEOs to decide any further actions necessary.
- b. This would only apply by exception to time sensitive actions where completion/continuity is needed, as opposed to new items of business that the Shadow Subcommittee will be required to initiate from April 2025.
- c. The items that may require urgent interim continuity action, could include some or all of the following examples:
 - i. Mount Vernon cancer service review and relocation.
 - ii. Specialised Prosthetics procurement.
 - iii. Contract completion and signature of specialised schedules.
 - iv. Kent Section 75 Agreement.
 - v. Neonatal Transfer Service.
- d. Joint Committee to sign off TOR for Specialised Subcommittee before 31 May.
- e. The Partnership Board continue as the ‘Shadow Specialised Subcommittee’ to enable business as usual to continue and avoid delays for the Hub Team from April, and until such time as TOR and levels of authority are agreed for subcommittees and sub working groups.
- f. Legal advice will be sought to align the Joint Committee, Subcommittee TOR, Collaboration and Delegation Agreements including levels of authority granted from the Joint Committee as soon as possible in Quarter one.

3. Limitations:

- a. This is a time limited ‘way of working’ where continuity and time sensitivity apply. This does not in any way negate the authority of the multi ICB Joint Committee or the Specialised Subcommittee. Any risks that are realised in Quarter one will be raised with the CEOs to decide any further actions necessary.

ICB Board Quality Update March 25

Overview

- Quality Updates
 - 2025/26 Planning and Quality Impact
 - Integrated Care System Mortality Review Group
 - Vaccination Update
 - MHRA National Safety Alert
 - BHFT Heart Function Service
- CQC System Compliance and Updates

Quality

- The Frimley Integrated Care Board builds on and reflects the National Quality Board (NQB) guidance on quality, risk response and escalation in Integrated Care Systems.
- The National Quality Board defines quality care as care that is safe, effective, provides a personalised experience, is well-led and sustainably resourced. It also clear that quality care must be equitable, focused on reducing inequalities and addressing wider determinants.



2025/26 Planning and Quality Impact

- Nationally the NHS faces significant challenges with Frimley being no exception, managing real pressures, while continuing to build momentum towards long-term solutions.
- At the end of January 2025, NHS England published the 2025/26 priorities and operational planning guidance for ICBs to digest, plan and implement.
- Frimley ICB along with System Partners are developing plans that are affordable within the financial allocation set to meet these priorities. We are exhausting all opportunities to improve quality, productivity and to tackle waste. As an ICB, we will need to make decisions on how to prioritise resources to best meet the health needs of our local population.
- Frimley ICB is committed to ensuring that all commissioning decisions, business cases and any other plans are evaluated for their impact on both quality and equality.
- A Quality Impact Assessment (QIA) will be used as part of and decisions made. A QIA a process used to evaluate the potential impact of proposed changes to services or projects on patient safety, clinical effectiveness, patient experience, staff experience, and equality, ensuring changes enhance, rather than detract from, the quality of care.
- The ICB Quality Team will work collaboratively with planning leads and our System Partners for the completion of the quality impact assessment and will be a source of expertise for advice and guidance.
- The System Quality Group (SQG) will hold an extra ordinary meeting to review all quality impact assessments, which will support the ICB Board in their discussions and approval of the plans.

Integrated Care System Mortality Review Group



- Learning from Deaths has been successful in driving NHS providers to develop a more structured and standardised approach to mortality reviews and to learn and improve outcomes for patients.
- Frimley Integrated Care System (ICS) established a system Mortality Review Group (MRG) to maximise the success of this by having a focused oversight, to enable review of processes but more importantly to share learning and support improvement.
- The MRG has been recognised regionally as best practice and other systems are keen to learn about our systems, processes and relationships.
- The group triangulates intelligence from a variety of sources, including Medical Examiner feedback, learning from the LeDeR Programme, and intelligence from provider 'Learning from Deaths' quarterly reports.
- As part of this process, the MRG identifies themes, one of which is the need to ensure consistency around End-of-Life care arrangements.
- The MRG has links with the Frimley End-of-Life (EoL) Steering Group to share intelligence, and the EoL group oversees a broad programme of analytical and improvement work.
- Shared intelligence helps to align improvement priorities on EoL topics such as effective implementation of the ReSPECT programme, and avoidance of unnecessary conveyances to hospital at end of life.

Vaccination Update

Flu Vaccination Programme

	65+	At Risk	2-3 years	Maternity
Frimley	76.4%	43.4%	49.8%	33.6%
South East	77.5%	47.4%	50.6%	37.3%
England	74.4%	44.1%	41.82	33.8%

Covid Vaccination Programme

	Uptake
Frimley	47%
South East	52%
England	44%

RSV Vaccination Programme

	Routine Cohort	Catch up cohort
Frimley	17.98%	52.58%
South East	21.29%	53.26%
England	16.64%	44.05%

RSV Coverage Pregnant women

	Maternity Services	GP Practices	Total no. of Vaccinations
Frimley	81.7%	18.3%	1,993
South East	67%%	33%	21,913
England	63%	37%	124,252

National Patient Safety Alert: Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls



- The Medicines & Healthcare products Regulatory Agency (MHRA) had received reports of deaths and serious injuries from entrapment or falls relating to medical beds, bed rails, trolleys, bariatric beds, lateral turning devices and bed grab handles and therefore in August 2023, issued a national safety alert with required actions.
- Since then, Frimley ICB have met with all System Partners to understand and scope current position and risks.
- New plans are in place for all new pieces of equipment being issued and we will continually work with System Partners, Suppliers and neighbouring systems to support this piece of work.
- There is a current risk to the system for historical pieces of equipment that has been issued. Frimley System are not an outlier in this risk as it has been identified both regionally and nationally.
- A Quality Impact Assessment is being completed and will be overseen by the System Quality Group.
- Information will be shared on websites (ICB and System Partners) with information on the alert and if local residents have any issues or equipment, then to make contact.
- The Patient Safety Incident response Framework and methodology will support planning and patient safety reviews in line with alert action requirement.

Quality & CQC Outcomes

Frimley Health Foundation Trust CQC Inspection

- The Care Quality Commission (CQC) inspected Frimley Park Hospital over 4th and 5th February and Wexham Park Hospital started their inspection on the 11th March. CQC will be assessing against 24 individual quality statements.
- The FHFT team are currently collating the data and evidence for fact checking for the Frimley Park Hospital inspection and will do the same for Wexham once their inspection is completed.

CQC Provider Compliance

Provider	CQC Rating			
	Outstanding	Good	Requires Improvement	Inadequate
FHFT		Good		
BHFT	Outstanding			
SABP		Good		
HCRG		Good		
SCAS				Inadequate
SECamb			Requires Improvement	

Provider	CQC Rating			
	Outstanding	Good	Requires Improvement	Inadequate
Primary Care	1	62	3	0

Provider	CQC Rating			
	Outstanding	Good	Requires Improvement	Inadequate
Nursing Homes	4	43	9	1
Residential Homes	6	23	8	0
LD	2	37	3	0

FRIMLEY INTEGRATED CARE BOARD

Title of Paper	Assertive Outreach Programme		
Agenda Item	7.1.2.0	Date of meeting	18 March 2025
Exec Lead	Sarah Bellars, Chief Nursing Officer and Graham Wareham, CEO of Surrey & Borders Partnership		
Author(s)	Transformation Lead, Adult Mental Health		

Purpose	To Approve	<input type="checkbox"/>	Link to Strategic Objective	<i>Strategic Objective 2 - Living Well</i>
	To Ratify	<input type="checkbox"/>		
	To Discuss	<input type="checkbox"/>		
	To Note	<input checked="" type="checkbox"/>		

Executive Summary	
<p>In July 2024, NHSE requested all systems review their current level of service provision and capacity in their Community Mental Health Services in relation to adequately and safely providing the function of assertive and intensive community support for people with serious mental illness, where engagement is a challenge.</p> <p>Frimley ICB has worked with our local Mental Health NHS Trusts (Berkshire Healthcare Foundation Trust & Surrey and Borders Partnership) alongside our neighbouring systems Buckinghamshire, Oxfordshire and Berkshire West (BOB) and Surrey Heartlands to provide a proposal for Assertive Outreach (AO) or intensive case management (ICM) to meet the needs of this group of patients.</p> <p>A robust evaluation using a maturity matrix provided by NHSE established the current Assertive Outreach provision and identified any potential gaps in service delivery policy and processes, developing priority areas and plans for focus. It is important to note that the NHSE guidance does not currently mandate a particular operating model or stand-alone team to ensure a dedicated Assertive Outreach Function and no dedicated new funding has been confirmed so systems are currently looking to work within existing resources to prioritise delivery of plans</p>	
Recommendation	Board members are asked to note the paper, which will form part of the onward assurance to NHS England.

Please provide details on the impact of following aspects	
Risk and Assurance	
Equality and Quality Impact Assessment	
Patient and Stakeholder Engagement	
Financial Impact and Legal implications	
Please indicate which CQC Theme and Quality Statements this QIA supports. Interim guidance for assessing integrated care systems March 2023 (cqc.org.uk)	Care provision, Integration and continuity

Reporting – has this paper been discussed at other meetings		
Committee Name	Date discussed	Outcome



Frimley ICB Assertive Outreach



The Context for Assertive Outreach

Following the conviction of Valdo Calocane and the Care Quality Commission (CQC) review of mental health services in Nottingham, a series of recommendations were made to NHS England (NHSE). In July 2024, NHSE requested all systems review their current level of service provision and capacity in their Community Mental Health Services in relation to adequately and safely providing the function of assertive and intensive community support for people with serious mental illness, where engagement is a challenge. Frimley ICB has worked with our local Mental Health NHS Trusts (Berkshire Healthcare Foundation Trust & Surrey and Borders Partnership) alongside our neighbouring systems Buckinghamshire, Oxfordshire and Berkshire West (BOB) and Surrey Heartlands to provide a proposal for Assertive outreach (AO) or intensive case management (ICM) to meet the needs of this group of patients.



The Objective for Assertive Outreach

Between July and September 2024 a robust evaluation using a maturity matrix provided by NHSE established the current Assertive Outreach provision and identified any potential gaps in service delivery policy and processes, developing priority areas & plans for focus. The ambition was that by maximising engagement and contact with people we strive to reduce the need to access the acute care pathways, avoid hospital admissions, reduce length of stay, reduce the involvement of the criminal justice system and ultimately reduce relapse to achieve better patient outcomes through providing goal-directed interventions.

Enhanced family & carer involvement also ran throughout.

This was a significant piece of work across BHFT and SABP the outcome of which highlighted that across the whole Frimley system there is a good level of knowledge and pro-active scoping of the populations needs across BHFT and SABP leading to a level of assurance that people falling into the cohort identified by the review are well supported by our community teams and not discharged without considered thinking and strong clinical oversight. However, there were some areas where further development of plans were required including identification of patients, workforce challenges & consistency of service offer.

It is important to note that the NHSE guidance does not currently mandate a particular operating model or stand-alone team to ensure a dedicated Assertive Outreach Function & no dedicated new funding has been confirmed so systems are currently looking to work within existing resources to prioritise delivery of plans.



Assertive Outreach

Those who will benefit from this service are people with the most complex needs across our communities, they often have multiple social needs, many will have had less positive experiences of health services in the past and often may not respond or may struggle to access and use services which are there to support and minimise harm.

The board will be aware of the recent changes to the governance and oversight of the ICB MH portfolio. The board has recently reviewed its priorities for the next two years and is currently consulting with partners across the system before these are finalised and taken to the mental health board in the spring.

The board has recommended that the three key priorities for our communities over the next two years are Assertive Outreach, Mental Health Beds and Flow and Neurodivergence.



Berkshire Healthcare Foundation Trust Assertive Outreach Plan

- Standard work is being developed to ensure this patient cohort are discussed in an MDT prior to any discharge, and work with families of those who do not engage.
- For meeting the needs of those who have intensive or assertive outreach needs, BHFT are managing/supporting this cohort of patients on generic caseloads, without a Assertive Outreach Team function across the community mental health team pathway. This is being done via clinical triage meetings, caseload management, supervision and team meetings.
- There is an intensive community rehabilitation team (CREST) in place who predominantly work with patients with psychosis who have significant periods of detained admissions. The teams such as CREST have capped caseloads and also staff in generic community mental health services with lower caseloads to facilitate a more assertive community approach.
- In one area, a voluntary sector provider has been commissioned to work with patients presenting with severe mental illness (SMI) who are difficult to engage through conventional community mental health team approaches.
- Formation of a time-bound action plan and clinically led workshop to refine and socialise 15 actions, including (but not limited to): implementation of an Intensive Case Management (ICM) model, 24/7 service awareness of patients on the intensive list, COMHAD (dual diagnosis) cohort work, depot passport rollout, focus on intersectionality work, triangulating – MHA, custody and poverty.



Surrey and Borders Partnership Assertive Outreach Plan

SABP identified clear cohorts of individuals in scope of assertive outreach (see breakdown to right) with the intention to better understand and improve their management and support, The SABP stratification of cohorts was praised by NHSE as an exemplar for others to follow.

They rapidly established a 12 week programme working with their community mental health and recovery service teams, with a focus on education and culture introducing a new assertive outreach team zone within their weekly zoning matrix to include the above cohorts (Cohorts 1 and 3) to create regular senior oversight of these individuals in their weekly MDT meeting and discussion of their management plan.

Multi-agency professionals meetings have rapidly been arranged for those extremely high-risk patients within Cohort 1 to ensure the appropriate actions are in place to safely manage their care.

Extra steps have also been taken to work with health partners to understand their work on Assertive Outreach, especially through SABP's HOMEFirst programme to keep people out of hospital and in contact with services.

Finally SABP have done a broader review of all mental health teams to ensure the fullness of implementation of appropriate policies and ensure they all have assertive outreach properly embedded within their functions.

- Cohort 1 - Individuals which fit a similar profile to Valdo Calocane i.e. high risk to others, not engaging, non-compliant

- Cohort 2 - Individuals who have been discharged back to the GP, Social Care which fit a similar profile to Valdo Calocane i.e. high risk to others, not engaging, non-compliant

- Cohort 3 - Individuals within team who may not quite fit this profile, but still may present as a high risk to others, difficult to engage with and are poorly to non-compliant with medications.

Through work on the maturity matrix SABP broadly defined x3 segments within this cohort: 1. at high risk and requiring assertive outreach support 2. At high risk but not currently receiving support 3. at a lower risk with no special support provided

Integrated Finance and Performance Report

Month 10

Frimley System Position as at Month 10



Allocative

(1) Managing Demand for Health Interventions



Technical

(2) Efficient Delivery of Health Intervention



Technical

(3) Organisational Internal Efficiency



Technical & Allocative

(4) Efficiency in Health Procurement



Allocative

(5) System Financial Opportunities

Overall position by Organisation	Plan	Actual	Variance	Mvmt vs M09	Plan	Actual	Variance	Mvmt vs M09
	YTD				FOT			
	£m							
FHFT Position Surplus/(Deficit)	(3.9)	(5.8)	(1.9)	2.2	0.0	0.0	0.0	0.0
ICB Position Surplus/(Deficit)	0.0	(1.6)	(1.6)	(0.1)	0.0	0.0	0.0	0.0
ICB Statutory Position Surplus/(Deficit)	(3.9)	(7.4)	(3.5)	2.1	0.0	0.0	0.0	0.0

The Frimley **system year to date position is £3.5m behind plan at M10**, an improvement of **£2.1m** against the reported M9 position. The ICB is **£1.6m** behind a breakeven plan and FHFT are **£1.9m** behind the planned position.

The system **forecast** remains at **break even**.

Integrated Finance and Performance Report - Finance Oversight

Key financial metrics for April 2024 to January 2025



	Target	Result	Variance	Forecast Outturn Variance	Achievement
	(YTD £m)	(YTD £m)	(YTD £m)	(Full Year £m)	
ICB Statutory Income	1,681.1	1,683.4	2.3	0.0	
ICB Statutory Expenditure	(1,685.0)	(1,690.8)	(5.8)	0.0	
ICB Statutory Surplus/(Deficit)	(3.9)	(7.4)	(3.5)	0.0	
Agency Cap - FHFT	19.6	17.9	1.7	£2.556m - 82.3 % (FOT Var to Cap)	
Capital position – ICB	1.0	0.3	0.8	0.0	
Capital position - FHFT	75.8	66.8	9.0	6.7	
Achieve Better Practice Payment Code - ICB	NHS Volume & Value 95%	Value - Met 99.83% Volume - Met 95.1%		N/A	
	Non-NHS Volume & Value 95%	Value - Met 96.4% Volume - Met 95.6%			
Achieve Better Practice Payment Code - FHFT	NHS Volume & Value 95%	Value - Not met 63.9% Volume - Not met 80.7%		N/A	
	Non-NHS Volume & Value 95%	Value - Not met 88.7% Volume - Not met 94.2%			

The Frimley system is £3.5m behind plan at M10, with £1.6m from the ICB and £1.9m from the Trust.

The Frimley system is £3.5m behind plan at M10. The improvement on last month has c£2m from the Trust with the ICB largely flat, reporting a small deterioration of £60k.

The ICB continues to deliver turnaround actions and offsetting both the planned efficiency gap and continuing cost pressures.

ICB Statutory Position = NHS Frimley Integrated Care Board & FHFT (100%)

ICB Statutory Surplus/(Deficit) includes ICB, FHFT (at 100%) and IS adjusted for intra co transactions

Invoices paid within Better Practice Payment Code >95%, volume & value

RAG rating relates to YTD results

*minor variances due to roundings to £m

Integrated Finance and Performance Report - Finance Oversight

ICB Capital

ICB Capital

Frimley ICB has submitted the 2024-25 Commissioner Capital Plan which has been approved in principle by NHS England.

The MIG working group had approved three MIG schemes in year, totalling £171k. Unfortunately, due to the new requirements released this financial year, Frimley ICB will not be able to fully utilise the MIG commissioner capital in 24/25.

A separate working group was created to identify and review the options available, to utilise the underspend. We had also discussed the options with NHS England, to ensure these would meet the relevant capital requirements. It was agreed that we would use the underspend to purchase IT equipment, the GPIT N365 Licences, Lloyd George Scanners and a levelling up piece of work for GP Check-in screens.

The ICB has now submitted the remaining four PID's to NHS England, for Common Infrastructure, the underspend utilisation of the N365 licences, IT kit and the Lloyd George Scanners. We are awaiting confirmation that these have been approved by the Regional team.



Approved Schemes:

NHSEI PID Reference	Scheme Name	Rationale	Scheme Category	Full PID Value	PIDs awaiting submission	PIDs awaiting approval	PIDs Approved	Balance remaining
QNQ-025-001	GPIT & Corporate replacement for Out of Warranty / Breakfix devices	Replacement programme for out of warranty GPIT equipment	GPIT	606	0	106	500	0
QNQ-025-002	Frimley CCG Primary Care MIG Schemes	Increasing clinical and admin capacity, improving access and infection control. Includes an increase on schemes, to cover any GPIT expenditure.	MIG	171	0	0	171	0
QNQ-025-003	Future Infrastructure	To bring the NEHF and SH practices onto GPNET the system used by the EB practices	GPIT	200	0	200	0	0
QNQ-025-004	Reserve for Frimley CCG Primary Care MIG Schemes	Increasing clinical and admin capacity, improving access and infection control	MIG	0	0	0	0	0
QNQ-025-005	GPIT Core - N365 Licences	To sustain the existing provision of N365 licenses in general practice	GPIT	176	0	176	0	0
QNQ-025-006	Lloyd George Scanners	Increasing clinical capacity, through the removal of paper notes stored on site, allowing this space to be repurposed for clinical rooms.	MIG	81	0	81	0	0
				1,234	0	563	671	0

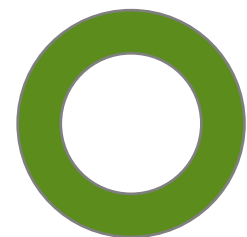
Integrated Finance and Performance Report

Appendix 1 – Performance Oversight

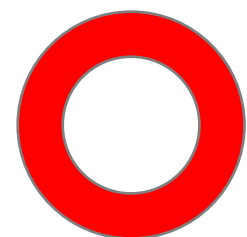
Exec Summary Performance Status Icon Key

Outer Ring = Position to Target

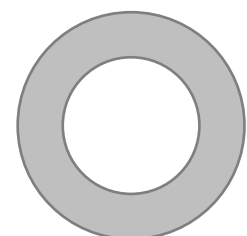
Outer Ring colour communicates the current value is:



At or above target



Below target



No target defined, comparison shown where available

Inner Icon = Trend (MoM or YoY)

Inner icon communicates the latest trend:



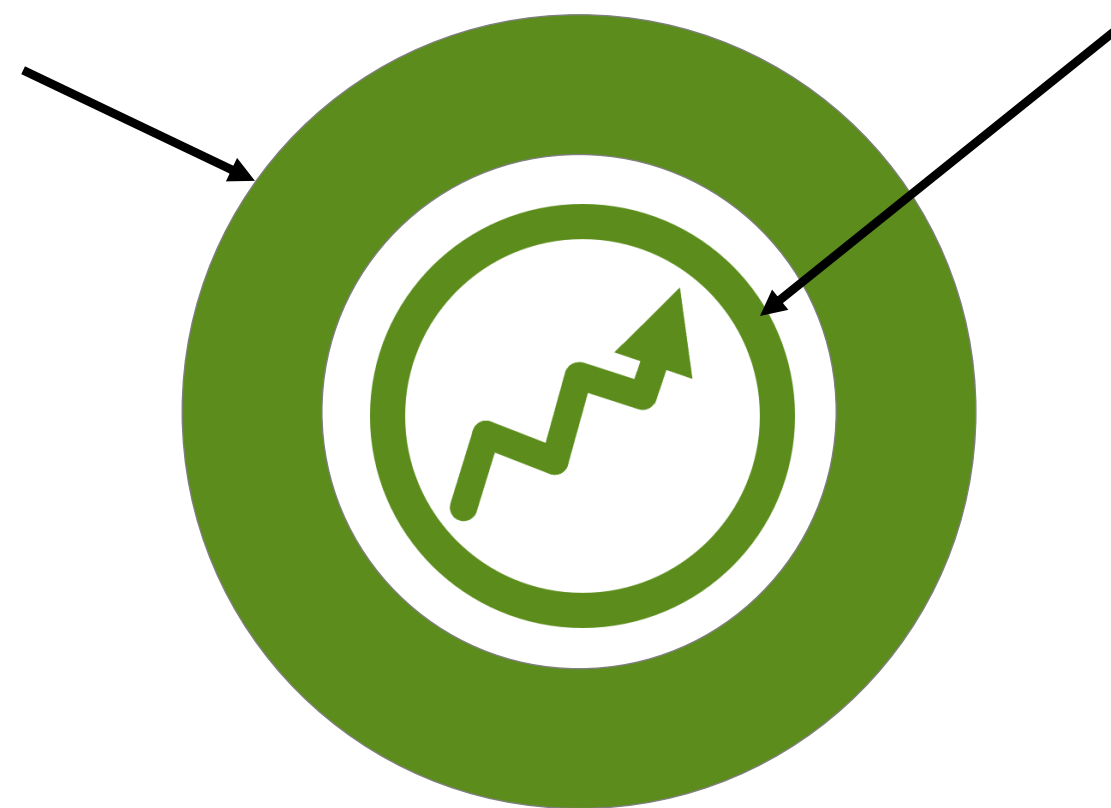
Improving trend



Declining trend



Stable, no clear trend



P = identifies data that is published publicly

DQ = identifies a data quality issue

Integrated Finance and Performance Report – Executive Summary



Measure	Status	Actual	Comparison / Target	Trend	Actions
Seen in 4 hrs (ED All types)		75% Jan 25	78%		<p>Note: Target has changed from 76% to 78% by March 2025.</p> <p>Main Risk: Demand continues to outstrip capacity.</p> <p>Main Action: Aldershot UCC co-located with FPH ED, completed on 27th November. Process of optimisation continues (e.g. 111). FHFT SDEC pathways and LOS reductions key to Type 1 performance. New DCOO started/reviewing ED Plan. Exploring establishment of UTC at WPH ED.</p>
Cancer: 62-day Combined RTT (FHFT)		72% Dec 24	85%		<p>Main Risk: Skin cancer demand has been challenged through summer, which has tipped into 62-day performance position. Position has largely recovered as of February but will impair December and January forecast positions relative to December performance.</p>



Integrated Finance and Performance Report – Executive Summary

Primary Care Development




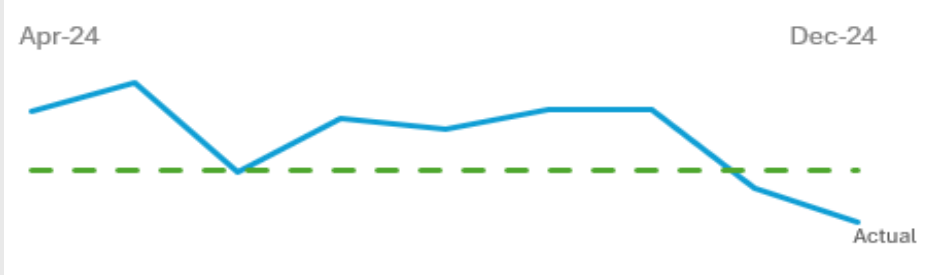

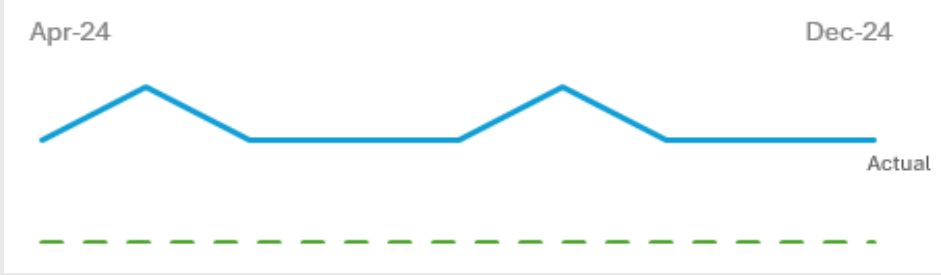


Measure	Status	Actual	Comparison / Target	Trend	Main Risk and Action
Same day/next day Appointments – 1-day standard achievement		85% Dec 24	83% YoY 2023-24		<ul style="list-style-type: none"> Continued implementation of the primary care transformation programme, including PCARP, Pharmacy First, MGPAM and PNG segmentation. Maturing of the transformation programme to focus on enabling practices to better balance the unscheduled/schedule activity key to progress <p>Risks:</p> <ul style="list-style-type: none"> Unpredictable impact from Collective Action from August 2024 onwards with direction from BMA Unwarranted variation, with a small number of practices not adopting MGPAM or PNG segmentation, being identified
Appointment within 14 days of booking – 14-day standard achievement...		90% Dec 24	92% YoY 2023-24		<ul style="list-style-type: none"> Continued implementation of the primary care transformation programme, including PCARP, Pharmacy First, MGPAM and PNG segmentation. Maturing of the transformation programme to focus on enabling practices to better balance the unscheduled/schedule activity key to progress <p>National Target: 85% - 90%</p> <p>Risks:</p> <ul style="list-style-type: none"> Unpredictable impact from Collective Action from August 2024 with working direction from BMA Unwarranted variation to be explored due to the shift in trend
Face to Face Appointments		52% Dec 24	64% England Average		<ul style="list-style-type: none"> Focus on same day access to support urgent care demand have resulted in models with greater reliance on digital and remote care, supported through the adoption of segmentation of patient needs <p>Risks:</p> <ul style="list-style-type: none"> Unpredictable impact from Collective Action from August 2024 with working direction from BMA Impact of focus on urgent same day care through intelligent patient needs segmentation supporting directive pathways for low acuity, low need patients Managing patient expectations in the current context



Integrated Finance and Performance Report – Executive Summary

Learning Disabilities, Mental Health and Children and Young People (CYP)

Measure	Status	Actual	Comparison / Target	Trend	Main Risk and Action
People with severe mental illness receiving a full annual physical health check and follow up interventions		65.5% Dec-24	75%		<p>Risk: New funding arrangement for Primary Care which may have impacted on appetite for GPs to undertake health checks. Also, absence of MH Clinical Lead following the passing of Dr Katie Simpson who was instrumental in taking this forward.</p> <p>Action: Portfolio Director to go to monthly Primary Care briefings to raise with GPs and going out to recruit new Clinical Lead whose priority it will be to support SMI Health Checks.</p>
Early Intervention Psychosis (EIP) – Proportion entering treatment waiting 2 weeks or less		36% Dec-24	60%		<p>Risk: If this is not a data quality issue then there is a risk that the most unwell are not being able to access help when needed leading to more intensive treatment and bed occupancy.</p> <p>Action: Portfolio to reach out to BHFT to investigate.</p>
Active inappropriate adult acute mental health out of area placements (OAPs) (Rounded)		10 Dec-24	Zero		<p>Risk: There are significant quality benefits to placing people in beds closer to their home not least the ability for family carers to be able to visit. It is however also acknowledged that waiting when you need a bed can also cause harm (wherever you need to wait) so sometimes using an OAP's is the better option to support that person in the absence of a local bed.</p> <p>Action: Significant work being undertaken in SABP.</p> <ul style="list-style-type: none"> Regional funding awarded for a dedicated Programme Director to work with us over 3 months to explore the development of a MH Virtual Ward. Frimley ICB has funded a Social Worker to compliment the HIOW discharge team to bolster resource to support HIOW patients move through hospital and be accommodated in the right place. We have recently completed housing needs assessment which is the foundation of our Housing Strategy 25-30 of which reducing OAPs is a key theme and driver for this strategy.

Workforce Report

February 2025

Contents

1. Headline workforce metrics
2. Temporary staffing
3. Primary care workforce
4. Frimley Academy
5. 2024/25 Staff survey (ICB)
6. Organisational Development delivery plan
7. WorkWell – an update
8. ICB Workforce metrics

Headlines

Against 24/25 Operational plans (M08)		FHFT	BHFT	SABP
	All workforce (wte)	0.6% under plan	1.1% under plan	1.5% over plan
	Substantive	1.0% over plan	0.6% over plan	1.0% over plan
	Bank	0.6% under plan	18.9% under plan	1.8% over plan
	Agency	14.4% under plan	0.5% over plan	0.6% over plan

Workforce Metrics (M08)	Metric	Regional	FHFT	BHFT	SABP
	Absence	4.8%	3.1%	4.1%	4.0%
	Vacancy	7.2%	8.2%	6.2%	10.4%
	Turnover	9.9%	9.9%	11.2%	16.3%

- FHFT continues to see the lowest absence rates in the SE, with a regional average of 4.8% (ranging from FHFT 3.4% to the highest at 7.3% SECAMB)
- Whilst FHFT has the lowest absence rates, of the 3.4% total absence, 13.7% is attributed to MSK/ other skeletal problems which is the highest in the SE (regional average for MSK absence is 9.9%). Further work is required to understand the data.
- All other ICBs (average total ICB) in the SE are at least 1.0% over plan for workforce. BHFT is one of two trusts in BOB performing under plan.

Bracknell Forest

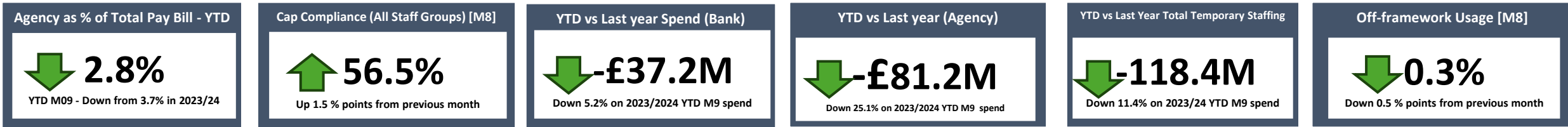
North East Hampshire and Farnham

Royal Borough of Windsor and Maidenhead

Slough

Surrey Heath

Temporary Staffing (M09)



Performance

Agency as a percentage of total pay bill [M9 YTD] for the SE region is 2.8% and below the NHSE national ceiling [3.2%], a significant improvement on the 2023/24 outturn [3.7%]. The region is on target to meet its 2024/25 agency expenditure limit. Cap compliance has increased to 56.5% [M8] from an average of 38% in 2023/24. Bank spend [YTD M9] has reduced by -£37.2M, a reduction of 5.2% on the same period in 2023/24, with agency spend reducing by £81.2M [25.1%] over the same period. Off-framework usage is at an all time low of 0.3% [M8]. The Collaborative won the HSJ Award for Data-Driven Transformation for its PowerBI dashboards. Outlier trusts continue to be supported on a 1-2-1 basis supported by ICB-level governance.

Agenda for Change AGENCY Project

The project has over the last year delivered new capabilities and outputs including an AfC agency rate ceiling cap card, a PowerBI dashboard and a supplier relationship management [SRM] plan supported by an AfC Temporary Staffing Success Framework and best practice on FutureNHS. The agency rate ceiling cap card was introduced in June 2024 with a further iteration in October 2024 and another planned for April 2025, which have increased rate ceiling compliance from 52% in 2024/25 M1 to 77% in M9. The PowerBI tool provides transparency on all trust rates and intelligence to negotiate with suppliers. At a regional level suppliers are targeted through the SRM plan where rates are either high or where they vary trust-to-trust.

Agenda for Change BANK Project

The project has over the last year delivered a regionwide AfC Bank Rate Framework which has enabled trusts with outlier rates to step-down rates, which has brought greater harmonisation to the region. This has been enabled by a PowerBI dashboard which publishes all trust bank rates for complete visibility. Support has also been provided to trusts to optimise their bank provisions and to change or update bank delivery models (e.g. joint procurement exercises for outsourced banks, outsourcing of inhouse banks or bringing outsourced banks inhouse based on trust needs and performance). Specialisms showing the highest rate variations are now being targeted and the focus for 2025/26 is to support usage reductions.

MEDICAL Temporary Staffing Project

The project has introduced Medical Agency and Bank rate frameworks across the region which has enabled trusts to either reduce agency rates or to commence JLNC consultations to bring higher rates into line with peers to ensure parity, fairness and value for money. PowerBI dashboards bring transparency to medical agency and bank rates for trusts, which has resulted in increased intelligence sharing and targeted rate reductions. Outlier trusts have received 1-2-1 support to swap out expensive agency workers with lower cost alternatives, to replace with permanent and peer networks share best practice. Collaborative medical banks and new software to manage cascades are also being introduced.

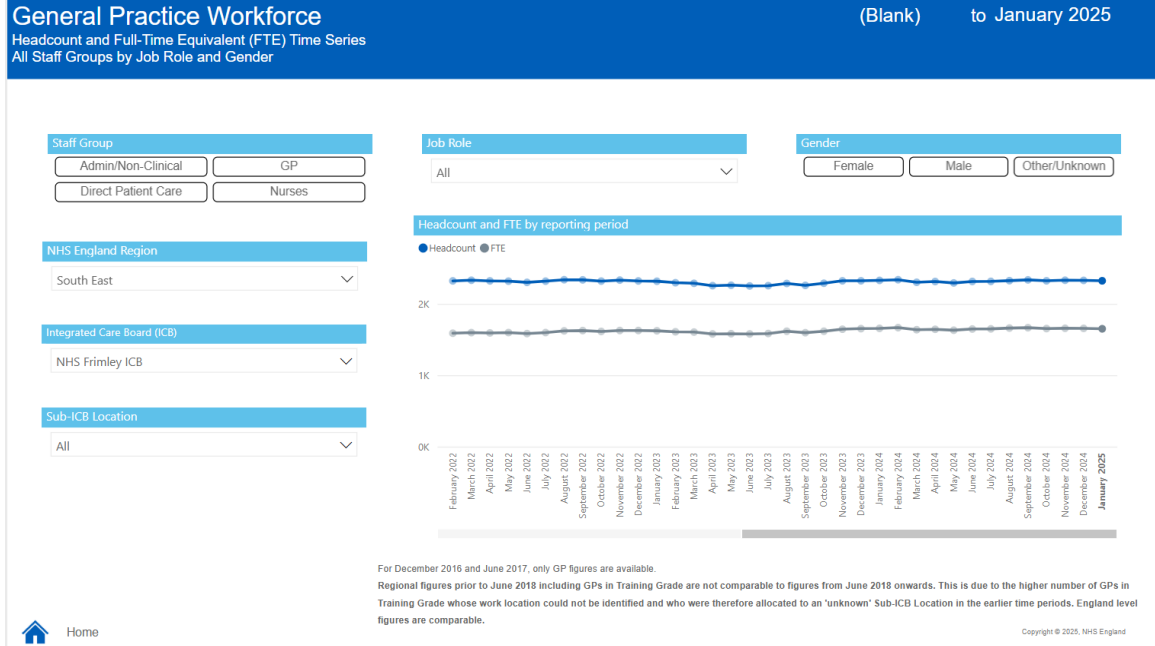
THEMATIC Projects and GOVERNANCE

A SE TS Programme Board oversees all delivery (receiving scorecards and dashboards on progress and priorities), supported by the three core project boards and ICB-level Temporary Staffing Delivery Groups (TSDGs) which enable joint working and sharing of best practice. A FutureNHS workspace is utilised to share toolkits and guidance. A monthly newsletter is issued to executive ICB and Trust stakeholders, alongside direct project communications. A thematic Mental Health Temporary Staffing project has shared best practice to reduce spend on agency MH workers within Acute settings and has brought together Community / Mental Health trusts for joint problem solving. A weekly meeting with NHSE ensures progress and alignment.

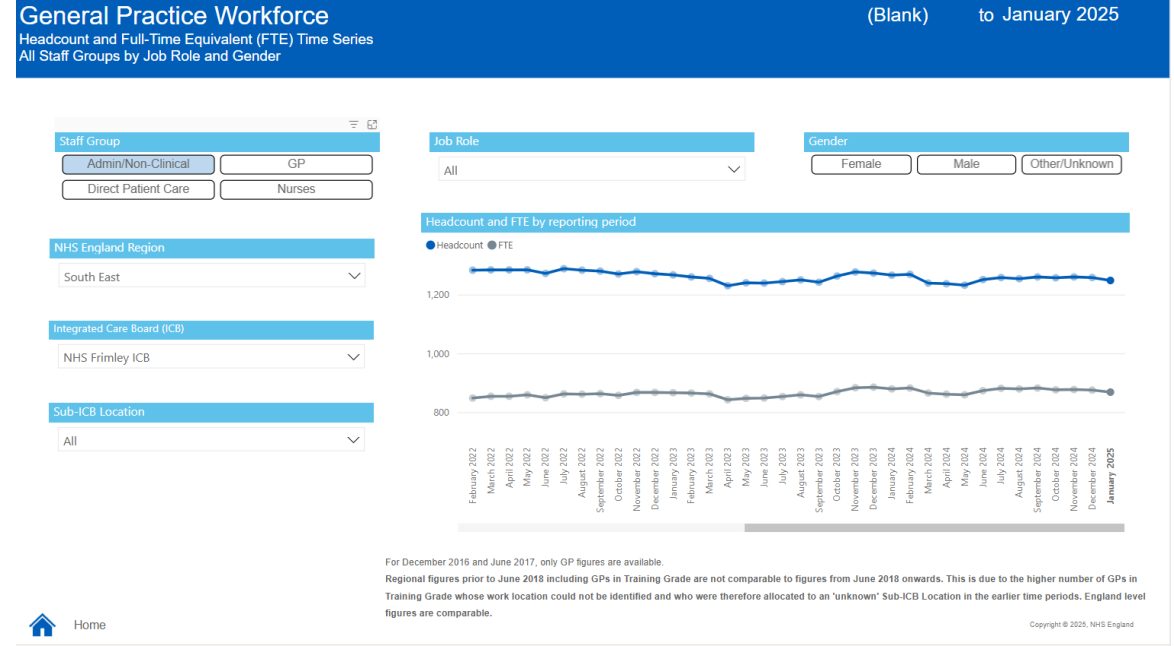
2025/26 Delivery Plan

The focus for 2025/26 will be to make significant gains with medical temporary staffing, by taking a holistic look at the medical workforce lifecycle (incl. workforce planning, job planning, rostering, abstractions, collaborative banks, bank fulfilment, agency fulfilment) to reduce usage whilst in tandem continuing to support step-downs of outlier rates. In addition, the AfC Agency and Bank projects will move to 'business as usual' footings by maintaining regional and ICB-level governance structures to ensure the gains are built upon to deliver against the 2025/26 NHSE agency and bank expenditure limits. Thematic reviews will also be conducted, as required, whilst continuing to support trusts on a 1-2-1 basis and through peer networks.

Frimley Primary Care Workforce Data (M10)



- All staff workforce FTE = 1651
- All staff Head Count = 2323
- The number of staff in post has been static since Sept 2017
- There are 271.4 staff per 100k population

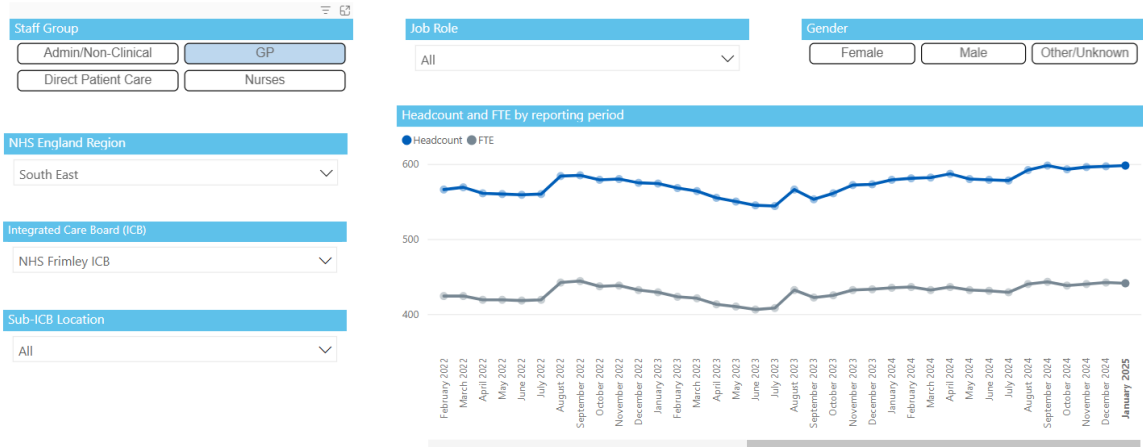


- Admin/non-clinical workforce FTE = 868
- Admin/non-clinical workforce Head Count = 1248
- The number of staff in post has been static since Dec 2019
- There are 101.71 staff per 100k population. This is lower than the all-England average of 119.93.
- 45.4% of the GP workforce is aged 55 or over. This is higher than the all-England average at 35.8% but is similar to other ICBs.

Frimley Primary Care Workforce Data (M10)

General Practice Workforce (Blank) to January 2025

Headcount and Full-Time Equivalent (FTE) Time Series
All Staff Groups by Job Role and Gender

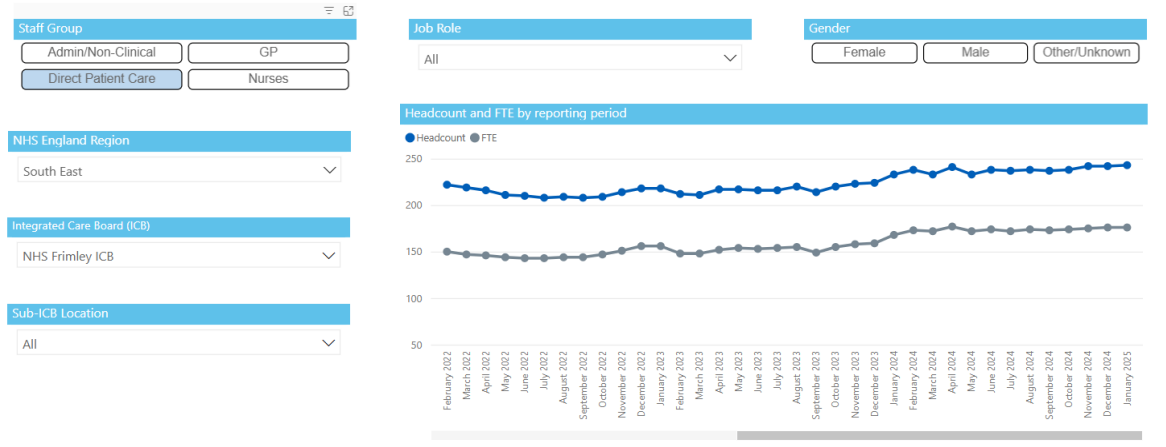


For December 2016 and June 2017, only GP figures are available.
Regional figures prior to June 2018 including GPs in Training Grade are not comparable to figures from June 2018 onwards. This is due to the higher number of GPs in Training Grade whose work location could not be identified and who were therefore allocated to an 'unknown' Sub-ICB Location in the earlier time periods. England level figures are comparable.

- GP workforce FTE = 441
- GP workforce Head Count = 598
- GP workforce has recovered to the same level as March 2021 figures (FTE =440, HC= 591)
- There are 40.19 staff per 100K population. This is lower than the all-England average of 44.29
- 26.3% of the GP workforce is aged 55 or over. This is higher than the all-England average at 22.8% but is similar to other ICBs.

General Practice Workforce September 2015 to January 2025

Headcount and Full-Time Equivalent (FTE) Time Series
All Staff Groups by Job Role and Gender



For December 2016 and June 2017, only GP figures are available.
Regional figures prior to June 2018 including GPs in Training Grade are not comparable to figures from June 2018 onwards. This is due to the higher number of GPs in Training Grade whose work location could not be identified and who were therefore allocated to an 'unknown' Sub-ICB Location in the earlier time periods. England level figures are comparable.

- Direct Patient Care workforce FTE = 176
- Direct Patient Care Head Count = 243
- There has been sustained growth in this workforce since the introduction of Additional Roles Reimbursement Scheme
- There are 20.69 staff per 100k population. This is lower than the all-England average of 27.34

Frimley Primary Care Workforce Data (M10)

General Practice Workforce

Headcount and Full-Time Equivalent (FTE) Time Series
All Staff Groups by Job Role and Gender

September 2015 to January 2025

Staff Group

Admin/Non-Clinical GP
Direct Patient Care Nurses

NHS England Region

South East

Integrated Care Board (ICB)

NHS Frimley ICB

Sub-ICB Location

All



For December 2016 and June 2017, only GP figures are available.
Regional figures prior to June 2018 including GPs in Training Grade are not comparable to figures from June 2018 onwards. This is due to the higher number of GPs in Training Grade whose work location could not be identified and who were therefore allocated to an 'unknown' Sub-ICB Location in the earlier time periods. England level figures are comparable.

Copyright © 2025, NHS England

[Home](#)

- Nursing workforce FTE = 166
- Nursing workforce Head Count = 241
- Nursing workforce has been in gradual decline since March 2016, although there is a more notable decline since May 2022. The increase in direct patient care roles has impacted on the workforce requirements for nursing
- There are 19.46 staff per 100k population. This is significantly lower than the all-England average at 26.44
- 37.1% of the nursing population is aged over 55 and therefore may be planning retirement. This is significantly higher than the all-England average at 33.8%

Frimley Primary Care Workforce Data (M10) - Key risks

General Practice Workforce

Selected Sub-ICB Location Information

January 2025

NHS Frimley ICB - D4U1Y

How to use this page

Firstly, select the Sub-ICB Location you are interested in to view selected statistics, including comparisons against all-England figures, and percentile rankings compared against other Sub-ICB Locations.

Then, to view further location information, select the practice you are interested in, then right click on the GP practice on the list and select the drill through option.

Number of patients

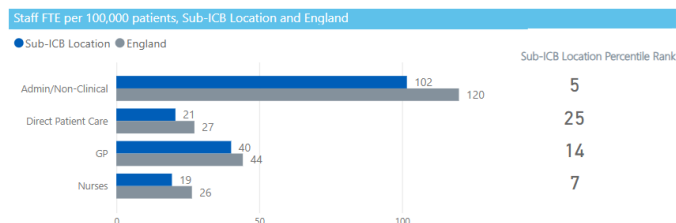
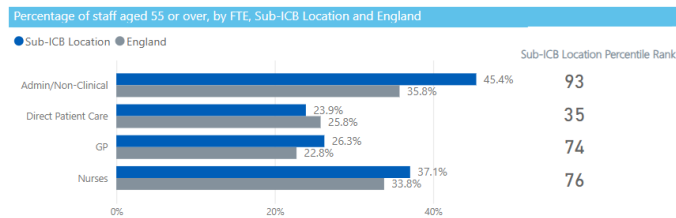
853,020

Sub-ICB Location

- NHS Devon ICB - 15N
- NHS Dorset ICB - 11J
- NHS Frimley ICB - D4U1Y**
- NHS Gloucestershire ICB - 11M
- NHS Greater Manchester ICB - 00T Bolton

GP Practices

- Practice Name
- 240 WEXHAM ROAD
- ALEXANDER HOUSE SURGERY
- ASCOT MEDICAL CENTRE
- BARTLETT GROUP PRACTICE
- BHARANI MEDICAL CENTRE
- BINFIELD SURGERY
- CAMBERLEY HEALTH CENTRE
- CHAPEL MEDICAL CENTRE
- CLAREMONT HOLYPORT SURGERY
- CLARENCE MEDICAL CENTRE
- COOKHAM MEDICAL CENTRE
- CORDWALLIS ROAD SURGERY
- CRONDALL NEW SURGERY
- CROSBY HOUSE SURGERY



GPs in Training Grades are excluded from these visuals to allow for fair comparison, as not all training placement locations are identified in the data. Copyright © 2025, NHS England

- Frimley have less staff per 100k population across all staffing groups. Each staffing group has lower than the all-England average. Would we go further faster if there was more investment in staffing? Is the estate capacity inhibiting staffing growth?
- Overall staffing and most staff groups have remained static. Growth in direct patient care roles is off-set by a reduction in nursing staff. We need to grow the workforce to meet the LTWP. Is this achievable?
- When triangulating workforce data with performance of primary care appointments, we can see that the number of appointments offered has risen. Is this due to introducing shorter appointment times, or is it because of online consultations? If the staffing levels are static, the productivity levels have improved.
- Of concern is that people appear to be waiting longer for an appointments evidenced by the 2 week wait data. In contrast we have one of the highest level of same day appointments across the country.
- Each of these risks are being reviewed and mitigated through the Primary Care Programme Board and a full update will be provided in March.



Integrated Finance and Performance Report – Executive Summary

Primary Care Development

Comparison / Target

Actual

Trend

Main Risk and Action

Same day/next day Appointments – 1-day standard achievement	84% Nov 24	81% YoY 2023-24	Jan 23 - Nov 24	<ul style="list-style-type: none"> Continued implementation of the primary care transformation programme, including PCARP, Pharmacy First, MGPAM and PNG segmentation. Deliver an effective prevention programme of immunisations and vaccinations into the winter season
Appointment within 14 days of booking – 14-day standard achievement...	88% Nov 24	91% YoY 2023-24	Aug 22 - Nov 24	<ul style="list-style-type: none"> Continued implementation of the primary care transformation programme, including PCARP, Pharmacy First, MGPAM and PNG segmentation. National Target: 85% - 90%
Face to Face Appointments	54% Nov 24	66% England Average	Jan 23 - Nov 24	<ul style="list-style-type: none"> Focus on same day access to support urgent care demand have resulted in models with greater reliance on digital and remote care, supported through the adoption of segmentation of patient needs



Primary Care ARRS (M10)

PCN	ARR Allocation	Actuals - YTD	FOT	Variance	Last claim submission
SHAPE	£600,235	£458,301	£591,990	£8,245	Jan-25
SPINE	£920,466	£779,083	£920,466	£0	Jan-25
Central Slough Network	£1,232,449	£1,080,885	£1,232,449	£0	Jan-25
LOCC	£1,062,048	£892,180	£1,050,664	£11,384	Jan-25
Bracknell (Including Binfield)	£832,015	£646,107	£779,547	£52,468	Jan-25
Braccan	£668,349	£549,048	£652,221	£16,129	Jan-25
The Health Triangle	£1,194,293	£1,099,645	£1,194,293	£0	Dec-24
Ascot	£741,849	£603,597	£725,207	£16,642	Jan-25
Maidenhead Including Symons)	£1,885,607	£1,337,348	£1,754,614	£130,993	Dec-24
Windsor	£1,483,666	£1,301,268	£1,483,666	£0	Jan-25
Aldershot	£1,160,423	£846,100	£1,120,515	£39,908	Dec-24
Farnborough	£1,317,582	£1,133,397	£1,317,582	£0	Jan-25
Farnham	£1,007,346	£781,305	£941,004	£66,342	Jan-25
Holly Tree Surgery	£140,337	£0	£0	£140,337	
Fleet	£1,005,032	£842,588	£1,005,032	£0	Dec-24
Yateley	£648,308	£552,082	£648,308	£0	Jan-25
Surrey Heath	£2,288,090	£1,890,760	£2,276,230	£11,860	Jan-25
	£18,188,096	£14,793,696	£17,693,787	£494,309	

PCN - GP Roles	ARR Allocation	Actuals - YTD	FOT
LOCC	£60,446	£50,093	£60,446
CSN	£70,144	£12,663	£21,106
Braccan	£38,039	£24,997	£37,405
Farnham	£57,333	£39,656	£57,333
FARNBOROUGH	£74,989	£28,671	£44,081
Yateley	£36,898	£26,090	£36,769
Surrey Heath	£130,225	£69,345	£130,225
SPINE	£52,388	£12,328	£24,657
Windsor	£84,442	£21,733	£54,921
	£604,904	£285,576	£466,942

- FOT can be inaccurate dependent on when the last portal submission was. Claims can vary month to month.
- PCNs with potential opportunity to recruit: Maidenhead
- Mitigations to risks of overspend: each time a PCN's variance enters a negative balance the Heads of Primary Care, discuss the claims with the PCN.
- All PCNs have written confirmation of their budget and the ICB position on overspend in each financial year. Once the budget has been fully utilised the PCN can continue to claim but no further funding is provided, and the continued employment of staff is at the PCNs own risk
- 9 out of 16 PCNs have utilised the additional ringfenced funding to recruit a newly qualified GP. 5 PCNs state they are actively recruiting. There will be an underspend against the national allocation available.

Background: Frimley Academy was established in 2018 as a long-term commitment to develop the leadership potential of our workforce and strengthen our collective system leadership capability across the Frimley system. [Our 20/20 and Wavelength Digital Leadership programmes](#) have [equipped and supported hundreds of clinical and non-clinical leaders and managers](#) from across health and social care, local authorities, community, voluntary sector and wider system and service with the skills, networks, and confidence **to lead change, drive system-wide projects, and collaborate across sectors to tackle complex challenges we face.**

Creating the Conditions for Collective Leadership that Better Serves Our Communities: Through this work, we strive [to foster a culture where 21st-century ICS leadership can thrive](#), where our people are better connected, [equipped to lead, and committed to working together to improve services, opportunities and outcomes for the residents we serve](#); and supported in developing their careers and becoming the best versions of themselves, so they can, in turn, inspire others to do the same.“

Current Focus (Jan –April) : 2025–27 Academy Programme Delivery

- **20/20 and Wavelength Contract Award** – ITT process completed; CoCreate awarded the contract.
- **Contract Finalisation** –developing performance management and contract service KPIs for contract sign off.
- **Programme scheduling and mobilisation** – updating programme architecture, building schedules to deliver four programmes from March - December, providing 180 new places.
- **Recruitment and Shortlisting** – number of applications for Academy programmes far outstrips supply.
- **System-Wide Stakeholder Engagement** – Scheduled for mid-March to:
 - Build mutual understanding and strengthen buy-in.
 - Connect key initiatives and harness insights.
 - Strengthen system alignment and build on the success achievements to date.

Other ongoing work:

- **Cultural Intelligence (CQ) Pilot** working with a small group of trained facilitators from across our network. Preparing to launch our first Developing CQ workshops as a cost-effective alternative to outsourcing CQ training.
- **NASA 4-D Team Development** – collaborating with the Regional Leadership Academy and four system colleagues to adapt the programme for the Frimley System as a cost-effective alternative to outsourced team leadership/development training.
- **Mirror Board** – programme design and development support.

Our Staff Survey ran in Q3 2024 and the below summarises key insights from the results:

- The survey had **71% of the organisation participate**, up from 60% last year, though still behind the ICB average of 76%
- The overall results show **positive improvements** against our 2023 organisational results, as well as outperformance of the ICB average responses

Key Strengths:

- **Overall positive score percentage, scored higher** both against both the ICB average as well as performance in 2023.
- **CEO & CMO directorates** both scored significantly better than organisational average and ICB average
- **Medical & Dental staff group** scored significantly better than organisational average and ICB average
- Significant improvement to net scores relating to **'Your Job', 'Your Organisation'** and **'Your Personal Development'** outperforming both ICB average and 2023 performance
- Significant outperformance against ICB average in questions relating to **quality of care**
- **Less people overall planning to leave the organisation** compared to 2023
- Outperformance of ICB average and improvement on 2023 average on questions relating to **raising concerns**
- Improvement across all questions relating to **Compassionate Culture**, compared to 2023 Frimley results.
- Significant increase to **people having realistic time pressures** compared to 2023
- Significant outperformance against ICB average for questions related to **having Autonomy and Control**

Key Areas for Further Improvement

- Dropped 4 ranks in ICB scores – now scoring 8th best, down from 4th best in 2023
- **POD directorate scored significantly worse** than organisational average and ICB average
- No improvement to net scores relating to **'Your Team'** and **'Your Managers'** compared to 2023 scores
- Significant underperformance against ICB average in questions relating to **working additional unpaid hours**
- Significant decline in scores relating to being **equipped to do your role** compared to 2023
- Significant decline in scores relating to **enjoyment of working with team members** compared to 2023
- Whilst **quality of appraisals** improved compared to 2023 and outperformed ICB average, they still show little engagement in process and low overall quality
- Whilst **health and wellbeing** did see year on year progress, **the overall figures still show concern and the need for further progress** in key areas such as; MSK issues, Not come to work when not feeling well enough and bullying

OD Delivery Plan – Focussing Activity

The OD Framework has four key pillars of activity, underpinned by three cross cutting themes. Within this mix there are a wide range of impactful activity that can be produced, but there is a clear need to ensure appropriate sequencing and delivery in context of organisational need and team resourcing.

In addition to the ongoing OD BAU activity, such as staff surveys and STaM, there is a need to deliver new transformational programmes of work for the organisation.

This transformational work needs to enable a build of activity, with immediate priorities creating groundwork for delivery of future activity as well as addressing key organisational needs that are live right now.

Immediate Focus – building foundations after the impact of change

Short Term Focus – building a comprehensive OD offer from the foundations

Longer Term Focus - building a pioneering OD service and embedding cultural change across the organisation



OD Delivery Plan – Strategic Drivers

The prioritisation of our OD activity into these three phases has come through testing with key stakeholders, alignment with the wider People Team as well as deep dive reviews within the OD team. In these sessions the focus has been on ensuring we meet the ambitions of the OD framework approach as well as are informed by the strategic drivers and organisational context we are in. The key elements of this are detailed below:

Change Context

The change programme has been difficult for the organisation, as any restructure with a threat of redundancy is. There is a need to address this and create a positive reset now before negative sentiments embed.

The change programme gives an opportunity to outline a clear vision for the organisation and establish priorities and ways of working. This window of opportunity is limited, with time since conclusion of the change programme diminishing impact.

Employee Wellbeing

Feedback from different groups has highlighted employee wellbeing as being an issue, with a need for further organisational focus.

The Staff Survey will give further information about this wellbeing issue, but interim resources can be used in the meantime to help address the gap.

Future Organisational Change

With further delegation of services from NHS England to the Southeast there is a need to ensure the OD plan sets up strong foundations for future change now.

Whilst the timeline for this future change is still being resolved, there is a need for change resilience for the organisation and our people, in addition to a need to sequence activity to ensure we can delivery activity once and well, rather than multiple times as new teams develop.

ICS Workforce Strategy & EDI

As the ICS Workforce Strategy is iterated and prioritised there is a need to ensure alignment with our internal OD framework and approach. This means focussing on setting up foundations at present, ready for further alignment as the wider ICS strategy is finalised.

Help to role model system EDI ambitions such as being an Anti-Racist organisation.

Outstanding Use of Resources

Our internal approach to learning, OD and wellbeing needs to account for the limitations there are in both the internal teams resource as well as the wider organisational budget for developmental activity.

This resource limitation means a key focus will be on how the central OD team can procure and get access for developmental products at both scale and with limited cost. The learning suite will help to address this gap in the first instance.

OD Delivery Plan – Immediate Focus

As part of our OD Delivery plan we have identified two key immediate focus areas that are vital to establishing a foundation for future development and growth as an organisation. By aligning our efforts with the four key pillars of activity, we aim to establish a strong foundation for future transformation. This activity is to be built upon by further focus areas for both the medium and longer term where we will leverage the foundations established to embed new OD approaches.

Creating Connection

Given the context of the change programme it is essential that work is done to create connection for our people both to the organisation as well as between the newly formed teams, leveraging our management communities. Key activity includes:

- Team Development Scoping
- Wider Leadership Forum
- Line Manager Forum
- Induction
- Quality conversations

OD Infrastructure

The processes, procedures and access points for OD activity in NHS Frimley needs a full review and transformation, helping to create space for our people to learn and look after themselves without the need for HR intervention. Key activity includes:

- New Learning Suite
- Hub Content Review
- Occupational Health Review
- Employee Assistance Programme Review
- Learning Process Implementation

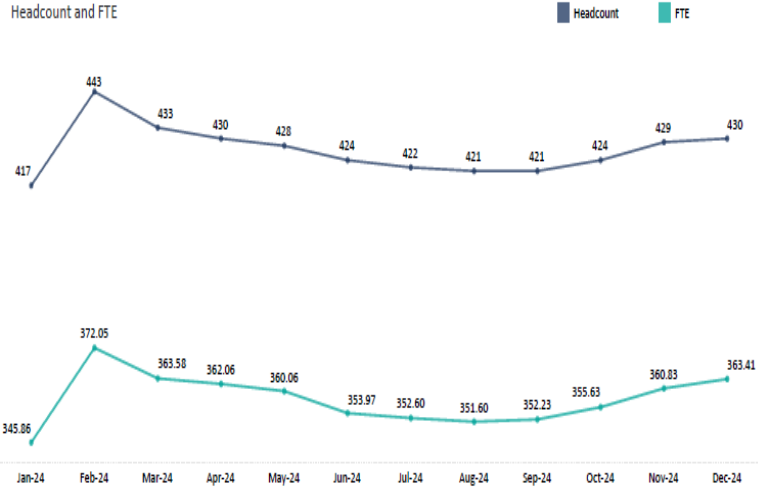
WorkWell Progress Update



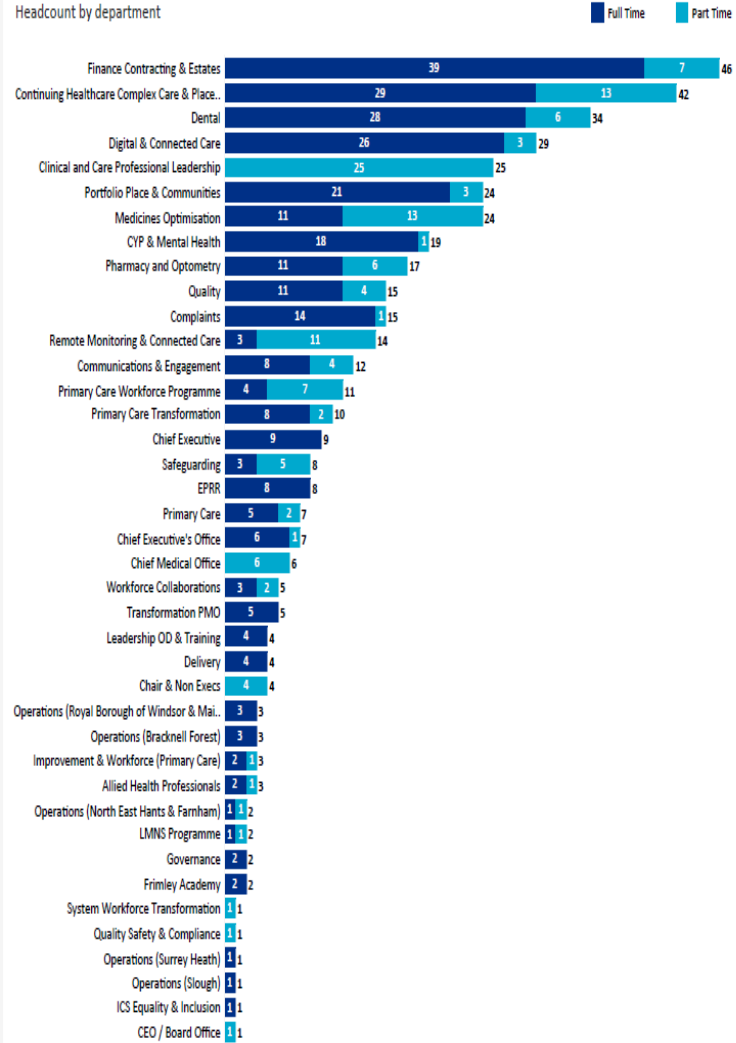
- Slough Spine PCN went live in January 2025
- Discussions with Slough Central PCN, Yateley PCN and Rushmoor CVS around the implementation of the service with staged start dates over February and March which will make up 76% of our population deliverables
- Working with Ability Slough on the integrated approach to employment support.
- Procurement have concluded their process via G Cloud Joy is the preferred provider, with confirmation of offer prior to any procurement legislation changes due end of February 25.
- Reporting elements of Joy including capturing Complaints and Compliments completed
- GetUBetter – Developing the KPI dashboard
- Submitted quarterly DWP MI report. Participant data will be reported monthly starting in March
- We have continued with the strategic mapping and making connections that will support and compliment the WorkWell Programme and the Get Britain Working White paper the these include
 - Connect to Work with Hampshire County Council
 - Reviewing Social prescribing offer in Bracknell
 - Surrey Heath Skills bootcamp
- Have updated the SE Work and Health Community of Practice Network on the Frimley WorkWell pilot and sharing he learning with neighbouring systems around the use of the JOY app.
- Shared with the Health & Growth Accelerator team at NHSE information on WorkWell and taken part in early discussion around the health system's role in reducing health-driven economic inactivity

ICB Workforce Metrics (M09)

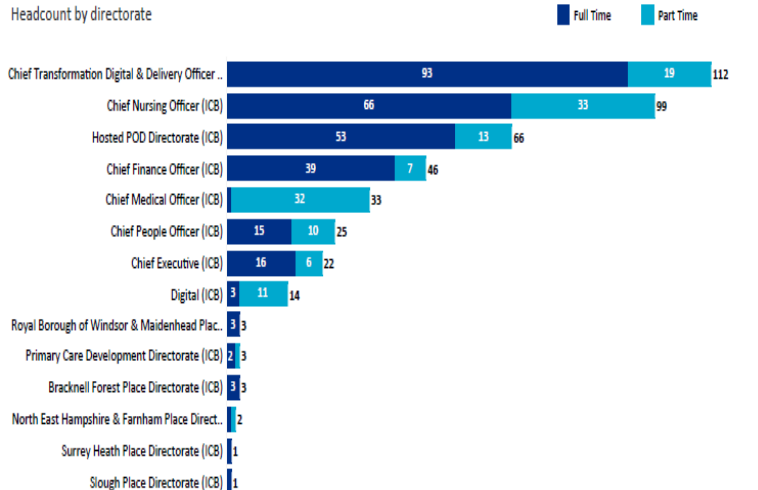
Headcount and FTE



Headcount by department



Headcount by directorate



Headcount	FTE	% Turnover	# Starters	# Leavers
430	363.41	0.93%	5	4
▲ 1	▲ 2.58	◆ 0.00%	▼ 4	◆ 0

% Total Sickness	% Short Term	% Long Term	# COVID-19
1.88%	0.59%	1.30%	0
▼ 0.54%	▼ 0.42%	▼ 0.12%	◆ 0

- Headcount and FTE has risen only very slightly since November 2024 to 430, and new starters have decreased from 9 last month to 5 this month. Further analysis of establishment vacancy reports will help with forecasting likely recruitment numbers in Q4 and beyond, and this work is being concluded by People and Finance Teams.
- Sickness rates have reduced again slightly – 3.59% in October to 2.08% in November and 1.88% in December - with a mix of short and long-term absence. We would usually expect rates to start increasing as we move into Autumn and Winter, although a focused effort in supporting managers, in addition to long term absences ending, may have influenced this reduction.

FRIMLEY INTEGRATED CARE BOARD

Title of Paper	Board Assurance Framework		
Agenda Item	8.1.0	Date of meeting	18 March 2025
Exec Lead	Caroline Corrigan – Chief People Officer		

Purpose	To Approve	<input type="checkbox"/>
	To Ratify	<input type="checkbox"/>
	To Discuss	<input checked="" type="checkbox"/>
	To Note	<input checked="" type="checkbox"/>

Link to Strategic Objective	<i>Relates to all Strategic Objectives</i>
------------------------------------	--

Executive Summary

Introduction:

The ICB board is asked to review the Board Assurance Framework, noting the updates to the mitigating actions that have been made since the document was last reviewed in January 2025.

The BAF reports on the ICB's Strategic Objectives and details the significant long-term risks to the achievement of these. The document provides assurance that the ICB is on track to deliver its Strategic Objectives and highlights where necessary, any gaps in controls and assurances and the associated actions. The BAF also provides assurances that any risks which may impact on the achievement of those Strategic Objectives are being appropriately managed.

Strategic Objectives 2024/25:

- Strategic Objective 1:** Starting Well
- Strategic Objective 2:** Living Well
- Strategic Objective 3:** People, Places and Communities
- Strategic Objective 4:** Our People
- Strategic Objective 5:** Leadership and Culture
- Strategic Objective 6:** Outstanding use of resource

Risk Appetite:

Using the Good Governance Institute (GGI) Framework the Board agreed the following 2024/25 Risk Appetite and Risk Thresholds which have been mapped to the risk domains in the BAF:

Risk Appetite	Description
None	We have no appetite for decisions or actions that will impact in anyway - avoid risk at all costs and all decisions taken to remove the risk
Minimal	We are only willing to accept the possibility of very limited risk and will avoid any decisions or actions that may result in heightened risk unless absolutely essential
Cautious	We are prepared to accept the possibility of limited risk. Our preference is for safe delivery options but we are able to tolerate low level risk and uncertainty. Every decision will be with the aim of mitigating the level of risk.
Open	We are willing to consider all potential delivery options and choose while providing an acceptable level of reward. Take a greater degree of risk and tolerate higher uncertainty to achieve a bigger reward.
Seek	We are eager to be innovative and to choose options offering greater rewards but have greater inherent risk. Eager to take on risk to achieve strategic objectives
Significant	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust. Will chose the option with greater reward and will accept any loss as the price for the reward.

Risk Thresholds

Using the above framework, the following Risk Appetite and Risk Thresholds have been agreed by the Board for the risk domains in the BAF.

Domains	Risk Appetite	Risk Threshold
QUALITY	Cautious	8
PEOPLE	Open	12
PERFORMANCE	Open	12
TRANSFORMATION	Seek	16
FINANCIAL	Open	12
REGULATORY	Open	12
REPUTATIONAL	Open	12

The Board has applied the following 2024/25 Risk Appetite and Risk Thresholds to each of the Strategic Objectives – this scoring allows the Finance and Performance Committee and the System Quality Group (committees of the Board) to manage the principle risks in accordance with the specific Risk Appetite and Risk Threshold agreed by the Board.

Domains	Risk Appetite	Risk Threshold
1. Starting Well	Cautious	8
2. Living Well	Cautious	8
3. People, Places and Communities	Seek	16
4. Our People	Open	12
5. Leadership and Culture	Open	12
6. Outstanding Use of Resources	Open	12

Effects of Controls and Trend Analysis:

Each of the following Strategic Objectives have been scored with an inherent (current) and residual risk (score after the risk has been mitigated) for Q4.

The effects of the controls show whether the Strategic Objective sits in or out of Risk Appetite Statement.

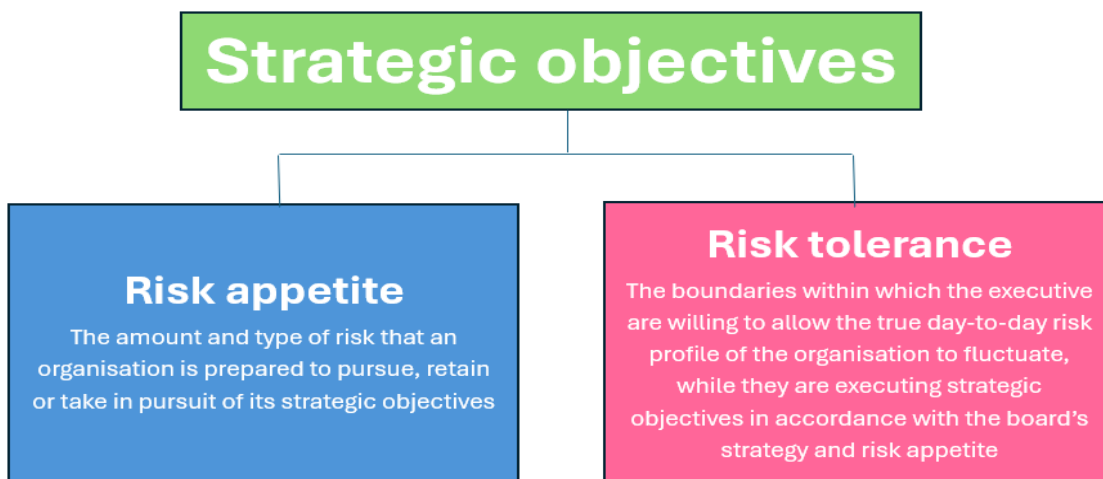
Strategic Objective	Q4 2024-25	Change since Q3
1. Starting Well	9 Out of Risk Appetite	No change
2. Living Well	9 Out of Risk Appetite	No change
3. Places, People and Communities	9 Within Risk Appetite	No change
4. Our People	12 Within Risk Appetite	No change
5. Leadership and Culture	16 Out of Risk Appetite	↑ Increase from 12 to 16
6. Outstanding use of resource	16 Out of Risk Appetite	No change

Strategic Objective 5 – Leadership and Culture has been updated to reflect new controls for the Pharmacy Optometry and Dentistry (POD) Commissioning Hub and transfer of Delegated Specialised Commissioning functions to the ICB. The risk score has been increased from 12 in Q3 to 15 in Q4, which means that the Strategic Objective now sits outside its Risk Appetite.

- The Board is asked to note that two Strategic Objectives sit within Risk Appetite Thresholds and four sit outside of the agreed Risk Appetite Thresholds.
- The Board is asked to consider the sorts of assurance(s) that it requires on plans to bring the Strategic Objectives back within the agreed Risk Appetite Thresholds.

For example, taking account of the external challenges that are impacting on the ICB’s ability to mitigate some risks to within their agreed Risk Appetite Threshold – for example, Strategic Objective 6 – Outstanding Use of Resources.

The “*Good Governance Institute*” definitions of Risk Appetite and Risk Tolerance are set out below:



- The Board will be asked to review and update its current 2024/25 Risk Appetite Statement and Threshold for 2025/26. The 2025/26 Risk Appetite and Thresholds will be agreed in Q1.

Board Assurance Framework and Risk Management Internal Audit Report Findings 2024/25:

The Board is provided with assurance that the ICB’s Internal Auditors have issued a final Board Assurance Framework and Risk Management Internal Audit Report for 2024/25 with a reasonable assurance rating.

Reporting Cycle:

Between the meetings the risks in the BAF will be regularly reviewed by the Committees of the Board, namely, the Finance and Performance Committee and the System Quality Group. These Board Committees will review the alignment between the BAF and the Corporate Risk Register (comprised of strategic risks 15 ↑) to ensure that risks are being appropriately managed.

The Board is provided with assurance that the BAF has been overseen by Intergrated Risk Group, which is made up of executive members of the Finance and Performance Committee and the System Quality Group. The role of the Integrated Risk Group is to provide an assessment of complex, significant or recurrent risks that are escalated to it via the Corporate Risk Register and monitor progress against plans and oversee the mitigation of any significant risks; it is also responsible for providing assurance on the completeness and accuracy of the BAF to the Board.

Recommendation	The Board is asked to review and agree its Board Assurance Framework for Q4.
-----------------------	--

	The Board is asked to note that in Q1 2025/26 it will be asked to review and update its Risk Appetite Statement and Risk Thresholds for the year ahead.
--	---

Please provide details on the impact of following aspects	
Risk and Assurance	
Equality and Quality Impact Assessment	
Patient and Stakeholder Engagement	
Financial Impact and Legal implications	
Please indicate which CQC Theme and Quality Statements this QIA supports. Interim guidance for assessing integrated care systems March 2023 (cqc.org.uk)	Governance, management & sustainability

Reporting – has this paper been discussed at other meetings		
Committee Name	Date discussed	Outcome

NHS Frimley ICB

Board Assurance Framework 2024/25

18-Mar-25

The Board Assurance Framework (BAF) sets out the principal risks to the achievement of the ICB's strategic objectives and is a practical means through which the Board can assess progress against delivery of these. In so doing, the BAF also serves as a primary source of evidence in describing how the ICB is discharging its responsibility for internal control.

The BAF further sets out the controls in place to manage these risks and the assurances available to support judgements as to whether the controls are having the desired impact. It additionally describes the actions to further reduce each risk.

Board Strategic Objectives 2024/25

Strategic Objective 1	Strategic Objective 2	Strategic Objective 3	Strategic Objective 4	Strategic Objective 5	Strategic Objective 6
Starting Well	Living Well	People, Places and Communities	Our People	Leadership and Cultures	Outstanding Use of Resources
We want all children to get the best start in life.	We want people from across all our communities to have the opportunity to live healthier lives.	We will ensure the voices of our residents, facilities and carers shape the ways we create healthier communities.	We want to be known as a great place to work, live and make a positive difference.	We will work together to build kind, inclusive and collaborative cultures which harness the risk diversity of people from across the system.	We will offer the best possible care and support where it is most needed, in the most affordable ways.
<p>*Developing a whole system transformation programme to support our offer to neurodiverse children to a needs led model, reducing the long waits for ADHD/Autism assessments</p> <p>*Strengthening the partnerships across our system to improve outcomes for children and young people with SEND through early help and peer support</p> <p>*Improving the options available for children needing residential care, and further develop and strengthen the processes and arrangements for joint funding with partner local authorities.</p>	<p>*Creation of the whole system clinical strategy to support shift of care to out of hospital settings and quantifiable effect on reducing hospital activity, making full advantage of virtual care and other 21st Century healthcare transformation opportunities and enable NHP build assumptions</p> <p>*Definition and achievement of Core20+5 interventions on reducing inequality of outcome for maternity, severe mental illness, respiratory, cancer and hypertension, as well as the Plus groups approved by the ICB Board in 2024</p>	<p>*Definition of a new way of working and taking decisions together at Place with Local Authority partners and ICB teams, contributing to increased discharges and admission avoidance, facilitated by an improved utilisation of the Better Care Fund</p> <p>*Support and refinement of the VCSE at scale model which is being developed and implemented</p> <p>*Leadership and support of the co-design for ICP v2.0</p>	<p>*Finalise the implementation of the ICB restructure, realising a £4.5m improvement in the pay expenditure of the organisation and embed the OD activities required to make the operating model a success</p> <p>*Establish the DWP-DHSC Work Well programme as a funded pilot site and ensure that the financial support available is used to create high impact, personalised support for Frimley residents</p>	<p>*Further develop, promote and implement the ICB's activities in delivering our system wide Equality, Diversity and Inclusion Strategy</p> <p>*Build upon our system leadership approach and workplan, including our continuing commitment and support to the Frimley Academy</p> <p>*Further development of the System Leadership capabilities through the implementation of our new operating model, which includes the new hosting functions of the ICB (i.e. Spec Com)</p>	<p>*Financial sustainability – break-even runrate by end of 25/26</p> <p>*Finalisation and publication of ICS Infrastructure Strategy</p> <p>*Progression of out of hospital capital estates schemes</p> <p>*New Hospital Programme – ICB responsibilities</p> <p>*CSU In-Housing and Pan-ICB digital architecture implemented</p>

Board Risk Appetite Statement 2024/25

Risk appetite is defined as the amount of risk that we are willing to seek or accept in the pursuit of long-term objectives.

It is key to achieving effective risk management and is agreed by the Board so that the nature and extent of significant risks we are willing to take in achieving our strategic objectives is understood. It represents a balance between the potential benefits of transformation, the challenges we face, and the threats change inevitably brings.

The Board will review its risk appetite annually or more frequently should the environment we operate in change significantly. The risk appetite sets the threshold for risk against key domains and enables the Board, its Committees and Boards and teams to effectively manage risks.

Risk Statement:

NHS Frimley recognises that long term sustainability of health and care services depends upon managing risks in relation to the delivery of our strategic objectives, and that our relationships with communities, staff and all our partners is key to our success. Our approach to our risk appetite is underpinned by the maturity of our system working.

We believe that no risk exists in isolation and that effective risk management is about finding the right balance between risks and opportunities to deliver our ambitions, to act in the best interests of our communities alongside delivering value for money. Our risk appetite approach recognises the need for risk trade-off conversations, creating a flexible framework within which we can drive transformation, make agile decisions and balance boldness and caution, risk and reward and cost and benefit. It also aims to provide a proportionate approach to risk reducing bureaucracy but ensuring appropriate rigour in our risk management.

We recognise that no health and care is risk free and when balancing risk, we will tolerate some more than others. For example: we will have a cautious approach to risks which impact quality (clinical quality, safety and patient experience) which means we prefer safe delivery options and take decisions that aim to mitigate the level of risk. When driving transformation and innovation we will seek options that have bigger rewards but greater risks to get there, using our risk approach to understand and balance the risk with benefits.

Overall NHS Frimley has an open appetite to take well-considered balanced risks to pursue innovation and opportunities where positive gains can be expected, whilst being confident that through good risk management the threats can be averted.

References: Good Governance Institute: Board guidance on risk appetite: 2020; NHSE/I Risk Appetite 2021

The Board has agreed its risk appetite in the following domains for 2024/25:

Domains	Risk Appetite	Risk Threshold
QUALITY	Cautious	8
PEOPLE	Open	12
PERFORMANCE	Open	12
TRANSFORMATION	Seek	16
FINANCIAL	Open	12
REGULATORY	Open	12
REPUTATIONAL	Open	12

Risk Appetite	Description
None	We have no appetite for decisions or actions that will impact in anyway - avoid risk at all costs and all decisions taken to remove the risk
Minimal	We are only willing to accept the possibility of very limited risk and will avoid any decisions or actions that may result in heightened risk unless absolutely essential
Cautious	We are prepared to accept the possibility of limited risk. Our preference is for safe delivery options but we are able to tolerate low level risk and uncertainty. Every decision will be with the aim of mitigating the level of risk.
Open	We are willing to consider all potential delivery options and choose while providing an acceptable level of reward. Take a greater degree of risk and tolerate higher uncertainty to achieve a bigger reward.
Seek	We are eager to be innovative and to choose options offering greater rewards but have greater inherent risk. Eager to take on risk to achieve strategic objectives
Significant	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust. Will chose the option with greater reward and will accept any loss as the price for the reward.

Risk Summaries

Strategic Objective 1: Starting Well													
BAF REF	Domain	Principle Risk	Risk Owner	System Board/Assurance Committee	Initial Risk rating (before mitigation)			Current Risk rating (after mitigation)			Risk Appetite / Threshold	Status (in/out of appetite)	Move from last quarter
					I	L	Rating (IxL)	I	L	Rating (IxL)			
SO1	Quality	CYP and their families may not have their agreed needs met, with the result of lasting negative impact for them their families and Health and social care in the future.	Chief Nursing Officer	F&P / SQG	3	4	12	3	3	9	CAUTIOUS 8	OUT	NO CHANGE

Strategic Objective 2: Living Well													
BAF REF	Domain	Principle Risk	Risk Owner	System Board/Assurance Committee	Initial Risk rating (before mitigation)			Current Risk rating (after mitigation)			Risk Appetite / Threshold	Status (in/out of appetite)	Move from last quarter
					I	L	Rating (IxL)	I	L	Rating (IxL)			
SO2	Quality	If we are unable to effectively implement and integrate the whole system strategy that supports the transformation of care to out-of-hospital settings, then the anticipated reduction in hospital activity may not be achieved. This may exacerbate health inequalities, leading to increased pressure on partner organisations, higher healthcare costs with risk to our recurrent financial sustainability and poorer access, outcomes and experiences for local communities.	Chief Medical Officer	F&P / SQG	4	4	16	3	3	9	CAUTIOUS 8	OUT	NO CHANGE

Strategic Objective 3: People, Places and Communities													
BAF REF	Domain	Principle Risk	Risk Owner	System Board/Assurance Committee	Initial Risk rating (before mitigation)			Current Risk rating (after mitigation)			Risk Appetite / Threshold	Status (in/out of appetite)	Move from last quarter
					I	L	Rating (IxL)	I	L	Rating (IxL)			
SO3	Transformation	A new approach to the ICP, Place governance and ICB team changes, policy uncertainty (BCF and adult social care discharge funding) and financial challenges for all system partners (health and local authorities) could create a challenging partnership environment and prevent the delivery of our shared priorities and goals	Chief Transformation and Digital Officer	F&P / SQG	4	4	16	3	3	12	SEEK 16	IN	NO CHANGE

Strategic Objective 4: Our People													
BAF REF	Domain	Principle Risk	Risk Owner	System Board/Assurance Committee	Initial Risk rating (before mitigation)			Current Risk rating (after mitigation)			Risk Appetite / Threshold	Status (in/out of appetite)	Move from last quarter
					I	L	Rating (IxL)	I	L	Rating (IxL)			
SO4-A	People	A) Workforce: We do not have the capacity and capability to deliver the required changes, realise the savings required and associated OD plan.	Chief People Officer	F&P / SQG	4	4	16	4	3	12	OPEN 12	IN	NO CHANGE

Strategic Objective 4: Our People													
BAF REF	Domain	Principle Risk	Risk Owner	System Board/Assurance Committee	Initial Risk rating (before mitigation)			Current Risk rating (after mitigation)			Risk Appetite / Threshold	Status (in/out of appetite)	Move from last quarter
					I	L	Rating (IxL)	I	L	Rating (IxL)			
SO4-B	People	B) WorkWell: We do not have the capacity and capability to deliver a WorkWell Programme, that delivers the required impact for the residents of Frimley.	Chief People Officer	F&P / SQG	4	4	16	3	4	12	OPEN 12	IN	NO CHANGE

Strategic Objective 5: Leadership and Cultures													
BAF REF	Domain	Principle Risk	Risk Owner	System Board/Assurance Committee	Initial Risk rating (before mitigation)			Current Risk rating (after mitigation)			Risk Appetite / Threshold	Status (in/out of appetite)	Move from last quarter
					I	L	Rating (IxL)	I	L	Rating (IxL)			
SO5	People	If we do not create an inclusive culture then we will not have the leadership capacity and capability to deliver for the communities we serve. If the ICB does not create an open, positive, transparent and inclusive culture then the cases of bullying, sexual misconduct, aggression and poor employee experience will lead to a higher number of employee relations cases, FTSU cases as well as a direct impact on delivery against our strategic workforce objectives.	Chief People Officer	F&P / SQG	4	4	16	3	4	16	OPEN 12	OUT	CHANGE

Strategic Objective 6: Outstanding Use of Resources													
BAF REF	Domain	Principle Risk	Risk Owner	System Board/Assurance Committee	Initial Risk rating (before mitigation)			Current Risk rating (after mitigation)			Risk Appetite / Threshold	Status (in/out of appetite)	Move from last quarter
					I	L	Rating (IxL)	I	L	Rating (IxL)			
SO6	FINANCIAL	The system fails to deliver the greatest possible value for the health and wellbeing of the population with the resource with which it is entrusted. This risk materialises owing to failure to deliver in-year financial balance and recurrent financial sustainability and/or secure sufficient capital and revenue resource to achieve strategic and operational aims, including delivery of the new hospital and associated transformation both of which are essential prerequisites to the minimisation of health inequalities and maximisation of healthy life years.	Chief Finance Officer	F&P / SQG	5	5	25	5	4	20	OPEN 12	OUT	NO CHANGE

BAF REF: SO1		Strategic Objective: 1. Starting Well		Principle Risk: CYP and their families may not have their agreed needs met, with the result of lasting negative impact for them their families and Health and social care in the future.			Risk Domain: Quality		Current Risk Score: 9				
Assurance Committee: Finance and Performance Committee / System Quality Group						Delegated Risk Owner: Chief Nursing Officer		Date Added to BAF: Q2 2024/25					
Initial Risk Rating (before mitigation)			Current Risk Rating (after			Risk Appetite / Threshold	Status (in/out appetite)	Risk Analysis	Qtr. 2 (24/25)	Qtr. 3 (24/25)	Qtr. 4 (24/25)	Qtr. 1 (25/26)	Qtr. 2 (25/26)
I	L	Rating (IxL)	I	L	Rating (IxL)								
3	4	12	3	3	9	CAUTIOUS 8	OUT	Current Rating	9	9	9	TBC	
Positive Assurance and Key Controls in Place								Gaps in Control and/or Assurance					
<p>1. Collaborative system CYP strategy - our golden thread which runs through everything we do. 5 clear priorities create a 'true north' for the portfolio helping us to prioritise and plan</p> <p>2. System children's board is established and operating well with ICB board member, Rachael Wardell chairing this meeting. Feeding in to this are 4 system groups - SEND, CYP MH, Neurodiversity and Paediatrics.</p> <p>3. Utilising place and provider mechanisms for hearing CYP voice - for example Together as One in Slough have supported the work of the portfolio, with support Youth Health Champions, Asthma in Schools, undertaking several pieces of work for us.</p> <p>4. Connecting housing and wider determinants into the work - for example using connected care data alongside LA insights to identify children at risk of respiratory illness this brings together a joint approach which enables the child's asthma to be supported and the improvements to the home such as damp and mould be made.</p> <p>5. Established Clinical Review Group to bring wider clinical expertise to assess needs that arise from health need.</p>								<p>There is a gap between the frameworks in use for determining eligibility for health funding, and expectation from partners of when a child should receive health funding. Increasingly challenging relationships with local authorities when planning care for children particularly where high cost associated for local authority. Continuity of service provision whilst integrated therapies procurement is undertaken. Capacity to deliver the whole system change needed to support young people who are neurodiverse. Capacity to deliver safety valve programmes within Local Authorities. Wait times for neurodiversity support will form part of the inspection framework in the near future leading to greater scrutiny and control from external regulators. Right to Choose framework being exploited by new and unverified providers to undertake assessments for neurodiversity with limited quality and financial control or oversight.</p>					
Mitigating Actions to Address Gaps						Target Date	Action Lead	Update					
Residential project aiming to provide a local short term high intensity intervention that aims for children to return to the family home rather than needing to come in to the care of the LA.						Apr-27	Director for Children, Mental Health, and Learning Disabilities	This project has closed due to the LAs not being able to commit to providing the service, procuring or funding the scheme. Currently working with NHSE to repurpose funding to support Aldershot CAMHS team to develop an alternative to ED for children in crisis. Similar scheme in E Berks based on Camden model is also being considered. January update the reallocation of the capital funding was not possible for the scheme above as it was not possible to use this for PFI funded property. There was no other scheme that we were able to deliver within the timescales so funding is being returned to NHSE. Conversations are, however continuing with our two providers to look at need and opportunity.					
Secure funding to bring LA partners together to further develop shared understanding of joint funding opportunities						Apr-25	Director for Children, Mental Health, and Learning Disabilities	Work is underway and additional funding has been allocated from the CYP budget to engage some external support to deliver. Expected recommendations to come to CYP board in January. January 25 update. Consilium Partners supported the Director for CYP with the review which is now complete. A date for a workshop with LA DCSs and their senior leads is being arranged for February.					
Establishing right to choose framework utilising provider selection regime to try to regain control of the quality of service providers.						Apr-25	Head of Transformation CYP, MH, SEND, ADHD and Autism	Service Spec has been agreed and work is on target					
Needs-led model for neurodiversity in both MH providers to be in place by 1st November.						01-Nov	Head of Transformation CYP, MH, SEND, ADHD and Autism	Working with BHFT and LAs and primary care - we have gone live with new referral pathway. Timelines currently being met. January Update The Frimley neurodiversity steering group has been established. Strengthened primary care support and working closely with Medicines Optimisation. work continues.					

BAF REF: SO2	Strategic Objective: 2. Living Well	If we are unable to effectively implement and integrate the whole system strategy that supports the transformation of care to out-of-hospital settings, then the anticipated reduction in hospital activity may not be achieved. This may exacerbate health inequalities, leading to increased pressure on partner organisations, higher healthcare costs with risk to our recurrent financial sustainability and poorer access, outcomes and experiences for local communities.					Risk Domain: Quality	Current Risk Score: 9					
Assurance Committee: Finance and Performance Committee / System Quality Group			Delegated Risk Owner: Chief Medical Officer				Date Added to BAF: Q2 2024/25						
Initial Risk Rating (before mitigation)			Current Risk Rating (after mitigation)			Risk Appetite / Threshold	Status (in/out appetite)	Risk Analysis	Qtr. 2 (24/25)	Qtr. 3 (24/25)	Qtr. 4 (24/25)	Qtr. 1 (25/26)	Qtr. 2 (25/26)
I	L	Rating (IxL)	I	L	Rating (IxL)								
3	4	12	3	3	9	CAUTIOUS 8	OUT	Current Rating	12	9	9	TBC	
Positive Assurance and Key Controls in Place								Gaps in Control and/or Assurance					
<p>Our ICS Living Well Ambition and refreshed ToR for the Living Well Board with partners</p> <p>Work well Delivery Board established reporting into the Living Well Board</p> <p>Work programmes managed by the Living Well Board are on track apart from one</p> <p>CORE20 'Plus' groups identified for outcome mapping</p> <p>ICS CVD Prevention Board established - targeted work to reduce burden of CVD Morbidity and Mortality and ranked third nationally for Hypertension management in March 2024</p> <p>Regular links to regional and national health inequalities groups/Boards</p> <p>7500 patients on remote monitoring and evidence of reduced hospital admissions, attendances and emergency callouts validated by external organisation; virtual ward occupancy highest in region</p>								<p>Work on Inclusion health groups .</p> <ul style="list-style-type: none"> * Inpatient smoking cessation programme. * Financial constraints might lead to inadequate investment into prevention and tackling health inequalities. * Additional resource may be required in both management of change and the investment in new preventative care models. This will be clearer to assess following the publication of the Government 10 Year Plan and any new financial flow mechanisms which we are anticipating will form a part of this. * Q4 action to create Strategic Commissioning Framework & new Procurement Policy 					
Mitigating Actions to Address Gaps						Target Date	Action Lead	Update					
Participating in the inclusion Health Regional Networks to progress work. To gain deeper insights into the needs of inclusion health groups, we will leverage the OHID South East data packs, augmented by Connected Care to enhance data accuracy and generate actionable insights.						Mar-25	Head of Prevention and Reducing Health Inequalities	The work is progressing well, and our initial exploration of the data for these groups has highlighted some data gaps that will require continued support from the Connected Care Team and partners. The first Community of Practice scoping meeting was in February 2025.					
Enable senior commitment and a joint board commitment between the ICB and the FHFT board to enable full establishment of the inpatient smoking cessation service.						Apr-25	ICB CMO	1) To discuss at ICB-FHFT Joint SLT in early 2025 2) To agree governance / point of sign off plan for decision making during the year ahead					

BAF REF: SO3		Strategic Objective: 3. People, Places and Communities		Principle Risk: A new approach to the ICP, Place governance and ICB team changes, policy uncertainty (BCF and adult social care discharge funding) and financial challenges for all system partners (health and local authorities) could create a challenging partnership environment and prevent the delivery of our shared priorities and goals				Risk Domain: Transformation		Current Risk Score: 9				
Assurance Committee: Finance and Performance Committee / System Quality Group						Delegated Risk Owner: Chief Transformation Officer			Date Added to BAF: Q2 2024/25					
Initial Risk Rating (before mitigation)			Current Risk Rating (after mitigation)			Risk Appetite / Threshold	Status (in/out appetite)	Risk Analysis	Qtr. 2 (24/25)	Qtr. 3 (24/25)	Qtr. 4 (24/25)	Qtr. 1 (25/26)	Qtr. 2 (25/26)	
I	L	Rating (IxL)	I	L	Rating (IxL)									
4	4	16	3	3	9	SEEK 16	IN	Current Rating	9	9	9	TBC		
Positive Assurance and Key Controls in Place								Gaps in Control and/or Assurance						
<ul style="list-style-type: none"> - Establishment of new Places and Communities Board to create senior alignment and readacross - Approach to ICP Refresh and deployment sponsored by Chair and CEO of the ICB with 2 x Chief Officer support - Ongoing structured engagement with Local Authority Chief Executives by ICB CEO and CTDDO to escalate and resolve issues as they arise - Refreshing all age CHC policies (for East Berkshire residents) including escalation process in partnership with LAs 								<ul style="list-style-type: none"> - No National policy direction for BCF and ASCDF. Funding through these sources embedded into recurrent operational delivery and system ambitions - Unknown implications of the Local Government Reform White Paper published in December 2024 						
Mitigating Actions to Address Gaps								Target Date	Action Lead	Update				
Working with LA partners to mitigate the NHS England approach to "engagement " on future of BCF								30/03/2025	CNO / Director for Places and Communities	In progress.				
Importance of strategic alignment between Places & Communities work and broader left shift / prevention / Living Well														
Ongoing LA Officer and Political engagement at a local level								30/03/2025	CEO / CNO / Director for Places and Communities	In progress.📧				

BAF REF: SO4-A		Strategic Objective: 4. Our People		1st Principle Risk: We do not have the capacity and capability to deliver the required changes, realise the savings required and associated OD plan				Risk Domain: People		Current Risk Score 12				
Assurance Committee: Finance and Performance Committee / System Quality Group/ People Board						Delegated Risk Owner: Chief People Officer			Date Added to BAF: Q2 2024/25					
Initial Risk Rating (before mitigation)			Current Risk Rating (after)			Risk Appetite / Threshold	Status (in/out appetite)	Risk Analysis	Qtr. 2 (24/25)	Qtr. 3 (24/25)	Qtr. 4 (24/25)	Qtr. 1 (25/26)	Qtr. 2 (25/26)	
I	L	Rating (IxL)	I	L	Rating (IxL)									
4	4	16	4	3	12	OPEN 12	IN	Current Rating	12	12	12	TBC		
Positive Assurance and Key Controls in Place								Gaps in Control and/or Assurance						
<ul style="list-style-type: none"> * Change Programme Group - Chief Officers and CEO * SLT reviewing ICB employment plans and risks and establishment controls * OD Plan developed and agreed*see gaps * Oversight via SLT Remuneration Committee oversight of all severance arrangements. * Monthly staff briefings focusing on communicating SLT plans and objectives * Staff survey is currently live * Statutory and mandatory training compliance plan in place which has now been signed off by SLT * Review of all current policies for ICB staff * Freedom to speak up ambassadors and staff networks in place 								<ul style="list-style-type: none"> * Recurrent funding of 'non recurrent funding' (for example SDF) for programmes which are staffed and mobilised. * Whilst there is an action map for our OD delivery plan, we are finalising the priorities and timescales. OD framework has been shared and signed off by SLT. * ICB organisation talent and succession strategy - currently being scoped 						
Mitigating Actions to Address Gaps			Target Date	Action Lead	Update									
ICB OD Refresh implementation will ensure there is a robust plan to support the organisational objectives post- restructure.			Q4 24/25	CPO	SLT and Board have approved the initial draft plans. Wider directorate requirements and discussions are underway.									
Development of a Wider Leadership Forum			Q3 24/25	CPO	Third WLF session held, with session getting better feedback than any other session previously held - noted improvement to levels of engagement and energy. Next session scheduled for 6th March and session agenda built in partnership with volunteers from the group. Future of WLF needs to be cemented, with future largely dictated by WLF group themselves.									
Line Managers forum to support the wider organisation			Q3 24/25	CPO	Line Manager forum held on the 19th of January, with session focussed on supporting yourself and your teams wellbeing. Session had greatest engagement level to date and an external speaker from TalkPlus present on the wellbeing topic. Next session will focus on getting input to what a future team development series would look like for Frimley ICB.									
Robust oversight and scrutiny of Statutory and Mandatory training requirements			Q3 24/25	CPO	Working in partnership with CSU colleagues we are standing up the change of system from ConsultOD to ESR for all StaM courses for 1st April deadline.									

BAF REF: SO4-B	Strategic Objective: 4. Our People	2nd Principle Risk: We do not have the capacity and capability to deliver a WorkWell Programme, that delivers the required impact for the residents of Frimley.						Risk Domain: People	Current risk score: 12				
Assurance Committee: Finance and Performance Committee / System Quality Group						Delegated Risk Owner: Chief People Officer		Date Added to BAF: Q2 2024/25					
Initial Risk Rating (before mitigation)			Current Risk Rating (after mitigation)			Risk Appetite / Threshold	Status (in/out appetite)	Risk Analysis	Qtr. 2 (24/25)	Qtr. 3 (24/25)	Qtr. 4 (24/25)	Qtr. 1 (25/26)	Qtr. 2 (25/26)
I	L	Rating (IxL)	I	L	Rating (IxL)								
4	4	16	3	4	12	OPEN 12	IN	Current Rating	12	12	12	TBC	
Positive Assurance and Key Controls in Place							Gaps in Control and/or Assurance						
<p>WorkWell Delivery Group - cross system group and chaired by a Director of Public Health. Delivery group will develop, test and monitor progress against projected referral numbers.</p> <p>Oversight of WorkWell Programme via the Living Well Board and updates also provided to the following Boards/Committees - Health and Wellbeing, People and Place and SLT.</p> <p>Future Delivery Plan - submitted and signed off by DWP.</p> <p>Programme resources in place and engaged with DWP and PA Consulting.</p> <p>Quarterly assurance and audit meetings/processes agreed and in place.</p>							<p>DWP data requirements for identifiable information not available.</p> <p>Referral requirements remain untested (benchmarked information unavailable)</p>						
Mitigating Actions to Address Gaps							Target Date	Action Lead	Update				
Working closely with DWP to establish (not just for Frimley but all 15 pilot areas) a secure and legal method to share the information.							Q1 25/26	Programme Manager, Frimley H&C	DPIA with DWP is now signed off.				
Information governance expertise sought to advise on risk and potential digital solutions.							Q3 25/26	Programme Manager, Frimley H&C	Ongoing				

BAF REF: S05		Strategic Objective: 5. Leadership and Culture		Principle Risk: If we do not create an inclusive culture then we will not have the leadership capacity and capability to deliver for the communities we serve. If the ICB does not create an open, positive, transparent and inclusive culture then the cases of bullying, sexual misconduct, aggression and poor employee experience will lead to a higher number of employee relations cases, FTSU cases as well as a direct impact on delivery against our strategic workforce objectives.				Risk Domain: People		Current Risk Score: 16			
Assurance Committee: Finance and Performance Committee / System Quality Group						Delegated Risk Owner: Chief People Officer			Date Added to BAF: Q2 2024/25				
Initial Risk Rating (before mitigation)		Current Risk Rating (after				Risk Appetite / Threshold	Status (in/out appetite)	Risk Analysis	Qtr. 2 (24/25)	Qtr. 3 (24/25)	Qtr. 4 (24/25)	Qtr. 1 (25/26)	Qtr. 2 (25/26)
I	L	Rating (IxL)		I	L								
4	4	16		4	4	16	OPEN 12	OUT	Current Rating	12	12	16	TBC
Positive Assurance and Key Controls in Place							Gaps in Control and/or Assurance						
<p>The System EDI Strategy including Anti-Racism Approach</p> <p>The Frimley Academy strategy and programmes of work</p> <p>The establishment and input of the ICB's Mirror Board</p> <p>The ICP Assembly focus and influence on key leadership strategies</p> <p>FTSU Guardian Network provides key assurance</p> <p>OD framework (embedding inclusivity across ICS)</p>							<p>Alignment between organisation and system leadership and EDI strategies</p> <p>Psychologically safe environment to explore complex cultural issues such as anti-racism.</p> <p>Lack of clear leadership capacity to oversee the delivery of delegated functions for Pharmacy, Optometry and Dental Commissioning and Specialised Commissioning on behalf of the 6 ICBs.</p>						
Mitigating Actions to Address Gaps							Target Date	Action Lead	Update				
Refresh of the Frimley Academy Strategy							Mar-25	CPO	The Academy has secured ICB Board support for next steps (including spending plan) - now moving forward with 2025-2027 planning and implementation.				
Development of an Anti-Racism Alliance							Mar-25	EDI System Lead and Provider Member BHFT	A system chief executive roundtable event held on the 28th Feb where commitment to an Alliance was agreed.				
Review the development of the Mirror Board							Feb-25	CPO & EDI System Lead	Mid evaluation of the Mirror Board completed. Full review at the end of the programme May 2025.				
<p>Appoint Programme Director to increase leadership capacity and oversight of POD and Specialised Commissioning. Strengthen programme governance using standard programme methodology reporting through joint arrangements between NHS England and the 6 ICBs to the SE Region Leadership Team (SERLT).</p> <p>Develop a robust transition plan for Specialised Commissioning Teams to ensure the smooth and effective migration of staff, functions and data & digital in July 2025 in collaboration with NHS England and 6 ICBs.</p> <p>For POD Commissioning ensure a robust case for change methodology is adopted to support the system make an effective decision regarding the future operational model based on evidence.</p>							Mar-25	CPO & Programme Director	Programme Director appointed.				
							Apr- 25		Governance and programme arrangements established for POD Commissioning.				
							Apr-25		POD Staff involvement in change commenced.				
							Mar-25		Collaboration established between NHS England and Frimley ICB to support the transition of Specialised Commissioning.				

BAF REF: SO6	Strategic Objective: 6. Outstanding Use of Resources	Principle Risk: The system fails to deliver the greatest possible value for the health and wellbeing of the population with the resource with which it is entrusted. This risk materialises owing to failure to deliver in-year financial balance and recurrent financial sustainability and/or secure sufficient capital and revenue resource to achieve strategic and operational aims, including delivery of the new hospital and associated transformation both of which are essential prerequisites to the minimisation of health inequalities and maximisation of healthy life years.						Risk Domain: Financial	Current Risk Score: 20				
Assurance Committee: Finance and Performance Committee / System Quality Group						Delegated Risk Owner: Chief Finance Officer			Date Added to BAF: Q2 2024/25				
Initial Risk Rating (before mitigation)			Current Risk Rating (after mitigation)			Risk Appetite / Threshold	Status (in/out appetite)	Risk Analysis	Qtr. 2 (24/25)	Qtr. 3 (24/25)	Qtr. 4 (24/25)	Qtr. 1 (25/26)	Qtr. 2 (25/26)
I	L	Rating (IxL)	I	L	Rating (IxL)								
5	5	25	5	4	20	OPEN 12	OUT	Current Rating	20	20	20	TBC	
Positive Assurance and Key Controls in Place								Gaps in Control and/or Assurance					
The system is developing rapid financial turnaround options which could mitigate the probability of the risk materialising. Options were presented to the October meeting of the system Finance & Performance Committee for discussion and recommendation to Board. There is an unavoidable trade-off between in-year financial balance and the availability of resource to service the need for "left shift" transformation which will require careful navigation and full recognition of the consequences of decisions to be taken. The "most likely" in-year position for the Trust and ICB at month 10 was a £3.5m deficit, and the system continues to forecast a breakeven position at yearend, although this is predicated on a number of RFT actions coming to fruition and remains high risk. The longer-term financial sustainability of the system will require much more material and substantive action.								Although many of the weaknesses identified in the "Getting the basics right" assessment in 2023 have been addressed, the system's financial reporting function is not as well developed as it would ideally be. There remains significant work to do on the establishment of a systematic, coherent, common PMO infrastructure to drive the delivery of identified "tranche 4" opportunities and the establishment of a single, consolidated system I&E to provide accurate and transparent financial intelligence to support decision making.					
Mitigating Actions to Address Gaps								Target Date	Action Lead	Update			
As the organisational design process concludes, the ICB will address gaps in its financial reporting establishment to facilitate the delivery of financial business partnering. The process has progressed but more remains to complete.								31/03/2025	CFO	In progress.			
Embedding the adoption and operation of the ePMO system across the whole system, enabling operational and clinical colleagues systematically and coherently to identify, develop and deliver transformational opportunities must be a requirement of the 25/26 delivery plan.								31/03/2025	CFO	ePMO system implemented, and the ICB continues to identify and develop opportunities.			
The 25/26 delivery plan must clearly identify actions required of system portfolio delivery boards, under the distributed leadership model, to facilitate their delivery on an ongoing basis. These actions will be included in the internal delivery plan to be signed off by the Board in May, post-agreement of the plan by NHS England.								31/03/2025	CFO	Continues in progress.			

Risk Score Matrix

	5	10	15	20	25
Likelihood	4	8	12	16	20
	3	6	9	12	15
	2	4	6	8	10
	1	2	3	4	5
	Impact				

Low risk	Medium risk	High risk	Significant risk
*1-3	*4-8	*9-12	15+

Likelihood Score

Likelihood score		(L)			
Descriptor	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
Frequency How often does it/might it happen	This will probably never happen/recur	Do not expect it to happen / recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen / recur but it is not persistent issue	Will undoubtedly happen / recur, possibly frequently
Probability Will it happen or not? % chance of not	<0.1 per cent	0.1-1 per cent	1-10 per cent	10-50 per cent	>50 per cent

Impact (Consequence) Score

Domains	Consequence score (impact levels) and examples of descriptors				
	1	2	3	4	5
Impact on the safety of patients, staff or public (physical/psychological harm)	Negligible • Minimal injury requiring no/minimal intervention or treatment. • No time off work	Minor • 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 • Moderate injury requiring professional intervention • Requiring time off work for 4-14 days • Increase in length of hospital stay by 4-15 days	Serious • Major injury leading to long-term incapacity/disability • Requiring time off work for >14 days • Increase in length of hospital stay by >15 days	Catastrophic • Incident leading to death • Multiple permanent injuries or irreversible health effects • An event which impacts on a

Adverse publicity / reputation	Rumors	Local media coverage – short-term reduction in public confidence	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 in the House)
Potential for public concern / media interest Damage to an individual's reputation	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met Damage to a	Local media coverage – long-term reduction in public confidence Damage to a services reputation	National media coverage with <3 days service well below reasonable public expectation Damage to an organisation's reputation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence	

			<ul style="list-style-type: none"> RIDDOR/agency reportable incident An event which impacts on a small number of patients 	<ul style="list-style-type: none"> Mismanagement of patient care with long-term effects 	<ul style="list-style-type: none"> Impacts on a large number of patients
Quality/complaints/ audit	<ul style="list-style-type: none"> Peripheral element of treatment or service suboptimal informal complaint /inquiry 	<ul style="list-style-type: none"> Overall treatment or service suboptimal Formal complaint Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report 	<ul style="list-style-type: none"> Totally unacceptable level or quality of treatment/ service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ Organisational development/ staffing/ competence	<ul style="list-style-type: none"> Short-term low staffing level that temporarily reduces service quality (< 1 day) 	<ul style="list-style-type: none"> Low staffing level that reduces the service quality 	<ul style="list-style-type: none"> Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training 	<ul style="list-style-type: none"> Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Significant numbers of staff not attending mandatory / key training 	<ul style="list-style-type: none"> Non-delivery of key objective /service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training key training on an ongoing basis
Statutory duty/ inspections	<ul style="list-style-type: none"> No or minimal impact or breach of guidance/ statutory duty 	<ul style="list-style-type: none"> Breach of statutory legislation Reduced performance rating if unresolved 	<ul style="list-style-type: none"> Single breach in statutory duty Challenging external recommendations/ improvement notice 	<ul style="list-style-type: none"> Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical reports 	<ul style="list-style-type: none"> Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance
					reputation.
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<ul style="list-style-type: none"> <5 per cent over project budget Schedule slippage 	<ul style="list-style-type: none"> 5–10 per cent over project budget Schedule slippage 	<ul style="list-style-type: none"> Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met 	<ul style="list-style-type: none"> Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	<ul style="list-style-type: none"> Loss of 0.1–0.25 per cent of budget Claim less than £10,000 	<ul style="list-style-type: none"> Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000 	<ul style="list-style-type: none"> Uncertain delivery of key objective/ Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time 	<ul style="list-style-type: none"> Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification / slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	<ul style="list-style-type: none"> Loss/ interruption of >8 hours Minor impact on environment 	<ul style="list-style-type: none"> Loss/interruption of >1 day Moderate impact on environment 	<ul style="list-style-type: none"> Loss/interruption of >1 week Major impact on environment 	<ul style="list-style-type: none"> Permanent loss of service or facility Catastrophic impact on environment
Data Loss / Breach of Confidentiality	Potentially serious breach. Less than 5 people affected or risk assessed as low eg files	<ul style="list-style-type: none"> Serious potential breach and risk assessed high eg unencrypted clinical records. Up to 20 people affected 	<ul style="list-style-type: none"> Serious breach of confidentiality eg up to 100 people affected 	<ul style="list-style-type: none"> Serious breach with either particular sensitivity eg sexual health details or up to 1000 people affected 	<ul style="list-style-type: none"> Serious breach with potential for ID theft or over 1000 people affected