Mid and South Essex Integrated Care System

NHS
Mid and South Essex
Integrated Care Board

Meeting of the Mid and South Essex Integrated Care Board

Friday 1 July 2022 at 3.00 pm

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Event Suite, Chelmsford City Museum, Oaklands Park, Moulsham Street, Chelmsford, Essex CM2 9AQ

Friday 1 July 2022, 3.00-5.00 pm

Agenda

No	Title	Action	Papers	Lead	Time	Page
Opening Business						
1.	Welcome and apologies for absence	Note	Verbal	Professor M Thorne	3.00 pm	-
2.	Declarations of interest	Note	Attached	Professor M Thorne	3.05 pm	3
3.	Questions from the Public	Note	Verbal	Professor M Thorne	3.10 pm	-
ICB Establishment						
4.	Receipt of constitution	To note	Attached	Professor M Thorne	3.20 pm	4
5.	Scheme of Reservation and Delegation (including Functions & Decisions map	Approve	Attached	A McKeever	3.25 pm	50
6.	Standing Financial Instructions	Approve	Attached	J Kearton	3.30 pm	84
7.	Establishment of Committees, including: • Terms of Reference • Appointment of Committee chairs	Approve	Attached	A McKeever	3.35 pm	111
8.	Adoption of suite of ICB policies, with particular reference to: • Standards of Business Conduct Policy • Conflict of Interests Policy • Risk Management Policy	Approve	Attached	A McKeever	3.45 pm	173
9.	Appointment of Lead roles, including: • Deputy Chair of ICB Board • Conflicts of Interest Guardian • Freedom to Speak Up Guardian • Emergency Accountable Officer • Senior Information Risk Officer (SIRO) • Caldicott Guardian • Data Protection Officer	Approve	Verbal	Professor M Thorne	3.55 pm	-
10.	Appointment of founder member of the Integrated Care Partnership	Approve	Verbal	Professor M Thorne	4.00 pm	269

Strategy						
11.	Finance Strategy	Note	Attached	J Kearton	4.05 pm	270
12.	Draft Working with People and Communities Strategy	Note	Attached	J Cripps	4.15 pm	323
Business						
13.	2022/23 Financial Plan / Budgets	Approve	Attached	J Kearton	4.35 pm	345
14.	Harmonisation of Commissioning Policies	Note	Attached	Dr R Fenton	4.45 pm	354
Closing Busines						
15.	ICB Forward Plan	Note	Attached	A McKeever	4.50 pm	359
16.	Any other business	Note	Verbal	Professor M Thorne	4.55 pm	-
17.	Date/time of next Board Meeting: **Thursday 15 September 2022 at 3.00pm**	Note	Verbal	Professor M Thorne	5.00 pm	-

Part I Board Meeting

Date of meeting	1 July 2022
Agenda item number	2
Title of report	Declarations of Interest
Purpose of report.	To ask ICB Board members to declare if they have an interest in any specific agenda items under discussion. A register of ICB Board members' interests is being updated with newly appointed Board members' declarations and will be published on the ICB's website.
Executive Lead	Professor Mike Thorne.
Report Author	Viv Barnes, Governance Lead.
Impact Assessments	Not applicable.
Financial implications	None identified.
Details of patient or public engagement or consultation.	Not applicable.
Conflicts of Interest:	As declared
Recommendation(s)	The Board is asked to note members' declarations of interest.

Part I Board Meeting

Date of meeting	1 July 2022
Agenda item number	4
Title of report	Mid and South Essex ICB Constitution
Purpose of report.	To receive the constitution of the MSE Integrated Care Board
Executive Lead	Professor Mike Thorne, Chair
Report Author	Viv Barnes, Governance Lead
Impact Assessments	Not applicable
Financial implications	None
Details of patient or public engagement or consultation.	The draft ICB Constitution was circulated to key stakeholders on 29 October 2021 for comment during its early development. The MSE Health & Care Partnership Board has received regular updates on the constitution at its meetings, most recently on 20 May 2022.
Conflicts of Interest:	None Identified
Recommendation(s)	The Board is asked to: • Receive the constitution of the MSE Integrated Care Board

Mid and South Essex ICB Constitution

1. Introduction

The Health and Care Act 2022 requires each of the new Integrated Care Boards, established as part of the statutory Integrated Care Sector arrangements, to have a constitution and sets out the essential content that must be included in the constitution.

This report summarises the process by with the constitution was developed and approved and presents the final constitution to the Board for information.

2. Main Report

In order to ensure compliance with the requirements for ICB constitutions set out in The Health and Care Act 2022, NHS England issued a model template and guidance for CCGs to use to begin developing the ICB constitutions.

The template constitution provides details of the ICB's Board membership and governance arrangements in relation to the following areas:

- Composition of the Board of the ICB.
- Appointments Process for the Board.
- Arrangements for the exercise of functions.
- Procedures for Making Decisions.
- Arrangements for Conflict of Interest Management and Standards of Business Conduct.
- Arrangements for ensuring Accountability and Transparency.
- Arrangements for Determining the Terms and Conditions of Employees
- Arrangements for Public Involvement.
- Standing Orders setting out the arrangements and procedures to be used for meetings and the processes to appoint the ICB committees.

The constitution for the Mid and South Essex ICB was developed to closely follow the NHS England template. The first draft of the constitution was shared with key local stakeholders on 29 October 2021 for comment and their feedback was incorporated into future iterations. The MSE Health & Care Partnership Board has also received regular updates on the constitution at its meetings, most recently on 20 May 2022.

As required by The Health and Care Act 2022, the five mid and south Essex predecessor CCGs were asked to propose the final version of the MSE ICB constitution to NHS England on 20 May 2022. This was enacted via the relevant arrangements within each CCG's Standing Orders for undertaking urgent decisions.

Following this submission, Dr Sean O'Kelly, Interim Director for the East of England region, advised on 1 June 2022 that the ICB constitution had been approved by NHS England and Improvement. The approval letter advised that the constitution had been through a rigorous assurance process, as a result of which it had been confirmed to be compliant and appropriate, that there has been adequate consultation and engagement undertaken by the CCGs when developing the ICB constitution, and that the constitution

had been proposed in line with the CCGs' existing constitutions and Schemes of Reservation and Delegation.

On 1 July 2022 NHS England brought the constitution into effect via provisions within The Integrated Care Boards (Establishment) Order 2022, hence it is only being presented to the Board for information on this occasion. Any future changes to the constitution will be proposed by the Chief Executive and considered and approved by the Board prior to making an application to vary the constitution to NHS England.

The constitution is supplemented by a Governance Handbook, available on the ICB's website, which includes the following documents:

- ICB Functions Map.
- Scheme of Reservation and Delegation, including Schedule of Detailed Delegated Financial Limits.
- Terms of Reference of ICB Committees.
- Standing Financial Instructions.

3. Recommendation

The Board is asked to note the Mid and South Essex Integrated Care Board constitution.

4. Appendices

Appendix A – Mid and South Essex Integrated Care Board Constitution

Mid and South Essex
Integrated Care Board

NHS Mid and South Essex Integrated Care Board

CONSTITUTION

Version	Date approved by the ICB	Effective date
V1.0	N/A	1 July 2022

CONTENTS

1 Introduction

1.1. Foreword

1.1.1 NHS England has set out the following as the four core purposes of ICSs:

a) Improve outcomes in population health and healthcare.
b) Tackle inequalities in outcomes, experience and access.
c) Enhance productivity and value for money.
d) Help the NHS support broader social and economic development.

1.1.2 The ICB will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including:

- Improving the health of children and young people.
- Supporting people to stay well and independent.
- Acting sooner to help those with preventable conditions.
- Supporting those with long-term conditions or mental health issues.
- Caring for those with multiple needs as populations age.
- Getting the best from collective resources so people get care as quickly as possible.

1.2 Name

1.2.1 The name of this Integrated Care Board is the NHS Mid and South Essex Integrated Care Board ("the ICB").

1.3 Area covered by the Integrated Care Board

1.3.1 The area covered by the ICB comprises the Borough of Basildon, District of Braintree, Borough of Brentwood, Borough of Castle Point, City of Chelmsford, District of Maldon, District of Rochford, City of Southend-on-Sea, and the Borough of Thurrock.

1.4 Statutory Framework

1.4.1 The ICB is established by order made by NHS England under powers in the 2006 Act.

1.4.2 The ICB is a statutory body with the general function of arranging for the provision of services for the purposes of the health service in England and is an NHS body for the purposes of the 2006 Act.

1.4.3 The main powers and duties of the ICB to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the 2006 Act).

1.4.4 In accordance with section 14Z25(5) of, and paragraph 1 of Schedule 1B to, the 2006 Act the ICB must have a constitution which must comply with the

requirements set out in that Schedule. The ICB is required to publish its constitution (section 14Z29). This constitution is published at www.midandsouthessex.ics.nhs.uk

1.4.5 The ICB must act in a way that is consistent with its statutory functions, both powers and duties. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to ICBs. Examples include, but are not limited to, the Equality Act 2010 and the Children Acts. Some of the statutory functions that apply to ICBs take the form of general statutory duties, which the ICB must comply with when exercising its functions. These duties include but are not limited to:

a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act).
b) Exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act).
c) Duties in relation children including safeguarding, promoting welfare etc. (including the Children Acts 1989 and 2004, and the Children and Families Act 2014).
d) Adult safeguarding and carers (the Care Act 2014).
e) Equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35).
f) Information law, (for instance, data protection laws such as the UK General Data Protection Regulation 2016/679 and Data Protection Act 2018 and the Freedom of Information Act 2000).
g) Provisions of the Civil Contingencies Act 2004.

1.4.6 The ICB is subject to an annual assessment of its performance by NHS England which is also required to publish a report containing a summary of the results of its assessment.

1.4.7 The performance assessment will assess how well the ICB has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under:

a) Section 14Z34 (improvement in quality of services).
b) Section 14Z35 (reducing inequalities).
c) Section 14Z38 (obtaining appropriate advice).
d) Section 14Z40 (duty in respect of research)
e) Section 14Z43 (duty to have regard to effect of decisions).
f) Section 14Z44 (public involvement and consultation)
g) Sections 223GB to 223N (financial duties).
h) Section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

1.4.8 NHS England has powers to obtain information from the ICB (section 14Z60 of the 2006 Act) and to intervene where it is satisfied that the ICB is failing, or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so (section 14Z61).

1.5 Status of this Constitution

1.5.1 The ICB was established on 1 July 2022 by The Integrated Care Boards (Establishment) Order 2022, which made provision for its Constitution by reference to this document.

1.5.2 This Constitution must be reviewed and maintained in line with any agreements with, and requirements of, NHS England set out in writing at establishment.

1.5.3 Changes to this Constitution will not be implemented until, and are only effective from, the date of approval by NHS England.

1.6 Variation of this Constitution

1.6.1 In accordance with paragraph 15 of Schedule 1B to the 2006 Act this Constitution may be varied in accordance with the procedure set out in this paragraph. The Constitution can only be varied in two circumstances:

a) Where the ICB applies to NHS England in accordance with NHS England's published procedure and that application is approved; and
b) Where NHS England varies the Constitution of its own initiative (other than on application by the ICB).

1.6.2 The procedure for proposal and agreement of variations to the Constitution is as follows:

a) The Chief Executive may periodically propose amendments to the Constitution, which shall be considered and approved by the Integrated Care Board prior to making an application to vary the Constitution to NHS England.
b) Proposed amendments to this Constitution will not be implemented until an application to NHS England for variation has been approved.

1.7 Related Documents

1.7.1 This Constitution is also supported by a number of documents which provide further details on how governance arrangements in the ICB will operate.

1.7.2 The following are appended to the Constitution and form part of it for the purpose of clause 1.6 and the ICB's legal duty to have a Constitution:

a) **Standing orders** – which set out the arrangements and procedures to be used for meetings and the processes to appoint the ICB committees.

1.7.3 The following do not form part of the Constitution but are required to be published:

a) **The Scheme of Reservation and Delegation (SoRD)** – sets out those decisions that are reserved to the board of the ICB and those decisions that have been delegated in accordance with the powers of the ICB and

which must be agreed in accordance with and be consistent with the Constitution. The SoRD identifies where, or to whom, functions and decisions have been delegated to.

b) **Functions and Decision map** - a high level structural chart that sets out which key decisions are delegated and taken by which part or parts of the system. The Functions and Decision map also includes decision making responsibilities that are delegated to the ICB (for example, from NHS England).

c) **Standing Financial Instructions** – which set out the arrangements for managing the ICB's financial affairs.

d) **The ICB Governance Handbook** – this brings together all the ICB's governance documents so it is easy for interested people to navigate. It includes:
   - The above documents a) – c).
   - Terms of reference for all committees and sub-committees of the board that exercise ICB functions.
   - Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act.
   - Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act.
   - The up-to-date list of eligible providers of primary medical services under clause 3.6.2.
   - Detailed arrangements for the nomination and selection process of board members, as required.

e) **Key policy documents** - which should also be included in the Governance Handbook or linked to it, including:
   - Standards of business conduct policy.
   - Conflicts of interest policy and procedures.
   - Patient and public engagement policy.

2 Composition of the Board of the ICB

2.1 Background

2.1.1 This part of the constitution describes the membership of the Integrated Care Board. Further information about the criteria for the roles and how they are appointed is in section 3.

2.1.2 Further information about the individuals who fulfil these roles can be found on our website at www.midandsouthessex.ics.nhs.uk

2.1.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB (referred to in this constitution as "the board" and members of the ICB are referred to as "board members") consists of:

a) A Chair.
b) A Chief Executive.
c) At least three Ordinary members.

2.1.4 The membership of the ICB (the board) shall meet as a unitary board and shall be collectively accountable for the performance of the ICB's functions.

2.1.5 NHS England Policy requires the ICB to appoint the following additional Ordinary Members:

a) Three executive members, namely:
   - Director of Finance (known locally as the Director of Resources).
   - Medical Director.
   - Director of Nursing (known locally as the Chief Nurse)
b) At least two non-executive members.

2.1.6 The Ordinary Members include at least three members who will bring knowledge and a perspective from their sectors. These members (known as Partner Members) are nominated by the following and appointed in accordance with the procedures set out in Section 3 below:

- NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description.
- The primary medical services (general practice) providers within the area of the ICB and are of a prescribed description.
- The upper tier local authorities that are responsible for providing social care and whose area coincides with or includes the whole or any part of the ICB's area.

2.1.7 While the Partner Members will bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the board, they are not to act as delegates of those sectors. The ICB is seeking knowledge and experience covering the full breadth of the ICB geography, its range of health and care services and professions.

2.2 Board membership

2.2.1 The ICB has 6 Partner Members:

a) Two members, one of whom brings the perspective of the acute sector and the other of whom brings the perspective of the mental health sector delivering services across the ICB's area.
b) One member nominated and selected to bring the perspective of the primary care sector within the ICB area.
c) Three members nominated by the upper tier local authorities whose area coincides with or includes the whole or any part of the ICB's area.

2.2.2 The ICB has also appointed the following further Ordinary members to the board:

a) One additional Non-executive Member.
b) Chief People Officer.

2.2.3 The board is therefore composed of the following members:

a) Chair.
b) Chief Executive.
c) 2 Partner members NHS trusts and foundation trusts.
d) 1 Partner member primary medical services.
e) 3 Partner members local authorities.
f) 3 Non-executive Members.
g) Director of Resources.
h) Medical Director.
i) Chief Nurse.
j) Chief People Officer.

2.2.4 The Chair will exercise their function to approve the appointment of the Ordinary Members with a view to ensuring that at least one of the Ordinary Members will have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

2.2.5 The board will keep under review the skills, knowledge, and experience that it considers necessary for members of the board to possess (when taken together) in order for the board effectively to carry out its functions and will take such steps as it considers necessary to address or mitigate any shortcoming.

3 Appointments Process for the Board

3.1 Eligibility criteria for board membership

3.1.1 Each member of the ICB must:

a) Comply with the criteria of the "fit and proper person test".
b) Be willing to uphold the Seven Principles of Public Life (known as the Nolan Principles).
c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.
d) Be willing to uphold the principles of the East of England Leadership Compact.

3.2 Disqualification criteria for board membership

3.2.1 A Member of Parliament.

3.2.2 A person whose appointment as a board member ("the candidate") is considered by the person making the appointment as one which could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

3.2.3 A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted:

a) In the United Kingdom of any offence, or
b) Outside the United Kingdom of an offence which, if committed in any part of the United Kingdom, would constitute a criminal offence in that part, and, in either case, the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.

3.2.4 A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, sections 56A to 56K of the Bankruptcy (Scotland) Act 1985 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).

3.2.5 A person who has been dismissed within the period of five years immediately preceding the date of the proposed appointment, otherwise than because of redundancy, from paid employment by any Health Service Body.

3.2.6 A person whose term of appointment as the Chair, a Member, a Director or a Governor of a health service body, has been terminated on the grounds:

a) That it was not in the interests of, or conducive to the good management of, the health service body or of the health service that the person should continue to hold that office.

b) That the person failed, without reasonable cause, to attend any meeting of that health service body for three successive meetings.
c) That the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest.
d) Of misbehaviour, misconduct or failure to carry out the person's duties.

3.2.7 A healthcare professional (within the meaning of section 14N of the 2006 Act) or other professional person who has at any time been subject to an investigation or proceedings, by any body which regulates or licenses the profession concerned ("the regulatory body"), in connection with the person's fitness to practise or any alleged fraud, the final outcome of which was:

a) The person's suspension from a register held by the regulatory body, where that suspension has not been terminated.
b) The person's erasure from such a register, where the person has not been restored to the register.
c) A decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded.
d) A decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.

3.2.8 A person who is subject to:

a) A disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or
b) An order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

3.2.9 A person who has at any time been removed from the office of charity trustee or trustee for a charity by an order made by the Charity Commissioners for England and Wales, the Charity Commission, the Charity Commission for Northern Ireland or the High Court, on the grounds of misconduct or mismanagement in the administration of the charity for which the person was responsible, to which the person was privy, or which the person by their conduct contributed to or facilitated.

3.2.10 A person who has at any time been removed, or is suspended, from the management or control of any body under:

a) Section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities), or
b) Section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).

3.3 Chair

3.3.1 The ICB Chair is to be appointed by NHS England, with the approval of the Secretary of State.

3.3.2 In addition to criteria specified at 3.1, this member must fulfil the following additional eligibility criteria

a) The Chair will be independent.

3.3.3 Individuals will not be eligible if:

a) They hold a role in another health and care organisation within the ICB area.
b) Any of the disqualification criteria set out in 3.2 apply

3.3.4 The term of office for the Chair will be three years and the total number of terms a Chair may serve is three.

3.4 Chief Executive

3.4.1 The Chief Executive will be appointed by the Chair of the ICB in accordance with any guidance issued by NHS England.

3.4.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England.

3.4.3 The Chief Executive must fulfil the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

3.4.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.
b) Subject to clause 3.4.3(a), they hold any other employment or executive role.

3.5 Partner Members – NHS trusts and foundation trusts (FTs)

3.5.1 These Partner Members are jointly nominated by the NHS trusts and/or FTs that provide services for the purposes of the health service within the ICB's area and meet the forward plan condition or (if the forward plan condition is not met) the level of services provided condition:

a) East of England Ambulance Service NHS Trust.
b) Essex Partnership University NHS Foundation Trust.
c) Mid and South Essex NHS Foundation Trust.
d) North East London NHS Foundation Trust.

3.5.2 These members must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be a CEO or Executive Director of one of the NHS Trusts or FTs within the ICB's area.
b) One member must provide current and on-going experience of the acute hospital sector.
c) One member must provide current and on-going knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.
d) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.5.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.5.4 These members will be appointed by the ICB Chief Executive subject to the approval of the Chair.

3.5.5 The appointment process will be as follows:

a) Joint Nomination:
- When a vacancy arises, each eligible organisation listed at 3.5.1 will be invited to make one nomination for each role (one for acute and one for mental health) .
- Eligible organisations may nominate individuals from their own organisation or another organisation.
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 10 working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c):
- If the number of nominations is equal to the number of partner member roles, there will be a confirmation process with the ICB Chair to ensure that the nominated partner member meets the criteria for board membership including the requirements of the role description and person specification and the disqualification criteria.
- In the event that there is more than one suitable nominee for each of the partner member roles, the full list of nominees will be considered by a panel convened by the Chief Executive.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is

initiated) and will confirm that nominees meet the requirements set out in clause 3.5.2 and 3.5.3.

- The panel will select the most suitable nominee for appointment via the shortlisting, interview, and selection process set out in the Governance Handbook.

c) Chair's approval:

- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.5.6 The term of office for these Partner Members will be three years and the total number of terms they may serve is three terms. However, where more than one trust can act on behalf of their sector the nomination and selection process will be revisited at the end of each term at the discretion of the Chair.

3.6 Partner Member - providers of primary medical services

3.6.1 This Partner Member is jointly nominated by providers of primary medical services for the purposes of the health service within the ICB's area and that are primary medical services contract holders responsible for the provision of essential services within core hours to a list of registered persons for whom the ICB has core responsibility.

3.6.2 The list of relevant providers of primary medical services for this purpose is published as part of the Governance Handbook. The list will be kept up to date but does not form part of this constitution.

3.6.3 This member must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be registered with the General Medical Council.
b) Be a practising provider of primary medical services within the ICB area.
c) Work as a GP in the ICB area for a minimum of 1 session per week.
d) Fulfil the requirements relating to the relevant experience, knowledge, skills and attributes set out in a role specification.

3.6.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.6.5 This member will be appointed by the ICB Chief Executive subject to the approval of the Chair.

3.6.6 The appointment process will be as follows:

a) Joint Nomination:

- When a vacancy arises, each eligible organisation described at 3.6.1 and listed in the Governance Handbook will be invited to make one nomination.

- Each nomination must be seconded by one of the other eligible organisations described at 3.6.1 and listed in the Governance Handbook.
- Eligible organisations may nominate an individual from their own organisation or another organisation.
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 10 working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c):
   - If the number of nominations is equal to the number of partner member roles, there will be a confirmation process with the ICB Chair to ensure that the nominated partner member meets the criteria for board membership including the requirements of the role description and person specification and the disqualification criteria.
   - In the event that there is more than one suitable nominee for the role, the full list of nominees will be considered by a panel convened by the Chief Executive.
   - The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.6.3 and 3.6.4.
   - The panel will select the most suitable nominee for appointment via the shortlisting, interview, and selection process set out in the Governance Handbook.

c) Chair's approval:
   - The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.6.7 The term of office for this Partner Member will be three years, subject to re-appointment following the process described in 3.6.5, and the total number of terms they may serve is three terms.

3.7 Partner Members - local authorities

3.7.1 These Partner Members are jointly nominated by the upper tier local authorities whose areas coincide with, or include the whole or any part of, the ICB's area. Those local authorities are:

a) Essex County Council
b) Southend on Sea City Council

c) Thurrock Council

3.7.2 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be the Chief Executive or hold a relevant Executive level role of one of the bodies listed at 3.7.1.
~~b)~~ The ICB is seeking knowledge and experience covering the full breadth of the ICB geography, its range of health and care services and professions.
a) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.7.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.7.4 This member will be recommended for appointment by the ICB Chief Executive subject to the approval of the Chair.

3.7.5 The appointment process will be as follows:

a) Joint Nomination:
- When a vacancy arises, each eligible organisation listed at 3.7.1 will be invited to make one nomination for each role.
- Eligible organisations may nominate individuals from their own organisation or another organisation.
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 10 working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c):
- If the number of nominations is equal to the number of partner member roles, there will be a confirmation process with the ICB Chair to ensure that the nominated partner member meets the criteria for board membership including the requirements of the role description and person specification and the disqualification criteria.
- In the event that there is more than one suitable nominee for each of the partner member roles, the full list of nominees will be considered by a panel convened by the Chief Executive.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is

initiated) and will confirm that nominees meet the requirements set out in clause 3.7.2 and 3.7.3.

- The panel will select the most suitable nominee for appointment via the shortlisting, interview and selection process set out in the Governance Handbook.

c) Chair's approval:

- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.7.6 The term of office for these Partner Members will be three years and the total number of terms they may serve is three terms.

3.8 Medical Director

3.8.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.
b) Be a registered Medical Practitioner.
c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.8.1 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.8.2 This member will be appointed by the ICB Chief Executive subject to the approval of the Chair.

3.9 Chief Nurse

3.9.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.
b) Be a registered Nurse.
c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.9.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.9.3 This member will be appointed by the ICB Chief Executive subject to the approval of the Chair.

3.10 Director of Resources

3.10.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.
b) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.10.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.10.3 This member will be appointed by the ICB Chief Executive subject to the approval of the Chair.

3.11 Non-Executive Members

3.11.1 The ICB will appoint three Non-executive Members.

3.11.2 These members will be appointed at the recommendation of the selection panel subject to the approval of the Chair of the ICB.

3.11.3 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Not be employee of the ICB or a person seconded to the ICB.
b) Not hold a role in another health and care organisation in the ICB area.
c) One member shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit Committee.
d) One other member should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration Committee.
e) A third member with specific knowledge, skills and experience that makes them suitable for their role.
f) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.11.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.
b) They hold a role in another health and care organisation within the ICB area.

3.11.5 The term of office for a non-executive member will be three years and the total number of terms an individual may serve is three terms, after which they will no longer be eligible for re-appointment.

3.11.6 Initial appointments may be for a shorter period in order to avoid all Non-executive Members retiring at once. Thereafter, new appointees will ordinarily retire on the date that the individual they replaced was due to retire in order to provide continuity.

3.11.7 Subject to satisfactory appraisal, the Chair may approve the re-appointment of a non-executive member up to the maximum number of terms permitted for their role.

3.11.8 One of the Non-executive Members, other than the Audit Chair, will be appointed by the Chair as Vice Chair of the ICB.

3.12 Other Board Members – Chief People Officer

3.12.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act.

3.12.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.12.3 This member will be appointed by the ICB Chief Executive subject to the approval of the Chair.

3.13 Board Members: Removal from Office

3.13.1 Arrangements for the removal from office of board members is subject to the term of appointment and application of the relevant ICB policies and procedures.

3.13.2 With the exception of the Chair, board members shall be removed from office if any of the following occurs:

a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this constitution, regulations or guidance.
b) If they fail to attend two consecutive meetings to which they are invited or show a pattern of absence (unless such absence has been agreed with the Chair in extenuating circumstances). A subsequent meeting with the Chair shall take place to determine whether the individual is able to continue to hold office.
c) If they are deemed to not meet the expected standards of performance at their annual appraisal.
d) If they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the ICB and is likely to bring the ICB into disrepute. This includes but it is not limited to dishonesty; misrepresentation (either knowingly or fraudulently);

defamation of any member of the ICB (being slander or libel); abuse of position; non-declaration of a known conflict of interest; seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise.

e) If they are deemed to have failed to uphold the Nolan Principles of Public Life.
f) If they are deemed to have failed to uphold the principles of the East of England Leadership Compact.

3.13.3 Members may be suspended pending the outcome of an investigation into whether any of the matters in 3.13.2 apply.

3.13.4 Executive Directors (including the Chief Executive) will cease to be board members if their employment in their specified role ceases, regardless of the reason for termination of the employment.

3.13.5 The Chair of the ICB may be removed by NHS England, subject to the approval of the Secretary of State.

3.13.6 If NHS England is satisfied that the ICB is failing or has failed to discharge any of its functions or that there is a significant risk that the ICB will fail to do so, it may:

a) Terminate the appointment of the ICB's Chief Executive; and
b) Direct the Chair of the ICB as to which individual to appoint as a replacement and on what terms.

3.14 Terms of Appointment of Board Members

3.14.1 With the exception of the Chair and Non-executive Members, arrangements for remuneration and any allowances will be agreed by the Remuneration Committee in line with the ICB remuneration policy and any other relevant policies published on the ICB website and any guidance issued by NHS England or other relevant body. Remuneration for Chairs will be set by NHS England. Remuneration for Non-executive Members will be set by a Non-executive Member remuneration panel, as set out in the Governance Handbook.

3.14.2 Other terms of appointment will be determined by the Remuneration Committee.

3.14.3 Terms of appointment of the Chair will be determined by NHS England.

3.15 Specific arrangements for appointment of Ordinary Members made at establishment

3.15.1 Individuals may be identified as "designate ordinary members" prior to the ICB being established.

3.15.2 Relevant nomination procedures for partner members in advance of establishment are deemed to be valid so long as they are undertaken in full and in accordance with the provisions of 3.5 to 3.7.

3.15.3 Any appointment and assessment processes undertaken in advance of establishment to identify designate ordinary members should follow, as far as possible, the processes set out in section 3.5-3.12 of this constitution. However, a modified process, agreed by the Chair, will be considered valid.

3.15.4 On the day of establishment, a committee consisting of the Chair, Chief Executive and one other will appoint the ordinary members who are expected to be all individuals who have been identified as designate appointees pre ICB establishment and the Chair will approve those appointments.

3.15.5 For the avoidance of doubt, this clause is valid only in relation to the appointments of the initial ordinary members and all appointments post establishment will be made in accordance with clauses 3.5 to 3.12.

4 Arrangements for the exercise of our functions

4.1 Good Governance

4.1.1 The ICB will, at all times, observe generally accepted principles of good governance. This includes the Seven Principles of Public Life (the Nolan Principles) and any governance guidance issued by NHS England.

4.2 General

4.2.1 The ICB will:

a) Comply with all relevant laws including but not limited to the 2006 Act and the duties prescribed within it and any relevant regulations.
b) Comply with directions issued by the Secretary of State for Health and Social Care.
c) Comply with directions issued by NHS England.
d) Have regard to statutory guidance including that issued by NHS England.
e) Take account, as appropriate, of other documents, advice and guidance issued by relevant authorities, including that issued by NHS England.
f) Respond to reports and recommendations made by local Healthwatch organisations within the ICB area.

4.2.2 The ICB will develop and implement the necessary systems and processes to comply with (a)-(f) above, documenting them as necessary in this constitution, its Governance Handbook and other relevant policies and procedures as appropriate.

4.3 Authority to Act

4.3.1 The ICB is accountable for exercising its statutory functions and may grant authority to act on its behalf to:

a) Any of its members or employees.
b) A committee or sub-committee of the ICB.

4.3.2 Under section 65Z5 of the 2006 Act, the ICB may arrange with another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority or any other body prescribed in Regulations, for the ICB's functions to be exercised by or jointly with that other body or for the functions of that other body to be exercised by or jointly with the ICB. Where the ICB and other body enters such arrangements, they may also arrange for the functions in question to be exercised by a joint committee of theirs and/or for the establishment of a pooled fund to fund those functions (section 65Z6). In addition, under section 75 of the 2006 Act, the ICB may enter into partnership arrangements with a Local Authority under which the Local Authority exercises specified ICB functions or the ICB exercises specified Local Authority functions, or the ICB and Local Authority establish a pooled fund.

4.3.3 Where arrangements are made under section 65Z5 or section 75 of the 2006 Act the board must authorise the arrangement, which must be described as appropriate in the SoRD.

4.4 Scheme of Reservation and Delegation (SoRD)

4.4.1 The ICB has agreed a scheme of reservation and delegation (SoRD) which is published in full in the Governance Handbook on the ICB website.

4.4.2 Only the board may agree the SoRD and amendments to the SoRD may only be approved by the board.

4.4.3 The SoRD sets out:

a) Those functions that are reserved to the board.
b) Those functions that have been delegated to an individual or to committees and sub committees.
c) Those functions delegated to another body or to be exercised jointly with another body, under section 65Z5 and 65Z6 of the 2006 Act.

4.4.4 The ICB remains accountable for all of its functions, including those that it has delegated. All those with delegated authority are accountable to the board for the exercise of their delegated functions.

4.5 Functions and Decision Map

4.5.1 The ICB has prepared a Functions and Decision Map which sets out at a high level its key functions and how it exercises them in accordance with the SoRD.

4.5.2 The Functions and Decision Map is published in the Governance Handbook on the ICB website.

4.5.3 The map includes:

a) Key functions reserved to the board of the ICB.
b) Commissioning functions delegated to committees and individuals.
c) Commissioning functions delegated under section 65Z5 and 65Z6 of the 2006 Act to be exercised by, or with, another ICB, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body.
d) Functions delegated to the ICB (for example, from NHS England).

4.6 Committees and Sub-Committees

4.6.1 The ICB may appoint committees and arrange for its functions to be exercised by such committees. Each committee may appoint sub-committees and arrange for the functions exercisable by the committee to be exercised by those sub-committees.

4.6.2 All committees and sub-committees are listed in the SoRD.

4.6.3 Each committee and sub-committee established by the ICB operates under terms of reference agreed by the board. All terms of reference are published in the Governance Handbook.

4.6.4 The board remains accountable for all functions, including those that it has delegated to committees and sub-committees and therefore appropriate reporting and assurance arrangements are in place and documented in terms of reference. All committees and sub-committees that fulfil delegated functions of the ICB will be required to:

a) Submit regular decision or assurance reports to the board.
b) Ensure attendance at board meetings of either the Chair or deputy Chair, when requested by the ICB Chair.
c) Comply with internal audit and external audit recommendations and the recommendations of committee effectiveness reviews.
d) Specify the arrangements for their meetings in their terms of reference in line with the standing orders or any specified alternative arrangements.

4.6.5 Any committee or sub-committee established in accordance with clause 4.6 may consist of or include persons who are not ICB Members or employees.

4.6.6 All members of committees and sub-committees that exercise the ICB commissioning functions will be approved by the Chair. The Chair will not approve an individual to such a committee or sub-committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

4.6.7 All members of committees and sub-committees are required to act in accordance with this constitution, including the Standing Orders as well as the SFIs and any other relevant ICB policy.

4.6.8 The following committees will be maintained:

a) **Audit Committee:** This committee is accountable to the board and provides an independent and objective view of the ICB's compliance with its statutory responsibilities. The committee is responsible for arranging appropriate internal and external audit.

The Audit Committee will be chaired by a Non-executive Member (other than the Chair of the ICB) who has the qualifications, expertise or experience to enable them to express credible opinions on finance and audit matters.

b) **Remuneration Committee:** This committee is accountable to the board for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB.

The Remuneration Committee will be chaired by a Non-executive Member other than the Chair or the Chair of Audit Committee.

4.6.9 The terms of reference for each of the above committees are published in the Governance Handbook.

4.6.10 The board has also established a number of other committees to assist it with the discharge of its functions. These committees are set out in the SoRD and further information about these committees, including terms of reference, are published in the Governance Handbook.

4.7 Delegations made under section 65Z5 of the 2006 Act

4.7.1 As per 4.3.2 the ICB may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other relevant bodies (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body).

4.7.2 All delegations made under these arrangements are set out in the ICB Scheme of Reservation and Delegation and included in the Functions and Decision Map.

4.7.3 Each delegation made under section 65Z5 of the Act will be set out in a delegation arrangement which sets out the terms of the delegation. This may, for joint arrangements, include establishing and maintaining a pooled fund. The power to approve delegation arrangements made under this provision will be reserved to the board.

4.7.4 The board remains accountable for all the ICB's functions, including those that it has delegated and therefore appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation and these are detailed in the delegation arrangements, summaries of which will be published in the Governance Handbook.

4.7.5 In addition to any formal joint working mechanisms, the ICB may enter into strategic or other transformation discussions with its partner organisations on an informal basis.

5 Procedures for Making Decisions

5.1 Standing Orders

5.1.1 The ICB has agreed a set of standing orders which describe the processes that are employed to undertake its business. They include procedures for:

- Conducting the business of the ICB.
- The procedures to be followed during meetings.
- The process to delegate functions.

5.1.2 The Standing Orders apply to all committees and sub-committees of the ICB unless specified otherwise in terms of reference which have been agreed by the board.

5.1.3 A full copy of the Standing Orders is included in Appendix 2 and forms part of this constitution.

5.2 Standing Financial Instructions (SFIs)

5.2.1 The ICB has agreed a set of Standing Financial Instructions (SFIs) which include the delegated limits of financial authority set out in the SoRD.

5.2.2 A copy of the SFIs is published in the Governance Handbook on the ICB website.

6 Arrangements for Conflict of Interest Management and Standards of Business Conduct

6.1 Conflicts of Interest

6.1.1 As required by section 14Z30 of the 2006 Act, the ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

6.1.2 The ICB has agreed policies and procedures for the identification and management of conflicts of interest which are published on the website.

6.1.3 All board, committee and sub-committee members and employees of the ICB will comply with the ICB policy on conflicts of interest in line with their terms of office and/or employment. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.

6.1.4 All delegation arrangements made by the ICB under Section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures comparable with those of the ICB.

6.1.5 Where an individual, including any individual directly involved with the business or decision-making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict and is subject to the provisions of this constitution, the Conflicts of Interest Policy and the Standards of Business Conduct Policy.

6.1.6 The ICB has appointed the Audit Chair to be the Conflicts of Interest Guardian. In collaboration with the ICB's governance lead, their role is to:

a) Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest.
b) Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest.
c) Support the rigorous application of conflict of interest management principles and policies.
d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation.
e) Provide advice on minimising the risks of conflicts of interest.

6.2 Principles

6.2.1 In discharging its functions, the ICB will abide by the principles of the East of England Leadership Compact, and the following principles:

a) Subsidiarity: arrangements should be designed to facilitate decisions being taken as close to local communities as possible, and at a larger scale where there are clear benefits from collaborative approaches and economies of scale.
b) Population-focused vision: decisions should be consistent with a clear vision and strategy that reflects the four core purposes
c) Shared understanding: partners should have a collective understanding of the opportunities available by working together and the impact of individual organisational decisions on other parts of the system.
d) Co-design and co-production: addressing system challenges and decision-making should involve working with people, communities, clinicians and professionals in an equal way, sharing influence, skills and experience to design, deliver and monitor services and projects.
e) Timely access to information and data: system partners should share accurate and complete data (quantitative and qualitative) in an open and timely manner to enable effective decision-making.
f) Clear and transparent decision-making: system partners should work in an open way ensuring that decision-making processes stand up to independent scrutiny.

6.3 Declaring and Registering Interests

6.3.1 The ICB maintains registers of the interests of:

a) Members of the ICB.
b) Members of the board's committees and sub-committees.
c) Its employees.

6.3.2 In accordance with section 14Z30(2) of the 2006 Act registers of interest are published on the ICB website.

6.3.3 All relevant persons as per 6.1.3 and 6.1.5 must declare any conflict or potential conflict of interest relating to decisions to be made in the exercise of the ICB's commissioning functions.

6.3.4 Declarations should be made as soon as reasonably practicable after the person becomes aware of the conflict or potential conflict and in any event within 28 days. This could include interests an individual is pursuing. Interests will also be declared on appointment and during relevant discussion in meetings.

6.3.5 All declarations will be entered in the registers as per 6.3.1.

6.3.6 The ICB will ensure that, as a matter of course, declarations of interest are made and confirmed or updated at least annually.

6.3.7 Interests (including gifts and hospitality) of decision-making staff will remain on the public register for a minimum of six months. In addition, the ICB will retain a record of historic interests and offers/receipt of gifts and hospitality for a minimum of six years after the date on which it expired. The ICB's published register of interests states that historic interests are retained by the ICB for the specified timeframe and details of whom to contact to submit a request for this information.

6.3.8 Activities funded in whole or in part by third parties who may have an interest in ICB business such as sponsored events, posts and research will be managed in accordance with the ICB policy to ensure transparency and that any potential for conflicts of interest are well-managed.

6.4 Standards of Business Conduct

6.4.1 Board members, employees, committee and sub-committee members of the ICB will at all times comply with this constitution and be aware of their responsibilities as outlined in it. They should:

a) Act in good faith and in the interests of the ICB.
b) Follow the Seven Principles of Public Life set out by the Committee on Standards in Public Life (the Nolan Principles).
c) Comply with the ICB Standards of Business Conduct Policy and any requirements set out in the policy for managing conflicts of interest.
d) Be willing to uphold the principles of the East of England Leadership Compact.

6.4.2 Individuals contracted to work on behalf of the ICB or otherwise providing services or facilities to the ICB will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the ICB's Standards of Business Conduct policy.

7 Arrangements for ensuring Accountability and Transparency

7.1 Principles

7.1.1 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 11(2) of Schedule 1B to the 2006 Act.

7.2 Meetings and publications

7.2.1 Board meetings, and committees composed entirely of board members or which include all board members, will be held in public except where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest.

7.2.2 Papers and minutes of all meetings held in public will be published.

7.2.3 Annual accounts will be externally audited and published.

7.2.4 A clear complaints process will be published.

7.2.5 The ICB will comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the ICB.

7.2.6 Information will be provided to NHS England as required.

7.2.7 The constitution and Governance Handbook will be published as well as other key documents including but not limited to:

a) Conflicts of interest policy and procedures.
b) Registers of interests.
c) Other key documents and policies, as appropriate.

7.2.8 The ICB will publish, with our partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years. The plan will explain how the ICB proposes to discharge its duties under:

- Sections 14Z34 to 14Z45 (general duties of integrated care boards), and
- Sections 223GB and 223N (financial duties).

And

- Proposed steps to implement the Integrated Care Strategy, having due regard to the Essex Joint Health and Wellbeing Strategy, Southend Health and Wellbeing Strategy, and Thurrock Health and Wellbeing Strategy.

7.3 Scrutiny and Decision Making

7.3.1 At least three Non-executive Members will be appointed to the board, including the Chair, and all of the board and committee members will comply with the Seven Principles of Public Life (the Nolan Principles) and meet the criteria described in the fit and proper person test.

7.3.2 Healthcare services will be arranged in a transparent way, and decisions around who provides services will be made in the best interests of patients, taxpayers and the population, in line with the rules set out in the NHS Provider Selection Regime.

7.3.3 The ICB will comply with the requirements of the NHS Provider Selection Regime including:

a) Complying with existing procurement rules until the provider selection regime comes into effect.

7.3.4 The ICB will comply with local authority health overview and scrutiny requirements.

7.3.5 The ICB will comply with the current procurement regulations at the time for all non-clinical goods/services purchases.

7.4 Annual Report

7.4.1 The ICB will publish an Annual Report in accordance with any guidance published by NHS England and which sets out how it has discharged its functions and fulfilled its duties in the previous financial year. An annual report must in particular:

a) Explain how the ICB has discharged its duties under section 14Z34 to 14Z45 and 14Z49 (general duties of integrated care boards).
b) Review the extent to which the ICB has exercised its functions in accordance with the plans published under section 14Z52 (forward plan) and section 14Z56 (capital resource use plan).
c) Review the extent to which the ICB has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised), and
d) Review any steps that the ICB has taken to implement any joint local health and wellbeing strategy to which it was required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.

8 Arrangements for Determining the Terms and Conditions of Employees.

8.1.1 The ICB may appoint employees, pay them remuneration and allowances as it determines and appoint staff on such terms and conditions as it determines.

8.1.2 The board has established a Remuneration Committee which is chaired by a Non-executive member other than the Chair or Audit Chair.

8.1.3 The membership of the Remuneration Committee is determined by the board. No employees may be a member of the Remuneration Committee, but the board ensures that the Remuneration Committee has access to appropriate advice by:

a) HR advisers being in attendance at meetings.

8.1.4 The board may appoint independent members or advisers to the Remuneration Committee who are not members of the board.

8.1.5 The main purpose of the Remuneration Committee is to exercise the functions of the ICB regarding remuneration included in paragraphs 18 to 20 of Schedule 1B to the 2006 Act. The terms of reference agreed by the board are published in the Governance Handbook on the ICB website.

8.1.6 The duties of the Remuneration Committee include:

a) Determining the remuneration of the Chief Executive, Directors and other Very Senior Managers and board members (other than Non-executive Members).
b) Determining arrangements for the termination of employment and other contractual and non-contractual terms of the Chief Executive, Directors and other Very Senior Managers and board members (other than Non-executive Members).
c) Agreeing the pay framework for clinical staff working within the ICB but outside of Agenda for Change Terms and Conditions.
d) Overseeing any discretionary payments outside of Agenda for Change pay policy for all staff.
e) Determining the arrangements for termination payments and any special payments for all staff.

8.1.7 The ICB may make arrangements for a person to be seconded to serve as a member of the ICB's staff.

9 Arrangements for Public Involvement

9.1.1 In line with section 14Z45(2) of the 2006 Act, the ICB has made arrangements to secure that individuals to whom services which are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:

a) The planning of the commissioning arrangements by the Integrated Care Board.
b) The development and consideration of proposals by the ICB.
c) Changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals (at the point when the service is received by them), or the range of health services available to them.
d) Decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

9.1.2 In line with section 14Z54 of the 2006 Act, the ICB has made the following arrangements to engage with its population on its system plan:

a) Overarching strategic communications and involvement planning through the system communications and engagement network in collaboration with partners across the ICS including NHS, local authority, community and voluntary sector organisations and through alliances.
b) Partner-led local conversations and awareness raising, community assets and place-based involvement plans.
c) Clinical and managerial involvement.
d) Communications and conversations with the population that are clinically and professionally informed and led.
e) Patient and public involvement in the development of communication materials and assets as appropriate.
f) Detailed conversations with professional bodies and trade unions.
g) Complying with Health Overview and Scrutiny requirements.

9.1.3 The ICB has adopted the ten principles set out by NHS England for working with people and communities, set out below.

a) Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.
b) Start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions.
c) Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.
d) Build relationships with excluded groups – especially those affected by inequalities.

e) Work with Healthwatch and the voluntary, community and social enterprise sector as key partners.
f) Provide clear and accessible public information about vision, plans and progress to build understanding and trust.
g) Use community development approaches that empower people and communities, making connections to social action.
h) Use co-production, insight and engagement to achieve accountable health and care services.
i) Co-produce and redesign services and tackle system priorities in partnership with people and communities.
j) Learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places.

9.1.4 In addition, the ICB has set out its vision for community involvement in more detail in the mid and south Essex patient and public engagement policy which can be found on the ICB website.

9.1.5 These principles will be used when developing and maintaining arrangements for engaging with people and communities.

9.1.6 These arrangements include a range of engagement activities, including, but not limited to patient participation groups, 'Virtual Views' citizens' panel and targeted outreach sessions. The ICB will have lead responsibility for the ICS engagement framework and provide advice, guidance and training to encourage a culture of co-production among wider teams to support its delivery as close to our communities as possible.

Appendix 1: Definitions of terms used in this Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022.
ICB board	Members of the ICB.
Area	The geographical area that the ICB has responsibility for, as defined in part 2 of this constitution.
Committee	A committee created and appointed by the ICB board.
Sub-committee	A committee created and appointed by and reporting to a committee.
Integrated Care Partnership	The joint committee for the ICB's area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's area.
Place-Based Partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the Integrated Care Board, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities, as well as primary care provider leadership, represented by Primary Care Network clinical directors or other relevant primary care leaders. In mid and south Essex these are also referred to as 'Alliances'.
Ordinary Member	The board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the board are referred to as Ordinary Members.
Partner Members	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are and appointed in accordance with the procedures set out in Section 3 having been nominated by the following: • NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description. • The primary medical services (general practice) providers within the area of the ICB and are of a prescribed description.

	• The local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.
Director of Finance	Known locally as the Director of Resources.
Health Service Body	Health service body as defined by section 9(4) of the NHS Act 2006 or (b) NHS foundation trusts.

Appendix 2: Standing Orders

1 Introduction

1.1 These Standing Orders have been drawn up to regulate the proceedings of Mid and South Essex Integrated Care Board so that the ICB can fulfil its obligations as set out largely in the 2006 Act (as amended). They form part of the ICB's constitution.

2 Amendment and review

2.1 The Standing Orders are effective from 1 July 2022.

2.2 The Standing Orders will be reviewed on an annual basis or sooner if required.

2.3 Amendments to these Standing Orders will be made as per clause 1.5.2 of the Constitution.

2.4 All changes to these Standing Orders will require an application to NHS England for variation to the ICB Constitution and will not be implemented until the Constitution has been approved.

3 Interpretation, application and compliance

3.1 Except as otherwise provided, words and expressions used in these Standing Orders shall have the same meaning as those in the main body of the ICB constitution and as per the definitions in Appendix 1.

3.2 These Standing Orders apply to all meetings of the board, including its committees and sub-committees, unless otherwise stated. All references to the board are inclusive of committees and sub-committees unless otherwise stated.

3.3 All members of the board, members of committees and sub-committees and all employees should be aware of the Standing Orders and comply with them. Failure to comply may be regarded as a disciplinary matter.

3.4 In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from the relevant Director, will provide a settled view which shall be final.

3.5 All members of the board, its committees and sub-committees and all employees have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

3.6 If, for any reason, these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the board for action or ratification and the Audit Committee for review.

4 Meetings of the Integrated Care Board

4.1 Calling Board Meetings

4.1.1 Meetings of the board of the ICB shall be held at regular intervals at such times and places as the ICB may determine.

4.1.2 In normal circumstances, each member of the board will be given not less than one month's notice in writing of any meeting to be held. However:

a) The Chair may call a meeting at any time by giving not less than 14 calendar days' notice in writing.
b) One third of the members of the board may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the board members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the board specifying the matters to be considered at the meeting.
c) In emergency situations the Chair may call a meeting with two calendar days' notice by setting out the reason for the urgency and the decision to be taken.

4.1.3 A public notice of the time and place of meetings to be held in public and how to access the meeting shall be given by posting it at the offices of the ICB body and electronically at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.

4.1.4 The agenda and papers for meetings to be held in public will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting that is not likely to be open to the public.

4.2 Chair of a meeting

4.2.1 The Chair of the ICB shall preside over meetings of the board.

4.2.2 If the Chair, or Vice Chair, is absent, or is disqualified from participating by a conflict of interest, the assembled members may appoint a temporary deputy to preside over meetings of the board.

4.2.3 The ICB board, acting on the advice of the Chair, shall appoint a Chair to all committees and sub-committees that it has established. The appointed committee or sub-committee Chair will preside over the relevant meeting. Terms of reference for committees and sub-committees will specify arrangements for occasions when the appointed Chair is absent.

4.3 Agenda, supporting papers and business to be transacted

4.3.1 The agenda for each meeting will be drawn up and agreed by the Chair of the meeting.

4.3.2 Except where the emergency provisions apply, supporting papers for all items must be submitted at least seven calendar days before the meeting takes place. The agenda and supporting papers will be circulated to all members of the board at least five calendar days before the meeting.

4.3.3 Agendas and papers for meetings open to the public, including details about meeting dates, times and venues, will be published on the ICB's website at www.midandsouthessex.ics.nhs.uk

4.4 Petitions

4.4.1 Where a valid petition has been received by the ICB it shall be reviewed in accordance with the arrangements published in the Governance Handbook.

4.5 Arrangements governing absence from Board meetings

4.5.1 With the permission of the person presiding over the meeting, the Executive Directors and the Partner Members of the board may nominate a deputy to attend a meeting of the board that they are unable to attend. The deputy may speak but may not vote on their behalf.

4.5.1 The decision of the person presiding over the meeting regarding authorisation of nominated deputies is final.

4.5.2 If a member of the ICB is unable to attend two consecutive meetings, other than as a result of illness or other exceptional circumstances, the member will meet with the Chair to determine their future ability to fulfil their role.

4.6 Virtual attendance at meetings

4.6.1 The board of the ICB and its committees and sub-committees may meet virtually using telephone, video and other electronic means when necessary, unless the terms of reference prohibit this. Arrangements for governing this process are included in the Governance Handbook.

4.7 Quorum

4.7.1 The quorum for meetings of the board will be seven members, including at least the following:

a) Either the Chair or Vice Chair.
b) Either the Chief Executive or the Director of Resources.
c) Either the Medical Director or the Chief Nurse.
d) At least one other independent member
e) At least one Partner Member.

4.7.2 For the sake of clarity:

a) No person can act in more than one capacity when determining the quorum.
b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest shall no longer count towards the quorum.

4.7.3 For all committees and sub-committees, the details of the quorum for these meetings and status of deputies are set out in the appropriate terms of reference.

4.8 Vacancies and defects in appointments

4.8.1 The validity of any act of the ICB is not affected by any vacancy among members or by any defect in the appointment of any member.

4.8.2 In the event of vacancy or defect in appointment the following temporary arrangement for quorum will apply:

a) For a limited period, the quorum will be reduced by one per vacancy.

4.9 Decision making

4.9.1 The ICB has agreed to use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.

4.9.2 Generally, it is expected that decisions of the ICB will be reached by consensus. Should this not be possible then a vote will be required. The process for voting, which should be considered a last resort, is set out below:

a) All members of the board who are present at the meeting will be eligible to cast one vote each.
b) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote, but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.
c) For the sake of clarity, any additional participants and observers will not have voting rights.
d) A resolution will be passed if more votes are cast for the resolution than against it.
e) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.
f) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

Disputes

4.9.3 Where helpful, the board may draw on third party support to assist them in resolving any disputes, such as peer review or support from NHS England.

Urgent Decisions

4.9.4 In the event of extraordinary circumstances requiring urgent decisions to be taken, every attempt will be made for the board to meet virtually. Where this is not possible the following will apply:

4.9.5 The powers which are reserved or delegated to the board may for an urgent decision be exercised by the Chair and Chief Executive (or relevant lead director in the case of committees) subject to every effort having made to consult with as many members as possible in the given circumstances (minimum of one other member).

4.9.6 The exercise of such powers shall be reported to the next formal meeting of the board (or committee in the case of committee urgent decisions) for formal ratification and Board urgent decisions will be reported to the Audit Committee for oversight.

4.10 Minutes

4.10.1 The names and roles of all members present shall be recorded in the minutes of the meetings.

4.10.2 The minutes of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be approved by the person presiding at it.

4.10.3 No discussion shall take place upon the minutes except upon their accuracy or where the person presiding over the meeting considers discussion appropriate.

4.10.4 Where providing a record of a meeting held in public, the minutes shall be made available to the public.

4.11 Admission of public and the press

4.11.1 In accordance with Public Bodies (Admission to Meetings) Act 1960 all meetings of the board and all meetings of committees which are comprised of entirely board members or all board members at which public functions are exercised will be open to the public.

4.11.2 The board may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

4.11.3 The person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the board's business shall be conducted without interruption and disruption.

4.11.4 As permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 as amended from time to time the public may be excluded from a meeting to suppress or prevent disorderly conduct or behaviour.

4.11.5 Matters to be dealt with by a meeting following the exclusion of representatives of the press and other members of the public shall be confidential to the members of the board.

5 Suspension of Standing Orders

5.1.1 In exceptional circumstances, except where it would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or NHS England, any part of these Standing Orders may be suspended by the Chair in discussion with at least two other members.

5.1.2 A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

5.1.3 A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Audit Committee for review of the reasonableness of the decision to suspend Standing Orders.

6 Use of seal and authorisation of documents

6.1.1 The ICB will use a seal for executing documents where necessary.

6.1.2 The seal shall be kept by the Chief Executive or a nominated manager in a secure place.

6.1.3 The following individuals or officers are authorised to authenticate use of the seal by their signature:

- The Chief Executive.
- The ICB Chair.
- The Director of Resources.

6.1.4 The full procedure and other conditions for the use of the seal, including the register of sealing, are included in the Governance Handbook.

Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

Part I Board Meeting

Date of meeting	1 July 2022
Agenda item number	5
Title of report	Scheme of Reservation and Delegation (including Functions and Decisions Map)
Purpose of report.	To present for approval the Scheme of Reservation and Delegation and Functions & Decisions Map.
Executive Lead	Anthony McKeever, Chief Executive Officer
Report Author	Nicola Adams, Associate Director of Corporate Governance
Impact Assessments	Not Applicable
Financial implications	None
Details of patient or public engagement or consultation.	Not Applicable
Conflicts of Interest:	None Identified
Recommendation(s)	The Board is asked to: • Approve the ICB Scheme of Reservation and Delegation and Functions & Decisions Map.

Scheme of Reservation and Delegation (SORD), including Functions & Decisions Map

1. Introduction

The Scheme of Reservation and Delegation (SORD) and Functions & Decisions Map are fundamental governance documents referenced within the ICB Constitution that set out the decision-making framework for the Mid and South Essex Integrated Care Board (ICB).

2. Main Report

The SORD, developed in accordance with the template issued by NHS England, documents the decisions reserved to the ICB Board and those functions/decisions that are delegated by the Board to Committees; to be exercised jointly; to other statutory bodies (currently there are none); to individual Board Members or employees; delegated to the Board by other organisations (such as delegated commissioning); and the schedule of detailed delegated financial limits (setting out the thresholds for decision making).

The SORD was developed from the governance arrangements within the ICB Constitution and Standing Orders, Committee Terms of Reference and key documents that set out how the ICB will operate and how its functions will be delivered. The Audit Committees of the former mid and south Essex Clinical Commissioning Groups received and reviewed the SORD and recommend it to the ICB for approval.

The Functions & Decisions Map show where and how decisions will be made by the ICB and Committees in accordance with the SORD and in the context of the wider integrated care system. It accords to the requirements of NHS England as a public facing document to articulate the decision-making processes of the ICB.

3. Conclusion

Both the SORD and the Functions & Decisions Map have been shared with the Executive Team, Chief Executive Officer and Chair and were submitted to NHS England as part of the Governance Handbook presented within the Readiness to Operate submission. Comments received on the documents have been incorporated into the latest revisions.

4. Recommendation

The Board is asked to approve the ICB Scheme of Reservation and Delegation and Functions & Decisions Map.

5. Appendices

Appendix A - Scheme of Reservation and Delegation

Appendix B - Functions & Decisions Map

Scheme of Reservation and Delegation

Decisions and functions reserved to the Board

Functions will be exercised by the Board unless they are delegated. This is the default position for any function that is not expressly delegated. The Board has set out specifically those matters it is choosing to reserve. The Board, regardless of any delegation arrangements it has made, remains legally accountable for the exercise of its functions.

	Decisions and functions reserved to the Board	Reference
The Board	**General Enabling Provision** The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers. The Board will establish the necessary systems and processes to comply with relevant law and regulations, directions issued by the Secretary of State, directions issued by NHS England, statutory guidance and advice issued by NHS England and relevant authorities and respond to reports and recommendations made by Healthwatch organisations in the ICB area.	Constitution 4.2.2
The Board	**Regulations and Control** Consider and approve proposed amendments to the ICB Constitution by the Chief Executive prior to making an application to vary the constitution to NHSE. Approve Standing Orders (SOs), a schedule of matters reserved to the Board (Scheme of Reservation and Delegation (SoRD)) of powers delegated from the Board to the Executive Team and other Committees, Functions and Decisions Map, Standing Financial Instructions (SFIs) and the Governance Handbook for the regulation of its proceedings and business. Approve to vary or amend the Standing Orders in accordance with the procedures for amending the Constitution as described above.	Constitution 1.6.2, Standing Orders 2.1.3, 2.1.4 Constitution 1.6.2, 1.7.2, 4.4.2, Standing Orders 2.1.3, 2.1.4 Constitution 1.6.2; Standing Orders 2.1.3

Scheme of Reservation and Delegation

	Decisions and functions reserved to the Board	Reference
	Approve delegation arrangements to ICB Committees, Joint Committees, to other Statutory Bodies, individual Board Members and employees is reserved to the Board. Including approval of committee terms of reference.	Constitution 4.6.1, 4.6.3, 4.6.6, 4.7.1
	The power to approve arrangements for Pooled Funds is reserved to the Board.	Constitution 4.7.3
	Approve arrangements for the management of conflicts of Interest defined within the Conflicts of Interest Policy, including publication of registers of interest.	Constitution 6.1.1, 6.3.2
	Require and receive the declaration of Board members' (and others as required) interests to discharge its duty to manage conflicts of interest.	Constitution 6.1.3, 6.1.4, 6.1.5, 6.3.1, 6.3.2, 6.3.7
	Approve arrangements for dealing with complaints and ensure a clear complaints process is published.	Constitution 7.2.4
	Ensure the ICB Complies with the Freedom of Information Act 2000 and Information Commissioner Office requirements.	Constitution 7.2.5
	Ensure systems and processes exist to comply with the requirements of the NHS Provider Selection Regime.	Constitution 7.3.2, 7.3.3
	Comply with Local Authority Health Overview and Scrutiny Requirements.	Constitution 7.3.4
	Ensure the ICB complies with all relevant procurement regulations.	Constitution 7.3.5
	Adopt the Executive structure to facilitate the discharge of business by the ICB and to agree modifications thereto except where these functions have been delegated to a Joint Committee.	

Scheme of Reservation and Delegation

	Decisions and functions reserved to the Board	Reference
	Receive reports from committees including those that the ICB is required by the Secretary of State or other regulation to establish and to action appropriately. Confirm the recommendations of the ICB's committees where the committees do not have executive powers. Approve arrangements relating to the discharge of the ICB's responsibilities as a corporate trustee for funds held on trust. Discipline members of the Board who are in breach of statutory requirements or SOs.	
The Board	**Appointments/Dismissal** Appoint the Ordinary Members of the Board, exercised by the Chair. Approve removal of members of the Board (other than the Chief Executive and Executive Members) at the recommendation of the Chair, to be executed by the Chair. The Chair of the ICB will be appointed by NHS England as set out within legislation. Appoint and dismiss other committees (and individual members) that are directly accountable to the Board. Appointment of Internal or External Auditors and the Counter Fraud officer following recommendations from the Audit Committee.	Constitution 2.1.5, 2.2.2, 2.2.4 Constitution 3.13 Constitution 4.6.1 Constitution 4.6.8
The Board	**Strategy, Annual Operational Plan and Budgets** Approve a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years. Approve and publish an Integrated Care System Plan and Capital Resource use Plan.	Constitution 7.2.8 Constitution 7.2.8, 7.4.1

Scheme of Reservation and Delegation

	Decisions and functions reserved to the Board	Reference
	Define the strategic aims and objectives of the ICB. Oversee and maintain accountability for the management of the ICB Risk Management Framework. Approve plans in respect of the application of available financial resources to support the agreed Annual Operational Plan (Financial Framework and Annual Budgets). Approve proposals for ensuring quality and developing clinical governance in services provided by the ICB or its constituent practices (ICB Quality Strategy), having regard to any guidance issued by the Secretary of State. Approve annually (with any necessary appropriate modification) the annual refresh of system plan. Approve and publish the ICB Engagement Framework setting out how the ICB complies with and delivers its duties to engage with the public. Approve Outline and Final Business Cases for Commissioning Investment if this represents a variation from the Plan, in line with the ICB SFIs and Schedule of Detailed Delegated Financial Limits.	Constitution 1.4.7 Constitution 9.1.7
The Board	**Policy Determination** Approve ICB Policies, except where delegated to specific committees for approval in accordance with the Committee Terms of Reference.	

Scheme of Reservation and Delegation

	Decisions and functions reserved to the Board	Reference
The Board	**Audit and Counter Fraud** Receive the annual management letter from the External Auditor and agreement of the Executive Team's proposed action, taking account of the advice, where appropriate, of the Audit Committee. Receive an annual report (and Head of Internal Audit Opinion) from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee. Receive an annual report from the Counter Fraud officer and agree action on recommendations where appropriate of the Audit Committee.	
The Board	**Annual Reports and Accounts** Receive and approve the ICB's Annual Report and Annual Accounts, to be externally audited and published. Receive and approve the Annual Report and Accounts for funds held on trust.	Constitution 7.2.3, 7.4.1
The Board	**Monitoring** Receipt of such reports as the Board sees fit from the Executive Team and other committees in respect of its exercise of powers delegated.	

Decisions and functions delegated by the Board to the ICB committees

Committee	Decisions and functions reserved to the Committee	Reference
Audit Committee	The Committee will, in accordance with the terms of reference of the Committee as approved by the Board as if written into the Scheme of Reservation and Delegation and	

Scheme of Reservation and Delegation

Committee	Decisions and functions reserved to the Committee	Reference
	ICB Constitution, provide oversight and assurance to the ICB Board on the adequacy of the governance, risk management and internal control processes within the ICB including: - Integrated governance, risk management and internal control - Internal Audit, External Audit and Counter Fraud - Freedom to Speak Up - Information Governance - Financial Reporting - Conflicts of Interest - Security - Governance - Emergency Planning, Preparedness and Resilience	Constitution 4.6.8
	The Audit Committee shall review instances of non-compliance with Standing Orders.	Standing Orders 3.1.6
Remuneration Committee	The Committee will, in accordance with the terms of reference of the Committee as approved by the Board as if written into the Scheme of Reservation and Delegation and ICB Constitution, exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006 and implement NHSE guidance, including: - Determining the remuneration of the Chief Executive, Directors and other Very Senior Managers and Board members (other than non-executive members). - Determining arrangements for the termination of employment and other contractual and non-contractual terms of the Chief Executive, Directors and other Very Senior Managers and Board members (other than non-executive members). - Agreeing the pay framework for clinical staff working within the ICB but outside of Agenda for Changes Terms and Conditions. - Determining the arrangements for termination payments and any special payments for all staff.	Constitution 3.14.1, 8.1.6
	The Remuneration Committee shall establish a Non-Executive Remuneration Panel to consider and agree arrangements for remuneration of Non-Executive Members.	Constitution 3.14.1

Scheme of Reservation and Delegation

Committee	Decisions and functions reserved to the Committee	Reference
Non-Executive Remuneration Panel	The Panel will, in accordance with the terms of reference of the Remuneration Committee as approved by the Board as if written into the Scheme of Reservation and Delegation and ICB Constitution exercise the function of setting the remuneration of Non-Executive Members of the Board.	Constitution 3.14.1
Finance & Investment Committee	The Committee will, in accordance with the terms of reference of the Committee as approved by the Board as if written into the Scheme of Reservation and Delegation and ICB Constitution: - Agree the financial framework including annual budgets - Make investment decisions /recommendations - Receive assurance on delivery of financial performance - Investigate any activity within its terms of reference.	
Quality & Safety Committee	The Committee will, in accordance with the terms of reference of the Committee as approved by the Board as if written into the Scheme of Reservation and Delegation and ICB Constitution, provide oversight and assurance that the ICB is delivering its functions in a way that secures continuous improvement in the quality of services (section 14Z34 of the Act) against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Bill 2021. This shall be reported within the ICB Annual Report. The committee is responsible for the development and implementation of the ICB's Quality Strategy, which sets out its plan for quality and safety and for assuring the Board of quality, safety and performance standards.	Constitution 7.4.1
System Oversight and Assurance Committee	The Committee will, in accordance with the terms of reference of the Committee as approved by the Board as if written into the Scheme of Reservation and Delegation and ICB Constitution, provide oversight on the delivery of performance and standards, key system programmes, enabling mutual accountability and providing assurance to the Board.	

Scheme of Reservation and Delegation

Committee	Decisions and functions reserved to the Committee	Reference
	The Group has no specific delegated powers for decision making but shall establish system leadership and partner groups to ensure the delivery of the system plan. It will assure system performance relating to agreed outcomes, quality and safety and operational performance against constitutional standards.	
Primary Care Commissioning Committee	The Committee will, in accordance with the terms of reference of the Committee as approved by the Board as if written into the Scheme of Reservation and Delegation and ICB Constitution, provide oversight and assurance to the ICB Board on the exercise of the ICB's delegated commissioning functions and any resources received for investment in primary care. The Committee will enable collective decisions on core contractual, quality and procurement of primary care services and oversee the Contracting framework for primary care, within their delegated budget approved by the ICB.	
Basildon & Brentwood Alliance Mid Essex Alliance South East Essex Alliance Thurrock Alliance	The Committee will, in accordance with the terms of reference of the Committee as approved by the Board as if written into the Scheme of Reservation and Delegation and ICB Constitution, contribute to the overall delivery of the ICS's objectives, create opportunities for the benefit of residents of the Alliances in accordance with Alliance Plans, to support health and wellbeing, bring care closer to home and to improve and transform services, undertaking appropriate local engagement and propose, co-ordinate and deliver local elements of the estates strategy. The committee will recommend to the Board the agreement of any Better Care Fund (BCF) and iBCF investment.	
Clinical & Multi-professional Congress	The Committee will, in accordance with the terms of reference of the Committee as approved by the Board as if written into the Scheme of Reservation and Delegation and ICB Constitution, act as an advisory committee providing clinical and multi-professional	

Scheme of Reservation and Delegation

Committee	Decisions and functions reserved to the Committee	Reference
	leadership to the system as well as involvement, advice and support to service development and transformation programmes. The Committee shall lead on Stewardship. The Committee has no delegated authority for decision making, however, must provide its oversight in order for decisions to be approved by the relevant Committee (such as the Finance & Investment Committee).	
System Leadership / Partner Groups	The system has established the following system leadership/partner groups: • System Leadership Group • System Finance Leaders Group • System Quality Group • Digital and Data • People Board • System Projects, Programmes & Performance The groups have no delegated powers, but function with the commitment that as a system all partners work to achieve the system plan as expected and that system aims and objectives are met. The groups report into the System Oversight and Assurance Group and thus are accountable to the ICB.	

Scheme of Reservation and Delegation

Decisions and functions delegated to be exercised jointly

Committee/entity that will exercise the function/decision	Decisions and functions delegated by the Board	Legal power	Governing arrangements
ICB/Essex County Council	**Better Care Fund** In accordance with Section 75 of the 2006 Act as amended the ICB and Council have entered into arrangements to established pooled budgets for the purpose of discharging the duties set out within the Act. All governance arrangements are defined within Section 75 Agreements as if written into the SORD.	Section 75, NHS Act 2006	Section 75 Agreement
ICB/Thurrock Council	**Better Care Fund** In accordance with Section 75 of the 2006 Act as amended the ICB and Council have entered into arrangements to established pooled budgets for the purpose of discharging the duties set out within the Act. All governance arrangements are defined within Section 75 Agreements as if written into the SORD.	Section 75, NHS Act 2006	Section 75 Agreement
ICB/Southend Council	**Better Care Fund** In accordance with Section 75 of the 2006 Act as amended the ICB and Council have entered into arrangements to established pooled budgets for the purpose of discharging the duties set out within the Act. All governance arrangements are defined within Section 75 Agreements as if written into the SORD.	Section 75, NHS Act 2006	Section 75 Agreement

Scheme of Reservation and Delegation

Decisions and functions delegated by the Board to other statutory bodies

Body	Decisions and functions delegated by the Board	Legal power	Governing arrangements
	There are currently no arrangements delegated by the Board to other statutory bodies		

Scheme of Reservation and Delegation

Decisions and functions delegated by the Board to individual Board Members and employees

Board Member / employee	Decisions and functions delegated by the Board	Reference
Chair	**Regulations and Control**	
	Authenticate use of the seal.	Standing Orders 6.1.3
	Suspend Standing Orders in conjunction with 2 other Board members.	Standing Orders 5.1.1
	In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from the relevant Director, will provide a settled view which shall be final.	Standing Orders 3.1.4
	To call meetings of the Board and preside over Board meetings.	Standing Orders 4.1.2, 4.2.1
	In conjunction with the Chief Executive (or relevant lead Director in the case of committees) and one other member, make an urgent decision on behalf of the Board/Committee.	Standing Order 4.9.5
	Discipline members of the Board (other than Executive Directors) who are in breach of statutory requirements or SOs.	
	Appointments/Dismissal	
	Appoint the Chief Executive of the ICB subject to the approval of NHS England.	Constitution 3.4.1
	Approve the appointments of the Partner Members of the Board.	Constitution 2.2.1, 3.5.4, 3.6.5, 3.7.4
	Approve the appointment of Executive Members of the Board.	Constitution 2.1.5, 2.2.2, 3.8.2, 3.9.3, 3.10.3, 3.12.3
	Approve the appointment or re-appointment of Non-Executive Members of the Board.	Constitution 3.11.2

Scheme of Reservation and Delegation

Board Member / employee	Decisions and functions delegated by the Board	Reference
	Appoint the Vice Chair of the Board.	Constitution 3.11.8
	Approve appointment of members of any committee.	Constitution 4.6.6; Standing Orders 4.2.3
	With the exception of the Executive Board Members, suspend or terminate members of the Board, as approved by the Board.	Constitution 3.13.3
Chief Executive	**Regulations and Control** Propose amendments to the Constitution to be considered and approved by the ICB prior to making an application to vary the Constitution to NHS England.	Constitution 1.6.2, Standing Orders 2.1.3, 2.1.4
	Establish a procedure for the use of the seal and keep (or nominate a manager to keep) the seal secure.	Standing Orders 6.1.1, 6.1.3
	Propose to the Board the adoption of the Executive structure to facilitate discharge of ICB business.	
	Discipline the Executive Director members of the Board who are in breach of statutory requirements or SOs.	
	Appointments/Dismissal Subject to the approval of the ICB Chair, appoint the Partner Members of the Board.	Constitution 3.5.4, 3.6.5, 3.7.4
	Subject to the approval of the ICB Chair, appoint the Executive Members of the Board.	Constitution 3.8.2, 3.9.3, 3.10.3, 3.12.3
	Subject to the recommendation of the selection panel, approve the appointment of the Non-Executive Members and their re-appointment (within the limit of terms of office)	Constitution 3.11.2, 3.11.7

Scheme of Reservation and Delegation

Board Member / employee	Decisions and functions delegated by the Board	Reference
	Statutory Functions / Duty In accordance with section 252A of the 2006 Act (as amended) act as the Accountable Emergency Officer (AEO) and Gold Commander for responding to Emergency Planning Resilience and Response events and declared incidents. **Operational Responsibilities** To approve and be the signatory of delegation agreements on behalf of the ICB.	
Director of Resources (Chief Finance Officer)	**Regulations and Control** Authenticate use of the seal. Develop systems and processes to comply with the requirements of the NHS Provider Selection Regime. Establish processes to ensure compliance with all relevant procurement regulations. **Annual Reports and Accounts** Preparation of the annual accounts and accounting tables within the Annual Report in accordance with relevant guidance and regulations, including those for funds held on trust. Arrange for annual accounts to be externally audited and published. **Statutory Functions / Duty** Ensure systems are in place to deliver the financial duties of the ICB (Sections 223GB, 223N, 223H and 223 J). Including establishing the annual budget and budget management processes.	Standing Orders 6.1.3 Constitution 7.3.2, 7.3.3 Constitution 7.3.5 Constitution 7.2.3 Constitution 1.4.7, 7.2.8

Scheme of Reservation and Delegation

Board Member / employee	Decisions and functions delegated by the Board	Reference
	Establish adequate arrangements to discharge ICB duties in relation to the Freedom of Information Act 2000 and Information Commissioner Office requirements. Develop the Capital Resource Use Plan for approval by the Board and report how the ICB has exercised its functions in accordance with the Plan within the Annual Report. **Operational Responsibilities** To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation, and best practice: Financial Strategy; Financial Operations; Planning and Reporting; Estates; Purchase of Healthcare; Digital Technology; Data and System Technology. To be the lead Executive Officer ensuring appropriate advice and explanations are provided to the Finance & Investment Committee. To be the Senior Information Risk Owner (SIRO) for the ICB. Maintain and refresh (where appropriate and subject to approval of the Board) the Schedule of Detailed Delegated Financial Limits. Establish and maintain the financial framework of the ICB as defined within Standing Financial Instructions as if written into the SoRD. Respond to the annual management letter from External Audit preparing proposed actions for to present to the Board after review by the Audit Committee. To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	Constitution 7.2.5 Constitution 7.4.1

Scheme of Reservation and Delegation

Board Member / employee	Decisions and functions delegated by the Board	Reference
Medical Director (Chief Medical Officer)	**Operational Responsibilities** To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice: Development (Clinical and Professional Leadership, Primary Care, including Primary Care Delegated functions and Primary Care Networks Development); Stewardship; Quality and Governance (Clinical and Professional Congress) and Medicines Optimisation. To be the lead Executive Officer ensuring appropriate advice and explanations are provided to the Clinical & Professional Congress. To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	
Chief Nurse	**Strategy, Annual Operational Plan and Budgets** Develop and propose to the Board the ICB Quality Strategy. **Statutory Functions / Duty** Ensure systems are in place to deliver improvement in quality of services (Section 14Z34) and report on the discharge of these duties within the Annual Report. Establish and publish clear arrangements for dealing with complaints in accordance with the Complaints Regulations including publishing an annual complaints report. **Operational Responsibilities** To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice: Patient Safety; Patient Experience; Safeguarding and Continuing Health Care.	Constitution 1.4.7, 7.2.8, 7.4.1 Constitution 7.2.4

Scheme of Reservation and Delegation

Board Member / employee	Decisions and functions delegated by the Board	Reference
	To be the lead Executive Officer ensuring appropriate advice and explanations are provided to the Quality & Safety Committee. To act as the Caldicott Guardian and the Designated Safeguarding Lead. To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	
Chief People Officer	**Strategy, Annual Operational Plan and Budgets** Develop and present to the Board for approval, proposals for organisational development. **Operational Responsibilities** To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice: Human Resources (ICB internal function); System Workforce. Ensure arrangements in place to provide an adequate workforce for the system. To be the lead Executive Officer ensuring appropriate advice and explanations are provided to the Remuneration Committee. To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	
Chief of Staff	**Regulations and Control** Ensure processes are in place to comply with Local Authority Health Overview and Scrutiny Requirements. Report urgent decisions to the Board for ratification.	Constitution 7.3.4 Standing Order 4.9.6

Scheme of Reservation and Delegation

Board Member / employee	Decisions and functions delegated by the Board	Reference
	Annual Reports and Accounts Preparation of the Annual Report in accordance with relevant guidance and regulations.	Constitution 7.4.1
	Statutory Functions / Duty In accordance with section 14Z30(2) of the 2006 Act establish systems and processes (defined within the Conflicts of Interest Policy) to manage conflicts of interest (including gifts and hospitality) and publish the registers of interest on the ICB website.	Constitution 6.1.3, 6.1.4, 6.1.5, 6.3.1, 6.3.2, 6.3.7
	To ensure that key governance documentation (Constitution, Standing Orders, Governance Handbook, Register of Interests and other key documents and policies as appropriate) are considered annually, reviewed and updated as necessary and published on the ICB website.	Constitution 7.2.7, Standing Orders 2.1.2
	Publish agenda's, papers and minutes for meetings held in public, including details about meeting dates, times and venues.	Constitution 7.2.2; Standing Orders 4.1.4, 4.3.3
	Ensure adequate arrangements are in place to govern Board and Committee meetings in accordance with the Constitution, Standing Orders and best practice, including the development of committee terms of reference.	Constitution 4.6.3, 4.6.6; Standing Orders 4.10, 4.11
	Operational Responsibilities To be the lead Executive Officer ensuring appropriate advice and explanations are provided to the Audit Committee. To have oversight of and ensure the correct functioning of the ICB and its Committees.	
	Ensure that non-compliance with Standing Orders are reported to the next formal meeting of the Board for action or ratification.	Standing Orders 3.1.6

Scheme of Reservation and Delegation

Board Member / employee	Decisions and functions delegated by the Board	Reference
	Establish a robust system for the management of risk (including defining the strategic aims and objectives; identify, evaluate and report on risks, establishment of a risk management policy). Management the policy framework of the ICB ensuring that policies are reviewed, updated and approved in a cyclical manner. To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	
Director of Strategy & Partnerships	**Strategy, Annual Operational Plan and Budgets** Develop and publish a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years. Develop the Integrated Care System Plan for approval by the Board reviewing, within the annual report, the extent to which the ICB has exercised its functions. **Statutory Functions / Duties** In accordance with section 14Z45 of the Act establish processes for public involvement and consultation in relation to commissioning arrangements and report on the discharge of these duties within the Annual Report; ensuring the ICB meets the ten principles set out by NHSE for working with people and communities. In accordance with section 116B(1) of the Local Government and Public Involvement in Health Act 2007 ensure that due regard is given to assessments and strategies. Ensure systems are in place to reduce inequalities (Section 14Z35) and report on the discharge of these duties within the Annual Report.	Constitution 7.2.8 Constitution 7.2.8 Constitution 1.4.7, 7.2.8, 7.4.1, 9.1.1, 9.1.2, 9.1.3 Constitution 1.4.7 Constitution 1.4.7, 7.2.8, 7.4.1

Scheme of Reservation and Delegation

Board Member / employee	Decisions and functions delegated by the Board	Reference
	Operational Responsibilities To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice: ICB Strategy: Community Resilience and Mobilisation; contribute to the development of a successful ICP and Strategic Partnerships; System Development Plan; MSE Partners; Communications and Engagement. Ensure the ICB discharges its responsibilities to lead the ICS Engagement Framework. To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	 Constitution 9.1.7
Director of Oversight, Assurance & Delivery	**Statutory Functions / Duties** In accordance with section 14Z38 of the Act establish arrangements for obtaining appropriate advice. In accordance with section 14Z43 of the Act meet the duty to have regard to wider effect of decisions and report of the discharge of this duty within the Annual Report. In accordance with section 116B(1) of the Local Government and Public Involvement in Health Act 2007 ensure that due regard is given to assessments and strategies. **Operational Responsibilities** To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice: Community Pathways; Acute Delivery; Children and Young People; Mental Health; Learning Disabilities; Performance and Analytics; Emergency Planning; Operations and Resilience; Individual Funding Requests and Service Restriction.	 Constitution 1.4.7 Constitution 1.4.7, 7.2.8, 7.4.1 Constitution 1.4.7

Scheme of Reservation and Delegation

Board Member / employee	Decisions and functions delegated by the Board	Reference
	To be the lead Executive Officer ensuring appropriate advice and explanations are provided to the System Oversight and Assurance Committee and any other relevant committees to which it reports. To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	
Alliance Directors	**Operational Responsibilities** To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice at place: Transformation and Engagement; Performance and Planning; Alliance Clinical Leadership. Be accountable for delivery of Alliance Plans To be the lead Executive Officer ensuring appropriate advice and explanations are provided to their respective Alliance and the ICB. To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	
Audit Committee Chair	To act as the Conflicts of Interest Guardian.	Constitution 6.1.6
On Call Director	To fulfil the duties required as set out by the Emergency Planning Team for managing escalations, incidents and out of hours cover as set out within associated ICB Policies.	

Scheme of Reservation and Delegation

Decisions and functions delegated to the Board by other organisations

Body making the delegation	Decisions and functions delegated to the Board	Reference
NHS England	In accordance with its statutory powers under section 65Z5 of the NHS Act, NHS England have delegated the exercise of Delegated Functions (for Primary Medical Services) to the ICB to commission a range of services for the people of the area as follows: • Decisions in relation to the commissioning, and management of Primary Medical Services. • Planning Primary Medical Services in the Area, including carrying out needs assessment. • Undertaking review of Primary Medical Services in respect of the Area. • Management of Delegated Funds in the Area. • Co-ordinating a common approach to the commissioning and delivery of Primary Medical Services with other health and social care bodies in respect of the Area where appropriate; and • Such other ancillary activities that are necessary in order to exercise the Delegated Functions. Such arrangements have been set out in the 'delegation agreement' and shall prevail as if written into the SORD.	Delegation Agreement.

Scheme of Reservation and Delegation

Schedule of Detailed Delegated Financial Limits

Please note that limits for Budget Holders will be set on a case by case basis up to the maximum limits shown in the schedules below.

Provision	Board	Committee	CEO or DoR	Executive Directors	Budget Holders (note 1)	Specified Individual
1. Virements						
Movements between care areas to be signed off by the Medical Director or Director of Resources.						
a Within cost centre.					X	
b Between cost centre in same directorate and care area.					X	
c Between directorates but in the same care area.				X (BOTH)		
Between care areas.			DoR			MD
d New allocations (specified use).				X		SFM
e New allocations (general).				X		

Scheme of Reservation and Delegation

Provision	Board	Committee	CEO or DoR	Executive Directors	Budget Holders (note 1)	Specified Individual
2. Approval of Business Cases (and limits for committing programme expenditure), including variation of contracts.						
In accordance with System Service Change / Business Case Policy.						
a Within existing agreed budgets:						
i < £250,000				X		
ii £250,001 - £1,000,000			X			
iii £1,000,001 - £5,000,000		F&IC				
iv > £5,000,001	X					
b In-year proposals with no budgetary provision:						
i < £100,000				X		
ii £100,001 - £250,000			X			
iii £250,001 - £2,500,000		F&IC				
iv > £2,500,000	X					

Scheme of Reservation and Delegation

		Provision	Board	Committee	CEO or DoR	Executive Directors	Budget Holders (note 1)	Specified Individual
3. Quotation, tendering and contract procedures for expenditure / income proposals, whether capital or revenue, purchases of disposals								
To clarify, these limits relate to contracts where the ICB is the contracting authority. Where another system partner is the contracting authority, that organisation's limits and processes will apply.								
(The value of the goods and services should be the total contract value, not the annual value and should be inclusive of fees but exclusive of VAT. Where the number of years is not specified or is open ended from year to year, a 3-year period should be assumed for the purpose of this calculation.)								
a		£501 - £5,000 (minimum 2 verbal quotations)					X	
b		£5,001 - £50,000 (minimum 3 written quotations)					X	
c	i	£50,001 - £213,447 (inc. VAT) (NON-CLINICAL GOODS/SERVICES) or				X		
	ii	£50,001 - £663,540 (inc. VAT)(CLINICAL GOODS/SERVICES) (follow competitive quote procedure, minimum of 4 written quotations against a written specification with detailed option appraisal).				X		
d	i	> £213,447 (inc. VAT) (Non-Clinical) or				X		
	ii	>£663,540 (inc. VAT)(Clinical), undertake full tender procedures				X		
e		Waiving of quotations and tenders subject to SOs and SFIs (All waivers to be reported to Audit Committee).		Audit	DoR			

Scheme of Reservation and Delegation

Provision	Board	Committee	CEO or DoR	Executive Directors	Budget Holders (note 1)	Specified Individual
4. Management of 'Running Costs' Budgets/Expenditure						
a Authorization of requisition / order / invoice within existing budget:						
i < £100,000					X	
ii £100,001 - £250,000				X		DDoR
iii £250,001 - £1,000,000			X			
iv £1,000,001 - £2,500,000		F&IC				
v > £2,500,001	X					
b Non-pay expenditure for which no specific budget has been set within running cost allowance:						
i < £25,000				(X)	X	
ii £25,001 - £100,000				X		DDoR
iii £100,001 - £500,000			X			
iv £500,001 - £2,500,000		F&IC				
v > £2,500,001	X					
c Engagement of staff not on the Establishment (within available budget and full year cost) - costs per employee:						
i < £50,000				X		
ii £50,001 - £100,000 (prior approval required from NHSE for contract appointments)			X			
iii £100,001 - £250,000 (prior approval required from NHSE)			CEO+DoR			
iv > £250,001 (prior approval required from NHSE) Reported to RemCom for information and scrutiny If the appointment relates to the CEO or DoR (in iii or iv above) the process will be reviewed by RemCom and recommended to the Governing Body for approval.		Rem Comm	CEO+DoR			
v IN ADDITION, for the recruitment of agency / contract staff, all contracts with either a total value of £50,000 or above, a day rate of £600 or greater and/or contracts that exceed 6 months require NHSE/I PRIOR approval.	NHSE/I Regional rep (>£600 per day), NHSE DoR (>£800 per day), NHSE/I Regional and National approval (>£900 per day)					

Scheme of Reservation and Delegation

	Provision	Board	Committee	CEO or DoR	Executive Directors	Budget Holders (note 1)	Specified Individual
5. Management of 'Commissioning / Programme Costs' Budgets / Expenditure							
a	Approval to commit funding associated within approved business case.				X		
b	Approval to commit funding other than an approved business case (as defined for the approval of business cases above)	Follow the same limits as per business case section 2. above					
c	Approval of expenditure greater than tender price/business case. Subject to remaining within approval and tender limits identified above.	Follow the same limits as per contracts section 3. above					
i	< 10% of approved tender.			X			
ii	> 10% of approved tender or business case would require review of need and affordability in accordance with the business case process defined above.	Follow the same limits as per business case section 2. above					
d	Approval of invoices within approved contract values:						
i	< £1,000,001					X	
ii	£1,000,001 - £10,000,000				X		
iii	£10,000,001 - £25,000,000			DoR (note 2)			DDoR
iv	> £25,000,000 to NHS providers within M&SE system			DoR (note 2)			DDoR
v	> £25,000,000 with other providers			DoR			
e	Engagement of staff not on the Establishment (within available budget and full year cost) - costs per employee						
i	< £50,000				X		
ii	£50,001 - £100,000 (prior approval required from NHSE for contract appointments)			X			
iii	£100,001 - £250,000 (prior approval required from NHSE)			CEO+DoR			
iv	> £250,001 (prior approval required from NHSE) Reported to RemCom for information and scrutiny EXCEPT: If the appointment relates to the CEO or DoR (in iii or iv above) the process will be reviewed by RemCom and recommended to the Governing Body for approval.		Rem Comm	CEO+DoR			
	IN ADDITION, for the recruitment of agency / contract staff, all contracts with either a total value of £50,000 or above, a day rate of £600 or greater and/or contracts that exceed 6 months require NHSE/I PRIOR approval.	NHSE/I Regional rep (>£600 per day), NHSE DoR (>£800 per day), NHSE/I Regional and National approval (£>900 per day)					

Scheme of Reservation and Delegation

Provision	Board	Committee	CEO or DoR	Executive Directors	Budget Holders (note 1)	Specified Individual
6. Continuing Healthcare						
a Approving Continuing Healthcare packages of care:						
i Up to CCG agreed standard rate per week					CHC Business Mgr	
ii Up to annual equivalent £100,000					Operational Lead	
iii Up to annual equivalent £150,000					Head of CHC / Deputy CN	
iv Over annual equivalent £200,000				Chief Nurse		
b Patient Transport (journeys outside of contract).					Any posts identified in 6a	

Scheme of Reservation and Delegation

Provision	Board	Committee	CEO or DoR	Executive Directors	Budget Holders (note 1)	Specified Individual
7. Losses, Write Off & Compensation						
a Losses due to theft, fraud, overpayment, fruitless payments, non-contracted activity, compensation payments:						
i < £5,000			X			
ii £5,001 - £25,000			CEO + DoR			
iii £25,001 - £100,000	X					
iv >£100,000	X (and reported to NHSE/I at year end)					
b Redress payments made in respect of Continuing Healthcare costs (except for routine reimbursement of care costs incurred due to delay in package set-up over permitted 28 days):						
i < £10,000		CEO + CN or DoR + CN				
ii > £10,000		CEO + DoR + CN				
c Write off of non-NHS debtors:						
i < £500				X		
ii > £500			X			
All instances of losses or write off will be reported to the audit committee.						
d Special severance or retention payments.						Reserved by NHSE/I

Scheme of Reservation and Delegation

Provision	Board	Committee	CEO or DoR	Executive Directors	Budget Holders (note 1)	Specified Individual
8. Primary Care Commissioning						
a Investment in Primary Care within the scope of the Statement of Financial Entitlements for General Medical Services and existing terms of GMS, PMS and APMS Contracts and within budget:						
i < £250,000				X		Dir PC
ii £250,001 - £1,000,000		PCCC				
iii £1,000,001 - £5,000,000		F&IC				
iv > £5,000,001	X					
Investment in Primary Care within the scope of the Statement of Financial Entitlements for General Medical Services and existing terms of GMS, PMS and APMS Contracts and outside of budget:						
i < £250,000				X		Dir PC
ii £250,001 - £1,000,000		PCCC				
iii £1,000,001 - £5,000,000		F&IC				
iv > £5,000,001	X					
b Investment in Primary Care outside of contractual entitlements will require the relevant business case and financial approvals process described in sections 2 and 5 to be followed	As per Business Case process (and reported back to the PCCC)					

Notes:
1. Limits for Budget Holders will be set on a case by case basis up to the maximum limits shown in the schedules below.
2. While the Interim DoR is also the CFO of MSEFT, the Interim DoR may not approve invoices or contract payments from the ICB to MSEFT.

Scheme of Reservation and Delegation

Definitions: Full title	Short title	Description
Executive Directors	Exec Dir	All Executive Directors of the ICB with a line report to the Chief Executive.
ICB Chief Executive	CEO	The ICB Chief Executive
Director of Resources	DoR	The ICB Director of Resources / Interim Director of Resources
Medical Director	MD	The ICB Medical Director
Chief Nurse	CN	The ICB Chief Nurse
Deputy DoR	DDoR	Named Directors of Finance within the Resources Directorate. To be confirmed once ICB structures are finalised but likely to be all direct reports to the Director of Resources
Director of Primary Care	Dir PC	Director of Primary Care
Depupty Director for Primary Care Development	DD PC	Depupty Director for Primary Care Development
Deputy Chief Nurse	Deputy CN	The ICB Deputy Chief Nurse
Head of CHC	Head of CHC	The ICB Head of CHC
CHC Business Mgr	CHC Business Mgr	Nominated CHC Business Managers. CHC team to maintain register. Specific posts to be confirmed once ICB structures are finalised.
Operational Lead	Operational Lead	Nominated CHC Operational Leads. CHC team to maintain register. Specific posts to be confirmed once ICB structures are finalised.
Budget Holder	Budget Holder	Any nominated budget holder. The limits in this DSoD are the maximum limits. Each budget holder will be granted a specific limit based on need and responsibility. See note 1.
Senior Finance Manager	SFM	Senior Finance Manager. For alloction of new budget allocations where the use is specified and thus no decision on which care area the funding is to be allocated to is needed.

Committee Name	Short Name
The ICB Board	Board
Finance & Investment Committee	F&IC
Audit Committee	Audit
Primary Care Commissioning Committee	PCCC
Remuneration Committee	Rem Comm

Residents of mid and south Essex

Appendix B

To contribute to the overall delivery of the ICS's objectives, create opportunities for the benefit of their residents, to support health and wellbeing, bring care closer to home and to improve and transform services.

Key:

- Partnership & Place
- ICB
- System Groups
- System / ICB Interface

Basildon & Brentwood Alliance

Mid Essex Alliance

Thurrock Alliance

South East Essex Alliance

Transformation Programme Oversight

System Projects & Programmes

Population Health Management

Digital, Data & Technology Board

People Board

System Quality Group

System Finance Leaders Group

System Leadership Group

System Partners Statutory Bodies

Audit Committee — Provides oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB. Oversees production of the Annual Report & Accounts

System Oversight & Assurance Cttee — Provides oversight on the delivery of performance and standards, key system programmes, enabling mutual accountability and providing assurance to the Board.

Assurance

Finance & Investment Committee — Agrees the financial framework, makes investment decisions / recommendations, receives assurance on delivery of financial performance.

Decision Making

Remuneration Committee — Agrees and recommends Pay, terms and conditions for board members.

Quality Committee — Responsible for the development and implementation of the ICB's Quality Strategy, which sets out its plan for quality and safety and for assuring the Board of quality and safety standards.

Assurance

Clinical & Multi-Professional Congress — Advisory committee providing clinical and multi professional leadership to the system as well as involvement, advice and support to service developments and transformation programmes. Leading on Stewardship

Advisory

Primary Care Commissioning Cttee — The Committee enables collective decisions on core contractual and procurement of primary care services. It oversees the contracting framework for primary care.

Decision Making

Southend, Essex & Thurrock Local Authorities

Essex, Southend & Thurrock Health & Wellbeing Boards

Integrated Care Partnership — Committee jointly convened by Local Authority and the ICB to create the Integrated Care Strategy.

Integrated Care Board — Statutory body bringing partners together locally, allocate resources to improve population health and deliver shared strategic priorities.

Operational Decision Making, ICB **Executive Team**

Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

Part I Board Meeting

Date of meeting	1 July 2022
Agenda item number	6
Title of report	ICB Standing Financial Instructions
Purpose of report.	To adopt the Standing Financial Instructions for the MSE ICB
Executive Lead	Dawn Scrafield, Director of Resources
Report Author	Jason Skinner, Director of Finance System Planning & Reporting
Impact Assessments	Not applicable
Financial implications	None
Details of patient or public engagement or consultation.	Not applicable
Conflicts of Interest:	None Identified
Recommendation(s)	The Board is asked to: • Agree to adopt the Standing Financial Instructions for the ICB.

ICB Standing Financial Instructions

1. Introduction

The Health and Care Act 2022 states that Clinical Commissioning Groups must propose the Constitution for the first Integrated Care Board (ICB) to be established for the ICB area. This paper presents the final draft of the Mid and South Essex ICB Constitution for approval ahead of formal submission to NHS England on 20 May 2022. Formal approval of the constitution is made by NHSE/I as part of the establishment of the ICB. The constitution is attached as **Appendix A**.

2. Recommendation

The Board is asked to note the ICB Constitution.

3. Appendices

Appendix A – Mid and South Essex Integrated Care Board Constitution

Classification: Official

Publication approval reference:

Mid and South Essex Integrated Care Board Standing Financial Instructions Template V.1

Version 1.0, 8 November 2021

NHS England and NHS Improvement may update or supplement this document. Elements of this guidance are subject to change until the legislation passes through Parliament and receives Royal Assent. We also welcome feedback from system and stakeholders to help us continually improve our guidance and learn from implementation. The latest versions of all NHS England and NHS Improvement guidance relating to the development of ICSs can be found at ICS Guidance.

ICS implementation guidance

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

They exist to achieve four aims:

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

Following several years of locally-led development, and based on the recommendations of NHS England and NHS Improvement, the government has set out plans to put ICSs on a statutory footing.

To support this transition, NHS England and NHS Improvement are publishing guidance and resources, drawing on learning from all over the country.

Our aim is to enable local health and care leaders to build strong and effective ICSs in every part of England.

Collaborating as ICSs will help health and care organisations tackle complex challenges, including:

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

Contents

1. Purpose and statutory framework

1.1.1 These Standing Financial Instructions (SFIs) shall have effect as if incorporated into the integrated Care Board's (ICB) constitution. In accordance with the National Health Service Act 2006, as amended by the Health and Care Act 2022, the ICB must publish its constitution.

1.1.2 In accordance with the Act as amended, NHS England is mandated to publish guidance for ICBs, to which each ICB must have regard, in order to discharge their duties.

1.1.3 The purpose of this governance document is to ensure that the ICB fulfils its statutory duty to carry out its functions effectively, efficiently and economically. The SFIs are part of the ICB's control environment for managing the organisation's financial affairs as they are designed to ensure regularity and propriety of financial transactions.

1.1.4 SFIs define the purpose, responsibilities, legal framework and operating environment of the ICB. They enable sound administration, lessen the risk of irregularities and support commissioning and delivery of effective, efficient and economical services.

1.1.5 The ICB is established under Chapter A3 of Part 2 of the National Health Service Act 2006, as inserted by the Health and Care Act 2022 and has the general function of arranging for the provision of services for the purposes of the health services in England in accordance with the Act.

1.1.6 Each ICB is to be established by order made by NHS England for an area within England, the order establishing an ICB makes provision for the constitution of the ICB.

1.1.7 All members of the ICB (its board) and all other Officers should be aware of the existence of these documents and be familiar with their detailed provisions. The ICB SFIs will be made available to all Officers on the intranet and internet website for each statutory body.

1.1.8 Should any difficulties arise regarding the interpretation or application of any of these SFIs, the advice of the chief executive or the director of resources must be sought before acting.

1.1.9 Failure to comply with the SFIs may result in disciplinary action in accordance with the ICBs applicable disciplinary policy and procedure in operation at that time.

2. Scope

2.1.1 All officers of the ICB, without exception, are within the scope of the SFIs without limitation. The term officer includes, permanent employees, secondees and contract workers.

2.1.2 Within this document, words imparting any gender include any other gender. Words in the singular include the plural and words in the plural include the singular.

2.1.3 Any reference to an enactment is a reference to that enactment as amended.

2.1.4 Unless a contrary intention is evident, or the context requires otherwise, words or expressions contained in this document, will have the same meaning as set out in the applicable Act.

3. Roles and Responsibilities

3.1 Staff

3.1.1 All ICB Officers are severally and collectively, responsible to their respective employer(s) for:

- abiding by all conditions of any delegated authority;
- the security of the statutory organisations property and avoiding all forms of loss;
- ensuring integrity, accuracy, probity and value for money in the use of resources; and
- conforming to the requirements of these SFIs

3.2 Accountable Officer

3.2.1 The ICB constitution provides for the appointment of the chief executive by the ICB chair. The chief executive is the accountable officer for the ICB and is personally accountable to NHS England for the stewardship of the ICB's allocated resources.

3.2.2 The director of resources reports directly to the ICB chief executive officer and is professionally accountable to the NHS England regional finance director.

3.2.3 The chief executive will delegate to the director of resources the following responsibilities in relation to the ICB:

- preparation and audit of annual accounts;
- adherence to the directions from NHS England in relation to accounts preparation;
- ensuring that the allocated annual revenue and capital resource limits are not exceeded, jointly, with system partners;
-

- ensuring the ICB meets its financial plan requirements and associated financial duties;
- ensuring that there is an effective financial control framework in place to support accurate financial reporting, safeguard assets and minimise risk of financial loss;
- meeting statutory requirements relating to taxation;
- ensuring that there are suitable financial systems in place (see Section 6)
- meets the financial targets set for it by NHS England;
- use of incidental powers such as management of ICB assets, entering commercial agreements;
- the Governance statement and annual accounts & reports are signed;
- planned budgets are approved by the relevant Board; developing the funding strategy for the ICB to support the board in achieving ICB objectives, including consideration of place-based budgets;
- making use of benchmarking to make sure that funds are deployed as effectively as possible;
- executive members (partner members and non-executive members) and other officers are notified of and understand their responsibilities within the SFIs;
- specific responsibilities and delegation of authority to specific job titles are confirmed;
- financial leadership and financial performance of the ICB;
- identification of key financial risks and issues relating to robust financial performance and leadership and working with relevant providers and partners to enable solutions; and

- the director of resources will support a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and process are in place to minimise risk.

3.3 Audit committee

3.3.1 The board and accountable officer should be supported by an audit committee, which should provide proactive support to the board in advising on:

- the management of key risks
- the strategic processes for risk;
- the operation of internal controls;
- control and governance and the governance statement;
- the accounting policies, the accounts, and the annual report of the ICB;
- the process for reviewing of the accounts prior to submission for audit, management's letter of representation to the external auditors; and the planned activity and results of both internal and external audit.

4. Management accounting and business management

4.1.1 The director of resources is responsible for maintaining policies and processes relating to the control, management and use of resources across the ICB.

4.1.2 The director of resources will delegate the budgetary control responsibilities to budget holders through a formal documented process.

4.1.3 The director of resources will ensure:

- the promotion of compliance to the SFIs through an assurance certification process;
- the promotion of long term financial heath for the NHS system (including ICS);
- budget holders are accountable for obtaining the necessary approvals and oversight of all expenditure incurred on the cost centres they are responsible for;
- the improvement of financial literacy of budget holders with the appropriate level of expertise and systems training;
- that the budget holders are supported in proportion to the operational risk; and
- the implementation of financial and resources plans that support the NHS Long term plan objectives.

4.1.4 In addition, the director of resources should have financial leadership responsibility for the following statutory duties:

- the duty of the ICB, in conjunction with its partner NHS trusts and NHS foundation trusts, to exercise its functions with a view to ensuring that, in respect of each financial year;
    - local capital resource use does not exceed the limit specified in a direction by NHS England;

- local revenue resource use does not exceed the limit specified in a direction by NHS England;

- the duty of the ICB to perform its functions so as to ensure that its expenditure does not exceed the aggregate of its allotment from NHS England and its other income; and

- the duty of the ICB, in conjunction with its partner trusts, to seek to achieve any joint financial objectives set by NHS England for the ICB and its partner trusts.

4.1.5 The director of resources and *any senior officer responsible* for finance within the ICB should also promote a culture where budget holders and decision makers consult their finance business partners in key strategic decisions that carry a financial impact.

5. Income, banking arrangements and debt recovery

5.1 Income

5.1.1 An ICB has power to do anything specified in section 7(2)(a), (b) and (e) to (h) of the Health and Medicines Act 1988 for the purpose of making additional income available for improving the health service.

5.1.2 The director of resources is responsible for:

- ensuring order to cash practices are designed and operated to support, efficient, accurate and timely invoicing and receipting of cash. The processes and procedures should be standardised and harmonised across the NHS System by working cooperatively with the Shared Services provider; and

- ensuring the debt management strategy reflects the debt management objectives of the ICB and the prevailing risks;

5.2 Banking

5.2.1 The Director of Resources is responsible for ensuring the ICB complies with any directions issued by the Secretary of State with regards to the use of specified banking facilities for any specified purposes.

5.2.2 The director of resources will ensure that:

- the ICB holds the minimum number of bank accounts required to run the organisation effectively. These should be raised through the government banking services contract; and

- the ICB has effective cash management policies and procedures in place.

5.3 Debt management

5.3.1 The director of resources is responsible for the ICB debt management strategy.

5.3.2 This includes:

- a debt management strategy that covers end-to-end debt management from debt creation to collection or write-off in accordance with the losses and special payment procedures;
- ensuring the debt management strategy covers a minimum period of 3 years and must be reviewed and endorsed by the ICB board every 12 months to ensure relevance and provide assurance;
- accountability to the ICB board that debt is being managed effectively;
- accountabilities and responsibilities are defined with regards to debt management to budget holders; and
- responsibility to appoint a senior officer responsible for day to day management of debt.

6. Financial systems and processes

6.1 Provision of finance systems

6.1.1 The director of resources is responsible for ensuring systems and processes are designed and maintained for the recording and verification of finance transactions such as payments and receivables for the ICB.

6.1.2 The systems and processes will ensure, inter alia, that payment for goods and services is made in accordance with the provisions of these SFIs, related procurement guidance and prompt payment practice.

6.1.3 As part of the contractual arrangements for ICBs officers will be granted access where appropriate to the Integrated Single Financial Environment ("ISFE"). This is the required accounting system for use by ICBs, Access is based on single access log on to enable users to perform core accounting functions such as to transacting and coding of expenditure/income in fulfilment of their roles.

6.1.4 The Director of resources will, in relation to financial systems:

- promote awareness and understanding of financial systems, value for money and commercial issues;
- ensure that transacting is carried out efficiently in line with current best practice – e.g. e-invoicing
- ensure that the ICB meets the required financial and governance reporting requirements as a statutory body by the effective use of finance systems;
- enable the prevention and the detection of inaccuracies and fraud, and the reconstitution of any lost records;
- ensure that the financial transactions of the authority are recorded as soon as, and as accurately as, reasonably practicable;
- ensure publication and implementation of all ICB business rules and ensure that the internal finance team is appropriately resourced to deliver all statutory functions of the ICB;
- ensure that risk is appropriately managed;

- ensure identification of the duties of officers dealing with financial transactions and division of responsibilities of those officers;

- ensure the ICB has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of the ICB;

- ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes; and

- where another health organisation or any other agency provides a computer service for financial applications, the Director of Resources shall periodically seek assurances that adequate controls are in operation.

7. Procurement and purchasing

7.1 Principles

7.1.1 The director of resources will take a lead role on behalf of the ICB to ensure that there are appropriate and effective financial, contracting, monitoring and performance arrangements in place to ensure the delivery of effective health services.

7.1.2 The ICB must ensure that procurement activity is in accordance with the Public Contracts Regulations 2015 (PCR) and associated statutory requirements whilst securing value for money and sustainability.

7.1.3 The ICB must consider, as appropriate, any applicable NHS England guidance that does not conflict with the above.

7.1.4 The ICB must have a Procurement Policy which sets out all of the legislative requirements.

7.1.5 All revenue and non-pay expenditure must be approved, in accordance with the ICB business case policy, prior to an agreement being made with a third party that enters a commitment to future expenditure.

7.1.6 All officers must ensure that any conflicts of interest are identified, declared and appropriately mitigated or resolved in accordance with the ICB standards of business conduct policy.

7.1.7 Budget holders are accountable for obtaining the necessary approvals and oversight of all expenditure incurred on the cost centres they are responsible for. This includes obtaining the necessary internal and external approvals which vary based on the type of spend, prior to procuring the goods, services or works.

7.1.8 Undertake any contract variations or extensions in accordance with PCR 2015 and the ICB procurement policy.

7.1.9 Retrospective expenditure approval should not be permitted. Any such retrospective breaches require approval from any committee responsible for approvals before the liability is settled. Such breaches must be reported to the audit committee.

8. Staff costs and staff related non pay expenditure

8.1 Executive Chief People Officer

8.1.1 The executive chief people officer [ECPO] will lead the development and delivery of the long-term people strategy of the ICB ensuring this reflects and integrates the strategies of all relevant partner organisations within the ICS.

8.1.2 Operationally the ECPO will be responsible for;

- defining and delivering the organisation's overall human resources strategy and objectives; and
- overseeing delivery of human resource services to ICB employees.

8.1.3 The ECPO will ensure that the payroll system has adequate internal controls and suitable arrangements for processing deductions and exceptional payments.

8.1.4 Where a third-party payroll provider is engaged, the ECPO shall closely manage this supplier through effective contract management.

8.1.5 The ECPO is responsible for management and governance frameworks that support the ICB employees' life cycle.

9. Annual reporting and Accounts

9.1.1 The director of resources will ensure, on behalf of the Accountable Officer and ICB board, that:

- the ICB is in a position to produce its required monthly reporting, annual report, and accounts, as part of the setup of the new organisation; and
- the ICB, in each financial year, prepares a report on how it has discharged its functions in the previous financial year;

An annual report must, in particular, explain how the ICB has:

- discharged its duties in relating to improving quality of services, reducing inequalities, the triple aim and public involvement;
- review the extent to which the board has exercised its functions in accordance with its published 5 year forward plan and capital resource use plan; and
- review any steps that the board has taken to implement any joint local health and wellbeing strategy.

9.1.2 NHS England may give directions to the ICB as to the form and content of an annual report.

9.1.3 The ICB must give a copy of its annual report to NHS England by the date specified by NHS England in a direction and publish the report..

9.2 Internal audit

The chief executive, as the accountable officer, is responsible for ensuring there is appropriate internal audit provision in the ICB. For operational purposes, this responsibility is delegated to the director of resources to ensure that:

- all internal audit services provided under arrangements proposed by the director of resources are approved by the audit committee, on behalf of the ICB board;
- the ICB must have an internal audit charter. The internal audit charter must be prepared in accordance with the Public Sector Internal Audit Standards (PSIAS);
- the ICB internal audit charter and annual audit plan, must be endorsed by the ICB Accountable Officer, audit committee and board;
- the head of internal audit must provide an annual opinion on the overall adequacy and effectiveness of the ICB Board's framework of governance, risk management and internal control as they operated during the year, based on a systematic review and evaluation;
- the head of internal audit should attend audit committee meetings and have a right of access to all audit committee members, the Chair and chief executive of the ICB.
- the appropriate and effective financial control arrangements are in place for the ICB and that accepted internal and external audit recommendations are actioned in a timely manner.

9.3 External Audit

The director of resources is responsible for:

- liaising with external audit colleagues to ensure timely delivery of financial statements for audit and publication in accordance with statutory, regulatory requirements;

- ensuring that the ICB appoints an auditor in accordance with the Local Audit and Accountability Act 2014; in particular, the ICB must appoint a local auditor to audit its accounts for a financial year not later than 31 December in the preceding financial year; the ICB must appoint a local auditor at least once every 5 years (ICBs will be informed of the transitional arrangements at a later date); and

- ensuring that the appropriate and effective financial control arrangements are in place for the ICB and that accepted external audit recommendations are actioned in a timely manner.

10. Losses and special payments

10.1.1 HM Treasury approval is required if a transaction exceeds the delegated authority, or if transactions will set a precedent, are novel, contentious or could cause repercussions elsewhere in the public sector.

10.1.2 The director of resources will support a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and process are in place to minimise risks from losses and special payments.

10.1.3 NHS England has the statutory power to require an integrated care board to provide NHS England with information. The information, is not limited to losses and special payments, must be provided in such form, and at such time or within such period, as NHS England may require.

10.1.4 As part of the new compliance and control procedures, ICBs must submit an annual assurance statement confirming the following:

- details of all exit packages (including special severance payments) that have been agreed and/or made during the year;
- that NHS England and HMT approvals have been obtained before any offers, whether verbally or in writing, are made; and
- adherence to the special severance payments guidance as published by NHS England.

10.1.5 All losses and special payments (including special severance payments) must be reported to the ICB audit committee and NHS England noting that ICBs do not have a delegated limit to approve losses or special payments.

10.1.6 For detailed operational guidance on losses and special payments, please refer to the ICB losses and special payment guide.

11. Fraud, bribery and corruption (Economic crime)

The ICB is committed to identifying, investigating and preventing economic crime.

The ICB director of resources is responsible for ensuring appropriate arrangements are in place to provide adequate counter fraud provision which should include reporting requirements to the board and audit committee, and defined roles and accountabilities for those involved as part of the process of providing assurance to the board. These arrangements should comply with the NHS Requirements the Government Functional Standard 013 Counter Fraud as issued by NHS Counter Fraud Authority and any guidance issued by NHS England and NHS Improvement.

12. Capital Investments & security of assets and Grants

12.1.1 The director of resources is responsible for:

- ensuring that at the commencement of each financial year, the ICB and its partner NHS trusts and NHS foundation trusts prepare a plan setting out their planned capital resource use;

- ensuring that the ICB and its partner NHS trusts and NHS foundation trusts exercise their functions with a view to ensuring that, in respect of each financial year local capital resource use does not exceed the limit specified in a direction by NHS England;

- ensuring the ICB has a documented property transfer scheme for the transfer of property, rights or liabilities from ICB's predecessor clinical commissioning group(s);

- ensuring that there is an effective appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

- ensuring that there are processes in place for the management of all stages of capital schemes, that will ensure that schemes are delivered on time and to cost;

- ensuring that capital investment is not authorised without evidence of availability of resources to finance all revenue consequences; and

- for every capital expenditure proposal, the director of resources is responsible for ensuring there are processes in place to ensure that a business case is produced.

12.1.2 Capital commitments typically cover land, buildings, equipment, capital grants to third parties and IT, including:

- authority to spend capital or make a capital grant;
- authority to enter into leasing arrangements.

12.1.3 Advice should be sought from the director of resources or nominated officer if there is any doubt as to whether any proposal is a capital commitment requiring formal approval.

12.1.4 For operational purposes, the ICB shall have nominated senior officers accountable for ICB property assets and for managing property.

12.1.5 ICBs shall have a defined and established property governance and management framework, which should:

- ensure the ICB asset portfolio supports its business objectives; and
- comply with NHS England policies and directives and with this standard

12.1.6 Disposals of surplus assets should be made in accordance with published guidance and should be supported by a business case which should contain an appraisal of the options and benefits of the disposal in the context of the wider public sector and to secure value for money.

12.2 Grants

12.2.1 The director of resources is responsible for providing robust management, governance and assurance to the ICB with regards to the use of specific powers under which it can make capital or revenue grants available to;

- any of its partner NHS trusts or NHS foundation trusts; and
- to a voluntary organisation, by way of a grant or loan.

12.2.2 All revenue grant applications should be regarded as competed as a default position, unless, there are justifiable reasons why the classification should be amended to non-competed.

13. Legal and insurance

13.1.1 This section applies to any legal cases threatened or instituted by or against the ICB. The ICB should have policies and procedures detailing:

- engagement of solicitors / legal advisors;
- approval and signing of documents which will be necessary in legal proceedings; and
- Officers who can commit or spend ICB revenue resources in relation to settling legal matters.

13.1.2 ICBs are advised not to buy commercial insurance to protect against risk unless it is part of a risk management strategy that is approved by the accountable officer.

Mid and South Essex Integrated Care System

NHS
Mid and South Essex
Integrated Care Board

Part I Board Meeting

Date of meeting	1 July 2022
Agenda item number	7
Title of report	Establishment of ICB Committees
Purpose of report.	To agree to the establishment of the ICB's Board committees, including approval of their Terms of Reference and the appointment of the chairs of each of committee.
Executive Lead	Anthony McKeever, Chief Executive
Report Author	Viv Barnes, Governance Lead.
Impact Assessments	Not applicable.
Financial implications	None identified.
Details of patient or public engagement or consultation.	Not applicable.
Conflicts of Interest:	None identified.
Recommendation(s)	The Board is asked to agree to the establishment and proposed Terms of Reference of the following committees: • Alliance Committees for Basildon & Brentwood, Mid Essex, South East Essex and Thurrock; • Audit Committee; • Clinical and Multi-Professional Congress; • Finance and Investment Committee; • Primary Care Commissioning Committee; • Quality Committee; • Remuneration Committee; • Strategic Oversight and Assurance Committee; and to appoint the chairs of each committee.

Establishment of ICB Committees

1. Introduction

Committees are a practical way to structure and manage the Board's work, as they can provide a more focused and efficient way of dealing with issues in lieu of the full Board. As such their main purpose is to provide assurance to the Board on the areas within their remit and to undertake delegated tasks on behalf of the Board.

The ICB is required to have certain statutory committees and it is proposed that a number of other committees are also established to support the Board in the exercise of its functions.

2. Terms of Reference

The governance structure of the ICB has been developed following detailed discussions with the designate ICB Chair and Chief Executive and the current Executive team.

In line with this governance structure, Terms of Reference have been developed for each of the ICB's committees. Template Terms of Reference were made available by NHS England for a number of ICB committees (Audit, Remuneration, Quality, Finance) and these were used to develop a local ICB template for all its committees. The original draft Terms of Reference were developed by Executive leads and then went through a detailed review process with the ICB Chair and Chief Executive, the current Executive team and subject matter experts.

The draft Terms of Reference were submitted to the relevant MSE CCG committees in common or system groups as part of the due diligence process.

The following Terms of Reference are being presented for adoption:

Alliance Committees for Basildon & Brentwood, Mid Essex, South East Essex and Thurrock

The key aim of the Alliance Committees is to bring key partners together 'at place' to create opportunities for people to live well. They will act as the interface between the ICB, ICP, Health & Wellbeing Boards, district and borough forums, PCNs and other bodies and take actions which improve health and wellbeing outcomes and reduce inequalities across their geography.

Generic Terms of Reference are presented for all the Alliance Committees for approval, which will then be developed at a local level within each locality and any substantial changes will be proposed by the Alliances and brought back to the Board for further approval. As part of this process, a Chair for each of the Alliance Committees will also be proposed to the ICB Chair.

Audit Committee

This is one of the statutory committees of the ICB and is responsible for providing oversight and assurance to the ICB Board on the adequacy of governance, risk management and internal control processes within the ICB.

The proposed Chair of the Audit Committee is George Wood, Non-Executive Member.

Clinical and Multi-Professional Congress

This committee supports the functions of the ICB Medical Director's office, including innovation and horizon scanning, clinical and care strategy, clinical leadership, changing clinical and care mindsets and providing assurance and statutory adherence.

The proposed Chair of the Clinical and Multi-Professional Congress is Dr Ronan Fenton, Medical Director.

Finance and Investment Committee

This committee provides oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable financial plans and associated financial performance in relation to services commissioned by the ICB. It provides objective oversight and scrutiny of system financial plans and decision, approves system investment decisions in line with the ICB Scheme of Delegation. reviews system financial performance and identifies key system issues and system risks requiring discussion or escalation to the Board.

An interim Chair of the Finance and Investment Committee is currently being confirmed until such time as an independent Chair is appointed.

Primary Care Commissioning Committee

This committee is responsible for improving and transforming primary care services, providing oversight and assurance to the ICB on the exercise of the ICB's delegated primary care commissioning functions, and adherence to the Statement of Financial Entitlements and contract monitoring for contracts held with Primary Care providers.

The Chair of this committee is currently being confirmed.

Quality Committee

This committee is responsible for scrutinising the robustness of, and providing assurance to the ICB, that there is an effective system of quality governance and internal control across the ICS that supports it to effectively deliver its strategic objectives and provide sustainable, high quality care.

The proposed Chair of the Quality Committee is Neha Issar-Brown, Non-Executive Member.

Remuneration Committee

This is one of the statutory committees of the ICB and is responsible for exercising the functions of the ICB in respect of paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006, specifically to confirm the ICB Pay Policy including adoption of any pay frameworks for all employees including senior managers/directors (including board members).

The proposed Chair of the Remuneration Committee is Joe Fielder, Non-Executive Member.

Strategic Oversight and Assurance Committee

The System Oversight and Assurance Committee (SOAC) is the primary governance forum to oversee the ICS's mutual accountability arrangements. It will take an overview of system performance relating to agreed outcomes and operational performance against constitutional standards and triangulate with equivalent processes for quality and safety and finance. It will act as the performance assurance committee of the ICB

The proposed Chair of the Oversight and Assurance Committee is Anthony McKeever, Chief Executive (co-chairing with NHS England).

3. Recommendations

The Board is asked to agree to the establishment and proposed Terms of Reference of the following committees:

- Alliance Committees for Basildon & Brentwood, Mid Essex, South East Essex and Thurrock;
- Audit Committee;
- Clinical and Multi-Professional Congress;
- Finance and Investment Committee;
- Primary Care Commissioning Committee;
- Quality Committee;
- Remuneration Committee;
- Strategic Oversight and Assurance Committee;

and to appoint the chairs of each committee.

4. Appendices

Appendix A – Alliance Committee Terms of Reference

Appendix B – Audit Committee Terms of Reference

Appendix C - Clinical and Multi-Professional Congress Terms of Reference.

Appendix D - Finance and Investment Committee Terms of Reference.

Appendix E - Primary Care Commissioning Committee Terms of Reference

Appendix F - Quality Committee Terms of Reference

Appendix G - Remuneration Committee Terms of Reference

Appendix H - Strategic Oversight and Assurance Committee Terms of Reference

Mid & South Essex Integrated Care Board

XX Alliance Committee

Terms of Reference

1. Constitution

The XX Alliance Committee (the 'Alliance') is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. Authority

The XX Alliance is authorised by the Board to:

- Investigate any activity within its terms of reference.
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference.
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation (SoRD) but may not delegate any decisions to such groups.

For the avoidance of doubt, the Committee will comply with the ICB Standing Orders, Standing Financial Instructions, and the SoRD.

3. Purpose

To contribute to the overall delivery of the ICS's objectives to create opportunities for the benefit of local residents, to support health and wellbeing, to bring care closer to home and to improve and transform services by providing oversight and assurance to the ICB Board on:

- The aim of the XX Alliance is to bring key partners together to provide the localism needed within the mid and south Essex system to create opportunities for people to live well in xx.
- This extends beyond the traditional boundaries of health and social care and incorporates wider system partners to tackle the social determinants of poor health and wellbeing with levelling-up in terms of outcomes and reduced disparities.
- There is a recognition by all partners in the system that the social determinants of poor

health and wellbeing need to be tackled by everyone levelled-up in terms of outcomes and reduced disparities. Developing this local partnership will support this.

- Where resources and funding have been aligned to the XX Alliance by partner organisations, the XX Alliance will determine the best allocation of those resources and funding based on agreed priorities and ensuring appropriate good stewardship. Where possible, incentivised budgets will prioritise upstream interventions which improve population health.
- The work of the XX Alliance will embody the MSE ICS principle of subsidiarity, that is addressing inequalities and disparities at local level while delivering ICS wide standards, outcomes and common clinical policies
- The XX Alliance will act as the interface between the ICP, Health & Wellbeing Boards, district and borough forums, PCNs etc. in translating strategy and outcomes for the benefit of residents within the Alliance, PCNs and local communities. It will be driven forward by decisive leadership which holds itself to account, who listen to local people, and have clear accountability for delivery.
- The XX Alliance will also provide the interface for advising those bodies of the vision for the Alliance, the priorities and how the Alliance will oversee delivery.
- The XX Alliance will, using data and information, take actions which improve health and wellbeing outcomes and reduce inequalities across its geography.

3.1 Duties

- The duties of the Committee will be driven by the integrated care strategy of the Integrated Care Partnership (ICP), the associated strategy and delivery plans of the ICB and the associated risks.
- An annual programme of business will be agreed with the ICB before the start of the financial year, however this will be flexible to new and emerging priorities and risks.
- The Committee has no executive powers, other than those delegated in the SoRD and specified in these terms of reference. Membership and attendance

4. Membership and attendance

4.1 Membership

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint no fewer than x members of the Committee based on their specific knowledge, skills and experience. Other members of the Committee need not be members of the ICB Board, but they may be.

The membership will comprise: to be specific

- primary care providers represented by PCN clinical directors or other relevant primary care leaders
- appointed Alliance clinical leaders
- local authorities including district and borough councils where relevant
- providers of acute, community and mental health services, including representatives of provider collaboratives where appropriate
- people who use care and support services and their representatives including

Healthwatch
- adult and children's social care professionals
- the voluntary, community and social enterprise sector (VCSE)
- the ICB e.g. relevant Director / nominated Senior Manager
- Independent Member (appointed)

4.2 Chair and vice chair

The Chair of the ICB will appoint a Chair of the XX Alliance Committee who has the specific knowledge skills and experience making them suitable to chair the Committee.

Committee members may appoint a Vice Chair from amongst the members.

In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number to Chair the meeting.

The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

4.3 Attendees

Only members of the Committee have the right to attend Committee meetings, however meetings of the Committee will also be attended by the following individuals who are not members of the Committee:

- ICB Executive Directors

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Boards, District and Borough Councils, Secondary and Community Providers and community and voluntary organisations.

4.4 Attendance

Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

5. Meetings Quoracy and Decisions

The XX Alliance Committee will meet at least x times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Meetings will be planned quarterly/bi-monthly/monthly subject to there being necessary business to transact. Additional meetings may take place as required.

- The Board, Chair or Chief Executive may ask the XX Alliance Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.
- In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

5.1 Quorum

- For a meeting to be quorate a minimum of x Members (50% of total members) of the Committee are required, including the Chair or Vice Chair of the Committee.
- If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.
- If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

5.2 Decision making and voting

- Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.
- Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.
- Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.
- If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

5.3 Urgent Decisions

- In the event that an urgent decision is required, every attempt will be made for the Committee to meet virtually.
- Where this is not possible an urgent decision may be exercised by the Committee Chair and relevant lead director subject to every effort having been made to consult with as many members as possible in the given circumstances (minimum of one other member).
- The exercise of such powers shall be reported to the next formal meeting of the Committee for formal ratification.

6. Responsibilities of the Committee

The Committee's duties can be categorised as follows:

6.1 Delivery of Alliance plans:

- Propose Alliance plans, and secure agreement by ICB, in response to the place-based elements of the ICP strategy and ICB plan.
- Secure progress against the place plan and provide assurance to the ICB that the plan is on target for delivery.
- Ensure relevant risks (including clinical and financial) are managed and mitigated as per the ICBs Risk Management Policy Framework.
- Manage operational delivery of the plan with all relevant partners.

6.2 Ensure the development of integrated multi-disciplinary care as per the agreed Alliance plan. This will include;

- Enabling people to access their shared digital care record to support joined-up, informed decisions around an individual's care
- Securing plans that are delivered by a capable, confident workforce which is planned in a way that allows services to wrap around individuals, their families, and carers.

6.3 Undertake appropriate local community engagement and involvement and provide account and assurance to relevant ICB committee on outcomes

6.4 Undertake agreed activities for the Alliance relating to health promotion and prevention.

6.5 Embed clinical and multi-professional engagement throughout the Alliance and across Alliances in support of the delivery of local plans and wider system priorities e.g., Stewardship and Population Health Management activities.

6.6 Projects to support delivery of Alliance-based plans:

- Prepare and secure approval of business cases as per the delegation set out in the SORD and SFIs setting out the requirements and case for transformation projects in support of Alliance plans.
- Propose to the ICB business cases in excess of the committee's delegation as set out in the SORD and SFIs, setting out the requirements and case for transformation projects to support delivery of Alliance plans and the overarching priorities and plans of the ICB.
- Monitor the delivery of agreed project objectives associated with transformation funds and undertake recovery actions where required.

6.7 Better Care Fund / S75:

- Agree the Alliance approach to BCF and recommend the business case to be submitted to the Board for approval subject to alignment with ICP and ICB policy and system wide strategy and plans.
- Ensure arrangements are supported through relevant statutory governance routes of partner organisations
- Provide assurance to the Board on the delivery of agreed outcomes for the BCF.
- Agreement and delivery of relevant s75 or joint funded initiatives within the scope of the SORD.

6.8 Driving Performance:

- Drive and oversee the delivery of the Alliance accountable ICB standards, outcomes, and common clinical policies
- Monitoring of resource utilisation at place, identifying recovery actions where required and participating in projects to realign resources in line with ICS programmes (e.g. PHM, stewardship).
- Provide assurance to the Board that management actions are in place and

succeeding to reduce inappropriate clinical variation.

6.9 In accordance with the strategy and prioritization framework for the ICB, propose and coordinate delivery of local elements of the estate strategy.

6.10 Ensure insight gained from local residents is used to shape the strategy and policy of both the Alliance. ICB and the ICS more generally.

7. Behaviours and Conduct

7.1 ICB values

Members will be expected to conduct business in line with the ICB values, objectives and Code of Conduct set out including the East of England Leadership Compact.

Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

7.2 Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make in accordance with the equality impact assessment process established by the ICB.

7.3 Conflicts of Interest

Members of the Committee will be required to declare any relevant interests to the ICB in accordance with the ICB's Conflicts of Interest Policy.

A register of Committee members' interests and those of staff and representatives from other organisations who regularly attend Committee meetings will be produced for each meeting. Committee members will be required to declare interests relevant to agenda items as soon as they are aware of an actual or potential conflict so that the Committee Chair can decide on the necessary action to manage the interest in accordance with the Policy.

7.4 Confidentiality

Issues discussed at Committee meetings, including any papers, should be treated as confidential and may not be shared outside of the meeting unless advised otherwise by the Chair.

8. Accountability and reporting

- The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.
- The Committee will undertake the agreed accountability review and assurance processes with the ICB.
- Regular reports on the delivery of place-based plans will be submitted to the ICB for assurance.

- The Chair of the Committee may be invited to attend the ICB as requested by the Chair of the ICB and the Chair of the ICB will be invited to attend the committee at least annually.

- The Chair of the Committee will be accountable to the Chair of the ICB for the conduct of the committee.

- The minutes of the meetings, including any virtual meetings, shall be formally recorded by the secretary and submitted to the Board in accordance with the Standing Orders.

- The Committee Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

9. Secretariat and Administration

The Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
- Where relevant records of members' appointments and renewal dates are maintained and the Board is prompted to renew membership and identify new members where necessary.
- Good quality minutes are taken in accordance with the standing orders, including a record of all decisions, and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
- The Chair is supported to prepare reports to the Board.
- The Committee is updated on pertinent issues/ areas of interest/ policy developments.
- Action points are taken forward between meetings and progress against those actions is monitored.

10. Review

The Committee will review its effectiveness at least annually.

These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Date of approval:

Date of review:

Mid & South Essex Integrated Care Board

Audit Committee

Terms of Reference

1. Constitution

The Audit Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. Authority

The Audit Committee is authorised by the Board to:

- Investigate any activity within its terms of reference.
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference.
- Commission any reports it deems necessary to help fulfil its obligations.
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice.
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation (SoRD) but may/ not delegate any decisions to such groups.

For the avoidance of doubt, the Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD.

3. Purpose

To contribute to the overall delivery of the ICP's objectives to create opportunities for the benefit of local residents, to support Health and Wellbeing, to bring care closer to home and to improve and transforming services by providing oversight and assurance to the ICB Board on the adequacy of governance, risk management and internal control processes within the ICB.

The duties of the Committee will be driven by the ICB's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year, however this will be flexible to new and emerging priorities and risks.

The Audit Committee has no executive powers, other than those delegated in the SoRD and specified in these terms of reference.

4. Membership and attendance

Membership

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint no fewer than 3 members of the Committee including 1 who is an Independent Non-Executive Members of the Board. Other members of the Committee need not be members of the Board, but they may be.

Neither the Chair of the Board, nor employees of the ICB will be members of the Committee.

Members will possess between them knowledge, skills and experience in accounting, risk management, internal, external audit; and technical or specialist issues pertinent to the ICB's business. When determining the membership of the Committee, active consideration will be made to diversity and equality. The membership will comprise:

- Audit Committee Chair (Chair)
- Partner Board member
- Non-Executive from an intra-system NHS Foundation Trust or Local Authority with knowledge, skills and experience in accounting, risk management and audit

Where a member of the Committee is unable to attend a meeting, a suitable deputy may be agreed with the Committee Chair. The deputy may not vote on behalf of the absent Committee member.

Chair and Vice Chair

The Chair of the ICB will appoint a Chair of the Audit Committee who has the specific knowledge, skills and experience making them suitable to chair the Committee.

The Chair of the Committee shall be independent and therefore may not chair any other committees. In so far as it is possible, they will not be a member of any other committee.

Committee members may appoint a Vice Chair from amongst the members.

In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number to Chair the meeting.

The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

Attendees

Only members of the Committee have the right to attend Committee meetings, however meetings of the Committee will also be attended by the following individuals who are not members of the Committee:

- Director of Resources or their nominated deputy.
- Representatives of both internal and external audit.
- Individuals who lead on risk management and counter fraud matters.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Boards, Secondary and Community Providers.

The Chief Executive should be invited to attend the meeting at least annually, including when the Committee considers the draft annual governance statement and the annual report and accounts.

The Chair of the ICB may also be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.

Attendance

Where an attendee of the Committee who is not a member of the Committee is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

Access

Regardless of attendance, External Audit, Internal Audit, Local Counter Fraud and Security Management providers will have full and unrestricted rights of access to the Audit Committee.

5. Meetings Quoracy and Decisions

The Audit Committee will meet at least 4 times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Meetings will be planned quarterly subject to there being necessary business to transact. Additional meetings may take place as required.

The Board, Chair or Chief Executive may ask the Audit Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

Quorum

For a meeting to be quorate a minimum of 2 independent non-executive members of the Committee are required, including the Chair or Vice Chair of the Committee.

If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

Urgent Decisions

In the event that an urgent decision is required, every attempt will be made for the Committee to meet virtually.

Where this is not possible an urgent decision may be exercised by the Committee Chair and relevant lead director subject to every effort having been made to consult with as many members as possible in the given circumstances (minimum of one other member).

The exercise of such powers shall be reported to the next formal meeting of the Committee for formal ratification.

6. Responsibilities of the Committee

The Committee's duties can be categorised as follows.

Integrated governance, risk management and internal control

To review the adequacy and effectiveness of the system of integrated governance, risk management and internal control across the whole of the ICB's activities that support the achievement of its objectives and to highlight any areas of weakness to the Board.

To ensure that financial systems and governance are established which facilitate compliance with DHSC's Group Accounting Manual, including the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications and for all work related to counter fraud, bribery and corruption as required by the NHS Counter Fraud Authority

To review the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of the ICB's objectives, the effectiveness of the management of principal risks.

To have oversight of system risks where they relate to the achievement of the ICB's objectives.

To ensure consistency that the ICB acts consistently with the principles and guidance established in HMT's Managing Public Money.

To seek reports and assurance from directors and managers as appropriate, concentrating on the systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

To identify opportunities to improve governance, risk management and internal control processes across the ICB.

Internal audit

To ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved;

- Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework;
- Considering the major findings of internal audit work, including the Head of Internal Audit Opinion, (and management's response), and ensure coordination between the internal and external auditors to optimise the use of audit resources;
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation; and
- Monitoring the effectiveness of internal audit and carrying out an annual review.

External audit

To review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and making recommendations to the governing body when appropriate);
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan;
- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee; and
- Reviewing all external audit reports, including to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.
- Ensuring the audit opinion provided by external audit is deemed appropriate and suitable to inform members whether the ICB remains a 'going concern' under the applicable standards and accounting principles and making onward recommendations to the Governing Body for adoption as appropriate
- Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services

Other assurance functions

To review the findings of assurance functions in the ICB, and to consider the implications for the governance of the ICB.

To review the work of other committees in the ICB, whose work can provide relevant assurance to the Audit Committee's own areas of responsibility.

To review the assurance processes in place in relation to financial performance across the ICB including the completeness and accuracy of information provided.

To review the findings of external bodies and consider the implications for governance of the ICB. These will include, but will not be limited to:

- Reviews and reports issued by arm's length bodies or regulators and inspectors: e.g. National Audit Office, Select Committees, NHS Resolution, CQC; and
- Reviews and reports issued by professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges and accreditation bodies).

Counter fraud

To assure itself that the ICB has adequate arrangements in place for counter fraud, bribery and corruption (including cyber security) that meet NHS Counter Fraud Authority's (NHSCFA) standards and ~~shall~~ review the outcomes of work in these areas.

To review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans, provide direct access and liaison with those responsible for counter fraud, review annual reports on counter fraud, and discuss NHSCFA quality assessment reports.

To ensure that the counter fraud service provides appropriate progress reports and that these are scrutinised and challenged where appropriate.

To be responsible for ensuring that the counter fraud service submits an Annual Report and Self-Review Assessment, outlining key work undertaken during each financial year to meet the NHS Standards for Commissioners; Fraud, Bribery and Corruption.

To report concerns of suspected fraud, bribery and corruption to the NHSCFA.

Cyber Security Management and Business Continuity

The Committee shall seek assurance on the effectiveness of:

- the systems and management arrangements established for addressing the risk of a Cyber Security attack and
- the associated Business Continuity planning and arrangements for maintaining corporate, operational and clinical services in the event of a loss of either IT or data due to a cyber attack.

Freedom to Speak Up

To review the adequacy of the ICB's arrangements for its employees, contractors and external parties to raise concerns, in confidence, in relation to financial, clinical management, or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.

Information Governance (IG)

To receive regular updates on IG compliance (including uptake & completion of data security training), data breaches and any related issues and risks.

To review the annual Senior Information Risk Owner (SIRO) report, the submission for the Data Security & Protection Toolkit and relevant reports and action plans.

To receive reports on audits to assess information and IT security arrangements, including the annual Data Security & Protection Toolkit audit.

To provide assurance to the Board that there is an effective framework in place for the management of risks associated with information governance.

Financial reporting

To monitor the integrity of the financial statements of the ICB and any formal announcements relating to its financial performance.

To ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

To review the annual report and financial statements (including accounting policies) before submission to the Board focusing particularly on:

- The wording in the Governance Statement and other disclosures relevant to the Terms of Reference of the Committee.
- Changes in accounting policies, practices and estimation techniques.
- Unadjusted mis-statements in the Financial Statements.
- Significant judgements and estimates made in preparing of the Financial Statements;
- Significant adjustments resulting from the audit.
- Explanations for significant variances.
- Letter of representation.
- Qualitative aspects of financial reporting.

Conflicts of Interest

The chair of the Audit Committee will be the nominated Conflicts of Interest Guardian.

The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

Security

The Committee shall ensure that the ICB has adequate arrangements in place for security that meet NHS England/ NHS Protect standards and review the outcomes of work in these areas.

Governance

The Committee shall seek assurance that the ICB has adequate arrangements in place to ensure that business is conducted in accordance with the law and proper standards and that its corporate governance arrangements are robust.

Emergency Planning, Resilience & Response and Business Continuity Management

The Committee shall seek assurance on implementation of Emergency Planning and Business Continuity arrangements.

Sustainability

The Committee will seek assurance on the delivery of the Mid and South Essex HCP / ICS Green Plan and associated actions to improve its carbon footprint and reducing the environmental impact of its services, including progress against the NHS Net Zero strategy.

Management

To request and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the ICB as they may be appropriate to the overall arrangements.

To receive reports of breaches of policy and normal procedure or proceedings, including such as suspensions of the ICB's standing orders, in order provide assurance in relation to the appropriateness of decisions and to derive future learning.

Delegated Authority

The Committee has delegated authority via the Scheme of Reservation and Delegation to make decisions in respect of the following:

- Approving minor amendments on behalf of the ICB Board or endorsing new and/or significant amendments for approval by the Board, of policies and procedures within its remit.

7. Behaviours and Conduct

ICB values

Members will be expected to conduct business in line with the ICB values and objectives and Code of Conduct set out in the East of England Leadership Compact.

Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

Conflicts of Interest

Members of the Committee will be required to declare any relevant interests to the ICB in accordance with the ICB's Conflicts of Interest Policy.

A register of Committee members' interests and those of staff and representatives from other organisations who regularly attend Committee meetings will be produced for each meeting. Committee members will be required to declare interests relevant to agenda items as soon as they are aware of an actual or potential conflict so that the Committee Chair can decide on the necessary action to manage the interest in accordance with the Policy.

Confidentiality

Issues discussed at Committee meetings, including any papers, should be treated as confidential and may not be shared outside of the meeting unless advised otherwise by the Chair.

8. Accountability and reporting

The Audit Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

The Chair of the committee may be invited to attend the ICB as requested by the Chair of the ICB.

The Chair of the Committee will be accountable to the Chair of the ICB for the conduct of the committee.

The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board in accordance with the Standing Orders.

The Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

The Audit Committee will provide the Board with an Annual Report, timed to support finalisation of the accounts and the Governance Statement. The report will summarise its conclusions from the work it has done during the year specifically commenting on:

- The fitness for purpose of the assurance framework.
- The completeness and 'embeddedness' of risk management in the organisation.
- The integration of governance arrangements.
- The appropriateness of the evidence that shows the organisation is fulfilling its regulatory requirements.
- The robustness of the processes behind the quality accounts.

9. Secretariat and Administration

The Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
- Records of members' appointments and renewal dates are maintained and the Board is prompted to renew membership and identify new members where necessary.
- Good quality minutes are taken in accordance with the standing orders, including a record of all decisions, and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
- The Chair is supported to prepare and deliver reports to the Board.
- The Committee is updated on pertinent issues/ areas of interest/ policy developments.
- Action points are taken forward between meetings and progress against those actions is monitored.

10. Review

The Committee will review its effectiveness at least annually.

These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the ICB Board for approval.

Date of approval:

Date of review:

Mid & South Essex Health & Care Partnership

Clinical and Multi-professional Congress

Terms of Reference

1 Constitution

1.1 The Clinical and Multi-professional Congress (CliMPC) is established by the Mid & South Essex Integrated Care Board (ICB) as a Committee of the Board in accordance with its Constitution.

1.2 These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the sub-committee and may only be changed with the approval of the Board.

1.3 The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2 Authority

2.1 CliMPC is authorised by the Board to:

- Investigate any activity within its terms of reference.
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by CliMPC) within its remit as outlined in these terms of reference.
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation (SoRD) but may/ not delegate any decisions to such groups.

2.2 For the avoidance of doubt, the Congress will comply with the ICB Standing Orders, Standing Financial Instructions and the SoRD

2.3 The Congress has an advisory role within the system, as shown in figure 1 below.

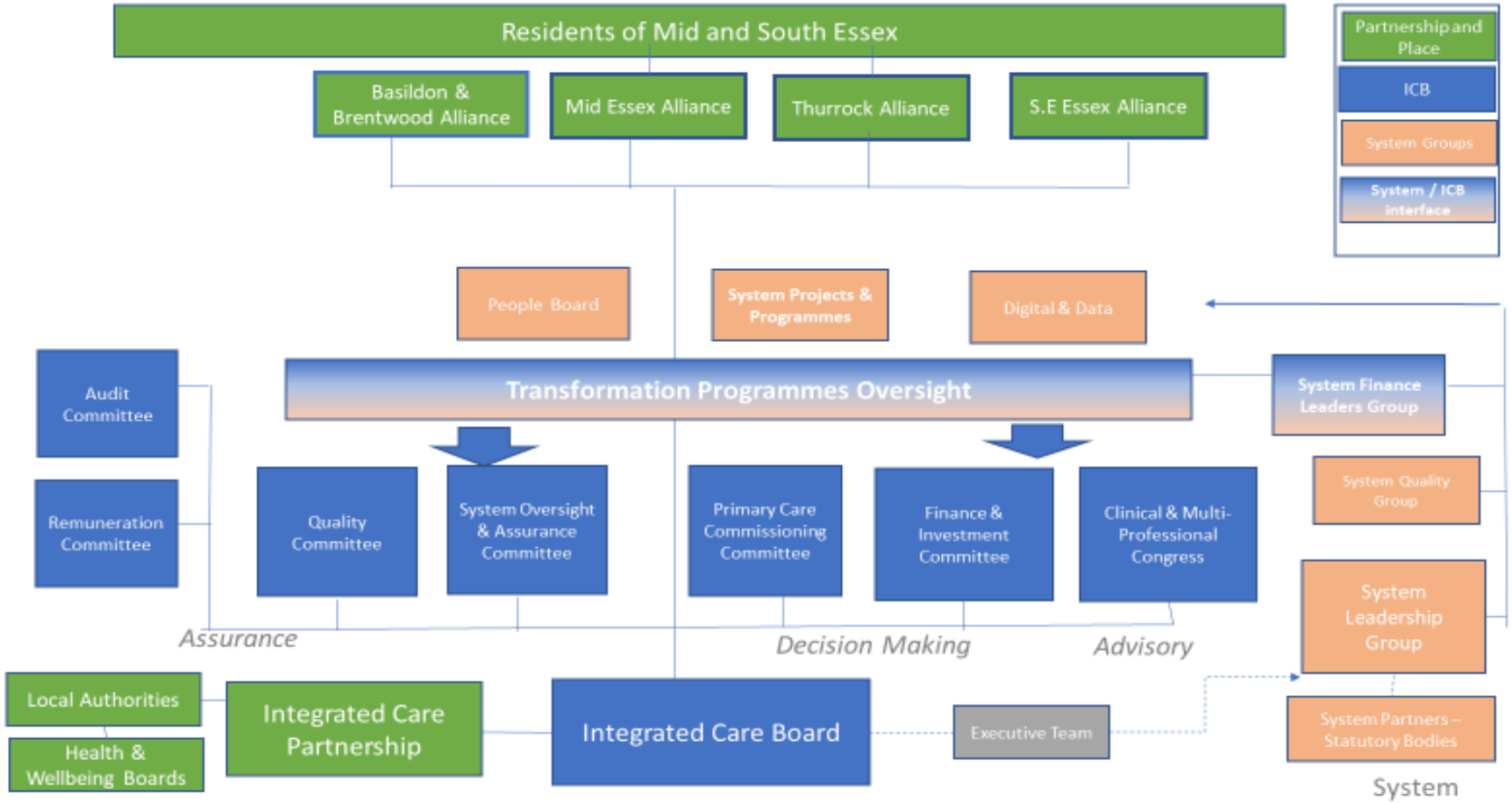


Figure 1: Committees of the Integrated Care Board

3 Purpose

3.1 To contribute to the overall delivery of Triple Aim for ICS's – better health and wellbeing for everyone, better quality of health and care services for everyone and sustainable use of health and care resources. The CliMPC will also support the ICS's objectives of creating opportunities for the benefit of local residents, bringing care closer to home and improving and transforming services by enabling, embodying and delivering on the functions of the ICB Medical Director's office, namely:

3.1.1 Innovation and horizon scanning – by developing and refining tools for assessing, advising and making recommendations on stewardship and other transformation proposals

3.1.2 Clinical and Care Strategy – by exploring, assessing and making recommendations on key system clinical and care priorities

3.1.3 Enable and engage Clinical Leadership – by taking responsibility for engaging, collaborating with and securing support from clinical and care professionals connected to their portfolio on aspects of the Congress' work.

3.1.4 Changing Clinical and Care mindsets – by being Ambassadors, responsible for enacting and ensuring support for the principles and practices of collaboration, population health management, targeting inequalities, improvement science and other approaches prioritised by the Congress.

3.1.5 Assurance and statutory adherence – by supporting the ICS Medical Director in discharging such specific assurance and statutory adherence functions as may be necessary.

3.1.6 Aim to support system work according to key ICS principles of:

- Reducing inequalities and unwarranted variation
- Helping our system become distinctive, attractive and successful by securing the respect and commitment of professionals who work in and around it.
- Informing and advancing the ICS's approach to standards, outcomes and common clinical policies – and to secure their deliberate achievement locally
- Actively participating in all decision making so that the voice of health and care staff is always heard and influences solutions.
- Doing once for the system where this makes sense.

3.2 The duties of CliMPC will be driven by the ICB's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year, however this will be flexible to new and emerging priorities and risks.

3.3 ClimPC has no executive powers, other than those delegated in the SoRD and specified in these terms of reference.

4 Membership and attendance

Membership

4.1 CliMPC members shall be appointed by interview.

4.2 Members will be appointed based on their specific knowledge, skills and experience.

4.3 The membership will comprise up to 15 members, as follows:

- ICB Medical Director (Chair)

- People with knowledge and experience from the following health and care sectors:
    - Community Care
    - Mental Health
    - Patient Engagement representative
    - Pharmacy
    - Primary Care
    - Public Health
    - Secondary Care
    - Social Care
    - Urgent and Emergency Care

4.4 Where a member is unable to attend a meeting, apologies must be sent in advance.

Chair and Vice Chair

4.5 The Chair of CliMPC will be the ICB Medical Director.

4.6 Committee members may appoint a Vice Chair from amongst the members.

4.7 In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number to Chair the meeting.

4.8 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

Attendees

4.9 Only members of CliMPC have the right to attend Committee meetings, however meetings of the Committee can be attended by others with the agreement of the Chair, as and when appropriate to assist it with its discussions on any particular matter.

4.10 The Chair may ask any or all of those who attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

5 Meetings Quoracy and Decisions

5.1 CliMPC will normally meet monthly, subject to there being necessary business to transact, and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

5.2 The Board, Chair or Chief Executive may ask the CliMPC to convene further meetings to discuss particular issues on which they want members' advice.

5.3 In accordance with the Standing Orders, CliMPC may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

Quorum

5.4 For a meeting to be quorate a minimum of 8 out of the 15 members are required, including the Chair or Vice Chair.

5.5 If any member of CliMPC has been disqualified from participating in an item on the

agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.6 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

5.7 Decisions will be taken in according with the Standing Orders. CliMPC will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

5.8 Only members may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

5.9 Where there is a split vote, with no clear majority, the Chair will hold the casting vote.

5.10 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

Urgent Decisions

5.11 In the event that an urgent decision is required, every attempt will be made for CliMPC to meet virtually.

5.12 Where this is not possible an urgent decision may be exercised by the Chair and subject to every effort having been made to consult with as many members as possible in the given circumstances.

5.13 The exercise of such powers shall be reported to the next formal meeting for formal ratification.

6 Responsibilities

6.1 CliMPC's duties are as follows:

6.1.1 Drive the identification and delivery of transformation programmes across the ICS.

6.1.2 Support health and care professionals to bring forward proposals on service transformation and improvement in a structured way, based around the ICS's Design Principles and Target Operating Model

6.1.3 Be accountable for providing clinical and professional scrutiny and critical appraisal of proposed service transformation plans to ensure that proposals will command support across the Partnership.

6.1.4 Take responsibility for ensuring that major changes to pathways within mid and south Essex are safe and conform to national standards and guidance where these exist, informing the ICB Board where potential risks to the safety and sustainability of services arise.

6.1.5 Act as a "sounding board" for proposed major transformation plans, taking into account existing evidence and national guidance, to ensure the best quality outcomes for the population

6.1.6 Ensure that service transformation plans are co-designed and produced with

patients, service users and residents.

6.1.7 Make recommendations to the ICB Board on proposals developed and scrutinised through the CMPC.

6.1.8 Support the identification and implementation of innovative solutions to system-wide challenges.

6.1.9 Ensure a robust framework for equality impact assessment of transformative change.

6.1.10 Support the strategic direction of the ICS Board.

6.1.11 Support the ICB Board where requested in developing and delivering :

- Clinical and professional leadership arrangements
- System outcomes framework
- Effective use of resources (linked to PHM)
- Clinical workforce issues (linked to People Board)
- Clinical information systems/resources (linked to Digital & work)

6.2 CliMPC members' roles may include:

6.2.1 Innovation and horizon scanning

- Enable the progress and adoption of current and future innovation and research (including through engagement with system thought leaders and transformation teams, regional EoE Academic Health Science Network (AHSN) and National Institute for Health Research (NIHR) teams, and appropriate partnership with Industry).
- Help create and establish a culture and environment for generating ideas and making them happen for the benefit of our population

6.2.2 Clinical and Care Strategy

- Champion practical improvements, including adoption of best practice and improvement against national benchmarking, in health and care services at scale, within organisations and at place.
- Support development and agreement of models of care with the wider clinical community and consider any impacts for other areas.

6.2.3 Enable and engage Clinical Leadership

- Shape and engage clinical leadership across the system so as to encourage distributed leadership and normalise collaboration and engagement.
- Gain clinical and professional ownership for the challenge of tackling variation, so that it becomes embedded in day to day practice

6.2.4 Changing Clinical and Care mindsets

- Support the empowerment of citizens to use information so that they can make decisions about their care and take personal responsibility for their health and wellbeing
- Support and advise clinical work-streams in developing financially sustainable and enduringly transformative pathways of care.

6.2.5 Assurance and statutory adherence

- Support system assurance to NHSE/I on clinical service matters
- Ensure Clinical effectiveness (e.g. Service Restriction Policies (SRP)/ Individual

Funding Requests (IFR)/ review of standards) is achieved across the system, with consistent adoption of best practice and common clinical policies and standards.

7 Behaviours and Conduct

Values

7.1 Members will be expected to conduct business in line with the ICB values, objectives and Code of Conduct set out inc. the East of England Leadership Compact.

7.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

7.3 Members must demonstrably consider the equality and diversity implications of decisions they make.

Conflicts of Interest

7.4 Members of CliMPC will be required to declare any relevant interests in accordance with the ICB's Conflicts of Interest Policy.

7.5 Members of ClimPC will be required to declare any relevant interests to the ICB in accordance with the ICB's Conflicts of Interest Policy.

7.6 A register of Committee members' interests and those of staff and representatives from other organisations who regularly attend Committee meetings will be produced for each meeting. Committee members will be required to declare interests relevant to agenda items as soon as they are aware of an actual or potential conflict so that the Committee Chair can decide on the necessary action to manage the interest in accordance with the Policy.

Confidentiality

7.7 Issues discussed at meetings, including any papers, should be treated as confidential and may not be shared outside of the meeting unless advised otherwise by the Chair.

8 Accountability and reporting

8.1 CliMPC is accountable to the Integrated Care Board and shall report to the Board on how it discharges its responsibilities.

8.2 The Chair of CliMPC may be invited to attend the Board as requested by the ICB Chair.

8.3 The Chair will be accountable to the ICB Chair for the conduct of CliMPC.

8.4 The minutes of the meetings, including any virtual meetings, shall be formally recorded by the secretary and submitted to the Board via the System Leadership Executive Group.

8.5 The Committee Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board

or require action.

8.6 It will be the responsibility of members collectively and individually to feed back to their own organisations, Places and PCNs. Summary reports and minutes will be provided to support this process.

9 Secretariat and Administration

9.1 CliMPC shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed having been agreed by the Chair.
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
- Records of members' appointments and renewal dates are maintained, with member renewals and/or new members identified where necessary.
- Good quality minutes are taken and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept.
- The Chair is supported to prepare and deliver reports to the ICB Board.
- Members are updated on pertinent issues/ areas of interest/ policy developments.
- Action points are taken forward between meetings and progress against those actions is monitored.

10 Review

10.1 CliMPC will review its effectiveness at least annually.

10.2 These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the ICB Board for approval.

Date of approval:

Date of review: Sep/ Oct

Mid & South Essex Integrated Care Board

Finance & Investment Committee

Terms of Reference

1. Constitution

1.1 The Finance & Investment Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) and is a Committee of the Board in accordance with its Constitution.

1.2 These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.3 The Committee is an executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. Authority

2.1 The Finance & Investment Committee is a formal committee of the ICB, which has delegated authority from the ICB details of which are set out in the Scheme of Reservation and Delegation. The Finance & Investment Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

2.2 The Committee is authorised by the Board to:

- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation (SoRD) but may not delegate any decisions to such groups.

2.3 For the avoidance of doubt, the Committee will comply with the ICB Standing Orders, Standing Financial Instructions, and the SoRD.

3. Purpose

3.1 The Finance & Investment Committee has a dual role on behalf of the ICB:

- Fulfilling the appropriate accounting obligations.
- Assure the ICB regarding the financial sustainability and risk mitigation in place across NHS system partners.

3.2 The purpose of the Committee is therefore as follows:

3.2.1 To provide oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable financial plans and associated financial performance in relation to services commissioned by the ICB, mitigating risk as appropriate in the context of system working.

3.2.2 To contribute to the overall delivery of the ICP's objectives to create opportunities for the benefit of local residents, to support Health and Wellbeing, to bring care closer to home and to improve and transform services by providing oversight and assurance to the ICB Board on the following areas:

- Objective oversight and scrutiny of system financial plans and decisions
- Approve system investment decisions in line with the ICB Scheme of Delegation
- Review system financial performance
- Identify key system issues and system risks requiring discussion or escalation to the Board

3.3 The duties of the Committee will be driven by the ICB's objectives and the associated system risks. An annual programme of business will be agreed before the start of the financial year, however this will be flexible to new and emerging priorities and risks.

3.4 The Finance and Investment committee has no executive powers, other than those delegated in the SoRD and specified in these ToR.

4. Membership and attendance

Membership

4.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

4.2 The Board will appoint no fewer than 5 members of the Committee, including at least one independent Non-Executive Member of the Board/external Chair, based on their specific knowledge, skills and experience. Other members of the Committee need not be members of the Board.

4.3 The Chair of the Finance & Investment Committee may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

4.4 Membership will comprise:

- Non-Executive Member of the Board (Chair) or External Chair
- Two Chairs of Finance Committees from intra-system NHS Foundation Trusts and/or Community Interest Companies providing NHS services
- Chief Executive of the ICB
- Executive Director of Resources of the ICB
- Executive Director Oversight, Assurance & Delivery of the ICB
- Executive Director of Strategy & Partnerships of the ICB
- Partner Member s151 Officer

4.5 Where a member of the Committee is unable to attend a meeting, a suitable deputy may be agreed with the Committee Chair. The deputy may vote on behalf of the absent Committee member.

Chair and vice chair

4.6 The Chair of the ICB will appoint a Non-Executive Member of the Board, with the relevant skills and experience, to chair the Finance and Investment Committee.

4.7 The Finance & Investment Committee may appoint a Vice Chair of the Committee from amongst its members.

4.8 In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number to Chair the meeting.

4.9 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

Attendees

4.10 Only members of the Committee have the right to attend Committee meetings, however meetings of the Committee may also be attended by the following individuals who are not members of the Committee by invitation:

- ICB Executive Directors
- Partner Member LA Finance Officers
- System Finance Leaders

4.11 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

4.12 Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from health partners.

Attendance

4.13 Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

5. Meetings Quoracy and Decisions

5.1 The Committee will meet at least 8 times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Meetings will be planned monthly subject to there being necessary business to transact. Additional meetings may take place as required.

5.2 The Board, Chair or Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

5.3 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

Quorum

5.4 For a meeting to be quorate a minimum of 4 Members (50% of total number of members) of the Committee are required, including the Chair or Vice Chair of the Committee and the Executive Director of Resources or their representative.

5.5 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.6 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

5.7 Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

5.8 Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

5.9 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

5.10 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

Urgent Decisions

5.11 In the event that an urgent decision is required, every attempt will be made for the Committee to meet virtually, via video conference facilities. Where this is not possible decisions should be achieved through email to all members of the committee in order to capture a transparent audit trail.

5.12 Where this is not possible an urgent decision may be exercised by the Committee Chair and relevant lead director subject to every effort having been made to consult with as many members as possible in the given circumstances (minimum of one other member).

5.13 The exercise of such powers shall be reported to the next formal meeting of the Committee for ratification.

6. Responsibilities of the Committee

6.1 The Committee's duties can be categorised as follows:

6.1.1 System financial management framework:

- Joint obligation to achieve financial balance in line with published guidance.
- Oversee and monitor delivery of the ICB key statutory requirementso set the strategic system financial framework and monitor performance against it.
- To ensure financial information systems and processes are established to make recommendations to the Board on financial planning in line with the

strategy and national guidance.

- To ensure health and social inequalities are taken into account in financial decision-making.

6.1.2 Resource allocations (revenue)

- To agree the approach for distribution of the resource allocation via commissioning and direct allocation to drive agreed change based on the ICB strategy.
- To advise on and oversee the process regarding the deployment of system-wide transformation funding taking advice and recommendation from System Finance Leadership Group (SFLG).
- To consider the recommendations of the SFLG in respect of the identification and allocation of resources where appropriate to address finance and performance related issues that may arise.
- To consider the recommendations of the System Leadership Group (SLEG) in respect of major investment/disinvestment outlined in business cases for material service change or efficiency schemes and to agree a process for sign off.

6.1.3 National framework:

- To advise the ICB on any changes to NHS and non-NHS funding regimes and consider how the funding available to the ICB can be best used within the system to achieve the best outcomes for the local population.
- To oversee national ICB level financial submissions.
- To receive assurance that the required preparatory work is scheduled to meet national planning timelines.

6.1.4 Financial monitoring information

- To agree a reporting framework for the ICB as a statutory body, using the chart of accounts devised by NHSE and the integrated single financial environment (ISFE) and the ICB as a system of bodies.
- To work with ICS partners to seek assurance over the financial reports from system bodies and provide feedback to them (being clear on how this role interacts with that of the audit committee).
- To recommend to the ICB Board a medium and long-term financial plan which demonstrates ongoing value and recovery.
- To develop an understanding of where costs sit across a system, system cost drivers and the impacts of service change on costs.
- To receive a Directorate of Resources risk register in order to be able to monitor financial and associated risks.

6.1.5 Performance:

- To oversee the management of the system financial target and the ICB ’s own financial targets.
- To agree key outcomes to assess delivery of the ICB financial strategy.
- To monitor and report to the Board overall financial performance against

national and local metrics, highlighting areas of concern.

- To monitor and report to the Board key service performance which should be taken into account when assessing the financial position.

6.1.6 System efficiencies:

- To ensure system efficiencies are identified and monitored across the ICB, in particular opportunities at system level where the scale of the ICB partners together and the ability to work across organisations can be leveraged.
- To ensure financial resources are used in an efficient way to deliver the objectives of the ICB and achieve financial sustainability.
- To review exception reports on any material breaches of the delivery of agreed efficiency improvement plan including the adequacy of proposed remedial action plans.

6.1.7 Capital:

- To ensure that the system estates & digital strategies and plans properly balance clinical, strategic and affordability drivers.
- To gain assurance that these plans are built into system financial plans.
- To monitor the system capital programme against the capital envelope and take action to ensure that it is appropriately and completely used.
- To ensure effective oversight of future prioritisation and capital funding bids.

6.1.8 Board Assurance Framework:

- Review and monitor those risks on the BAF and Corporate Risk Register which relate to finance and ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner.
- To co-ordinate system financial BAF risk reporting and liaise with system partners to ensure consistency in articulation and mitigation of financial risk.

6.1.9 Work Programmes:

- Have oversight of and approve the Terms of Reference and work programmes for the groups reporting into the Finance & Investment Committee.

6.1.10 Investment & Procurement:

- To consider business cases / service proposals and recommend appropriate action, e.g. procurement route, ensuring compliance with appropriate legislation and guidance. The committee will approve investments and procurements within its delegated limits.
- To review procurement outcomes and approve the award of contracts and/or make recommendations to the ICB, in accordance with the Scheme of Delegation.
- To review and monitor the procurement programme and the contestability plan for key programmed procurements.
- To review lessons learned from procurements and recommend changes to practice and procedures where necessary.

6.2 The Committee has delegated authority via the Scheme of Reservation and Delegation to make decisions in respect of the following:

- Approving minor amendments on behalf of the ICB Board or endorsing new and/or significant amendments for approval by the Board, of policies and procedures within its remit.
- To be replicated from the Scheme of Reservation and Delegation once finalised.

7 Behaviours and Conduct

ICB values

7.1 Members will be expected to conduct business in line with the ICB values, objectives and Code of Conduct set out including the East of England Leadership Compact.

7.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

7.3 Members must demonstrably consider the equality and diversity implications of decisions they make in accordance with the equality impact assessment process established by the ICB.

Conflicts of Interest

7.4 Members of the Committee will be required to declare any relevant interests to the ICB in accordance with the ICB's Conflicts of Interest Policy.

7.5 A register of Committee members' interests and those of staff and representatives from other organisations who regularly attend Committee meetings will be produced for each meeting. Committee members will be required to declare interests relevant to agenda items as soon as they are aware of an actual or potential conflict so that the Committee Chair can decide on the necessary action to manage the interest in accordance with the Policy.

Confidentiality

7.6 Issues discussed at Committee meetings, including any papers, should be treated as confidential and may not be shared outside of the meeting unless advised otherwise by the Chair.

8 Accountability and reporting

8.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

8.2 Undertake the agreed accountability review and assurance processes with the ICB.

8.3 Regular reports on the delivery of plans will be submitted to the ICB for assurance.

8.4 The Chair of the committee may be invited to attend the ICB as requested by the Chair of the ICB and the Chair of the ICB will be invited to attend the committee at least annually.

8.5 The Chair of the Committee will be accountable to the Chair of the ICB for the conduct of the committee.

8.6 The minutes of the meetings, including any virtual meetings, shall be formally recorded by the secretary and submitted to the Board in accordance with the Standing Orders.

8.7 The Committee Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

9 Secretariat and Administration

9.1 The Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
- Records of members' appointments and renewal dates are maintained and the Board is prompted to renew membership and identify new members where necessary.
- Good quality minutes are taken in accordance with the standing orders, including a record of all decisions, and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
- The Chair is supported to prepare and deliver reports to the Board.
- The Committee is updated on pertinent issues/ areas of interest/ policy developments.
- Action points are taken forward between meetings and progress against those actions is monitored.

10 Review

10.1 The Committee will review its effectiveness at least annually.

10.2 These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Date of approval:

Date of review:

Mid & South Essex Integrated Care Board

Primary Care Commissioning Committee

Terms of Reference

1 Constitution

1.1 The Primary Care Commissioning Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

1.2 These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.3 The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2 Authority

2.1 The Primary Care Commissioning Committee is authorised by the Board to:

- Investigate any activity within its terms of reference.
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference.
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation (SoRD) but may/ not delegate any decisions to such groups.

2.2 For the avoidance of doubt, the Committee will comply with the ICB Standing Orders, Standing Financial Instructions and the SoRD.

3 Purpose

3.1 To improve and transform services, provide oversight and assurance to the ICB on the exercise of the ICB's delegated primary care commissioning functions, adherence to the Statement of Financial Entitlements and contract monitoring for contracts held with Primary Care providers (including those holding contracts in-scope of the ICBs Commercial Framework for Primary Care).To contribute to the overall delivery of the ICB's objectives to create opportunities for the benefit of local residents, to support Health and Wellbeing, to bring care closer to home and to improve and transform services by

3.2 The duties of the Committee will be driven by the ICB's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial

year, however this will be flexible to new and emerging priorities and risks.

3.3 The Primary Care Commissioning Committee has no executive powers, other than those delegated in the SoRD and specified in these terms of reference.

4 Membership and attendance

Membership

4.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

4.2 The Board will appoint no fewer than x members of the Committee based on their specific knowledge, skills and experience. Other members of the Committee need not be members of the Board, but they may be.

4.3 The membership will comprise:

- Non-Executive Member (Chair) or Partner Member
- Medical Director or nominated deputy
- Director of Resources or nominated deputy
- Director of Nursing or nominated deputy
- Director of Primary Care
- NHS Alliance Directors
- ICB Primary Care Partner Member

4.4 Where a member of the Committee is unable to attend a meeting, a suitable deputy may be agreed with the Committee Chair. The deputy may not vote on behalf of the absent Committee member.

Chair and Vice Chair

4.5 The Chair of the ICB will appoint a Chair of the Primary Care Commissioning Committee who has the specific knowledge, skills and experience making them suitable to chair the Committee.

4.6 Committee members may appoint a Vice Chair from amongst the members.

4.7 In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number to Chair the meeting.

4.8 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

Attendees

4.9 Only members of the Committee have the right to attend Committee meetings, however meetings of the Committee will also be attended by the following individuals who are not members of the Committee:

- Local Representative Committees representative/s
- NHS England

- Healthwatch

4.10 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

4.11 Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter *Attendance*

4.12 Where an attendee of the Committee who is not a member of the Committee is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

5 Meetings Quoracy and Decisions

5.1 The Primary Care Commissioning Committee will meet at least 4 times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Meetings will be planned bi-monthly subject to there being necessary business to transact. Additional meetings may take place as required.

5.2 The Board, Chair or Chief Executive may ask the Primary Care Commissioning Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

5.3 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

Quorum

5.4 For a meeting to be quorate a minimum of 4 Members (50% of total number of members) of the Committee are required, including the Chair or Vice Chair of the Committee.

5.5 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.6 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

5.7 Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

5.8 Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

5.9 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

5.10 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

Urgent Decisions

5.11 In the event that an urgent decision is required, every attempt will be made for the Committee to meet virtually.

5.12 Where this is not possible an urgent decision may be exercised by the Committee Chair and relevant lead director subject to every effort having been made to consult with as many members as possible in the given circumstances (minimum of one other member).

5.13 The exercise of such powers shall be reported to the next formal meeting of the Committee for formal ratification.

6 Responsibilities of the Committee

6.1 The Committee's duties are as follows:

- To promote and champion primary care within the mid and south Essex system, as well as regionally and nationally.
- To monitor delivery of the primary care strategy, and the associated commercial framework, and their implementation across the whole system and within each of the four "Places".
- To oversee implementation of the Quality Strategy within Primary Care across Mid and South Essex.
- To oversee the delivery of equitable access to primary care across mid and south Essex.
- To oversee the reduction of health inequalities through primary care.
- To oversee the effective integration of primary care into neighbourhood teams.
- To agree primary care system wide work programmes, bids or returns on behalf of the ICB e.g. estates/capital submissions.
- To maintain an overview of the financial position for primary care in mid and south Essex. including tracking investment against agreed financial plans. and the stewardship of primary care resources overall, Financial position to include the delegated fund, system development funding and other resource received, or utilised, for investment in primary care as agreed through the F&IC
- To provide a forum for co-ordinating the development of Primary Care Networks beyond the requirements included within the Network DES and in line with the principles as agreed within the ICBs Primary Care Commercial Framework
- To provide a forum for other system partners to liaise with on matters that affect primary care (e.g. development of strategic plans).
- To provide a forum for sharing innovation and best practice.
- To provide a forum for sharing qualitative data such as complaints, concerns, serious incidents

- To receive assurance that action plans and risks relating to primary care quality are being addressed and that practices are being supported to improve quality.
- To monitor and review risks within the Committee's remit and identify any additional risks.
- To exercise the ICB's delegated primary care commissioning functions in relation to:
    - GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract).
    - Directed Enhanced Services.
    - Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF) aligned to the implementation of the ICB's Commercial Framework for General Practice.
    - Decision making on whether to establish new GP practices in an area,
    - Approving practice mergers,
    - Making decisions on 'discretionary' payments (e.g., returner/retainer schemes) within the scope of the Statement of Financial Entitlements.

6.2 The Committee has delegated authority via the Scheme of Reservation and Delegation to make decisions in respect of the following:

- Approving minor amendments on behalf of the ICB Board, or endorsing new and/or significant amendments for approval by the Board, of policies and procedures within its remit.

7 Behaviours and Conduct

ICB values

7.1 Members will be expected to conduct business in line with the ICB values, objectives and Code of Conduct set out inc. the East of England Leadership Compact.

7.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

7.3 Members must demonstrably consider the equality and diversity implications of decisions they make.

Conflicts of Interest

7.4 Members of the Committee will be required to declare any relevant interests to the ICB in accordance with the ICB's Conflicts of Interest Policy.

7.5 A register of Committee members' interests and those of staff and representatives from other organisations who regularly attend Committee meetings will be produced

for each meeting. Committee members will be required to declare interests relevant to agenda items as soon as they are aware of an actual or potential conflict so that the Committee Chair can decide on the necessary action to manage the interest in accordance with the Policy.

Confidentiality

7.6 Issues discussed at Committee meetings, including any papers, should be treated as confidential and may not be shared outside of the meeting unless advised otherwise by the Chair.

8 Accountability and reporting

8.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

8.2 The Chair of the committee may be invited to attend the ICB as requested by the Chair of the ICB.

8.3 The Chair of the Committee will be accountable to the Chair of the ICB for the conduct of the committee.

8.4 The minutes of the meetings, including any virtual meetings, shall be formally recorded by the secretary and submitted to the Board in accordance with the Standing Orders.

8.5 The Committee Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

9 Secretariat and Administration

9.1 The Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
- Records of members' appointments and renewal dates are maintained, including a record of all decisions, and the Board is prompted to renew membership and identify new members where necessary.
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
- The Chair is supported to prepare and deliver reports to the Board.
- The Committee is updated on pertinent issues/ areas of interest/ policy developments.

- Action points are taken forward between meetings and progress against those actions is monitored.

10 Review

10.1 The Committee will review its effectiveness at least annually.

10.2 These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the ICB Board for approval.

Date of approval:

Date of review:

Mid & South Essex Integrated Care Board

Quality Committee

Terms of Reference

1 Constitution

1.1 The Quality Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

1.2 These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.3 The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2 Authority

2.1 The Quality Committee is a formal committee of the ICB, which has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time. The Quality Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

2.2 The Committee is authorised by the Board to:

- Investigate any activity within its terms of reference.
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference.
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, Standing Orders and Scheme of Reservation and Delegation (SoRD) but may/ not delegate any decisions to such groups.

2.3 For the avoidance of doubt, the Committee will comply with the ICB Standing Orders, Standing Financial Instructions and the SoRD.

3 Purpose

3.1 The Committee has been established to contribute to the overall delivery of the ICP's objectives to create opportunities for the benefit of local residents, to support Health and Wellbeing, to bring care closer to home and to improve and transform services by providing oversight and providing the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Act 2022.

3.2 The Committee exists to scrutinise the robustness of, and provide assurance to the ICB, that there is an effective system of quality governance and internal control across the ICS that supports it to effectively deliver its strategic objectives and provide sustainable, high quality care. The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

3.3 The duties of the Committee will be driven by the ICB's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year, however this will be flexible to new and emerging priorities and risks.

3.4 The Quality Committee has no executive powers, other than those delegated in the SoRD and specified in these ToR.

4 Membership and attendance

Membership

4.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

4.2 The Board will appoint no fewer than x members of the Committee, including at least 1 Independent Non-Executive Members of the Board, based on their specific knowledge, skills and experience. Other members of the Committee need not be members of the Board, but they may be.

4.3 Neither the Chair of the Board or employees of the ICB will be members of the Committee. When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

4.4 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

4.5 The membership will comprise:

- Non-Executive Member of the Board (Chair)
- ICB Director of Nursing
- ICB Medical Director
- Other members to be determined (e.g. acute provider representative, primary care representative, local authority lead, Mental Health / Community provider representative?

4.6 Where a member of the Committee is unable to attend a meeting, a suitable deputy may be agreed with the Committee Chair. The deputy may vote on behalf of the absent Committee member.

Chair and Vice Chair

4.7 The Chair of the ICB will appoint a Non-Executive Member of the Board to Chair the Quality Committee who has the specific knowledge, skills and experience making them suitable to chair the Committee.

4.8 Committee members may appoint a Vice Chair from amongst the members of the Quality Committee.

4.9 In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number to Chair the meeting.

4.10 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

Attendees

4.11 Only members of the Committee have the right to attend Committee meetings, however meetings of the Committee will also be attended by the following individuals who are not members of the Committee:

- To be added

4.12 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

4.13 Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Boards, Secondary and Community Care Providers.

Attendance

4.14 Where an attendee of the Committee who is not a member of the Committee is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

5 Meetings Quoracy and Decisions

5.1 The Quality Committee will meet at least 6 times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Meetings will be planned bi-monthly subject to there being necessary business to transact. Additional meetings may take place as required.

5.2 The Board, Chair or Chief Executive may ask the Quality Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

5.3 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

Quorum

5.4 For a meeting to be quorate a minimum of x Members (50% of total number of members) of the Committee are required, including the Chair or Vice Chair of the Committee, the Director of Nursing or Medical Director and 2 other members.

5.5 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.6 If the quorum has not been reached, then the meeting may proceed if those attending

agree, but no decisions may be taken.

Decision making and voting

5.7 Decisions will be taken in according with the Standing Orders and recorded within the Committee minutes. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

5.8 Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

5.9 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

5.10 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

Urgent Decisions

5.11 In the event that an urgent decision is required, every attempt will be made for the Committee to meet virtually.

5.12 Where this is not possible an urgent decision may be exercised by the Committee Chair and relevant lead director subject to every effort having been made to consult with as many members as possible in the given circumstances (minimum of one other member).

5.13 The exercise of such powers shall be reported to the next formal meeting of the Committee for formal ratification.

6 Responsibilities of the Committee

6.1 The Committee's duties are as follows:

- Seek and receive assurance that there are robust processes in place for the effective management of all elements of quality (safety, effectiveness, positive experience, well-led and sustainable, and equitable)
- Scrutinise structures in place to support quality planning, control and improvement, to be assured that the structures operate effectively and that timely action is taken to address areas of concern
- Agree and put forward the key quality priorities that are included within the ICB strategy/ annual plan
- Oversee and monitor delivery of the ICB key statutory requirements including those relating to the safeguarding of children and adults.
- Review and monitor those risks on the Board Assurance Framework (BAF) and Operational Risk Registers which relate to quality, and high-risk operational risks which could impact on care and ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner
- Oversee and scrutinise the ICB's response to all relevant (as applicable to quality) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the Department of Health and Social Care (DHSC),

NHS England Improvement (NHSE/I) and other regulatory bodies / external agencies (e.g. Care Quality Committee (CQC), National Institute for Health and Care Excellence (NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained

- Maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation and assure the ICB that these are disseminated and implemented across all sites
- Oversee and seek assurance on the effective and sustained delivery of the ICB Quality Improvement Programmes
- Ensure that mechanisms are in place throughout the system to review and monitor the effectiveness of the quality of care delivered by providers and place
- Receive assurance that the system identifies lessons learned from all relevant sources, including, incidents, never events, complaints and claims, enquiries from MPs/Local Representatives and Patient Stories and ensures that learning is disseminated and embedded
- Receive assurance that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from death (including coronial inquests and Prevention of Future Death (PFD) reports)
- To be assured that people drawing on services are systematically and effectively involved as equal partners in quality activities
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for infection prevention and control
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for equality and diversity as it applies to service users
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety
- Have oversight of and approve the Terms of Reference and work programmes for the groups reporting into the Quality Committee (e.g System Quality Groups, Infection Prevention and Control, Safeguarding Boards / Hubs etc)
- To maintain oversight and scrutiny of the Continuing Health Care Service for adults, Individual Placements Team and children's continuing health care.
- To maintain oversight and scrutiny of quality within Primary Care and the nursing/residential care sector
- To maintain oversight and scrutiny of the quality of local maternity services

6.2 The Committee has delegated authority via the Scheme of Reservation and Delegation to make decisions in respect of the following:

- Approving minor amendments on behalf of the ICB Board, or endorsing new and/or significant amendments for approval by the Board, of policies and procedures within its remit.

7 Behaviours and Conduct

ICB values

7.1 Members will be expected to conduct business in line with the ICB values, objectives and Code of Conduct set out in the East of England Leadership Compact.

7.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, Standards of Business Conduct Policy.

Equality and diversity

7.3 Members must demonstrably consider the equality and diversity implications of decisions they make.

Conflicts of Interest

7.4 Members of the Committee will be required to declare any relevant interests to the ICB in accordance with the ICB's Conflicts of Interest Policy.

7.5 A register of Committee members' interests and those of staff and representatives from other organisations who regularly attend Committee meetings will be produced for each meeting. Committee members will be required to declare interests relevant to agenda items as soon as they are aware of an actual or potential conflict so that the Committee Chair can decide on the necessary action to manage the interest in accordance with the Policy.

Confidentiality

Issues discussed at Committee meetings, including any papers, should be treated as confidential and may not be shared outside of the meeting unless advised otherwise by the Chair.

8 Accountability and reporting

8.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

8.2 The Chair of the committee may be invited to attend the ICB as requested by the Chair of the ICB.

8.3 The Chair of the Committee will be accountable to the Chair of the ICB for the conduct of the committee.

8.4 The minutes of the meetings, including any virtual meetings, shall be formally recorded by the secretary and submitted to the Board in accordance with the Standing Orders.

8.5 The Committee Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

8.6 The Committee will advise the Audit Committee on the adequacy of assurances available and contribute to the Annual Governance Statement.

9 Secretariat and Administration

9.1 The Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
- Records of members' appointments and renewal dates are maintained and the Board is prompted to renew membership and identify new members where necessary.
- Good quality minutes are taken in accordance with the standing orders, including a record of all decisions, and agreed with the chair and that a record of matters arising, action points, and issues to be carried forward are kept.
- The Chair is supported to prepare and deliver reports to the Board.
- The Committee is updated on pertinent issues/ areas of interest/ policy developments.
- Action points are taken forward between meetings and progress against those actions is monitored.

10 Review

10.1 The Committee will review its effectiveness at least annually which will feed into the annual Governance Statement, and will complete an annual report submitted to the ICB Board

10.2 These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the ICB Board for approval.

10.3 The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Date of approval:

Date of review:

Mid & South Essex Integrated Care Board

Remuneration Committee

Terms of Reference

1 Constitution

1.1 The Remuneration Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

1.1 These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.2 The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2 Authority

2.1 The Remuneration Committee is authorised by the Board to:

- Investigate any activity within its terms of reference.
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference.
- Commission any reports it deems necessary to help fulfil its obligations.
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice.
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation (SoRD) but may/ not delegate any decisions to such groups.

2.2 For the avoidance of doubt, the Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD.

3 Purpose

3.1 To exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006, specifically to confirm the ICB Pay Policy including adoption of any pay frameworks for all employees including senior managers/directors (including board members).

3.2 The duties of the Committee will be driven by the ICB's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial

year, however this will be flexible to new and emerging priorities and risks.

3.3 The Remuneration Committee has no executive powers, other than those delegated in the SoRD and specified in these terms of reference.

4 Membership and attendance

Membership

4.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

4.2 The Board will appoint no fewer than 3 members of the Committee including 2 independent non-executive members of the Board based on their specific knowledge, skills and experience. Other members of the Committee need not be members of the Board, but they may be.

4.3 Neither the Chair of the Audit Committee nor any employees of the ICB may be members of the Committee.

4.4 The Chair of the Board may be a member of the Committee but may not be appointed as the Chair.

4.5 When determining the membership of the Committee, active consideration will be made to diversity and equality.

4.6 The membership will comprise:

- Remuneration Committee Chair (non-executive member)
- Non-executive member
- Partner Board member

4.7 Where a member of the Committee is unable to attend a meeting, a suitable deputy may be agreed with the Committee Chair. The deputy may not vote on behalf of the absent Committee member.

Chair and Vice Chair

4.8 The Chair of the ICB will appoint a Chair of the Remuneration Committee who has the specific knowledge, skills and experience making them suitable to chair the Committee.

4.9 Committee members may appoint a Vice Chair from amongst the members.

4.10 In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number to Chair the meeting.

4.11 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference.

Attendees

4.12 Only members of the Committee have the right to attend Committee meetings, however meetings of the Committee may also be attended for all or part of a meeting by the following individuals who are not members of the Committee:

- The ICB's most senior HR Advisor or their nominated deputy
- Director of Resources or their nominated deputy
- Chief Executive or their nominated deputy

4.13 Such attendees will not be eligible to vote.

4.14 The Chair may ask any or all of those in attendance who are not members to withdraw to facilitate open and frank discussion of particular matters.

4.15 No voting individual should be present during any discussion relating to:

- Any aspect of their own pay;
- Any aspect of the pay of others when it has an impact on them.

4.16 Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter, including representatives from the Health and Wellbeing Boards, Secondary and Community Providers.

Attendance

4.17 Where an attendee of the Committee who is not a member of the Committee is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

5 Meetings Quoracy and Decisions

5.1 The Committee will meet in private.

5.2 The Remuneration Committee will meet at least 2 times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Meetings will be planned six monthly subject to there being necessary business to transact. Additional meetings may take place as required.

5.3 The Board, Chair or Chief Executive may ask the Remuneration Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

5.4 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

Quorum

5.5 For a meeting to be quorate a minimum of 2 Members of the Committee are required, including the Chair or Vice Chair of the Committee.

5.6 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.7 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

5.8 Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

5.9 Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

5.10 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

5.11 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

Urgent Decisions

5.12 In the event that an urgent decision is required, every attempt will be made for the Committee to meet virtually.

5.13 Where this is not possible an urgent decision may be exercised by the Committee Chair and relevant lead director subject to every effort having been made to consult with as many members as possible in the given circumstances (minimum of one other member).

5.14 The exercise of such powers shall be reported to the next formal meeting of the Committee for formal ratification.

6 Responsibilities of the Committee

6.1 The Committee's duties are as follows:

6.1.1 For the Chief Executive, Executive Directors and other Very Senior Managers on the VSM pay scale and other Board members apart from Non-Executive Members:

- Determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses and other contractual or non-contractual payments.
- Determine arrangements for termination of employment and other contractual terms and non-contractual terms.

6.1.2 Agree the pay framework for clinical staff working within the ICB but outside of Agenda for Change terms and conditions.

6.1.3 Oversee off payroll contracts via receipt of bi-annual reporting.

6.1.4 For all staff:

- Oversee any payments outside of agenda for change pay policy, for example but not limited to on call payments.
- Determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate.

6.1.5 In order to avoid conflicts of interest, the remuneration of Non-Executive Members will be determined by a separate Lay Member Remuneration Panel comprising the ICB Chair, Chief Executive, Director of People and 1 Partner Member.

7 Behaviours and Conduct

ICB values

7.1 Members will be expected to conduct business in line with the ICB values, objectives and Code of Conduct set out in the East of England Leadership Compact.

7.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

7.3 Members must demonstrably consider the equality and diversity implications of decisions they make.

Conflicts of Interest

7.4 Members of the Committee will be required to declare any relevant interests to the ICB in accordance with the ICB's Conflicts of Interest Policy.

7.5 A register of Committee members' interests and those of staff and representatives from other organisations who regularly attend Committee meetings will be produced for each meeting. Committee members will be required to declare interests relevant to agenda items as soon as they are aware of an actual or potential conflict so that the Committee Chair can decide on the necessary action to manage the interest in accordance with the Policy.

Confidentiality

7.6 Issues discussed at Committee meetings, including any papers, should be treated as confidential and may not be shared outside of the meeting unless advised otherwise by the Chair.

8 Accountability and reporting

8.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

8.2 The Chair of the committee may be invited to attend the ICB as requested by the Chair of the ICB.

8.3 The Chair of the Committee will be accountable to the Chair of the ICB for the conduct of the committee.

8.4 The minutes of the meetings, including any virtual meetings, shall be formally recorded by the secretary and submitted to the Board in accordance with the Standing Orders.

8.5 The Committee Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

9 Secretariat and Administration

9.1 The Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
- Records of members' appointments and renewal dates are maintained and the Board is prompted to renew membership and identify new members where necessary.
- Good quality minutes are taken in accordance with the standing orders , including a record of all decisions, and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
- The Chair is supported to prepare and deliver reports to the Board.
- The Committee is updated on pertinent issues/ areas of interest/ policy developments.
- Action points are taken forward between meetings and progress against those actions is monitored.

10 Review

10.1 The Committee will review its effectiveness at least annually.

10.2 These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the ICB Board for approval.

Date of approval:

Date of review:

Mid & South Essex Integrated Care Board

System Oversight and Assurance Committee

Terms of Reference

1 Purpose

1.1. The System Oversight and Assurance Committee (SOAC) is the primary governance forum to oversee the ICS's mutual accountability arrangements. It will take an overview of system performance relating to agreed outcomes and operational performance against constitutional standards and triangulate with equivalent processes for quality and safety and finance. It will act as the performance assurance committee of the ICB.

1.2. These Terms of Reference describe the scope, function and ways of working for the SOAC. They should be read in conjunction with the Partnership Memorandum of Understanding and Compacts.

2 Context

2.1 The partnership approach to system oversight will be geared towards performance improvement and development. It will be data-driven, evidence-based and rigorous. The focus will be on supporting the spread and adoption of innovation and best practice between Partners. Peer review will be a core component of the methodology.

2.2 NHS England & Improvement has adopted a new relationship with NHS Partners in mid and south Essex, enacting streamlined oversight arrangements under which:

- Partners will take the collective lead on oversight of providers, commissioners and Places in accordance with the terms of the Partnership MoU;
- NHSEI will in turn focus on holding the NHS bodies in the Partnership to account as a whole system for delivery of the NHS Constitution and Mandate, financial and operational control, outcomes and quality;
- NHSEI will intervene in the individual partners only where it is necessary or required for the delivery of their statutory functions and will (where it is reasonable to do so, having regard to the nature of the issue) in the first instance work through the ICB to seek a resolution prior to making an intervention with the Partner.

2.3 To support Partnership development as an Integrated Care System there will be a process of aligning resources from NHSEI to support delivery and establish an integrated single assurance and regulation approach.

3 Responsibilities of the System Oversight & Assurance Committee

3.1 The SOAC will provide oversight and challenge, focused around the system's performance against agreed outcome measures, NHS constitutional standards and associated transformation programmes and aligned to key safety and quality measures.

3.2 It supports the joint accountability function for and on behalf of the partners and provides a single mechanism of providing assurance to the Integrated Care board, individual Boards and Governing Bodies and committees established across statutory organisations to monitor performance. *Over time, it is expected that the SOAC will align individual governance arrangements for monitoring of performance, enabling joint accountability and reporting to fulfill the statutory functions of individual organisations.* The committee will support and operate *in line with principles and functions set out in the Memorandum of Understanding between NHSE/I and MSE.*

3.3 The SOAC will:

3.3.1 Oversee the development of a dashboard of key outcome, performance, and quality and transformation metrics for the Partnership, linking with the system Data and Intelligence function.

3.3.2 Take an overview of performance and transformation at whole system, place and organisation levels in relation to ICP objectives and wider national requirements.

3.3.3 Create links with key groups responsible for day-to-day management of performance enabling the SOAC to conduct regular "deep dives" into areas of system performance, These groups include:

Internal

- Elective Care Oversight Board
- Mental Health Partnership Board
- Local Maternity Services Transformation Board
- Transforming Care Partnership
- Place-based transformation boards
- Clinical Quality Review Group(s) / System Quality Group
- System Finance Leaders' Group
- Clinical & Professional Forum
- MSE People Board
- Diagnostic Programme Board
- Cancer, Palliative and End of Life Board
- Community Partnership Board
- Strategic Urgent and Emergency Care Boars
- Home First
- Mental Health Partnership Board
- Children and Young People Taskforce

External

- NHS England & Improvement
- Care Quality Commission
- Quality Surveillance Groups

3.3.4 Lead the development of a framework for peer review and support for the Partnership and oversee its application.

3.3.5 Provide assurance to the ICB on delivery of performance standards, highlighting relevant risks and mitigating actions to correct non delivery, and escalating key risks, controls and assurances to the ICB in line with agreements set out in system Compacts.

3.3.6 Make recommendations to the System Leadership Group and the ICB on the deployment of improvement support across the ICP, and on the need for more formal action and interventions. Actions will include the requirement for:

- Agreement of improvement or recovery plans;
- More detailed peer-review of specific plans;
- Commissioning expert external review;
- Co-ordination of formal intervention and improvement support;
- Restrictions on access to discretionary funding and financial incentives.

3.3.7 Make recommendations to the Integrated Care Board in respect of the deployment of improvement support across the Partnership, and on the need for more formal action and interventions where further escalation has been necessary, in line with the system oversight framework, NHSE MoU, Compacts (see Appendix 1) and escalating risks to the ICBs Board Assurance Framework as necessary and in line with the ICB Risk Management Policy.

3.3.8 Receive reports from ICP priority programmes and enabling workstreams on issues which require escalation.

4 Membership

4.1 The membership of the SOAC will include representation from each sector of the Partnership. Members will be nominated so as to reflect appropriate representation from each of the four Places in mid and south Essex.

4.2 The membership will comprise:

- ICB Chief Executive (Co-Chair)
- Lead Director NHSE/I (Co-Chair)
- Deputy Chief Executive, MSEFT (Deputy Chair)
- Nominated Chief Nurse from Chief Nurse group
- Nominated Director, EPUT
- Nominated Director, NELFT
- Nominated Director, Provide
- Nominated Director, EEAST
- Nominated Director, IC24
- Nominated lead from the Basildon & Brentwood Alliance [NHS or Local Authority]
- Nominated lead from the Mid Essex Live Well Partnership [NHS or Local Authority]
- Nominated lead from the South East Essex Partnership [NHS or Local Authority]
- Nominated lead from the Thurrock Alliance [NHS or Local Authority]
- Nominated lead from Clinical and Multi-Professional Forum
- Nominated lead from System Finance Leaders' Group

- Executive Director of Oversight, Assurance & Delivery, Mid & South Essex Integrated Care Board
- Executive Chief People Officer Mid & South Essex Integrated Care Board
- Executive Director of Strategy & Partnerships, Mid & South Essex Integrated Care Board
- Director of Communications & Engagement, Mid & South Essex Integrated Care Board

Local Authority senior Officers will be invited to attend SOAC quarterly

4.3 If a member is unable to attend a meeting of the SOAC, s/he will be responsible for identifying a suitable deputy to attend on their behalf. Such a deputy must have sufficient seniority and understanding of the issues to be considered, to represent their organisation, place or group.

4.4 Additional attendees may routinely include:

- SROs for identified quality and performance areas
- SROs and programme leads for transformation programmes

5 Quoracy and voting

5.1 The SOAC is not a formal decision making body. The Committee will operate on the basis of joint accountability and consensus.

Quorum

- Chair
- 2 x ICB Executives
- 1 Provider Executive
- 1 Alliance / LA member

Decision Making and Voting

5.2 Under exceptional circumstances any substantive difference of views among members will be reported to the Integrated Care Board.

6 Accountability and reporting

6.1 The SOAC does not have any powers or functions formally delegated by the Boards or governing bodies of its constituent organisations although this may change over time. As a committee of the ICB, it provides a performance assurance function to the Board

6.2 In line with principles and functions set out in the Memorandum of Understanding between NHSE/I and MSE, NHSEI may, where appropriate, enact certain regulatory and system oversight functions through the committee. Where appropriate NHSE/I will utilise its role as Co-Chair to fulfil this function.

6.3 The SOAC will formally report, through the Chair, to the Integrated Care Board It will make recommendations, where appropriate to the Integrated Care Board, the System Leadership Group and partner organisations as required.

7 Conduct and Operation

7.1 The SOAC will normally meet monthly.

7.2 Extraordinary meetings may be called for a specific purpose at the discretion of the Chair. A minimum of five working days notice will be given when calling an extraordinary meeting.

7.3 The agenda and supporting papers will be sent to members and attendees no less than five working days before the meeting. Urgent papers will be permitted in exceptional circumstances at the discretion of the Chair.

7.4 Draft action notes will be issued within 10 working days of each meeting. Minutes of the meeting will be reported to the Integrated Care Board.

8 Secretariat

8.1 The secretariat function for the SOAC will be provided by the ICB. A member of the team will be responsible for arranging meetings, recording notes and actions from each meeting, preparing agendas, and agreeing these with the Chair.

9 Review

9.1 These terms of reference and the membership of the SOAC will be reviewed at least annually. Further reviews will be undertaken in response to any material developments or changes in the wider governance arrangements of the ICS.

Mid and South Essex Integrated Care System

NHS
Mid and South Essex
Integrated Care Board

Part I Board Meeting

Date of meeting	1 July 2022
Agenda item number	8
Title of report	Adoption of ICB Policies
Purpose of report.	To request the ICB Board to approve the suite of policies developed for the new organization.
Executive Lead	Anthony McKeever, Chief Executive.
Report Author	Viv Barnes, Governance Lead. Sara O'Connor, Head of Corporate Governance.
Impact Assessments	Equality impact assessments have been undertaken and included as an appendix within every policy.
Financial implications	None identified.
Details of patient or public engagement or consultation.	Each policy provides details of the engagement undertaken during its development.
Conflicts of Interest:	None identified.
Recommendation(s)	The Board is asked to formally adopt the draft ICB Policies set out in **Appendix A**, with particular reference to the following policies: • Standards of Business Conduct Policy. • Conflict of Interests Policy. • Risk Management Policy.

Adoption of ICB Policies

1. Introduction

1.1. A suite of policies has been developed for adoption by the new Integrated Care Board (ICB) as set out in **Appendix A**. This report confirms the arrangements that were put in place to develop, review and endorse these policies.

2. Process for Development and Review of ICB Policies

2.1. A comprehensive list of current policies was developed to identify policies required for the ICB, as well as any additional policies required to enable the organisation to discharge its new duties.

2.2. Where possible, existing policies were consolidated into a single version and key policies required for 'Day 1' of the ICB were agreed. Policy authors were then identified.

2.3. A new Policy for Developing Policies was developed, including a policy template, to meet accessibility standards.

2.4. Draft policies were reviewed by appropriate stakeholders and then submitted to the relevant MSE CCG committees as part of the due diligence process.

2.5. Complete versions of three governance policies - Standards of Business Conduct, Management of Conflicts of Interest and Risk Management - are included in the Board papers as they are of particular relevance to Board members.

2.6. Once approved, the final policies are will be uploaded to the ICB staff intranet and website so that they are readily accessible to both staff and members of the public.

2.7. There remain a small number of policies that have not yet been finalised and are not essential to be in place from Day 1. These will be submitted to the appropriate ICB Committee for endorsement prior to seeking Board approval at a later date.

2.8. The Board is asked to note that three Information Governance (IG) Policies, namely the IG Framework and Policy, Information Sharing Policy and the Information and Cyber Security Policy, will be reviewed and updated once new staffing structures are in place and the ICS-wide approach to IG is decided.

2.9. The Governance Team will have responsibility for ensuring that ICB policies are regularly reviewed and uploaded to the intranet/website.

3. Recommendations

3.1. The Board is asked to formally adopt the draft ICB Policies as set out in **Appendix A**.

4. Appendices

Appendix A – Summary of ICB Policies for adoption

Appendix B – Standards of Business Conduct Policy

Appendix C – Conflicts of Interest Policy

Appendix D – Risk Management Policy

Appendix A

Ref Number:	Workstream	Work Area	Policy Name	Review Process
001	Comms & Engagement	Comms & Engagement	Media Relations Policy	Audit Committee
002	Comms & Engagement	Comms & Engagement	Social Media Policy	Audit Committee
004	Financial Framework & Use of Resources	Finance	Accounting and Financial Management	Audit Committee
006	Financial Framework & Use of Resources	Finance	Banking and Cashflow Management Policy	Audit Committee
007	Financial Framework & Use of Resources	Finance	Creditors and Purchase Policy	Audit Committee
008	Financial Framework & Use of Resources	Finance	Debtors and Sales Order Policy	Audit Committee
010	Financial Framework & Use of Resources	Information Governance	Information Governance Management & Framework Policy	Audit Committee
011	Financial Framework & Use of Resources	Information Governance	Information Sharing Policy	Audit Committee
012	Financial Framework & Use of Resources	Information Governance	Records Management & Information Lifecycle Policy	Audit Committee
013	Financial Framework & Use of Resources	Information Governance	Access to Information Policy	Audit Committee
014	Financial Framework & Use of Resources	Information Governance	Information and Cyber Security Policy	Audit Committee
016	Governance, Accountability & Risk	Governance	Policy for Policies	Audit Committee
017	Governance, Accountability & Risk	Governance	Risk Management Policy	Audit Committee
018	Governance, Accountability & Risk	Governance	Conflicts of Interest, Gifts and Hospital and Commercial Sponsorship	Audit Committee
019	Governance, Accountability & Risk	Governance	Standards of Business Conduct Policy	Audit Committee
020	Governance, Accountability & Risk	Governance	Lone Worker Policy	Audit Committee
021	Governance, Accountability & Risk	Governance	Health & Safety Policy (including Fire Safety, First Aid and Manual Handling)	Audit Committee
022	Governance, Accountability & Risk	Governance	Legal Services Policy	Audit Committee
023	Governance, Accountability & Risk	Governance	Raising Concerns (Whistleblowing) Policy	Audit Committee
024	Governance, Accountability & Risk	Governance	Incident Reporting	Audit Committee
025	Governance, Accountability & Risk	Governance	Management of Violence & Aggression Policy	Audit Committee
026	Governance, Accountability & Risk	Governance	Counter-Fraud, Bribery & Corruption Policy	Audit Committee
027	Governance, Accountability & Risk	Governance	Forensic Readiness Policy	Audit Committee
029	Governance, Accountability & Risk	EPRR / Estates	Security and Lockdown Policy	Audit Committee
030	Governance, Accountability & Risk	EPRR	Business Continuity Policy	Audit Committee
031	Governance, Accountability & Risk	EPRR	On Call Director Policy	Audit Committee
032	Governance, Accountability & Risk	Equality & Health Inequalities	Health Inequalities Impact Assessment Policy and Guidance	Executives
033	Leadership & People Development	HR	Equality in Employment	Remuneration Committee
034	Leadership & People Development	HR	Recruitment & Selection	Remuneration Committee
035	Leadership & People Development	HR	Job Evaluation	Remuneration Committee
036	Leadership & People Development	HR	Disclosure and Barring Policy	Remuneration Committee
037	Leadership & People Development	HR	Nurse Revalidation Policy	Remuneration Committee
038	Leadership & People Development	HR	Professional Registration Policy	Remuneration Committee
039	Leadership & People Development	HR	Probation Policy	Remuneration Committee
040	Leadership & People Development	HR	Stress Management	Remuneration Committee
041	Leadership & People Development	HR	Flexible Working Policy	Remuneration Committee
042	Leadership & People Development	HR	Grievance Policy	Remuneration Committee
043	Leadership & People Development	HR	Managing Performance Policy	Remuneration Committee
044	Leadership & People Development	HR	Absence Management Policy	Remuneration Committee
045	Leadership & People Development	HR	Disciplinary Policy	Remuneration Committee

046	Leadership & People Development	HR	Hybrid Working Policy	Remuneration Committee
047	Leadership & People Development	HR	Annual Leave Policy	Remuneration Committee
048	Leadership & People Development	HR	Special Leave Policy	Remuneration Committee
049	Leadership & People Development	HR	Maternity, Paternity & Adoption Leave Policy	Remuneration Committee
050	Leadership & People Development	HR	Parental Leave Policy	Remuneration Committee
051	Leadership & People Development	HR	Shared Parental Leave	Remuneration Committee
052	Leadership & People Development	HR	Fostering Policy	Remuneration Committee
053	Leadership & People Development	HR	Learning & Development Policy	Remuneration Committee
054	Leadership & People Development	HR	Appraisal Policy	Remuneration Committee
055	Leadership & People Development	HR	Organisational Change and Pay Protecton Policy	Remuneration Committee
056	Leadership & People Development	HR	Dignity at Work Policy	Remuneration Committee
058	Leadership & People Development	HR	Management of Leavers Policy	Remuneration Committee
060	Leadership & People Development	HR	Close Personal Relationships at Work	Remuneration Committee
061	Leadership & People Development	HR	Domestic Violence and Abuse Policy	Remuneration Committee
062	Quality & Safety	Quality	Complaints, Compliments and Concerns Management Policy	Patient Safety & Quality
063	Quality & Safety	Quality	Safeguarding Adults and Children (including Children in Care/Looked After Children) Po	Patient Safety & Quality
064	Quality & Safety	Quality	Safeguarding Supervision Policy	Patient Safety & Quality
065	Quality & Safety	Quality	Management of Allegations against staff, volunteers and people in positions of trust w	Patient Safety & Quality
066	Quality & Safety	Quality	Safeguarding Children & Adults at risk of Domestic Abuse Policy	Patient Safety & Quality
067	Quality & Safety	Quality	Serious Incidents Process Policy	Patient Safety & Quality
068	Quality & Safety	Quality	All Age Continuing Care Policy	Patient Safety & Quality
069	Quality & Safety	Quality	Personal Health Budgets: Ethos, Practice and Guidance Policy	Patient Safety & Quality
070	Quality & Safety	Quality	Management of Perplexing Presentations and Fabricated or Induced Illness in Children	Patient Safety & Quality
071	Quality & Safety	Quality	Counter-Terrorism and Security Act 2015 (including Prevent Duty and Radicalisation) P	Patient Safety & Quality
072	Quality & Safety	Quality	Quality Assurance Visits Policy	Patient Safety & Quality
073	Quality & Safety	Quality	Mental Capacity Act 2005 and Deprivation of Liberty Policy	Patient Safety & Quality
074	Quality & Safety	Quality	Communicable Disease Outbreak and Incident Management Policy	Patient Safety & Quality

Appendix B

Standards of Business Conduct Policy

Document Control:

Policy Name	Standards of Business Conduct Policy
Policy Number	MSEICB 019
Version	V1.0
Status	Draft ICB Policy
Author / Lead	Head of Corporate Governance, Mid Essex CCG
Responsible Executive Director	The Chief Executive has delegated responsibility to the Chief of Staff
Responsible Committee	Audit Committee
Date Ratified by Responsible Committee	1 February 2022
Date Approved by Board/Effective Date	1 July 2022
Next Review Date	1 July 2025
Target Audience	• Mid and South Essex (MSE) Integrated Care Board (ICB) members and staff (including temporary/bank/agency/work experience staff). • Contractors engaged by the ICB. • Staff from other MSE Integrated Care Partnership (ICP) organisations who are members of ICB Committees/Sub-Committees and other groups.
Stakeholders engaged in development of Policy (internal and external)	• Mid and South Essex CCG Governance Leads. • Human Resources. • Information Governance Lead. • Associate Director, Attain (independent Procurement Specialists). • MSE CCGs Audit Committees meeting in common
Impact Assessments Undertaken *(Delete if non-applicable)*	• Equality and Health Inequalities Impact Assessment

Version History

Version	Date	Author (Name and Title)	Summary of amendments made
0.1	17/12/2021	Sara O'Connor Head of Corporate Governance, Mid Essex CCG	First draft of new Policy for Integrated Care Board
0.2	14/01/22	As above	Updated following comments from other Governance Leads

Version	Date	Author (Name and Title)	Summary of amendments made
0.3	17/01/22	As above	Section 5.15 updated following review by Information Governance Lead.
0.4	20/01/22	As above	Section 5.2 amended to reflect feedback from internal audit and LCFS
0.5	01/02/22	Above	Minor amendments at request of Audit Committees in common.
0.5	26/05/22	Sara O'Connor	Updated to confirm policy is based on current NHS guidance but will be revised in the event of updated guidance.
0.6	27/05/22	Viv Barnes	Updated reference to Fit and Proper Person and minor amendments to V.05.
0.7	21/06/22	Sara O'Connor	Policy Reference No. added, references to associated policies updated.

Contents

1. Introduction

1.1. As a public body, the Mid and South Essex Integrated Care Board (the ICB) has a duty to ensure high standards of corporate and personal conduct. The ICB is accountable to Parliament for the services it provides and for delivering effective, economic and efficient use of taxpayers' money. All Board members, employees and others acting on behalf of the ICB must therefore uphold the highest standards of business conduct when performing their role in relationships with stakeholders, partners and suppliers, and outside of their role where such a relationship might be open to public scrutiny.

1.2. Officers and members of public bodies, including the ICB, are subject to the provision of special legislation, guidelines and codes of conduct designed to protect the public interest and public confidence, which has been set out within the Health and Social Care Act 2012, Health and Care Act 2022 and other legislation or NHS guidance including:

- The Seven Principles of Public Life
- Managing Conflicts of Interest in the NHS.
- NHS Code of Conduct and Code of Accountability (2004, revised 2013).
- The Fit and Proper Persons requirement of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Professional Standards Authority: Standards for members of NHS Boards and CCG Governing bodies in England (2012).
- The Association of the British Pharmaceutical Industry (APBI) Code of Professional Conduct relating to hospitality / gifts from the pharmaceutical industry.
- The Bribery Act 2010.
- Companies Act 2006 – Directors Duties (The duty not to accept benefits from third parties: Section 176) which is relevant to Community Interest Companies.
- Local Authority local Codes of Conduct.

1.3. This policy reflects current NHS guidance and it is recognised that the ICB's partner members may have slightly differing codes of conduct, however all organisations are bound by their common duty to comply with the Seven Principles of Public Life.

1.4. All individuals within the scope of this policy must act with probity when dealing with the assets of the ICB and the NHS in the use of information acquired in the course of their duties and must abide by the Seven

Principles of Public Life (the 'Nolan Principles) as set out by the Committee on Standards in Public Life – see **Appendix B**.

2. Purpose / Policy Statement

2.1. This is the ICB's policy for upholding high standards of business conduct and public service and values. The policy provides a central reference guide setting out the principles of conduct that should be followed when working on behalf of the ICB that will enable individuals to meet the duties set out in relevant legislation and guidance.

2.2. The ICB's Conflicts of Interest Policy and other associated policies referred to throughout should be read in conjunction with this policy.

2.3. Staff who are in doubt as to any aspects of this policy should first seek the advice of their line manager and/or the ICB Governance Lead.

3. Scope

3.1. This policy applies to:

- Mid and South Essex (MSE) Integrated Care Board (ICB) members and staff (including temporary/bank/agency/work experience staff).
- Contractors engaged by the ICB.
- Staff from other MSE Integrated Care Partnership (ICP) organisations who are members of ICB Committees/Sub-Committees and other groups.

4. Definitions

- **Accountability** – honest and ethical conduct and being willing for judgements to be made about one's progress, with tasks to be evaluated by others to respond positively to those judgements to better help secure the outcomes the ICB is seeking
- **Corruption** - an impairment of integrity, virtue, or moral principle, bribery or a departure from correct behaviour.
- **Fraud** - includes dishonestly making a false representation, failing to disclose information or abusing a position held, with the intention of making a financial gain or causing a financial loss. The Fraud Act 2006 has no specific definition of fraud, but instead describes ways fraud can be committed as outlined in section 6.2 below.
- **Gift** - any item of cash or goods, or any service, which is provided for personal benefit, free of charge or at less than its commercial value.
- **Gifts and Hospitality Register** – a record of any declarations made by staff in relation to gifts and/or hospitality whether accepted or declined.

- **Honesty** – to act truthfully
- **Hospitality –** the relationship between guest and host, or the act or practice of being hospitable. Specifically, this includes the reception and entertainment of guests including the provision of food and drink.
- **Integrity:** to not act or take decisions in order to gain financial or other material benefits for oneself, family, or friends. This includes declaring and resolving any interests and relationships.
- **Leadership -** the ability of an individual or a group of individuals to influence and guide other members of an organisation. It is expected that leaders should actively promote and robustly support the principles set out in this policy and be willing to challenge poor behaviour wherever it occurs.
- **Openness** – the quality of being honest and willing to talk, including taking decisions in a transparent manner.
- **Probity** – adherence to the highest principles and standards.
- **Professionalism** - to take responsibility for ensuring that one has the relevant knowledge and skills to perform one's role and to be bound by and act in accordance with any professional codes of conduct.
- **Responsibility -** to be fully accountable for one's behaviour, work and decisions, including delegated responsibilities and responsibilities for staff and services.
- **Sponsorship** - events such as meetings and educational events for which sponsorship is received from any non-NHS source or events organised by other parties which are sponsored by the ICB.
- **Staff -** an individual employed by the ICB, Board Members and anyone acting on behalf of the ICB either in a permanent, temporary, contracting or advocacy capacity.
- **Transparency** - the open sharing of information between an organisation and its stakeholders, including staff and members of the public.
- **Values** - the principles set out by the ICB to which the organisation aspires and which inform staff behaviour and organisational culture.

5. Roles and Responsibilities

5.1. ICB Board members

5.1.1. ICB Board members should set a vigorous and visible example of high standards of business conduct which will have a consequential influence on the behaviour of all those who work within, or on behalf of, the organisation

5.1.2. The role of the ICB Board and its members in relation to business conduct is to lead by example in upholding and promoting the standards set out in the Standards for NHS Boards and use them to create a culture in which their values can be adopted by all.

5.2. **Audit Committee**

5.2.1. The Audit Committee and its Chair will have responsibility for monitoring the ICB's compliance with this policy.

5.3. **Chief Executive**

5.3.1. The Chief Executive Officer of the ICB has delegated responsibility for Standards of Business Conduct to the Chief of Staff.

5.4. **Policy Author**

5.4.1. The policy author will have responsibility for reviewing and updating the policy on an annual basis or should legislation, guidance, organisational change or other circumstances necessitate an earlier review.

5.5. **ICB Governance Lead**

5.5.1. The ICB Governance Lead is responsible for:

- Providing staff and other relevant individuals with advice, support, and guidance to enable them to uphold high standards of business conduct.
- Ensuring that appropriate arrangements are in place to effectively manage and record/report any issues relating to breaches of this or associated policies.
- Supporting the Conflicts of Interest Guardian to enable them to effectively carry out their responsibilities.
- Ensuring that senior managers provide adequate, appropriate and transparent reporting to the ICB Board, its committees, stakeholders and the public as required by the Health and Social Care Act 2012 and Health and Care Act 2022.

5.6. **Line Managers**

5.6.1. Line managers are responsible for upholding and promoting high standards of business conduct and ensuring staff reporting to them adhere to the requirements of this policy and for providing adequate, appropriate and transparent reporting to the ICB Board and its committees, stakeholders and the public.

5.7. **All Staff**

5.7.1. All staff and other individuals covered by the scope of this policy, and other policies referred to throughout, are personally responsible for ensuring that:

- They do not place themselves in a position that risks or appears to risk conflict between their private interests and their ICB duties.

- They are familiar with and adhere to the principals and values set out within this policy and any other related documents which many be issued.
- They seek clarification from their line manager on any points which they are not clear.
- They report any known or suspected deviations from policy to their manager or to the ICB Governance Lead.

6. Policy Detail

6.1. **Standing Orders (SOs), Standing Financial Instructions (SFIs) and Scheme of Reservation and Delegation (SoRD)**

6.1.1. All ICB staff must carry out their duties in accordance with the ICB's SOs, SFIs and SoRD. These documents set out the statutory and governance framework in which the ICB operates and there is considerable overlap between the contents of this policy and the provisions of the SOs, SFIs and SoRD.

6.1.2. ICB staff must refer to and act in accordance with the SOs, SFIs and SoRD to ensure the current ICB process is followed. In the event of doubt, ICB staff should seek advice from their line manager and/or the ICB Governance Lead.

6.1.3. In the event of any conflict arising between the details of this policy and the SOs, SFIs and SoRD, the provisions of the SOs, SFIs and SoRD shall prevail.

6.2. **Prevention of Fraud and Bribery**

6.2.1. The ICB's arrangements for the prevention of fraud and bribery are detailed within the Counter-Fraud, Bribery and Corruption Policy and the Management of Conflicts of Interest Policy.

6.2.2. Bribery is defined as giving or offering someone a financial or other advantage to encourage that person to perform their functions or activities improperly or to reward that person for having already done so, or requesting, agreeing to receive or accepting the advantage offered.

6.2.3. The Bribery Act 2010 reformed the criminal law of bribery, making it easier to tackle this offence proactively in both the public and private sectors. It introduced a corporate offence which means that commercial organisations, including NHS bodies, will be exposed to criminal liability, punishable by an unlimited fine, for failing to prevent bribery.

6.2.4. The ICB is committed to preventing fraud and encourages staff with concerns or reasonably held suspicion about potentially fraudulent activity or practice to report these immediately to the ICB Local Counter Fraud Specialist eleni.gill@wmas.nhs.uk or 07827 308906 or the Director of

Resources (DoR) or to the Chair or Chief Executive Officer where it would not be appropriate to report to the DoR.

6.2.5. Staff can also refer matters directly and confidentially to the NHS Fraud and Corruption Reporting Line on 0800 028 4060 or by filling in an online form at https://cfa.nhs.uk/reportfraud

6.3. Conflicts of Interest

6.3.1. The ICB's arrangements for managing conflicts of interest are detailed within the Conflicts of Interest Policy. Failure to adhere to the policy relating to the declaration of interests may constitute the criminal offence of fraud if an individual could be gaining unfair advantages or financial rewards for themselves or a family member/friend or associate.

6.3.2. Individuals must declare interests upon their appointment or when the interest is acquired. If an individual's circumstances change, it is their responsibility to update their declaration of interest as soon as possible and in any event within 28 days, rather than waiting to be asked.

6.3.3. Individuals must also declare any relevant interests during meetings, procurement processes or other business transactions/dealings to ensure that appropriate arrangements to manage the conflict can be implemented.

6.3.4. Any concern that a relevant personal interest may not have been declared should be reported to the ICB Governance Lead or the ICB Local Counter Fraud Specialist.

6.4. Gifts and Hospitality: Refusal and Acceptance

6.4.1. The ICB's arrangements regarding the acceptance/refusal of Gifts and Hospitality are detailed within the Conflicts of Interest Policy, which sets out how to respond to offers of case or cash equivalents, gifts and hospitality from suppliers, non-suppliers, patients and their relatives, and the criteria for declaring these.

6.5. Personal Conduct

6.5.1. **Appropriate Behaviour:** All staff should ensure that they behave in an appropriate manner in accordance with the ICB's policies and values when dealing with other staff, stakeholders and members of the public. They should respect fellow staff members and the role they play, acting with courtesy at all times. Inappropriate or unwanted behaviour (whether aggressive/abusive or discriminatory) will not be tolerated by the ICB and will be dealt with in accordance with the appropriate Human Resources policy or procedure.

6.5.2. **Ethical Codes of Conduct:** Many staff members will be a member of an institute or professional body. A key part of any professional membership is abiding by the profession's 'code of ethics'. Staff should ensure that they adhere to their professional obligations.

6.5.3. **Dress Code:** All staff should ensure their appearance, attire and personal hygiene is befitting their role within the ICB.

6.5.4. **Lending or Borrowing:** Lending or borrowing of money between staff should be avoided, particularly where the amounts are significant. It is a particularly serious breach of discipline for any member of staff to use their position to place pressure on someone in a lower pay band, a business contact, or a member of the public to loan them money.

6.5.5. **Betting or Gambling:** No member of staff may bet or gamble when on duty or on ICB premises, except small lottery syndicates or sweepstakes related to national events such as the World Cup or Grand National among immediate colleagues.

6.5.6. **Trading and Canvassing/Advertising:** Trading on official premises is prohibited, whether for personal gain or on behalf of others. Canvassing/advertising within the office by, or on behalf of, outside bodies or firms (including non-ICB interests of staff or their relatives) is also prohibited. Official email accounts and official documentation such as letter headed paper should not be used for private enterprise and may constitute an offence of fraud.

6.5.7. **Charitable Collections:** Charitable collections must be authorised by the ICB Governance Lead. Other flag day appeals are not permitted, and collection tins or boxes must not be placed in offices. With line management agreement, collections may be made among immediate colleagues and friends to support small fundraising initiatives, such as raffle tickets and sponsored events.

6.5.8. **Informal Collections:** Permission is not required for informal collections amongst immediate colleagues on an occasion like retirement, marriage/civil partnership or a new job.

6.5.9. **Bankruptcy or Insolvency:** Any member of staff who becomes bankrupt or insolvent must inform their line management and Human Resources as soon as possible. Staff who are bankrupt or insolvent may not be eligible to work in posts that involve duties which might permit the misappropriation of public funds or involve the handling of money.

6.5.10. **Criminal Proceedings:** A member of staff who is the subject of any criminal proceedings, including, but not restricted to:

- driving offences,
- being interviewed under caution by any investigative agency including (but not limited to) the Police, National Crime Agency, Department of Work and Pensions, HMRC, UK Border Agency, Health and Safety Executive and Local Authorities.
- receiving a caution/conditional caution,
- being fined,
- being issued with a fixed penalty notice,
- being reprimanded,

- being issued with a cannabis warning,
- being issued with a Community Resolution Order,
- being arrested,
- being convicted of any criminal offence, and
- receiving a summons to appear at any Court*

must inform their line management and Human Resources as soon as the member of staff is made aware of the proceedings.

*This list is not exhaustive.

6.6. Disclosure and Barring Service

6.6.1. Some posts within the ICB will require vetting via the Disclosure and Barring Service (DBS). These requirements are set out within the relevant job description. DBS checks will be undertaken where appropriate and in accordance with the ICB Recruitment Policy and Disclosure and Barring Policy.

6.7. Personal Development and Training

6.7.1. Staff are expected to participate in regular work reviews with their line manager, including annual appraisal, and to undertake any training and development identified as necessary from such reviews. This includes completing mandatory training modules within the required timescales.

6.8. Staff Expenses

6.8.1. Staff expenses (such as mileage or actual travel and parking costs) shall be claimed in accordance with the ICB's Reimbursement of Staff Expenses and Travel Policy. Such claims for expenses shall be reasonable and only over and above what staff members would normally incur in their normal journey to work.

6.8.2. In some cases (when required to stay away from home) it may be necessary for staff to claim reimbursement for the cost of accommodation and meals. This shall be only 'reasonable' costs and must be in line with ICB policy and approved by the staff member's line manager prior to the costs being incurred.

6.9. Outside Employment and Private Practice

6.9.1. Employees of the ICB are required to inform the ICB if they are engaged in or wish to engage in outside employment/private practice in addition to their work with the ICB. The purpose of this is to ensure that the ICB is aware of any potential conflict of interest with the employee's ICB role.

6.9.2. The process for declaring outside employment and private practice is detailed within the ICB's Conflicts of Interest, Gifts and Hospitality and Commercial Sponsorship Policy.

6.9.3. The ICB reserves the right to refuse permission where it believes an unresolvable conflict will arise.

6.10. Political Activities

6.10.1. Any political activity should not identify an individual as an employee of the ICB. Conferences or functions run by a political organisation should not be attended in an official capacity, except with prior written permission from the ICB Governance Lead.

6.11. Commercial Sponsorship

6.11.1. The ICB's arrangements regarding commercial sponsorship are set out within the ICB's Conflicts of Interest, Gifts and Hospitality and Commercial Sponsorship Policy.

6.12. Suppliers and Contractors

6.12.1. All ICB staff who are in contact with suppliers and contractors (including external consultants), and in particular those who are authorised to sign purchase orders or enter into contracts for goods and services, are expected to adhere to professional standards in line with those set out in the Code of Ethics of the Chartered Institute of Purchasing and Supply.

6.12.2. All ICB staff must treat prospective contractors or suppliers of services to the ICB equally and in a non-discriminatory way, act in a transparent manner and follow the ICB's Procurement Policy and Conflicts of Interest Policy regarding the managing of conflicts of interest during procurement processes.

6.13. Raising Concerns – Whistleblowing and Complaints

6.13.1. It is the duty of every member of staff to speak up about genuine concerns in relation to patient safety, criminal activity, breach of a legal obligation (including negligence, breach of contract or breach of administrative law), miscarriage of justice, danger to health and safety or the environment, and the covering up of any of these in the workplace. The ICB's Raising Concerns Policy sets out the arrangements for raising and handling staff concerns.

6.14. Other Initiatives

6.14.1. As a general principle, any financial gain resulting from external work where use of ICB time or title is involved (e.g. speaking at training events/conferences, writing articles etc, even when done in own time) and/or which is connected with ICB business will be paid to the ICB.

6.14.2. As a general rule, any patents, designs, trademarks or copyright resulting from the work (e.g. research) of an employee of the ICB carried out as part of their employment by the ICB shall be the Intellectual Property of the ICB, unless agreed otherwise.

6.14.3. Approval from both the employee's line manager and the ICB Governance Lead should be sought prior to entering into an obligation to undertake external work connected with the business of the ICB, e.g. writing articles for publication, speaking at conferences.

6.14.4. Where the undertaking of external work, gaining patent or copyright or the involvement in innovative work benefits or enhances the ICB's reputation or results in financial gain for the ICB, consideration will be given to rewarding employees subject to any relevant guidance for the management of Intellectual Property in the NHS issued by the Department of Health.

6.15. Confidentiality, Information Security, Social Media and Mobile Phones

6.15.1. Information concerning the ICB which is not in the public domain must not at any time be divulged to any unauthorised person. Similarly, patient data or personal data concerning staff must not be divulged, in line with the Data Protection Act, 1998. This duty of confidence remains after termination of employment and applies to all individuals working within ICB.

6.15.2. Care should be taken that confidentiality is not breached inadvertently by, for instance discussing confidential matters in public places, such as whilst travelling by train, or by leaving portable IT equipment containing confidential information where it might easily be stolen, such as on full view in a parked car. Data should only be distributed using mechanisms with an appropriate level of security.

6.15.3. ICB staff must maintain confidentiality of personal information and commercially sensitive data at all times, as per the ICB's Information Governance policies..

6.15.4. ICB staff must guard against providing information on the operations of the ICB which might provide a commercial advantage to any organisation (private or NHS) in a position to supply goods or services to the ICB. For particularly sensitive procurements/contracts ICB staff might be asked to sign a nondisclosure agreement.

6.15.5. Staff must be careful to ensure that they do not breach the ICB's Social Media Policy or Information Governance policies by acting in a way that could bring the ICB into disrepute. Posts made by staff should therefore be considered and appropriate, in the knowledge that they could be identified as an ICB employee (or appear as if they are acting on behalf of the ICB). Misconduct in this area could result in disciplinary action in accordance with human resources policies.

6.15.6. Staff should restrict personal use of mobile phones or other electronic devices to a minimum during working hours, although the ICB understands that some personal use (i.e. to deal with urgent issues or emergencies) might be necessary.

6.15.7. Staff should follow the ICB business meeting etiquette protocol set out at **Appendix C.**

7. Monitoring Compliance

7.1. Compliance with this policy will be monitored as part of the routine monitoring undertaken by the ICB Governance Lead, with any persistent or significant breaches being reported to the Audit Committee.

7.2. Staff operating outside of this policy may be subject to disciplinary proceedings in accordance with ICB Human Resources policies, which could lead to the termination of their employment/contract or position with the ICB and possible prosecution.

8. Staff Training

8.1. All new staff will be inducted regarding the ICB's policies and procedures and expected standards of business conduct.

8.2. The ICB will ensure that mandatory training, and role-appropriate training, on the management of conflicts of interest, acceptance/refusal of gifts and hospitality and commercial sponsorship, is offered to all employees, governing body members, members of ICB committees and sub-committees and other individuals with involvement in ICB decision-making to ensure they understand what conflicts are and how to manage them effectively. Completion rates of mandatory training modules will be monitored by the ICB Governance Lead with the support of the Human Resources Department.

9. Arrangements For Review

9.1. This policy will be reviewed every three years. An earlier review will be carried out in the event of any relevant changes in legislation, national or local policy/guidance, organisational change or other circumstances which mean the policy needs to be reviewed.

9.2. If only minor changes are required, the sponsoring Committee has authority to make these changes without referral to the Integrated Care Board. If more significant or substantial changes are required, the policy will need to be ratified by the relevant committee before final approval by the Integrated Care Board.

10. Associated Policies, Guidance and Documents

- ICB Constitution (particularly Standing Orders and Standing Financial Instructions)

Associated Policies

- Conflicts of Interest, Gifts and Hospitality and Commercial Sponsorship Policy
- Counter-Fraud, Bribery and Corruption Policy
- Disclosure and Barring Policy
- Procurement and Contracting Policy
- Information Governance Management and Framework Policy
- IG Resource Guide
- Reimbursement of Staff Expenses and Travel Policy
- Raising Concerns Policy
- Defining the Boundaries between NHS and Private Healthcare
- Recruitment Policy
- Social Media Policy

11. References

- The Bribery Act 2010
- Companies Act 2006 – Directors Duties (The duty not to accept benefits from third parties: Section 176) which is relevant to Community Interest Companies.
- The Patents Act 1977
- The Copyright, Designs and Patents Act 1988
- Managing Conflicts of Interest in the NHS
- NHS Code of Conduct and Code of Accountability (2004, revised 2013)
- Professional Standards Authority: Standards for members of NHS Boards and CCG Governing bodies in England (2012);
- The Association of the British Pharmaceutical Industry (APBI) Code of Professional Conduct relating to hospitality / gifts from pharmaceutical / external industries.
- Code of Ethics of the Chartered Institute of Purchasing and Supply.

12. Equality Impact Assessment

12.1. The EIA has identified a positive impact and is included at **Appendix A.**

Appendix A - Equality Impact Assessment

INITIAL INFORMATION

Name of policy: Standards of Business Conduct Policy **Version number (if relevant):** 1.0	**Directorate/Service**: Corporate / Chief Executive's Office
Assessor's Name and Job Title: Head of Corporate Governance, Mid Essex CCG	**Date:** February 2022

OUTCOMES
Briefly describe the aim of the policy and state the intended outcomes for staff
The Standards of Business Conduct Policy will support the organisation and staff to uphold high standards of business conduct and public service values including accountability, probity and openness. The policy provides a central reference guide setting out the principles of conduct that should be followed when working on behalf of the ICB that will enable individuals to meet the duties set out in relevant legislation and guidance.
EVIDENCE
What data / information have you used to assess how this policy might impact on protected groups?
The CCGs regularly monitor the make-up of their workforce, including protected groups.
Who have you consulted with to assess possible impact on protected groups? If you have not consulted other people, please explain why?
The policy has been shared with the Staff Engagement Group for feedback and comment.

ANALYSIS OF IMPACT ON EQUALITY

The Public Sector Equality Duty requires us to **eliminate** discrimination, **advance** equality of opportunity and **foster** good relations with protected groups. Consider how this policy / service will achieve these aims.

N.B. In some cases it is legal to treat people differently (objective justification).

- ***Positive outcome*** *– the policy/service eliminates discrimination, advances equality of opportunity and fosters good relations with protected groups*
- ***Negative outcome*** *– protected group(s) could be disadvantaged or discriminated against*
- ***Neutral outcome*** *– there is no effect currently on protected groups*

Please tick to show if outcome is likely to be positive, negative or neutral. Consider direct and indirect discrimination, harassment and victimisation.

Protected Group	Positive outcome	Negative outcome	Neutral outcome	Reason(s) for outcome
Age	X			Section 5.5.1 makes it clear that aggressive/abusive or discriminatory behaviour will not be tolerated and will be dealt with in accordance with the relevant HR procedure. It is anticipated that any concerns that members of protected groups may have regarding raising concerns will be alleviated by the assurances provided within the Raising Concerns (Whistleblowing) Policy.
Disability (Physical and Mental/Learning)	X			As above
Religion or belief	X			As above
Sex (Gender)	X			As above
Sexual Orientation	X			As above
Transgender/Gender Reassignment	X			As above
Race and ethnicity	X			As above
Pregnancy and maternity (including breastfeeding mothers)	X			As above
Marriage or Civil Partnership	X			As above

MONITORING OUTCOMES
Monitoring is an ongoing process to check outcomes. It is different from a formal review which takes place at pre-agreed intervals.
What methods will you use to monitor outcomes on protected groups?
Any breaches of this policy will be reported to the Audit Committee and triangulated with other information held by the ICB in relation to incidents, complaints or disciplinary action involving individuals who believe they have been mis-treated due to their protected groups status.

REVIEW
How often will you review this policy / service?
Annually
If a review process is not in place, what plans do you have to establish one?
N/A

Appendix B – The Nolan Principles

The seven principles of public life set out by the Committee on standards in public life (the Nolan principles)

1. Selflessness

Holders of public office should act solely in terms of the public interest.

2. Integrity

Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

3. Objectivity

Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

4. Accountability

Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

5. Openness

Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

6. Honesty

Holders of public office should be truthful.

7. Leadership

Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

Appendix C – Business Meeting Etiquette

- Prepare well for the meeting as your contribution is integral to the proceedings.
- Send any reports you are producing in the correct format, with a completed cover sheet, in good time to meet the secretary's deadline.
- You will be expected to have read the papers so that the meeting discussion can focus on key elements in order to make decisions. If you are presenting a paper, please assume that the Committee members have read it so your introduction should be concise and limited to the key points.
- Switch off your mobile phone and any other devices and keep them out of sight to avoid distraction to others.
- Acknowledge any introductions or opening remarks with a brief recognition of the Chair and other participants.
- Always address the Chair when making your points and talk through the Chair to the committee members.
- Never interrupt anyone or talk over someone else – even if you disagree strongly. Note what has been said and return to it later with the Chair's permission.
- Do not hold side conversations when someone else is talking.
- When speaking, be brief and ensure what you say is relevant.
- With the exception of meetings held in public, it is a serious breach of business etiquette to divulge information to others not entitled to receive information about matters discussed during a meeting. What has been discussed should be considered as confidential.
- Decisions by the Board are final and can only be revisited in exceptional circumstance.
- The Board is the final arbiter on all issues, once the decision is reached it is critical for good governance that all members assist in its implementation.
- It is the responsibility of the Chair to maintain order, keep to allotted times, manage conflicts of interest, allow everyone to have their say, provide focus to deliver successful outcomes, and to ensure the agenda meets the needs of good governance.
- It is the membership's responsibility to respect the role of the Chair and to assist them in the delivery of the above.
- The underlying principles of the meeting etiquette pointers are good manners, courtesy and consideration, which if adhered to will reduce the chance of offence and misunderstanding.

Management of Conflicts of Interest Policy

(Including Gifts and Hospitality, Outside Employment, Commercial Sponsorship and other situations where conflicts might arise)

Document Control:

Policy Name	Conflicts of Interest Policy
Policy Number	MSEICB 018
Version	1.0
Status	Draft ICB Policy
Author / Lead	Sara O'Connor, Head of Corporate Governance, Mid Essex CCG
Responsible Executive Director	The Chief Executive has delegated responsibility to the Chief of Staff
Responsible Committee	Audit Committee
Date Ratified by Responsible Committee	1 February 2022
Date Approved by Board/Effective Date	1 July 2022
Next Review Date	1 July 2023
Target Audience	• Mid and South Essex (MSE) Integrated Care Board (ICB) members and staff (including temporary/bank/agency/ voluntary/work experience staff). • Contractors engaged by the ICB. • Staff from other MSE Integrated Care Partnership (ICP) organisations who are members of ICB Committees/Sub-Committees and other groups.
Stakeholders engaged in development of Policy (internal and external)	• Mid and South Essex CCG Governance Leads. • Human Resources. • Information Governance Lead. • Kevin Edwards, Associate Director, Attain. • MSE Staff Engagement Group. • MSE CCGs Audit Committees meeting in common
Impact Assessments Undertaken	• Equality and Health Inequalities Impact Assessment

Version History

Version	Date	Author (Name and Title)	Summary of amendments made
0.1	14/01/2022	Sara O'Connor Head of Corporate Governance, Mid Essex CCG	First draft of new Policy for Integrated Care Board based on NHSE/I Model Conflicts of Interest Policy template
0.2	20/01/22	As above	Amended to reflect feedback from internal audit and LSMS and

Version	Date	Author (Name and Title)	Summary of amendments made
			insertion of additional guidance regarding sponsored events (S15).
0.3	31/01/22	Viv Barnes, Governance Lead	Minor revisions to reflect Staff Engagement Group feedback.
0.4	26/05/22	Sara O'Connor and Viv Barnes	Amended to reflect latest guidance on managing conflicts of interest within ICBs, including training requirements and Audit Committee comments.
0.5	21/06/22	Sara O'Connor	Policy Reference Number added.

Contents

1. Introduction

1.1. Mid and South Essex Integrated Care Board (the ICB) and the people who work with and for us, collaborate closely with other organisations, delivering high quality care for our patients.

1.2. These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely. However, there is a risk that conflicts of interest may arise. The policy is based on current NHS guidance regarding the management of conflicts, gifts and hospitality, commercial sponsorship, outside employment or other situations where conflicts might arise and will be revised on receipt of any relevant updated guidance relating to ICBs.

1.3. Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly are key principles in the NHS Constitution. The ICB is committed to maximising our resources for the benefit of the whole community. As an organisation and as individuals, we have a duty to ensure that all our dealings are conducted to the highest standards of integrity, that NHS monies are used wisely by using our finite resources in the best interests of patients, providing best value for taxpayers and being accountable to our residents and patients for the decisions we take.

1.4. The ICB will:

- Ensure that this policy and supporting processes are clear and help staff understand what they need to do.
- Identify a team or individual with responsibility for:
  - Keeping this policy under review to ensure it is in line with current guidance.
  - Providing advice, training and support for staff on how interests should be managed.
  - Maintaining register(s) of interests.
  - Audit this policy and its associated processes and procedures at least annually.
- **NOT** avoid managing conflicts of interest.
- **NOT** interpret this policy in a way which stifles collaboration and innovation with our partners. Measures implemented to manage conflicts of interest will allow the ICB to function as intended in legislation.

1.5. It is a requirement for the ICB to have CB Board members from primary care, Trusts/Foundation Trusts and the local authorities in order to support achievement of organisational alignment ensuring that decisions of the ICB Board are well informed from a range of perspectives. The Board and its committees will be appropriately composed and take account of the different perspectives individuals will bring from their respective sectors to help inform decision making.

1.6. Decision-making must be geared towards meeting the statutory duties of

the ICB at all times, including the 'triple aim' to consider the effects of its decisions on:

- The health and wellbeing of the population
- The quality of services provided or arranged by both the ICB and other relevant bodies
- The sustainable and efficient use of resources by the ICB and other relevant bodies

1.7. Interim Guidance on the functions and governance of the ICB has been published by NHS England and Improvement, which includes principles to support ICBs in managing conflicts of interest. These principles have been incorporated within this policy.

1.8. Any individual involved in decisions relating to ICB functions must be acting clearly in the interests of the ICB and of the public, rather than further direct or indirect financial personal, professional or organisational interests.

1.9. Partner Members will be expected to act in accordance with paragraph 1.8 above and whilst it should not be automatically assumed that they are personally or professionally conflicted just by virtue of being an employee, director, partner or otherwise holding a position with one of the relevant organisations, the possibility of actual and perceived conflicts of interests arising will remain. For all decisions, ICBs will need to carefully consider whether an individual's role in another organisation could result in actual or perceived conflicts of interest and whether or not that outweighs the value of the knowledge they bring to the process.

1.10. The ICB will consider the composition of decision-making forums and distinguish between those individuals who should be involved in formal decision taking and those whose input informs decisions. This will include considering the perspective the individual brings and the value they add to both discussions around particular decisions and in actually taking part in decisions, including the ability to shape the ICB's understanding of how best to meet patients' needs and deliver care for the population.

1.11. Actions to mitigate conflicts of interest should be proportionate and should seek to preserve the spirit of collective decision-making wherever possible. Mitigation should take account of a range of factors including the perception of any conflicts and how a decision may be received if an individual with a perceived conflict is involved in that decisions, and the risks and benefits of having a particular individual involved in making the decision. Section 16.9.4 below sets out possible mitigations.

2. Purpose

2.1. This policy and associated policies and procedures referred to throughout, including NHS England and Improvement (NHSE/I) conflict of interest

guidance, will help our staff manage conflicts of interest risks effectively.

2.2. The policy:

- Introduces consistent principles and rules.
- Provides simple advice about what to do in common situations.
- Supports good judgement about how to approach and manage interests.

3. Scope

3.1. This policy applies to:

- Mid and South Essex (MSE) Integrated Care Board (ICB) members and staff (including temporary/bank/agency/ voluntary/work experience staff).
- Contractors engaged by the ICB.
- Staff from other MSE Integrated Care Partnership (ICP) organisations who are members of ICB Committees/Sub-Committees and other groups

4. Definitions and Categories of Interests

4.1. **Conflict of Interest** - A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by **another** interest they hold.

A conflict of interest may be:

- **Actual** - there is a material conflict between one or more interests, or
- **Potential** – there is the possibility of a material conflict between one or more interests in the future.

Individuals may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

4.2. **Financial interest -** Where an individual may get direct financial benefit[1] from the consequences of a decision they are involved in making.

4.3. **Non-financial professional interest** - Where an individual may obtain a non-financial professional benefit from the consequences of a decision

[1] This may be a financial gain, or avoidance of a loss.

they are involved in making, such as increasing their professional reputation or promoting their professional career.

4.4. **Non-financial personal interests** - Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.

4.5. **Indirect interests:** Where an individual has a close association[2] with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

4.6. **Decision-Making Staff:** Those staff who are more likely than others to have a decision-making influence on the use of taxpayers' money, because of the requirements of their role. The ICB considers decision-making staff to be:

- Executive, non-executive and partner members of the ICB Board (or equivalent roles) who have decision making roles which involve the spending of taxpayers' money.
- Members of advisory groups which contribute to direct or delegated decision making on the commissioning or provision of taxpayer funded services.
- Staff at Agenda for Change band 8d and above.
- Administrative and clinical staff who have the power to enter into contracts on behalf of the ICB.
- Administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment, and formulary decisions.

5. Roles and Responsibilities

5.1. Chief Executive

The Chief Executive Officer of the ICB has overall accountability for managing conflicts of interest within the ICB.

5.2. Chief of Staff

The Chief Executive has delegated responsibility to the Chief of Staff for managing conflicts of interest.

[2] A common sense approach should be applied to the term 'close association'. Such an association might arise, depending on the circumstances, through relationships with close family members and relatives, close friends and associates, and business partners.

5.3. All ICB Employees and Board members

The ICB uses the skills of many different people, all of whom are vital to our work. This includes people on differing employment terms, who for the purposes of this policy we refer to as 'staff' and are listed below:

- All Board members and salaried employees.
- All prospective employees who are part-way through recruitment.
- Contractors and sub-contractors.
- Agency/bank staff.
- Committee, sub-committee and advisory group members (who may not be directly employed or engaged by the organisation, for example staff employed/engaged by member organisations of the Mid and South Essex Integrated Care Partnership).

As a member of staff you should:

- Familiarise yourself with this policy and follow it.
- Refer to NHSE/I guidance on managing conflicts of interest for the rationale behind this policy.
- Use your common sense and judgement to consider whether the interests you have could affect the way taxpayers' money is spent.
- Regularly consider what interests you have and declare these as they arise. If in doubt, declare.
- **NOT** misuse your position to further your own interests or those close to you.
- **NOT** be influenced or give the impression that you have been influenced by outside interests.
- **NOT** allow the outside interests you have to inappropriately affect the decisions you make when using taxpayers' money.
- Seek clarification from your line manager on any points which are not clear.

5.4. Audit Committee

5.4.1. The Audit Committee will have responsibility for monitoring the ICB's compliance with this policy.

5.5. Conflicts of Interest Guardian

5.5.1. The Chair of the Audit Committee will be the ICB's Conflict of Interest Guardian and, in collaboration with the ICB Governance Lead, will:

- Act as a conduit and safe point of contact for staff, members of the public and healthcare professionals who have any concerns with regards to conflicts of interest.
- Support the rigorous application of this and associated policies

- Provide independent advice and judgement where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation.

5.5.2. Contact details for the Audit Committee Chair/Conflicts of Interest Guardian are at **Appendix D**.

5.6. Policy Author

5.6.1. The policy author will have responsibility for reviewing and updating the policy in line with Section 8.

5.7. ICB Governance Lead

5.7.1. The ICB Governance Lead, with the support of other governance team staff, is responsible for:

- Providing staff and other relevant individuals with advice, support, and guidance to enable them to manage conflicts of interest.
- Maintaining appropriate registers and other records relating to the management of conflicts of interest.
- Ensuring that appropriate arrangements are in place to effectively manage and record/report any issues relating to breaches of this or associated policies.
- Supporting the Conflicts of Interest Guardian to enable them to effectively carry out their responsibilities.
- Ensuring that senior managers provide adequate, appropriate and transparent reporting to the ICB Board, its committees, stakeholders and the public as required by the Health and Social Care Act 2012 and the Health and Care Act 2022.

5.8. Line Managers

5.8.1. Line managers are responsible for upholding and promoting high standards in relation to the management of conflicts of interest, gifts, hospitality and commercial sponsorship, ensuring staff reporting to them adhere to the requirements of this policy and for providing adequate, appropriate and transparent reporting to the ICB Board and its committees, stakeholders and the public.

6. Policy Detail

6.1. Identification & Declaration of Interests (Including Gifts and Hospitality)

6.1.1. All staff should identify and declare material interests at the earliest opportunity (and in any event within 28 days).

6.1.2. If staff are in any doubt as to whether an interest is material they should declare it so that it can be considered.

6.1.3. Declarations should be made:

- On appointment with the organisation – the ICB will implement appropriate arrangements to facilitate this.
- When staff move to a new role or their responsibilities change significantly.
- At the beginning of a new project/piece of work/procurement process.
- As soon as circumstances change and new interests arise (e.g. during a meeting when interests staff hold are relevant to the matters in discussion).

6.1.4. The Declaration of Interest form is available at **Appendix B** and as a separate document on the ICB's intranet.

6.1.5. Where an interest is declared, the individual's line manager should review the form and agree any mitigating action required to manage any conflicts which should be recorded on the form for transferring to the appropriate register.

6.1.6. Declarations of Interest forms submitted outside of recruitment processes should be returned to the Governance team.

6.1.7. After expiry, an interest will remain on register(s) for a minimum of six months and a private record of historic interests will be retained for a minimum of six years.

6.2. Proactive Review of Interests

6.2.1. The ICB will require all staff to formally review and, if necessary, update their declaration of interest annually.

6.2.2. Reminders for staff to review and update their declarations of interest will be provided via the ICB's intranet bi-annually.

6.2.3. The ICB will implement arrangements to prompt ICB Board members and other decision-making staff to review and update their declarations of interest on a regular basis by:

- Including 'declarations of interest' on meeting agendas.
- Providing a register to each meeting of the ICB Board and its main committees/groups setting out the interests of relevant members and regular attendees.

- Implementing arrangements to ensure that staff participating in projects, new pieces of work and procurement processes are required to declare relevant interests.

6.3. Maintenance of Records

6.3.1. The ICB will maintain the following registers:

- Register of Interests.
- Register of Gifts and Hospitality.
- Register of Commercial Sponsorship.
- Register of Procurement Decisions.

6.3.2. All declared interests that are material will be promptly transferred to the register by the Governance team.

6.4. Publication

6.4.1. The ICB will publish the interests declared by decision-making staff in the relevant registers available on the ICB website.

6.4.2. This information will be refreshed on a bi-monthly basis.

6.4.3. Registers of interests for publicly held Board or Committee meetings will be made available within meeting papers available on the ICB website.

6.4.4. Registers will also be made available for inspection, via telephoning 01268 594350 to make an appointment with the Governance team, at Phoenix Court, Christopher Martin Road, Basildon Essex SS14 3HG

6.4.5. If decision-making or other staff have substantial grounds for believing that publication of their interests should not take place, they should contact the ICB Governance Lead to explain why. In exceptional circumstances, for instance where publication of information might put a member of staff at risk of harm, with the agreement of the Conflicts of Interest Guardian, information may be withheld or redacted on public registers. However, this would be the exception and information will not be withheld or redacted merely because of a personal preference.

6.5. Wider Transparency Initiatives

6.5.1. The ICB fully supports wider transparency initiatives in healthcare and encourages staff to engage actively with these.

6.5.2. Relevant staff are strongly encouraged to give their consent for payments they receive from the pharmaceutical industry to be disclosed as part of the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative. These “transfers of value” include payments relating to:

- Speaking at and chairing meetings.
- Training services.
- Advisory board meetings.
- Fees and expenses paid to healthcare professionals.
- Sponsorship of attendance at meetings, which includes registration fees and the costs of accommodation and travel, both inside and outside the UK.
- Donations, grants and benefits in kind provided to healthcare organisations.

6.5.3. Further information about the scheme can be found on the ABPI website: http://www.abpi.org.uk/our-work/disclosure/about/Pages/default.aspx

6.6. Management of Interests - General

6.6.1. If an interest is declared but there is no risk of a conflict arising then no action is warranted. However, if a material interest is declared then the general management actions that could be applied include:

- Restricting staff involvement in associated discussions and excluding them from decision making.
- Removing staff from the whole decision-making process.
- Removing staff responsibility for an entire area of work.
- Removing staff from their role altogether if they are unable to operate effectively in it because the conflict is so significant.

6.6.2. Each case will be different and context-specific, and the ICB will always clarify the circumstances and issues with the individuals involved. Staff should maintain a written audit trail of information considered and actions taken.

6.6.3. Staff who declare material interests should make their line manager or the person(s) they are working to aware of their existence.

6.6.4. The ICB Governance Lead and/or the Conflicts of Interest Guardian will provide advice on possible disputes about the most appropriate management action to ensure that interests do not (and do not appear to) affect the integrity of the ICB's decision-making process.

6.7. Management of Interests – Common Situations

6.7.1. Sections 6.8 to 6.20 set out the principles and rules to be adopted by staff in common situations, and what information should be declared.

6.8. Gifts

6.8.1. Staff should not accept gifts that may affect, or be seen to affect, their professional judgement.

6.8.2. Gifts from suppliers or contractors:

- Gifts from suppliers or contractors doing business (or likely to do business) with the organisation should be declined, whatever their value.
- Low cost branded promotional aids such as pens or post-it notes may, however, be accepted where they are under the value of £6 in total and need not be declared.

6.8.3. Gifts from other sources (e.g. patients, families, service users):

- Gifts of cash and vouchers to individuals should always be declined.
  - Staff should not ask for any gifts.
  - Gifts valued at over £50 should be treated with caution and only be accepted on behalf of behalf of the ICB and not in a personal capacity. These should be declared by staff to the ICB. Governance Lead in order to agree how these should be used, for example, donated to a local charity.
  - Modest gifts accepted under a value of £50 do not need to be declared.

6.8.4. A common sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).

6.8.5. Multiple gifts from the same source over a twelve month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50.

6.8.6. The acceptance or rejection of gifts should be declared on the form provided at **Appendix C** and submitted to Corporate Governance Team.

6.9. Hospitality (including Meals, Refreshments, Travel and Accommodation)

6.9.1. Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement.

6.9.2. Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event.

6.9.3. Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. This can be accepted, and

must be declared, if modest and reasonable. Prior approval by the relevant Director must be obtained.

6.9.4. Meals and refreshments:

- Under a value of £25 - may be accepted and need not be declared.
- Of a value between £25 and £75 - may be accepted and must be declared.
- Over a value of £75 - should be refused unless (in exceptional circumstances) prior approval by the relevant Director is given. A clear reason should be recorded on the organisation's register(s) of interest as to why it was permissible to accept.
- A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or a reasonable estimate).

6.9.5. Travel and accommodation:

- Modest offers to pay some or all travel and accommodation costs related to attendance at events may be accepted and must be declared.
- Offers which go beyond modest or are of a type that the organisation itself might not usually offer, need prior approval by the relevant Director. They should only be accepted in exceptional circumstances and must be declared.
- A clear reason should be recorded on the organisation's register(s) of interest as to why it was permissible to accept travel and accommodation of this type. A non-exhaustive list of examples includes:
  - offers of business class or first class travel and accommodation (including domestic travel).
  - offers of foreign travel and accommodation.

6.9.6. The acceptance or rejection of hospitality should be declared on the form provided at **Appendix C** and submitted to the Corporate Governance Team.

6.10. Outside Employment

6.10.1. The ICB requires employees, committee members, contractors and others engaged under a contract with the ICB to declare if they are employed or engaged in any employment, business, consultancy or voluntary role in addition to their work with the ICB.

6.10.2. Staff must declare any existing outside employment/engagement on their appointment and any new outside employment/engagement when it arises.

6.10.3. Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks.

6.10.4. Where contracts of employment or terms and conditions of engagement permit, staff will be required to seek prior approval from the ICB to engage in outside employment.

6.10.5. The ICB may also have legitimate reasons within employment law for knowing about outside employment of staff, even when this does not give rise to risk of a conflict.

6.10.6. The ICB reserves the right to implement appropriate arrangements to manage any conflict(s) and to refuse permission for outside employment where it believes a conflict will arise which cannot be effectively managed.

6.10.7. As set out within the ICB's Standards of Business Conduct Policy, trading on official premises is prohibited, whether for personal gain or on behalf of others. Canvassing/advertising by, or on behalf of, outside bodies or firms (including non-ICB interests of staff or their relatives) is also prohibited. Official ICB email accounts and documentation such as letter headed paper should not be used for private enterprise and may constitute an offence of fraud.

6.10.8. The ICB will implement arrangements to facilitate the declaration of outside employment by new staff upon their appointment by completion of the Declaration of Interest form at **Appendix B.** This process will be managed by the ICB's Human Resources and Governance Teams with relevant outside employment interests being recorded within the register of interest.

6.11. Shareholdings and other ownership issues

6.11.1. Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the ICB or member organisations of the wider Integrated Care Partnership.

6.11.2. Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

6.11.3. There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

6.11.4. Shareholdings and other ownership issues should be declared on the form provided at **Appendix B** and will be recorded within the register of interests.

6.12. Patents

6.12.1. Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by the organisation.

6.12.2. Staff should seek prior permission from the ICB before entering into any agreement with bodies regarding product development, research, work on pathways etc, where this impacts on the ICB's time, or uses its equipment, resources or intellectual property.

6.12.3. Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

6.12.4. Relevant patents must be declared on the form provided at **Appendix B** and submitted to the Corporate Governance Team for recording within the register of interests.

6.13. Loyalty Interests

6.13.1. Loyalty interests should be declared by staff involved in decision making where they:

- Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role.
- Sit on advisory groups or other paid or unpaid decision making forums that can influence how an organisation spends taxpayers' money.
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.
- Are aware that the ICB does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

6.13.2. Loyalty interests must be declared on the form provided at **Appendix B** and submitted to the Corporate Governance Team for recording within the register of interests.

6.14. Donations

6.14.1. Donations made by suppliers or bodies seeking to do business with the ICB should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.

6.14.2. Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the ICB, or is being pursued on behalf of the ICB's own registered charity (if any) or other charitable body and is not for their own personal gain.

6.14.3. Staff must obtain permission from the ICB if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the organisation's own.

6.14.4. Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued.

6.14.5. Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

6.14.6. The ICB will maintain records in line with the above principles and rules and relevant obligations under charity law.

6.15. Sponsored events

6.15.1. Line manager and governance advice must be sought before accepting any type of sponsorship as this can be a controversial issue.

6.15.2. In the case of sponsored events, sponsorship should never be accepted from organisations whose business would not be seen as being compatible with the ethos of the NHS, e.g. organisations that are associated with:

- matters that are damaging to health or associated with gambling, alcohol, tobacco, illegal drugs, weight control or politics
- the promotion of prescription-only drugs to the general public, or other promotion that contravenes that ABPI Code of Practice to the Pharmaceutical Industry.
- Pornography or other companies involved in the sexual exploitation of adults or children
- The manufacture of firearms or other weapons

- Legal services which overtly promote compensation and personal injury services and claims management companies acting on their behalf.

6.15.3. Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit to the ICB and the NHS.

6.15.4. During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.

6.15.5. No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.

6.15.6. At the ICB's discretion, sponsors or their representatives may attend or take part in the event but they should not have a dominant influence over the content or the main purpose of the event.

6.15.7. The involvement of a sponsor in an event should always be clearly identified.

6.15.8. Staff within the organisation involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.

6.15.9. Staff arranging sponsored events must declare this to the organisation by using the form at **Appendix C**.

6.15.10. The organisation will maintain records regarding sponsored events in line with the above principles and rules.

6.16. Sponsored Research

6.16.1. Funding sources for research purposes must be transparent.

6.16.2. Any proposed research must go through the relevant health research authority or other approvals process.

6.16.3. There must be a written protocol and written contract between staff, the organisation, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services.

6.16.4. The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service.

6.16.5. Staff should declare involvement with sponsored research to the ICB by using the form at **Appendix B.**

6.16.6. The ICB will retain written records of sponsorship of research, in line with the above principles and rules.

6.17. Sponsored Posts

6.17.1. External sponsorship of a post requires prior approval from the ICB. Requests should be submitted to the Executive Chief People Officer.

6.17.2. Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and withdraw if appropriate.

6.17.3. Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise.

6.17.4. Sponsored post holders must not promote or favour the sponsor's products, and information about alternative products and suppliers should be provided.

6.17.5. Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

6.17.6. The ICB will retain written records of sponsorship of posts, in line with the above principles and rules.

6.17.7. Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content in the rest of this policy.

6.18. Clinical Private Practice

6.18.1. Clinical staff should declare all private practice on appointment, and/or any new private practice when it arises[3] including:

- Where they practise (name of private facility).
- What they practise (specialty, major procedures).
- When they practise (identified sessions/time commitment).
- Action taken to mitigate against a conflict, including details of any approvals given to depart from the terms of this policy.

[3] Hospital Consultants are already required to provide their employer with this information by virtue of Para.3 Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf

6.18.2. Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

- Seek prior approval of the ICB before taking up private practice.
- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.[4]
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines: https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf

6.18.3. Hospital Consultants should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on their behalf.

6.18.4. Staff should declare involvement with clinical private practice to the ICB by using the form at **Appendix B** which should be submitted to the Corporate Governance Support Officer for inclusion on the relevant register.

6.19. Strategic Decision Making Groups

6.19.1. In common with other NHS bodies the ICB uses a variety of different groups to make key strategic decisions about things such as:

- Entering into (or renewing) large scale contracts.
- Awarding grants.
- Making procurement decisions.
- Selection of medicines, equipment, and devices.

6.19.2. The interests of those who are involved in these groups should be well known (as highlighted on registers of interests provided to each meeting) so that they can be managed effectively. For this organisation these groups are: The ICB's strategic decision making groups include:

- The ICB Board
- The ICB's main Committees as set out in its Constitution
- Mid and South Essex Medicines Optimisation Committee

6.19.3. These groups should adopt the following principles:

- Chairs should consider any known interests of members in advance, and begin each meeting by asking for declaration of relevant material interests.

[4] These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf)

- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.
- Any new interests identified should be added to the appropriate register.
- The vice chair (or other non-conflicted member) should chair all or part of the meeting if the chair has an interest that might prejudice their judgement.

6.19.4. If a member has an actual or potential interest the chair should consider the following approaches and ensure that the justification and reason for the chosen action is documented in the minutes of the meeting and (where appropriate) other records:

- Requiring the member to not attend the meeting.
- Excluding the member from receiving meeting papers relating to their interest.
- Excluding the member from all or part of the relevant discussion and/or decision and where necessary, securing technical or local expertise from an alternative unconflicted source.
- Including a conflicted person in the discussion and decision where there is a clear benefit to them being included in both – however, including the conflicted person in the actual decision should be done after careful consideration of the risk and with proper mitigation in place. The rationale for inclusion should also be properly documented and included in minutes.
- Noting the nature and extent of the interest but judging it appropriate to allow the member to remain and participate.
- Removing the member from the group or process altogether.
- Consider using a sub-committee to remove potential conflict from core committee membership.

6.19.5. The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. Good judgement is required to ensure proportionate management of risk.

6.20. Procurement

6.20.1. Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour which is against the interest of patients and the public.

6.20.2. Those involved in procurement exercises for and on behalf of the organisation should keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage of procurement steps should be

taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process.

6.20.3. In relation to the provider selection regime, where decisions are being taken as part of a formal competitive procurement of services, any individual who is associated with an organisation that has a vested interest in the procurement should recuse themselves from the process.

6.20.4. The procedure for managing conflicts of interest during procurements is set out in the ICB's Procurement and Contracting Policy.

6.21. Identifying and Reporting Breaches

6.21.1. There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as 'breaches'.

6.21.2. Staff who are aware about actual breaches of this policy, or who are concerned that there has been, or might be, a breach, should report these concerns to one of the officers listed below, whose contact details are set out on **Appendix D**:

- The ICB Governance Lead.
- The Conflicts of Interest Guardian.
- The Director of Resources.
- The ICB's Local Counter Fraud Specialist.

6.21.3. To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Every individual has a responsibility to do this. For further information about how concerns should be raised please refer to the ICB's Raising Concerns Policy.

6.21.4. The ICB will investigate each reported breach according to its own specific facts and merits and give relevant parties the opportunity to explain and clarify any relevant circumstances.

6.21.5. Following investigation, the ICB will:

- Decide if there has been or is potential for a breach and, if so, what the severity of the breach is.
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum.
- Consider who else inside and outside the organisation should be made aware
- Take appropriate action as set out in the next section.

6.22. Taking Action in Response to Breaches

6.22.1. Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of the organisation and could involve organisational leads for staff support (e.g. Human Resources), fraud (e.g. Local Counter Fraud Specialist), members of the management or executive teams and auditors.

6.22.2. Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process and procedures.
- Consideration as to whether HR/employment law/contractual action should be taken against staff or others.
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS Counter Fraud Authority, the Police, statutory health or social care bodies (such as NHS England, NHS Improvement or the Care Quality Commission, Local Government Association, and/or health professional regulatory bodies.

6.22.3. Inappropriate or ineffective management of interests can have serious implications for the organisation and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches in accordance with the ICB's Disciplinary Policy.

6.22.4. Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the ICB can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach. This includes:

- Employment law action against staff, which might include
- Informal action (such as reprimand or signposting to training and/or guidance).
- Formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal).
- Reporting incidents to the external parties described above for them to consider what further investigations or sanctions might be.
- Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach.
- Legal action, such as investigation and prosecution under fraud, bribery and corruption legislation.

6.23. Learning and Transparency Concerning Breaches

6.23.1. Anonymised reports on breaches, the impact of these, and actions taken will be considered by the Audit Committee and any other relevant committee/group.

6.23.2. To ensure that lessons are learnt and management of interests can continually improve, anonymised information on breaches, the impact of these, and action taken will be prepared and published on the ICB's website, as appropriate, or made available for inspection by the public upon request.

7. Monitoring Compliance

7.1. Compliance with this policy will be monitored in the following ways:

- As part of the routine monitoring undertaken by the ICB Governance Lead.
- Monitoring completion rates of mandatory training relating to the management of conflicts of interest and taking action where necessary to improve completion rates.
- Annual audit of arrangements to manage conflicts of interest undertaken by the ICB's auditors.
- Anonymised reporting on breaches and significant issues relating to the management of conflicts of interest to the Audit Committee or other relevant committee.
- By submission of any returns required by NHSE/I in relation to the management of conflicts of interest, which will be signed-off by the Conflicts of Interest Guardian.

8. Staff Training

8.1.1. Staff at Band 7 and above and any other staff defined as decision making staff will be required to undertake training deemed to be mandatory by NHSE/I or the ICB on the management of conflicts of interest available via the Electronic Staff Record (ESR) or E-Learning for Health (ELfH) systems.

8.1.2. Those staff with responsibility for providing advice and support regarding the management of conflicts of interest (including the ICB Governance Lead, other governance staff and the Conflicts of Interest Guardian) will be required to undertake appropriate additional training relating to the management of conflicts of interest available on ESR or ELfH.

8.1.3. Additional training needs may be identified, for example, where a breach has occurred or to provide a member of staff with additional knowledge to undertake their role effectively.

8.1.4. Completion of mandatory training will be monitored and action taken to address completion rates where necessary.

9. Arrangements For Review

9.1. This policy will be reviewed one year from the establishment of the ICB, following which the frequency of future reviews will be agreed. An earlier review will be carried out in the event of any relevant changes in legislation, national or local policy/guidance, organisational change or other circumstances which mean the policy needs to be reviewed.

9.2. If only minor changes are required, the sponsoring committee (Audit Committee) has authority to make these changes without referral to the ICB Board. If more significant or substantial changes are required, the policy will need to be ratified by the relevant committee before final approval by the ICB Board.

10. Associated Policies, Guidance And Documents

10.1. Associated Guidance and Legislation

- NHSE/I Interim Guidance on the Functions and Governance of the Integrated Care Board
- www.england.nhs.uk/ourwork/coi
- Freedom of Information Act 2000
- ABPI: The Code of Practice for the Pharmaceutical Industry (2014)
- ABHI: Code of Business Practice
- NHS Code of Conduct and Accountability (July 2004)

10.2. Associated ICB Policies

- Standards of Business Conduct Policy
- Raising Concerns Policy
- Procurement and Contracting Policy
- Disciplinary Policy
- Counter-Fraud, Bribery and Corruption Policy

11. References

This policy is based on Managing Conflicts of Interest in the NHS (Model Policy for Organisations) April 2017.

12. Equality Impact Assessment (EIA)

12.1. The EIA has identified no equality issues with this policy.

12.2. The EIA has been included as **Appendix A**.

Appendix A - Equality Impact Assessment

INITIAL INFORMATION

Name of policy: Conflicts of Interest Policy **Version number (if relevant):** 1.0	**Directorate/Service**: Corporate / Chief Executive's Office
Assessor's Name and Job Title: Sara O'Connor, Head of Corporate Governance	**Date:** May 2022

OUTCOMES
Briefly describe the aim of the policy and state the intended outcomes for staff
This policy is designed to enable the ICB and its staff and partner organisations to effectively manage conflicts of interest in situations where conflicts might arise (e.g. during decision making/procurement processes, offers of gifts and hospitality, commercial sponsorship and outside employment).
EVIDENCE
What data / information have you used to assess how this policy might impact on protected groups?
The ICB monitors the composition of its workforce under the nine protected equality characteristics and reports on this annually. This information helps the ICB to assess the potential impact of its policies upon staff.
Who have you consulted with to assess possible impact on protected groups? If you have not consulted other people, please explain why?
The policy is based on the NHS England/Improvement Policy template for managing conflicts. The Staff Engagement Group have been consulted on the policy and their feedback will be considered before the policy is finalised.

ANALYSIS OF IMPACT ON EQUALITY

The Public Sector Equality Duty requires us to **eliminate** discrimination, **advance** equality of opportunity and **foster** good relations with protected groups. Consider how this policy / service will achieve these aims.

N.B. In some cases it is legal to treat people differently (objective justification).

- ***Positive outcome*** *– the policy/service eliminates discrimination, advances equality of opportunity and fosters good relations with protected groups*
- ***Negative outcome*** *– protected group(s) could be disadvantaged or discriminated against*
- ***Neutral outcome*** *– there is no effect currently on protected groups*

Please tick to show if outcome is likely to be positive, negative or neutral. Consider direct and indirect discrimination, harassment and victimisation.

Protected Group	Positive outcome	Negative outcome	Neutral outcome	Reason(s) for outcome
Age			X	There is a risk that staff from protected groups may be reluctant to use the policy because of fear of discrimination, harassment or victimisation, however it is considered that this risk will be minimised by the assurances given in the associated Raising Concerns Policy and reference within the Conflicts of Interest Policy that employees will not be penalised for raising honest concerns and by the regular monitoring of cases.
Disability (Physical and Mental/Learning)			X	As above.
Religion or belief			X	As above
Sex (Gender)			X	As above
Sexual Orientation			X	As above
Transgender/Gender Reassignment			X	As above
Race and ethnicity			X	As above
Pregnancy and maternity (including breastfeeding mothers)			X	As above
Marriage or Civil Partnership			X	As above

MONITORING OUTCOMES
Monitoring is an ongoing process to check outcomes. It is different from a formal review which takes place at pre-agreed intervals.
What methods will you use to monitor outcomes on protected groups?
An anonymised summary of breaches will be provided to the Audit Committee. If pertinent, the summary will identify where an individual's protected group status was relevant to the circumstances investigated and identify any lessons learned in this respect.

REVIEW
How often will you review this policy / service?
Every three years unless circumstances require an earlier review. (Minimum every three years)

If a review process is not in place, what plans do you have to establish one?
N/A

Appendix B – Declarations of Interest Form

Declaration of Interest form (for ICB Board members, Employees/Bank/Agency Staff/Contractors, GPs and members of ICB Committee/Sub-Committees/Groups)

To be completed and signed <u>even if a 'Nil' Return</u>

Name:		**Email Address:**	
		Tel No:	
Position within, or relationship with, the ICB			
Name & Position of Head of Service/Senior ICB Manager: (who will sign-off form where an interest is declared)			

Please list below details of actual or potential interests held by you, or state 'Nil' if there are no interests that need to be declared. Interests declared by those staff considered to be 'decision-makers', as defined within the ICB's Management of Conflicts of Interest Policy, will be included within the publicly available Register of Interests posted on the ICB website unless an objection to publication is received (see below).

Declared Interest (Name of the Organisation <u>and</u> nature of business)	**Type of Interest** (see guidance notes below – please mark 'X')			**Is the interest direct or indirect?** (see guidance notes below)	**Nature of Interest**	**Date of Interest**		**Action taken to mitigate risk** Action to be agreed with Head of Service (with support from ICB Governance Lead if required) who must sign p2 of this form
	Financial Interest	**Financial Professional Interest**	**Professional Personal Interest**			**From**	**To** (Insert end date if interest is time limited. Advise ICB Gov Lead when interest ceases)	

NB: The names of individuals who make a 'Nil' declaration will not be included in the publicly available register of interests.

Fair Processing Statement

This information submitted will be held by the ICB for the reasons specified on this form and to comply with the NHS Act 2006 (section 14O(1)), the ICB's Constitution and the ICB's policies. This information may be held in both manual and electronic form, in accordance with the Data Protection Act 2018. The information will be held securely by the ICB, but, as per the NHS Act 2006 (section 14O(2)), will be made available to the public on request and, as per NHSE/I mandatory guidance on managing conflicts of interest, in the case of Governing Body members and other staff/individuals who have declared an interest, published on the ICB website.

Declaration

I confirm the information provided above is complete and correct. I acknowledge that any changes in this declaration must be notified to the ICB as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, or internal disciplinary action may result.

I **do / do not [delete as applicable]** object to my name and details of declared interests being published on registers that the ICB holds.

If you are raising an objection, please give reasons and a decision will be made by the ICB's Conflict of Interests Guardian whether to redact this information from the publicly available register(s).

Signed: _____ **Date**:_____
(Individual making the declaration of interest(s)

'Nil' declarations do not need to be signed-off by the Head of Service/Senior ICB Manager. Where one or more interests have been declared, individuals must discuss and agree how these interests will be managed with their Head of Service/Senior ICB Manager, who must then sign this form before submission to the ICB Governance Lead. Agreed action taken to mitigate the risk must be recorded in the last column of the table on the first page of this form. Declarations from non-ICB employees, will be signed-off by the ICB Governance Lead.

Signed: _____ **Position:** _____

Date:_____
(Head of Service/Senior ICB Manager)
Please return to: Corporate Governance Team

DEFINITION OF AN INTEREST

A conflict of interest may be “actual” or “potential”.

Actual	Potential
There is a material conflict between one or more interests	There is the possibility of a material conflict between one or more interests in the future.

It should be noted that a benefit may arise from the making of a gain or the avoidance of a loss. Interests fall into four categories as set out in the table below (not exhaustive). It is also important to avoid any ‘**perception**’ that a conflict of interest has occurred. Therefore, if you have any doubt as to whether an interest should be declared, please seek advice from the ICB Governance Lead.

Interest	Description
Direct Financial Interests	This is where an individual may get direct financial benefits from the consequences of a commissioning decision. This could, for example, include being: • A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations. This includes involvement with a potential provider of a new care model. • A shareholder (or similar owner interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations. • A management consultant for a provider; • A provider of clinical private practice; • Employment outside of the ICB; • In receipt of secondary income; • In receipt of a grant from a provider; • In receipt of any payments (for example honoraria, one off payments, day allowances or travel or subsistence) from a provider • In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and • Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).
Direct Non-Financial Professional Interests	This is where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career. This may, for example, include situations where the individual is: • An advocate for a particular group of patients; • A GP with special interests e.g., in dermatology, ophthalmology, acupuncture etc.

Interest	Description
	• An active member of a particular specialist professional body (although routine GP membership of the Royal College of General Practitioners RCGP, British Medical Association (BMA) or a medical defence organisation would not usually by itself amount to an interest which needed to be declared); • An advisor for Care Quality Commission (CQC) or National Institute for Health and Care Excellence (NICE); • Engaged in a research role. • The development and holding of patents and other intellectual property rights which allow staff to protect something that they create, preventing unauthorised use of products or the copying of protected ideas; or • GPs and practice managers or other practice staff who are members of the ICB governing body or committees of the ICB, should declare details of their roles and responsibilities held within their GP practices.
Direct Non-Financial Personal Interests	This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is: • A voluntary sector champion for a provider; • A volunteer for a provider; • A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation; • Suffering from a particular condition requiring individually funded treatment; • A member of a lobby or pressure groups with an interest in health and care.
Indirect Interests	This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision (as those categories are described above). For example, this should include: Spouse / partner; Close family member or relative e.g., parent, grandparent, child, grandchild or sibling, aunt/uncle/niece nephew etc. Close friend or associate; or Business partner. Whether an interest held by another person gives rise to a conflict of interest will depend upon the nature of the relationship between that person and the individual and the role of the individual within the ICB.

Appendix C – Gifts and Hospitality Declaration Form

Declaration of Gifts, Hospitality, and Sponsored Events Form

Name of member of staff offered gift(s) or hospitality:		**Email Address:**	
		Tel No:	
Position within, or relationship with, the Integrated Care Board			

GIFT(S) AND/OR HOSPITALITY – please see table below (pages 3 and 4) for guidance on what can be accepted (in some cases with prior approval) or must be refused, and what must be declared. Please refer to Section 6.15 of the Conflicts of Interest Policy regarding Sponsored Events.

Date of Offer	Date of Receipt (if applicable)	Details of Gift / Hospitality / Sponsorship	Estimated Value	Supplier / Offeror Name and Nature of Business	Details of Previous Offers or Acceptance by this Offeror/ Supplier/Sponsor	Declined or Accepted?	Reason for Accepting or Declining

REVIEW BY HEAD OF SERVICE	
Name and Position of Manager reviewing and signing-off acceptance/rejection of gift or hospitality.	
Reason for recommending acceptance/rejection, where applicable (see guidance below).	
Signature of Manager	
Date:	

Fair Processing Statement

The information submitted will be held by the ICB for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that the ICB holds. The Data Protection Officer can be contacted at Jane.marley@nhs.net.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in this declaration must be notified to the ICB as soon as practicable and no later than 28 days after I am aware that changes are required. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, professional regulatory or internal disciplinary action may result.

I do / do not (delete as applicable) object to this information being included on registers that the ICB holds and publishes on its website.
NB: *If you are raising an objection, please give reasons and a decision will be made by the ICB's Conflict of Interests Guardian whether to redact this information from the publicly available register(s).*

Signed: _____ **Date:** _____

Please return completed and signed form to ICB Governance Lead.

GUIDANCE ON ACCEPTING, REFUSING AND DECLARING GIFTS, HOSPITALITY AND SPONSORSHIP

Gifts

A 'gift' is defined as any item of cash or goods, or any service, which is provided for personal benefit, free of charge or at less than its commercial value. ICB staff should not ask for any gifts. ICB staff should also not accept any unsolicited offers of gifts or hospitality that may affect, or be seen to affect, their professional judgement. The rules for accepting, refusing and declaring gifts and hospitality are summarised below.

If the actual value of a gift is unknown, a 'common sense' approach should be applied to the valuing of such gifts, by using an estimated amount that a reasonable person would make as to its value. Multiple gifts from the same source over a twelve month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50. For further information, please refer to the ICB's Policy on Gifts & Hospitality.

Hospitality

'Hospitality' means offers of meals, refreshments, travel, accommodation and other expenses in relation to attendance at meetings, conferences, education/training or other events. ICB staff, or others working on behalf of the ICB, should not ask for, or accept, hospitality that may affect, or be seen to affect their professional judgement. Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event.

Relevant Paragraph within G&H Policy	Types of Gifts and Hospitality and thresholds for acceptance/refusal.	Accept or Refuse?	Must I Declare the Offer/Gift/Hospitality?
6.8.2	Gifts made by suppliers or contractors linked (currently or prospectively) to the ICB's business. However, see exception below.	**Refuse**	**Yes** – all such offers must still be declared.
6.8.2	Low cost branded promotional aids from suppliers or contractors may be accepted and not declared where they are under the value of a common industry standard of £6.	**Acceptable**	**No**
6.8.3	Cash or cash equivalents (including vouchers, tokens, offers of remuneration to attend meetings whilst in a capacity working for or representing the ICB) whatever their value and whatever their source;	**Refuse**	**Yes** – all such offers must still be declared.
6.8.3	Items of low value such as diaries, calendars, stationery and other gifts acquired from meetings, events or conferences and modest gifts such as flowers and small tokens of appreciation from patients, families and members of the public to staff for work well done may be accepted where the notional value is under £50. These gifts do not have to be declared.	**Acceptable**	**No**
6.8.3	Gifts offered from other sources (i.e. other than suppliers or contractors) and valued		

Relevant Paragraph within G&H Policy	Types of Gifts and Hospitality and thresholds for acceptance/refusal.	Accept or Refuse?	Must I Declare the Offer/Gift/Hospitality?
	at over £50 should be treated with caution and only be accepted on behalf of the ICB (i.e. to the ICB's charitable funds) not in a personal capacity and must be declared.	**Acceptable** (but treat with caution)	**Yes** – all such offers must still be declared.
6.8.3	Gifts offered from other sources (i.e. other than suppliers or contractors) should be declined if accepting them might give rise to perceptions of bias or favouritism, and a common sense approach should be adopted as to whether or not this is the case. All such gifts should be declared to a Line Manager, and the Head of Corporate Governance, who will recommend refusal or acceptance.	**Refuse** if there could be a perception of bias/favouritism.	**Yes** – all such offers must still be declared.
6.9.4	Modest hospitality, under the value of £25, provided in normal and reasonable circumstances may be acceptable, although it should be on a similar scale to that which the ICB might offer in similar circumstances (e.g. tea, coffee, light refreshments at meetings). A common sense approach should be adopted as to whether hospitality offered is modest or not.	**Acceptable**	**Yes** – if offered by suppliers or contractors linked (currently or prospectively) to the ICB's business **No** – if offered from other sources.
6.9.4	Offers of hospitality of a value between £25 and £75.	**Acceptable**	**Yes** – all such offers must still be declared.
6.9.4	Hospitality (including meals, refreshments, travel, accommodation) of a value above £75 unless (in exceptional circumstances) senior prior approval is given (a clear reason should be recorded on the gifts & hospitality register as to why it was permissible to accept).	**Refuse** (unless senior prior approval given in exceptional circumstances)	**Yes – all such offers must still be declared.**
6.15 – 6.17	**Sponsorship** Line manager and governance advice must be sought before accepting any type of sponsorship as this can be a controversial issue. In the cases of sponsored events, sponsorship should **never** be accepted from organisations whose business would not be seen as being compatible with the ethos of the NHS, e.g. organisations that are associated with:	**Discuss with Line Manager and obtain Governance advice regarding acceptance or refusal.**	**Yes – all sponsorship must be declared.**

Relevant Paragraph within G&H Policy	Types of Gifts and Hospitality and thresholds for acceptance/refusal.	Accept or Refuse?	Must I Declare the Offer/Gift/Hospitality?
	• Matters that are damaging to health or associated with gambling, alcohol, tobacco, weight control or politics • The promotion of prescription-only drugs to the general public or other promotion that contravenes that ABPI Code of Practice to the Pharmaceutical Industry. • Pornography or other companies involved in the sexual exploitation of adults or children • The manufacture of firearms or other weapons • Legal services which overtly promote compensation and personal injury services and claims management companies acting on their behalf		

Appendix D – Contact Details of Officers referred to within the Policy

ICB Governance Lead – to be inserted

Corporate Governance Team – to be inserted

Audit Committee Chair / Conflicts of Interest Guardian – to be inserted

Director of Resources – to be inserted

Local Counter Fraud Specialist – to be inserted

Appendix D

Risk Management Policy

Document Control:

Policy Name	Risk Management Policy
Policy Number	MSEICB 017
Version	1.0
Status	Draft
Author / Lead	Head of Corporate Governance, MECCG
Responsible Executive Director	The Chief Executive has delegated responsibility to the Chief of Staff
Responsible Committee	Audit Committee
Date Ratified by Responsible Committee	4 March 2022
Date Approved by Board/Effective Date	1 July 2022
Next Review Date	1 July 2024
Target Audience	• Mid and South Essex (MSE) Integrated Care Board (ICB) members and staff (including temporary/bank/agency/voluntary/work experience staff). • Contractors engaged by the ICB. • Staff from other MSE organisations who are members of ICB Committees/Sub-Committees and other groups.
Stakeholders engaged in development of Policy (internal and external)	• Mid and South Essex CCG Governance Leads. • MSE CCGs Audit Committees meeting in common.
Impact Assessments Undertaken *(Delete if non-applicable)*	• Equality and Health Inequalities Impact Assessment

Version History

Version	Date	Author (Name and Title)	Summary of amendments made
0.1	09/02/22	Sara O'Connor, Head of Corporate Governance, MECCG	First draft of ICB Risk Management Policy
0.2	22/02/22	Viv Barnes, Director of Governance and Performance	Minor amendments made following review of first draft.
0.3	25/02/22	David Triggs, Head of Corporate Governance, B&B CCG	Minor amendments
0.4	04/03/22	Sara O'Connor	Updated following comments received from Audit Committee members, 4 March 2022.

Version	Date	Author (Name and Title)	Summary of amendments made
0.5	June 2022	Mike Thompson	Review of policy with Chair of ICB.
1.0	21/06/22	Sara O'Connor	Policy Reference number added to final draft.

Contents

1. Introduction

1.1. The Mid and South Essex (MSE) Integrated Care Board ('the ICB') works collaboratively across the Mid and South Essex Health and Care System ('the ICS') footprint to manage risks that have the potential to affect the achievement of its objectives. This policy sets out how the ICB will identify and manage risk.

1.2. The ICB acknowledges that risks will arise during the commissioning of health services and tackling health inequalities in an innovative and effective way, but that taking risks can bring benefits and opportunities when managed appropriately. The ICB does not aim to create a risk-free environment, but rather one in which risk is appropriately identified and routinely managed via embedded structures and processes, to enable it and partner organisations to provide safe, high quality, and value for money services for the MSE population.

1.3. The ICB recognises the importance of involving and working with local partners and other stakeholders to identify, prioritise and manage shared risks. Consequently, a close working relationship will be forged with partners and stakeholders to establish a process to manage system wide risks as the ICS and ICP evolve.

2. Purpose / Policy Statement

2.1. This policy sets out the overarching framework and process for the management of ICB risks by the Board, members of staff and persons engaged in business on behalf of the ICB.

2.2. The aim of the policy is to establish and maintain a framework for risk management which:

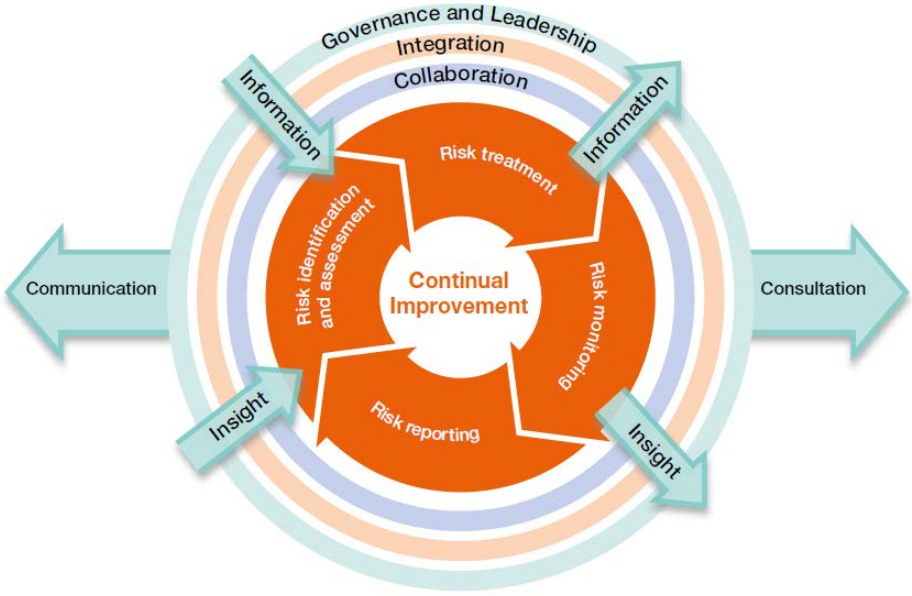
- Supports the ICB in achieving its strategic objectives and realising the significant safety, quality, financial and other organisational benefits from effectively managing risk.
- Ensures processes are based on best practice, national guidance and take account of organisational needs.
- Promotes an integrated risk management approach across all areas of corporate and clinical/professional risk which is embedded within day-to-day operational functions across MSE.
- Assists the ICB Board in agreeing the Governance Statement which forms part of the Annual Report and Accounts.
- Ensures that risks are managed systematically and consistently to avoid the ICB and members of the wider ICS being exposed to extreme levels of risk threatening the way in which they operate.

2.3. Resources available for managing risk are finite. The ICB will aim to

achieve a prioritised and effective response to risk, whilst striking a balance between cost and benefit. The ICB will therefore take action to manage risk to a level which the ICB can justify as being tolerable. This will be achieved by the Board agreeing and reviewing the ICB's 'risk appetite' on an annual basis as detailed in Section 6.4.

2.4. A risk management framework operated in isolation is ineffective unless it supports continual learning. The ICB will implement processes to ensure risks are adequately identified, analysed, prioritised, mitigated and reported/communicated at all levels of the organisation, including the ICB's main committees and the Board. Regular reporting will enable the ICB to monitor changes in its risk profile and provide assurance that controls are effective (or not) and will enable learning to be shared.

2.5. The way in which those accountable for risk management should engage with the risk management process is depicted in the diagram below, adapted from HM Treasury: The Orange Book. Management of Risk – Principles and Concepts (2020) – referred to hereafter as 'The Orange Book'.



3. Scope

3.1. This policy applies to the following (collectively known as members of staff):

- Mid and South Essex (MSE) Integrated Care Board (ICB) members
- Members of staff (including temporary/bank/agency/voluntary/work experience staff).
- Contractors engaged by the ICB.

- Members of staff from other MSE partner organisations who are members of ICB Committees/Sub-Committees, advisory groups/other groups or otherwise involved in ICB business.

3.1. The policy applies to all areas of the ICB's responsibilities and activities and all ICB premises and other assets.

4. Definitions

- **Strategic Objectives –** the main objectives (aims) agreed by the ICB as set out in the MSE Health and Care Partnership Strategy, against which all risks are mapped. The ICB will also set other objectives, including those set out within ICP and Alliance Plans. The ICB's current strategic objectives are set out in **Appendix B** and will be reviewed annually.

- **Hazard** - any source (incident/event/circumstances) of potential damage, harm or adverse effect on someone, something, the organisation or the environment.

- **Risk** – the potential of a situation or event to impact on the achievement of specific objectives. Risks can arise in many ways and include clinical, non-clinical, financial, environmental, workforce, equality and diversity and reputational risks. In the Orange Book, risk is defined as the "uncertainty of outcome, whether positive opportunity or negative threat, of actions and events".

- Risk is characterised by two factors, being a combination of the

  - **consequences/impact** of a hazard and the

  - **likelihood** of occurrence.

- **Risk Rating** - the level of risk at a particular point in time (i.e. initial, current or target risk rating) expressed by calculating the risk rating score by using the impact and likelihood assessment tables at **Appendices C and D** and the risk rating matrix at **Appendix E**. Depending on the score, risks will be categorised as Red, Amber or Green (often referred to as the 'RAG' rating).

- **Inherent Risk** - the level of exposure arising from a specific risk before any action has been taken to manage it. This is often referred to as the 'initial risk rating'

- **Residual Risk** - it is the level of exposure arising from a specific risk after mitigating action has been taken to manage it.

- **Risk Appetite** - also known as the 'target risk rating', it is the amount of risk that the organisation is prepared to accept, tolerate or be exposed to at any one point in time.

- **Strategic Risk** - a risk with the potential to have significant impact upon the achievement of strategic objectives affecting the whole or several areas of the organisation (as opposed to one department). These risks have the highest potential for external impact.
  Red rated/extreme risks will be recommended by the Responsible Director/Committee to the Board for consideration as strategic risks and inclusion on the BAF.

- **Operational Risks** – a risk that is most likely to impact on an organisation's ability to undertake its day to day internal functions in a safe and efficient manner. These risks tend to affect one department or a specific area of business. Operational risks will be escalated to the Board for consideration as a strategic risk (and inclusion on the BAF) if they are risk rated 'red/extreme'.

- **Project Risks** – a risk associated with a specific project that is not likely to have an impact beyond the remit/lifetime of that project. Risks or issues identified during the project will be rated having regard to the context of each project. Consequently, highly rated project risks might not need to be included on the corporate risk register or BAF. However, project managers should ensure that any significant risks that might compromise the success of the project are escalated to the Director with responsibility for the project so they can consider including the risk on the corporate register or BAF, taking advice from the Governance Lead in this regard.

- **Risk Management** - a proactive and integral approach to the management of those risks that might affect the achievement of an organisation's objectives.

- **Integrated Risk Management** - the management of risk across the organisation at varying levels via a range of processes. In addition to the maintenance of the risk register and BAF, this includes undertaking specific risk assessments, performance reporting and the management of incidents, complaints and claims. Taking an integrated risk management approach enables the triangulation of data/findings and the sharing of learning.

- **Risk Profile** - the documented overall assessment of the range/type, number and rating of risks faced by the organisation.

- **Risk Materialisation** – the time at which a hazard or adverse circumstances thought possible occur.

- **Controls** - measures implemented to reduce risk and prevent harm. These include systems and structures, processes, policies, guidelines, professional practice and training.

- **Assurances** – evidence relied upon by the organisation to provide it with a level of assurance that its controls are effective (positive assurance) or ineffective (negative assurance). Sources of assurance can be internal or external, with the latter considered to provide a higher level of assurance. Types of assurance include internal/external audits, inspections by regulatory and professional bodies (e.g. Care Quality Commission inspections), monitoring reports to Board/committees, testing of financial, IT and other systems, and assessment of the ICB's systems and processes against specific standards.

- **Board Assurance Framework (BAF)** – the key document used to record and report to the Board significant risks (strategic risks) to achieving its strategic objectives, listing controls/action being taken and sources of assurance. It is used to support the Governance Statement that the Chief Executive is required to sign-off at the end of each financial year.

- **Risk Register** - a document detailing all risks identified by the organisation, similar in format to the BAF. The ICB will maintain a central repository/database of all risks to enable risk registers to be produced for departmental/committee and other meetings.

- **Responsible Executive Director** - the Executive Director with overall responsibility for managing risks within their remit. These individuals will be identified on the risk register and BAF.

- **Risk Lead** – the operational lead (i.e. a senior manager or workstream lead) who has been delegated responsibility for managing specific risks. These individuals will be identified on the risk register and BAF and are responsible for ensuring action is taken to mitigate risks and for providing updates on their status for inclusion on the risk register and BAF.

5. Roles and Responsibilities

5.1. Chief Executive

5.1.1. The Chief Executive of the ICB has overall accountability for effective risk management within the ICB in line with legislation and guidance issued by NHS England and Improvement (NHSE/I).

5.1.2. The Chief Executive will report annually to the ICB Board on the adequacy of internal control and risk management within the Governance Statement that forms part of the Annual Report and Accounts.

5.2. ICB Board

5.2.1. The Board is accountable and responsible for ensuring that the ICB has an effective programme for managing risks that might compromise the achievement of its objectives. The Board will seek regular assurance via the BAF, from its committees, partner organisations and other sources regarding the effectiveness of controls and will ensure further mitigating action is taken where necessary.

5.2.2. The Board will decide which risks will be categorised as strategic risks for inclusion on the Board Assurance Framework. Recommendations for strategic risks will usually be made by the Responsible Director.
The Board has authority to:

- Accept operational risks which have been rated red/extreme as strategic risks. If Board members are of the opinion that a red/extreme rating is not justified at the current time, the risk will be re-rated appropriately and remain an operational risk.
- Accept lower rated risks as strategic risks if circumstances merit regular Board level oversight, for example, where a lower-rated risk has the potential to significantly impact on interdependent strategic risks.
- Close existing strategic risks or de-escalate them to operational level.
- Agree that risks not yet included on the ICB's risk registers or BAF are added.
- Prioritise action required to mitigate risk.

5.3. Audit Committee

5.3.1. The Audit Committee has responsibility for monitoring the ICB's compliance with this policy and is the 'sponsoring committee' referred to in Section 9 below.

5.3.2. The Audit Committee will seek assurance that risks are being appropriately and robustly managed via receipt of a report on the BAF, the minutes of other ICB committee meetings and other reports on specific issues requested by the committee.

5.3.3. The Audit Committee will review the outcome of the annual internal audit of governance and risk management arrangements which, along with other assurances received, will enable the committee to recommend the Governance Statement is signed-off by the Chief Executive at the end of each financial year.

5.3.4. The Audit Committee also has responsibility for reviewing and monitoring any specific risks within its remit and for providing regular assurance to the ICB Board, including escalation of significant risks where necessary.

5.4. Other ICB Committees, Sub-Committees and Groups

5.4.1. Other ICB committees, sub-committees or groups have responsibility for reviewing and monitoring specific risks within their remit and for providing regular assurance to the ICB Board (or in the case of sub-committees, to the relevant committee) and escalation of significant risks where necessary.

5.4.2. ICB Committees will recommend red rated risks within their remit are categorised as strategic risks for inclusion on the BAF.

5.4.3. ICB Committees will also recommend removal of strategic risks from the BAF, or their closure, as appropriate.

5.5. Chief of Staff

5.5.1. The Chief Executive has delegated overarching responsibility for risk management to the Chief of Staff, with each Executive Director being responsible for risks aligned to their functions.

5.6. Director of Resources

5.6.1. The Director of Resources has delegated responsibility for financial risk management and will ensure:

- The effectiveness of the ICB's financial control systems.
- Significant financial risks faced by the ICB are identified and managed effectively.
- Audit Committee and Internal Audit effectively perform their roles in assuring the ICB's system of internal control.
- Robust counter fraud arrangements are in place and comply with NHS standards in relation to counter fraud.

5.6.2. The Director of Resources also acts as the ICB Senior Information Risk Owner.

5.7. Chief Nurse

5.7.1. The Chief Nurse has lead responsibility for the safety and quality of services and is accountable for safeguarding children and adults, working in partnership with responsible local authorities and other key agencies to ensure that the ICB's statutory safeguarding duties are met.

5.7.2. The Chief Nurse provides assurance to the Boards regarding patient safety and quality within commissioned services in line with local and national legislation and guidance and will ensure that any associated risks are appropriately captured on the risk register and escalated to the Board and BAF where necessary.

5.7.3. The Chief Nurse also acts as the ICB Caldicott Guardian.

5.8. NHS Alliance Directors, Executive Directors and other Managers

5.8.1. NHS Alliance Directors, Executive Directors and other managers are responsible for ensuring that appropriate and effective risk management processes are in place within their designated areas and scope of responsibility and that they comply with the requirements of the ICB's risk management arrangements, including regularly reviewing risks with their staff at directorate/departmental meetings and reporting risks to the appropriate Committee or Board, including making recommendations to add, close or re-categorise risks as appropriate.

5.8.2. They are responsible for ensuring that all members of their staff are aware of risks relevant to their area of work and of their personal responsibilities as set out in section 5.11 of this policy. They must ensure their staff receive appropriate information, instruction and training to enable them to undertake their roles effectively and safely.

5.8.3. Responsible Executive Directors may delegate the management of some of the operational risk management processes to an appropriate senior manager, who will be named as the 'Risk Lead' on the risk register/BAF.

5.9. Policy Author

5.9.1. The policy author will have responsibility for developing and updating the policy in line with Section 9.

5.10. Governance Lead

5.10.1. The Governance Lead has responsibility for managing the risk management process, including liaising with risk leads for updates, production of the BAF and corporate risk registers for Board/Committee meetings, and provision of risk management training.

5.11. All Members of ICB Staff

5.11.1. All members of staff are individually responsible for:

- Familiarising themselves with the content of this policy and associated procedures and following these.

- Identifying, assessing and putting systems in place to mitigate any risks to the achievement of the ICB's strategic objectives and those within their remit, to ensure risks are managed and escalated where appropriate through the risk register and associated processes.
- Reporting incidents/accidents and near misses using the ICB incident reporting procedure.
- Being aware of their duty under legislation to maintain safe working practices and to take reasonable care of their own health, safety and welfare and that of others by complying with all relevant ICB policies, procedures and guidance.
- Being aware of any emergency procedures relevant to their role and place of work, e.g. security/lockdown and fire safety procedures.
- Completing their mandatory training and attending risk management training and development events relevant to their role.

5.12. Partnership Working

5.12.1. The interface between organisations is often where significant risks arise due to a lack of clarity regarding responsibility and accountability. The ICB will work closely and collaboratively with its partner organisations to reduce the possibility of this occurring by strengthening and integrating risk management arrangements as the ICS and ICP develop.

5.12.2. The ICB will endeavour to involve partners in all aspects of risk management as appropriate. Key partners include GP Practices, providers of shared services to the ICB, provider Trusts, independent sector providers, local authorities, the Police, statutory and voluntary bodies and patient representative groups.

5.12.3. The ICB will work with key stakeholders on identified risks, including child protection, discharge arrangements, workforce planning, in accordance with joint structures that exist between agencies. These arrangements include Partnership Boards and oversight groups such as the System Leaders Executive Group (SLEG), System Finance Leaders Group (SFLG) and System Oversight and Assurance Group (SOAG).

6. Policy Detail

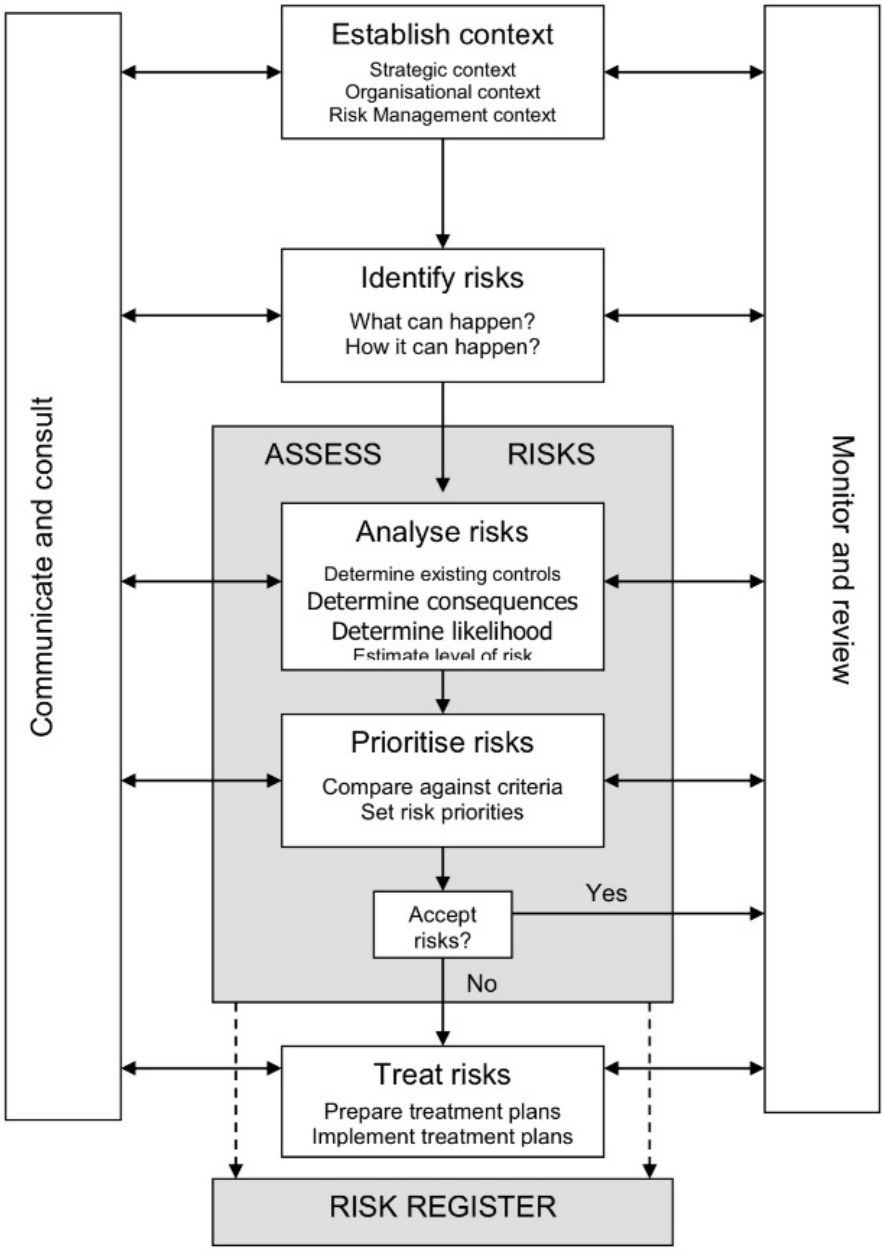
6.1. Overview of Risk Management Process

6.1.1. The ICB has adopted the Australia/New Zealand risk management model, advocated within the Orange Book, which sets out the following stages to manage risk:

- Establish the context

- Identification of hazards
- Analyse risk
- Prioritise risk
- Treat risk
- Monitor and review
- Communicate and Consult.

The table below summarises this model:



6.1.2. **Establishing the context** defines the scope for the risk management process and sets the criteria against which risks will be assessed. The scope should be determined within the context of the ICB's objectives.

6.1.3. **Identification of Risk** will generate a comprehensive list of risks based on events that might create, enhance, prevent, degrade, accelerate, or delay the achievement of objectives. The ICB will use a wide range of information and horizon scanning to identify risks across the ICS footprint and beyond. To embed risk management a combined 'top-down' and 'bottom-up' approach will be taken with all staff, workstreams, departments and local Alliances encouraged to report risks that might affect their ability to meet their specific objectives, affect patient care or affect the worklife of ICB staff. Identified risks will be mapped against workstreams/departments/ Alliances in accordance with the ICB's organisational structure.

6.1.4. **Analysis of Risks** involves developing an understanding of the risk, including whether it could have multiple (positive or negative) consequences and the impact of these, its interdependence with other risks, and taking a decision on how to treat it. The effectiveness of existing controls should be considered.

6.1.5. **Risk Evaluation** involves the scoring/rating of risks, to determine their initial and current risk rating to assist with prioritisation of risks. Risk ratings must be regularly reviewed. A rationale for any changes made to risk ratings must be provided on the risk register/BAF. The Governance Lead will assist risk leads to adopt a consistent approach to the scoring of risks as part of risk update meetings or related correspondence.

6.1.6. **Prioritisation** of risk treatment implementation will ensure that the most highly rated risks are given precedence and will determine the organisational level to which the risk must be reported. Prioritisation should be in accordance with legal, regulatory and other organisational requirements and imperatives.

6.1.7. **Treatment of Risks** - Addressing risk can turn uncertainty to the ICB's benefit by constraining threats and taking advantage of opportunities. There are four broad categories of how risks are managed:

- **Tolerate:** A decision is taken to accept the risk involved and to not take further action to mitigate. This might be because it is within the ICBs' risk appetite; the ability to reduce the risk is very limited; or the cost of acting is disproportionate to the potential benefit gained. Any 'tolerated' risks must have contingency plans developed for managing the impact/consequences should the risk materialise.
- **Treatment:** Most risks are addressed this way by introducing new or strengthening existing controls to reduce the level of risk to an acceptable level.

- **Transfer:** This can be achieved by conventional insurance or by contracting the service to another provider / third party. The relationship with the body to whom the risk is transferred should be managed effectively to successfully transfer the risk. However, in some cases, the risks will not be fully transferrable and consequently the ICB might retain some element of risk such as those relating to its statutory duties or reputational damage.
- **Terminate**: Depending on the type of risk and the ICB's risk appetite, the only sensible option might be to terminate the risk. For example, by decommissioning a service or terminating specific activity. This is a limited option in the NHS and the impact must therefore be fully considered before a decision is made.

6.1.8. Once the most appropriate way of treating a risk has been agreed, an action plan will be drawn up and implemented.

6.1.9. Each stage of the risk management process should be documented to evidence a systematic approach for audit purposes, to develop the ICB's knowledge of risk to aid decision-making, and to facilitate monitoring/consultation and communication of risks.

6.1.10. The arrangements for reporting risks, dependent on their current rating, is as follows:

- **Extreme / Red risk (score of 15 or above):** Immediate action required. The Responsible Executive Director and Risk Lead must take responsibility for development and implementation of an appropriate risk action plan and ensure progress against this is reported to the relevant committee and ICB Board. Risks rated 'extreme' will be recommended by the Responsible Director/Committee to the ICB Board for inclusion on the BAF (see section 5.2.2.)
- **High / Amber risk (score between 8 and 12):** Within one month an appropriate action plan must be agreed, usually with a deadline for completion within 6 months. To be reported to the relevant committee.
- **Low / Green risk (score between 1 and 6):** Acceptable risk. Periodic monitoring and review to be undertaken at Directorate/Departmental level to ensure that risk has not escalated and controls remain effective.

6.2. Description of Risks

Risks will be described on risk registers and the BAF in the following format:

"If this happens/As a result of *(description of potential hazard/circumstances)*

There is a risk that *(explanation of what could happen)*

Resulting in *(description of potential consequences)"*

6.3. Controls and Assurances

6.3.1. Existing controls and sources of assurance will be mapped against each risk.

6.3.2. The effectiveness of controls will be regularly monitored by managers and via the identified assurance processes. Where gaps in controls are identified, action will be taken to address these taking into account the ICB's risk appetite and the cost/benefit of doing so (see paragraph 2.3 above and 6.4 below)

6.3.3. Where a specific risk's score does not reach its 'target rating' and has remained static over three iterations of the BAF or risk register, the relevant Director/manager may be required to attend the relevant Committee/Board meeting to explain the reasons for this and provide assurance regarding action being taken.

6.4. Risk Appetite

6.4.1. The ICB's risk appetite is the amount of risk that the organisation is prepared to accept, tolerate or be exposed to at any one point in time. Setting the risk appetite assists with the prioritisation of risk.

6.4.2. The ICB Board will express the risk appetite score/rating for relevant categories of risk by using the 5 x 5 matrix used for assessing risk at **Appendix E.**

6.4.3. The risk appetite will be recorded as the 'target score/rating' for each risk on the risk register and BAF to enable the ICB Board and committees to monitor when this has been achieved. Once the target score/rating is achieved, a decision will be taken whether it is appropriate to close the risk.

6.4.4. For the purposes of agreeing risk appetite, risks will be categorised as below:

- Finance
- Fraud and Negligent Financial Loss
- Clinical Quality & Patient Safety
- Statutory & Regulatory Compliance
- Reputation
- Partnerships, Engagement and Collaborative Working
- Innovation and Transformation
- Provider Performance
- Commissioning
- National Policy
- Clinical Engagement
- Information Security

6.4.5. The ICB's agreed risk appetite is set out at **Appendix F** (exemplar currently inserted until ICB risk appetite is confirmed).

7. Monitoring Compliance

7.1.1. The Governance Lead is responsible for monitoring the ongoing compliance with this policy and ensuring that an appropriate risk management culture is embedded across the ICB.

7.1.2. The Audit Committee is accountable to the Board for ensuring that the risk management process is effective and will ensure that the Annual Internal Audit Plan incorporates yearly assurance to the Board on the robustness of the ICB's risk management arrangements to support completion of the Governance Statement.

8. Staff Training

8.1.1. All staff will be made aware of the Risk Management Policy as part of their local induction by their line manager including their role and the forms of support available to them. Line managers will be responsible for ensuring that employees' ongoing risk management training needs are assessed during induction and reviewed annually via the staff appraisal process.

8.1.2. The Governance Lead will provide ongoing risk management support to relevant staff and will offer one-to-one meetings with all Risk Leads or attendance at team meetings to assist in the review of their risks prior to each Board or Committee meeting.

8.1.3. The Governance Lead will also offer risk awareness training to supplement any that might be made mandatory for all or specific groups or staff via the e-learning portal as required.

9. Arrangements For Review

9.1.1. This policy will be reviewed no less frequently than every two years. An earlier review will be carried out in the event of any relevant changes in legislation, national or local policy/guidance, organisational change or other circumstances which mean the policy needs to be reviewed.

9.1.2. If only minor changes are required, the responsible Committee has authority to make these changes without referral to the Integrated Care Board. If more significant or substantial changes are required, the policy will need to be ratified by the relevant committee before final approval by the Integrated Care Board.

10. Associated Policies, Guidance and Documents

10.1. Associated Documents

- Board Assurance Framework
- Risk Registers
- Risk Management Training Slides
- General Risk Assessment Template

10.2. Associated Policies

- Anti-Fraud, Bribery and Corruption Policy
- Health & Safety Policy
- Information Governance Policy
- Management of Conflicts of Interest Policy (including Gifts and Hospitality, Commercial Sponsorship and Outside Employment)
- Raising Concerns Policy
- Standards of Business Conduct Policy

11. References and Sources of Further Information

- The Orange Book: Management of Risk – Principles and Concepts; HM Treasury, October 2004.
- Risk Management Assessment Framework: a tool for departments: HM Treasury, July 2009
- NHS England: Risk Management Policy and Process Guide
- National Patient Safety Agency: Risk Assessment Programme Overview
- Department of Finance and Personnel: Policy and Framework for Risk Management
- HM Treasury: Managing Risks with Delivery Partners
- HM Treasury: Thinking about Risk (Managing your risk appetite: A Practitioner's Guide)
- COSO: Enterprise Risk Management – Integrated Framework
- COSO: ERM Risk Assessment in Practice
- COSO: Enterprise Risk Management – Understanding and Communicating Risk Appetite
- COSO: Internal Control – Integrated Framework.

12. Equality Impact Assessment

12.1. The EIA has identified a positive impact and is included at **Appendix A**.

Appendix A - Equality Impact Assessment

INITIAL INFORMATION

Name of policy and version number : Risk Management Policy, **Version:** 0.1	**Directorate/Service**: Corporate / Chief Executive's Office
Assessor's Name and Job Title: Sara O'Connor, Head of Corporate Governance, Mid Essex CCG	**Date:** 18 February 2022

OUTCOMES
Briefly describe the aim of the policy and state the intended outcomes for staff
The Risk Management Policy will support the organisation and staff to achieve a consistent method for identifying and managing/mitigating risks which threaten to achieve the organisation's strategic and other objectives.
EVIDENCE
What data / information have you used to assess how this policy might impact on protected groups?
The ICB regularly monitors the make-up of its workforce, including protected groups.
Who have you consulted with to assess possible impact on protected groups? If you have not consulted other people, please explain why?
The policy has been shared with the CCG Governance Leads and MSE CCG Audit Committee members/attendees, including internal audit.

ANALYSIS OF IMPACT ON EQUALITY

The Public Sector Equality Duty requires us to **eliminate** discrimination, **advance** equality of opportunity and **foster** good relations with protected groups. Consider how this policy / service will achieve these aims.

N.B. In some cases it is legal to treat people differently (objective justification).

- ***Positive outcome*** *– the policy/service eliminates discrimination, advances equality of opportunity and fosters good relations with protected groups*
- ***Negative outcome*** *– protected group(s) could be disadvantaged or discriminated against*
- ***Neutral outcome*** *– there is no effect currently on protected groups*

Please tick to show if outcome is likely to be positive, negative or neutral. Consider direct and indirect discrimination, harassment and victimisation.

Protected Group	Positive outcome	Negative outcome	Neutral outcome	Reason(s) for outcome
Age	X			The policy refers to equality and diversity risks (4.3) and makes it clear that all staff are able to raise risks that might affect their worklife (6.1.3).
Disability (Physical and Mental/Learning)	X			As above
Religion or belief	X			As above
Sex (Gender)	X			As above
Sexual Orientation	X			As above
Transgender / Gender Reassignment	X			As above
Race and ethnicity	X			As above
Pregnancy and maternity (including breastfeeding mothers)	X			As above
Marriage or Civil Partnership	X			As above

MONITORING OUTCOMES
Monitoring is an ongoing process to check outcomes. It is different from a formal review which takes place at pre-agreed intervals.
What methods will you use to monitor outcomes on protected groups?
Regular review of the BAF and risk registers, which include risks relating to equality and diversity and workforce, and ensuring that appropriate mitigating action is taken to address these risks.

REVIEW
How often will you review this policy / service?
Every 2 years as a minimum and earlier if there are any significant changes in legislation, policy or good practice.
If a review process is not in place, what plans do you have to establish one?
N/A

Appendix B – Strategic Objectives

To be confirmed.

Appendix C – Impact Assessment Table

Level	Objectives / Projects	Clinical / Injury	Patient Experience	Complaints / Claims	Service / Business Interruption	Staffing and Competence / HR / OD	Financial / Materiality	Adverse Publicity / Reputation
1 Low	Insignificant cost increase / schedule slippage Barely noticeable reduction in scope or quality.	Minor Injury not requiring first aid.	Unsatisfactory patient experience not directly related to patient care.	Locally resolved complaint.	Loss / interruption > 1 hour.	Short term low staffing level temporarily reduces service quality (<1 day)	< £50k	Rumours
2 Medium	Less than 5% over budget / schedule slippage. Minor reduction in quality / scope.	Minor injury or illness, first aid treatment needed.	Unsatisfactory patient experience partly related to patient care – readily resolvable.	Justified complaint peripheral to clinical care.	Loss / interruption > 8 hours.	On-going low staffing level reduces service quality.	£50k – < £100K	Local media – Short-term. Minor effect on staff morale / service.
3 High	5-10% over budget / schedule slippage. Reduction in quality or scope.	Moderate injury or illness, requiring first aid or medical treatment i.e. fractures. RIDDOR / Agency Reportable.	Mismanagement of patient care.	Below excess claim. Justified complaint involving lack of appropriate care.	Loss / interruption > 1 day.	Late delivery of key objective / service due to lack of staff. Minor error due to poor training. On-going unsafe staffing level.	£100K – < £500K	Local media – Long-term. Significant effect on staff morale / Service.
4 Major	10-25% over budget / schedule slippage.	Major injuries, or long-term incapacity / disability (loss of limb)	Serious mismanagement of patient care.	Claim above excess level.	Loss / interruption > 1 week.	Uncertain delivery of key objective / service due to lack of staff.	£500K - < £1m	National Media - < 3 days.

Level	Objectives / Projects	Clinical / Injury	Patient Experience	Complaints / Claims	Service / Business Interruption	Staffing and Competence / HR / OD	Financial / Materiality	Adverse Publicity / Reputation
	Doesn't meet secondary objectives.			Multiple justified complaints.		Serious error due to poor training.		
5 Critical	>25% over budget / schedule slippage. Doesn't meet primary objectives.	Death or major permanent incapacity.	Totally unsatisfactory patient outcome or experience.	Multiple claims or singe major claim.	Permanent loss of service or facility.	Non delivery of key objective / service due to lack of staff. Loss of key staff. Critical error due to insufficient training.	>£1m	National media - > 3 days. MP Concern (questions in House)

Appendix D – Likelihood Assessment Table

Level	Description	Controls	Resources	KPIs/Output
1 Rare	The event **may** only happen in **exceptional circumstances**. < 20% chance or occurrence Could occur within 5 to 10 years	System controls are **sound** and **working effectively.** Policies and procedures established and followed.	**Stable** staff environment. **Good** training & development (T&D). **Positive** staff morale. **Suitable** premises / working environment	KPIs established and met. Full reporting to mgt & board. Accurate / valid mgt info
2 Unlikely	The event **could** occur (recur) at **some time**. 20% - 40% chance of occurrence Could occur within 1 to 5 years	System controls are **essentially sound** but minor weaknesses may still exist. Policies and procedures in place, but may not always by followed.	**Fairly stable** staff environment. **Some** T&D issues. **Generally positive** staff morale. Premises suitable, but a **little restrictive**.	KPIs generally established / met. Reporting to mgt / board generally good. Mgt info generally accurate / valid, may be some errors.
3 Possible	The event **may well** occur (recur) at some time, **but may not**. 40% - 60% chance of occurrence Could occur within 1 year	Some systems control **may be missing** or **applied inconsistently.** Policies and procedures generally exist, some may be missing or they may not be followed in a number of cases.	**Some** staff turnover / sickness. T&D **could be improved**. Staff morale **indifferent.** Premises in need of **some repair** / larger premises required	KPIs established, but not always met / monitored. Mgt info available, not always reported to mgt / board, sometimes unreliable.
4 Likely	The event **will occur** (recur) in **most circumstances**. (Could probably happen) 60% - 80% chance of occurrence Could occur within 6 months	A number of key controls **are missing** or controls are **not followed.** Policies and procedures generally lacking.	**Medium** staff turnover / sickness. **Lack** of T&D. **Low** staff morale. Premises requires **high level of repair** or is highly inappropriate (i.e. size)	Lack of appropriate KPIs or clear fall in performance. Lack of reports to mgt / Board. Data generally unreliable in most cases.
5 Almost Certain	The event is **expected to occur** (recur) in **all circumstances**. (Will happen, just a matter of when) 80% - 100% chance of occurrence Could occur within 1 month	Serious **lack of controls.** No policies / procedures established.	**Unstable** staff environment (i.e. high turnover / sickness). High use of agency staff. **Poor** T&D. **Negative** staff morale. **Unsuitable** premises / working environment.	KPIs not established / met. Lack of reporting to mgt / board. Unreliable management information.

Appendix E – Risk Rating Matrix

		Severity of Impact				
		Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Critical (5)
Likelihood of Occurrence	Rare (1)	1	2	3	4	5
	Unlikely (2)	2	4	6	8	10
	Possible (3)	3	6	9	12	15
	Likely (4)	4	8	12	16	20
	Almost certain (5)	5	10	15	20	25

Appendix F – Example Risk Appetite

Risk Category	Appetite	Acceptable Risk Score	Rationale
Finance	Moderate	10	The ICB will seek to reduce risk levels to moderate and will seek to avoid risks above this level. However, this should not underestimate the challenges that the ICB will have in maintaining expenditure within allocated resources limits.
Fraud and negligent financial loss	Low	5	The ICB will not tolerate financial losses from fraud and negligent conduct as this represents corporate failure to safeguard public resources.
Clinical Quality and Patient Safety	Low	5	The ICB holds patient and staff safety in the highest regard and will not accept any risks that threaten this. The ICB will commission high quality services for our patients. We will only rarely accept risks which threaten that goal.
Statutory and Regulatory Compliance	Moderate	10	The ICB will comply with all applicable legislation and will not accept any risk which (if realised) would result in non-compliance.
Reputation	Moderate	10	The ICB will maintain high standards of conduct and will not accept risks as a result of circumstances that may cause reputational harm, such as a loss of loyalty, respect or commitment from stakeholders, and/or undermine public confidence.
Partnerships, Engagement and Collaborative Working	High	12	The ICB will work with practices and other organisations (including but not restricted to other CCGs and Local Authorities) to ensure the best outcome for patients and communities. The ICB is willing to accept the risks associated with a collaborative approach.
Innovation and Transformation	High	12	The ICB encourages a culture of innovation and are willing to accept risks associated with this approach where they do not threaten risk areas that the ICB is not prepared to accept (as defined above e.g. quality patient care / safety).
Provider Performance	Moderate	8	The ICB accepts that Provider performance is challenged and there are underlying workforce deficits which mean that changes of performance can take some time to realise.
Commissioning	Moderate	8	Innovative approaches for commissioning incorporate an inherently high level of risk, which can impact on the delivery of outcomes.
National Policy	Low	5	The ICB will follow national policy.
Clinical Engagement	Low	5	The ICBs place importance on the positive effects of clinical engagement and will endeavour to manage issues that risk this.
Information Security	Low	5	The ICB has low appetite for the loss or breach of its business and customer data in pursuit of its objectives. The security of physical and digital information assets will be protected as per the requirements of the Data Security Toolkit via information

Risk Category	Appetite	Acceptable Risk Score	Rationale
			governance and information technology policies and procedures and regular testing of these, to ensure that the necessary data flows between partner organisations are maintained effectively and are secure.

Part I Board Meeting

Date of meeting	1 July 2022.
Agenda item number	10
Title of report	Appointment of Founder Member of the Mid and South Essex Integrated Care Partnership.
Purpose of report.	To request the Board to approve the appointment of Professor Michael Thorne, Chair of the Mid and South Essex Integrated Care Board, as the founder member of the Mid and South Essex Integrated Care Partnership.
Executive Lead	Anthony McKeever, Chief Executive.
Report Author	Sara O'Connor, Head of Corporate Governance.
Impact Assessments	Not applicable.
Financial implications	None identified.
Details of patient or public engagement or consultation.	Not applicable.
Conflicts of Interest:	None identified.
Recommendation(s)	The Board is asked to approve Professor Michael Thorne as the Founder Member of the Mid and South Essex Integrated Care Partnership.

Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

Part I Board Meeting

Date of meeting	1 July 2022
Agenda item number	11
Title of report	MSE Finance Strategy
Purpose of report.	The report details the finance strategy for MSE which is an enabling strategy to support the commitments of the ICS. Through the System Finance Leaders Group, a full system finance strategy was developed and shared through partner governance arrangements during November and December 2021. This was also discussed at System Leadership Executives, where extensive feedback was received, resulting in a number of revisions involving partners' contributions. Alongside the full version of the system finance strategy, there is an executive summary version of the finance strategy which is both inviting and brings alive the financial picture of Mid & South Essex for our public and partners in an accessible way.
Executive Lead	Dawn Scrafield, Interim Director of Resources
Report Author	As above
Impact Assessments	N/A
Financial implications	N/A
Details of patient or public engagement or consultation.	The executive summary version of the finance strategy was approved by the Health and Care Partnership Board in May 2022.
Conflicts of Interest:	None identified
Recommendation	The Board is asked to approve and sign off the Finance Strategy

Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

Appendix A

Mid and South Essex Finance Strategy

Mid and South Essex Health and Care Partnership

NHS

Document Control:

Date: 22/06/2022
Version: v12

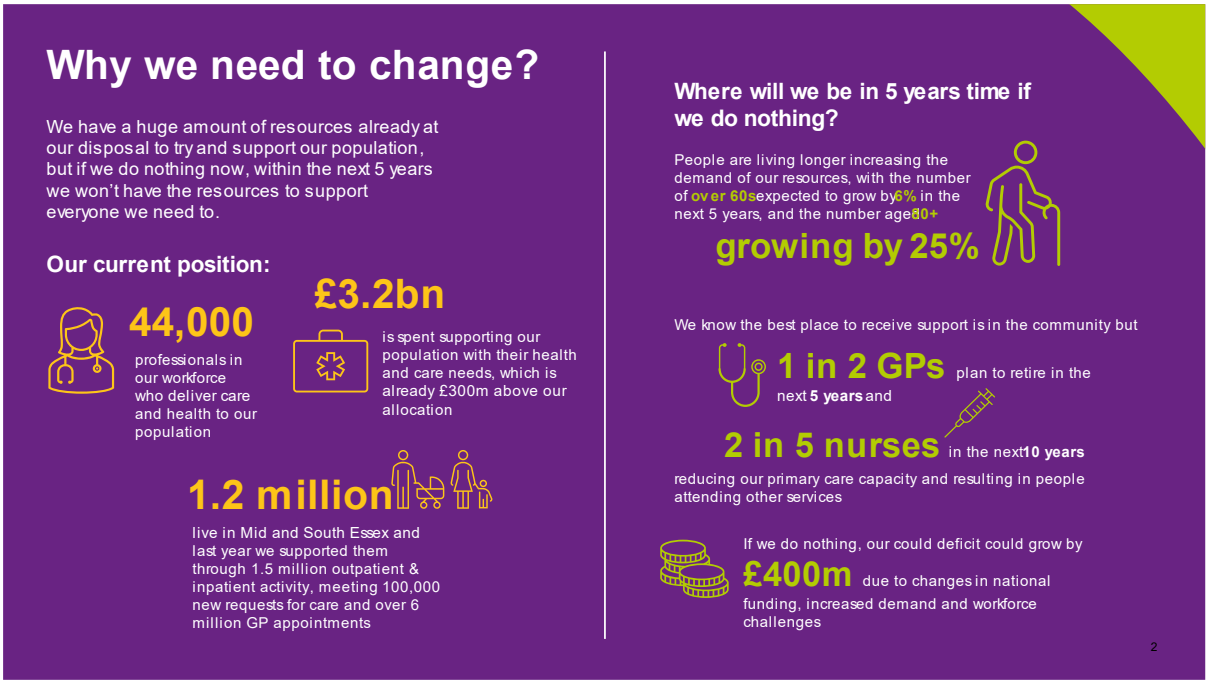
Contents

Introduction

The legislative proposals expected to be formally implemented from 2022 present our Mid and South Essex Integrated Care System (ICS) with an opportunity that is once in a generation. The System grew in its collective resilience to the demands of COVID-19, and, together with new System thinking and funding flows, local organisations are collectively looking to rebalance how funds are committed to achieve long term financial sustainability.

Our mid and south Essex ("MSE") System receives in excess of £3.2bn of funding to deliver health and care across our System. System funding of £2.2bn relates directly to the delivery of health care and £1bn of Council income associated with the provision of adult social care, children & young people, and public health services. The system is financially and operationally challenged.

The figure below sets out some of the challenges we are facing now but also over the next 5 years but operationally and financially.



Creating the flexibility for investment into our population living well is key as evidence demonstrates 80% of the determinants of healthcare needs are due to factors not directly related to care provided.

The formation of the Integrated Care System ("ICS") facilitates a new way of collaborative working, enabling operational and financial challenges to be managed more effectively as a collective partnership, driving improvements at scale. This was hugely beneficial during the pandemic and the system took significant steps towards working better together taking a whole-system approach. We must build on the core principles we are committed to:

- to operate fairly and transparently,
- to operate both collectively and individually,
- that our shared focus is on the benefits for our residents and patients.

Underpinning the principles, we recognise the need to manage risk effectively as a system. However, there is still some way to go towards partners working as a joined-up entity.

The funding envelope for MSE presents the ICS with an opportunity to transform services, reduce health inequalities and improve the wellbeing of its local population. However, to achieve this effectively we must plan to deliver recurrent and sustainable efficiencies as a system to mitigate an enduring financial deficit and avoid impending financial challenges following funding announcements and more importantly create the headroom to resource change through transformation and innovation.

This document sets out the MSE ICS Financial Strategy in four parts:

- Our vision and ambition ('The why')

- Defining the potential (‘What’)
- Framework for aligning future resources (‘The how’)
- Managing the transition (‘The when’)

Our Vision and Ambition

1. Vision

As the MSE system we are committed to achieving the triple aim:

- Better population health;
- Better quality of care; and
- Financially sustainable services.

To achieve the best possible outcomes for our population we need to think differently to prevent avoidable ill health and as partners act as one through transparency and collaboration.

The finance strategy is a key enabler for the way we use our money to deliver our system ambitions.

2. Ambition

The triple aim is our commitment, but our ambition for mid and south Essex is set out below:

Historically our system has delivered an 'acute centric' model of care which is not sustainable and not always the best model to improve population health outcomes. The emergency pathway often results in a higher long term care dependency and unnecessary patient experiences. **As a system we have the ambition to prioritise the prevention of ill health through evidence-based investment.**

The consequence of decades of care being built around ill health results in infrastructure geared towards the unwell. **We have the ambition to develop systems to support 'well people' proactively take control of their health.** Our Alliances, supporting our Primary Care Networks are critical to engage with our residents so we can achieve this significant shift in the way we use our resources.

We have the potential with the partners and the skills in our system to change the way we are working, through programmes such as Stewardship. **Using innovation and continuous improvement we have the ambition to maximise the benefit our partnership pound can offer in care for our residents across mid and south Essex.**

The system financial framework is functioning with a system operating budget and a risk management approach which enables a stable planning footing. **We have the ambition to align future resources to the business priorities and will only invest where there is no resource improvement potential.**

The financial sustainability review highlighted the opportunities we have as a system to optimise resource improvements. **Over the next 3 financial years we have the ambition to recurrently release more than £100m through efficiency.** Delivering these improvements involves the ambition to reduce avoidable demand for acute services, reduce our reliance on bank and agency staffing and as a system support the downsizing of acute capacity through productivity measures which can only be achieved through the stabilisation of legacy activity and transforming the ways of working.

The reset of national financial allocations has enabled the system to plan for a breakeven position. **We have the ambition to maintain financial balance through a healthy combination of cash release and productivity efficiency measures.**

As a system we are committed to achieve financial sustainability with the ambitious goal of achieving recurrent balance and improved financial resilience by the end of 2024/25. We have a vibrant, experienced, and skilled finance community working across partners to maximise the MSE partnership pound.

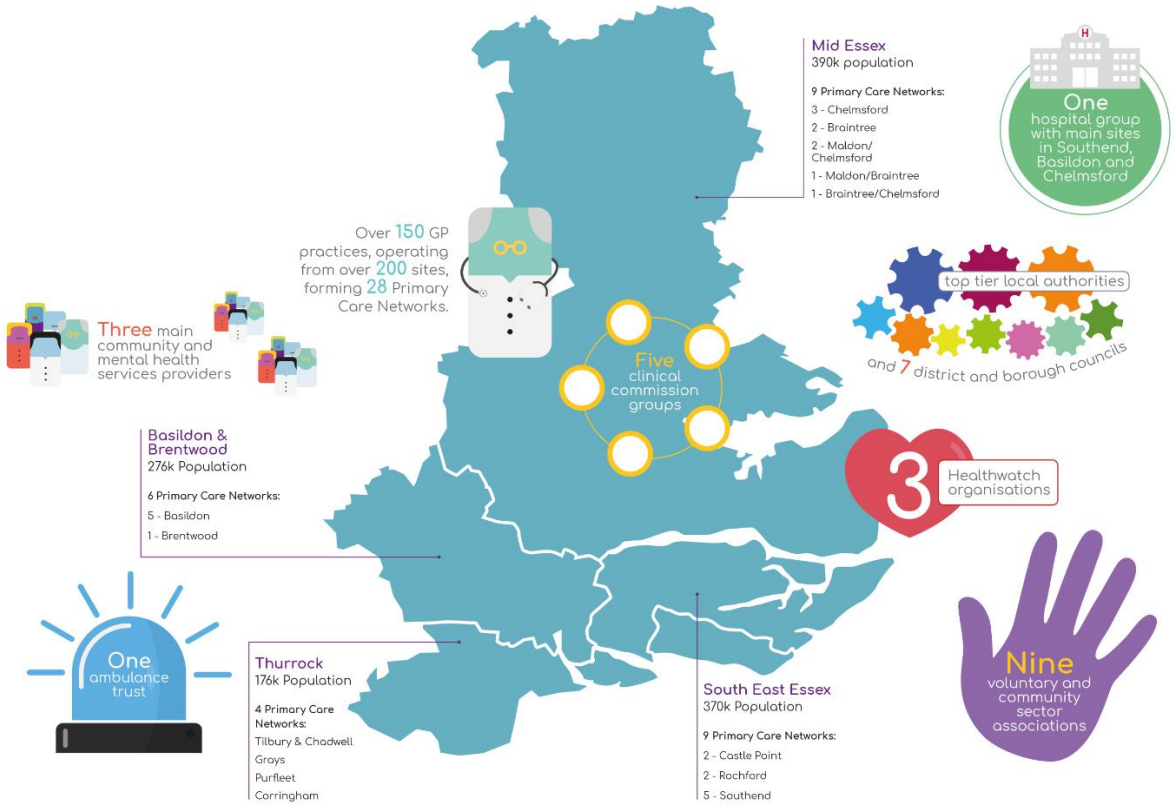
3. System Overview

The Mid and South Essex Health and Care Partnership (HCP) serves a population of 1.2m people.

We comprise:

- 1 upper tier Local Authority (Essex County Council) working with 7 district authorities;
- 2 unitary Local Authorities (Southend-on-Sea Borough Council and Thurrock Council);
- 1 Acute Hospital Trust (Mid & South Essex NHS Foundation Trust (MSEFT));
- 3 Community and Mental Health providers (Essex Partnership University Foundation Trust (EPUT); North East London NHS Foundation Trust (NELFT); and Provide Community Interest Company (Provide);
- 1 Ambulance Trust (East of England Ambulance Services Trust (EEAST);
- Pre-establishment of Integrated Care Body (ICB) 5 Clinical Commissioning Groups (CCGs);
- 3 Healthwatch Organisations; and
- 9 Community and Voluntary Sector Organisations.

Our 4 Alliances (Basildon & Brentwood, Mid Essex, South East Essex and Thurrock) and 27 Primary Care Networks (covering 149 GP practices) are critical to our work.



The Partnership Board has an independent, non-executive chair (Professor Michael Thorne CBE).

Our Partnership has a single Executive Lead and Accountable Officer (Anthony McKeever).

Executive leads from statutory partner organisations across MSE come together into the System Leadership Executive Group.

Joint Accountability for quality and safety, performance and system transformation are overseen by a System Oversight and Assurance Group, attended by partner organisations including NHSEI local director, and chaired, alternately, by the Joint Accountable Officer/Partnership Executive Lead and the NHSEI Director of Strategy and Transformation.

A key part of our system governance is the established System Finance Leadership Group which is pivotal in enabling system collaboration. An annual work plan is agreed by the Health & Care Partnership Board which sets out a number of the key priorities, including the development of an ambitious financial framework for our system.

Another key forum is the Finance & Investment Committee, which is a formal committee of the ICB, whose purpose is to provide oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable financial plans and associated financial performance in relation to services commissioned by the ICB, mitigating risk as appropriate in the context of system working.

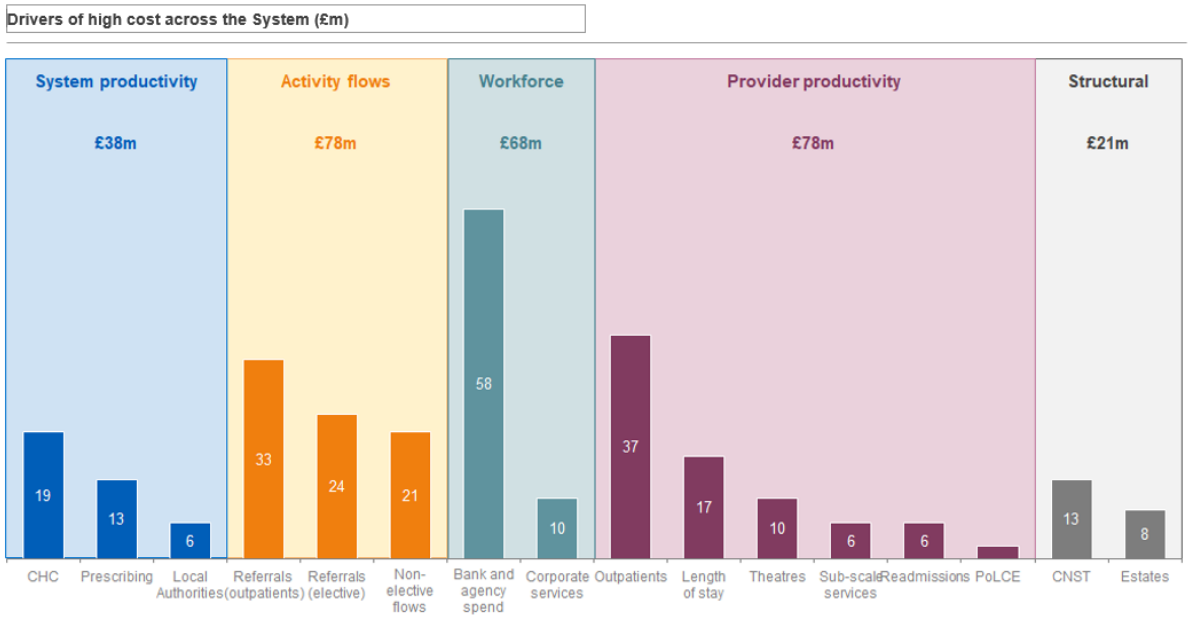
Defining the potential

4. Financial Sustainability Overview

Many partners within the System have had a long standing recurrent underlying financial challenge for many years. In April 2021 partners collectively commenced a financial sustainability review. This review considered the scale of the financial challenge across the system, the drivers of high cost at operational, strategic, and structural levels, and designing interventions required to address these challenges.

Using the 2019/20 funding flows and baseline the review concluded five drivers behind high cost.

A similar detailed drivers of deficit review needs to be progressed in local authority partners to ensure a full understanding of the system financial challenges and increased clarity on how we can work most effectively together to address these. These reviews need to continue to happen to refresh our understanding and ensure we are working collectively together on the priority areas.



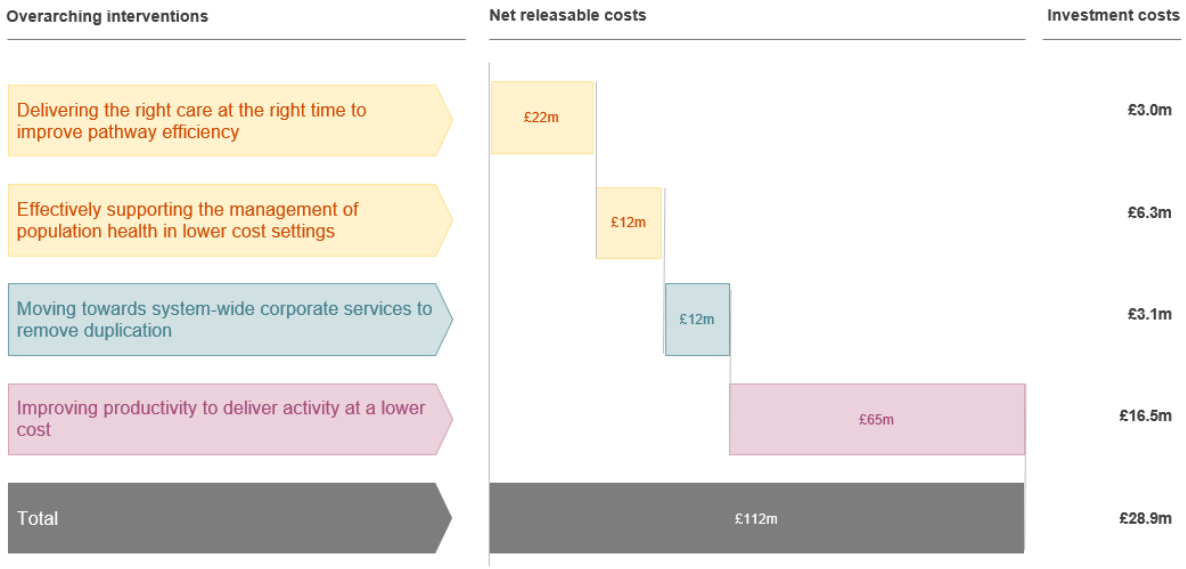
Note: This does not reflect the releasable costs and does not account for the impact of overlaps between areas.

The identified £6m local authority saving is not a directly realisable health saving, however, to achieve this requires system partner collaboration.

Interventions were developed on the basis of extensive hypothesis put forward by system partners and tested with relevant benchmarking comparisons and best practice. Five intervention themes were identified that address the underlying drivers of deficit and move the System towards financial sustainability. Themes are as follows:

1. Delivering the right care at the right time to improve pathway efficiency;
2. Effectively supporting the management of population health in lower cost settings;
3. Improving productivity to deliver activity at a lower cost;
4. Moving towards system-wide corporate services to remove duplication; and
5. Embedding financial and operational performance management.

Each intervention has been designed to address the financial challenges identified. At the time of undertaking the work across all of the intervention's releasable costs of c£141m have been identified, and £29m of estimated replacement costs potentially required to set up/expand services to release these savings. The net benefit of transformation savings expected through system collaboration is assessed as c£112m, [which includes £6m of identified long term residential opportunities which would support LA partners with improvement against their underlying deficit].



In summary, the review shows that:

- A concerted and collaborative effort is required to address the number of referrals made, both into and within the acute system. It is acknowledged that our implementation of GP triage and Advice and Guidance has been sub-optimal in the past therefore there is confidence that this presents us with opportunity.
- It shows that once patients are in the acute system there is scope for improved efficiencies with regards to elective pathways (Outpatients and Theatres). This has potential to reduce time spent in hospital ((elective and non-elective length of stays, and number of outpatient follow-ups).

Additionally, improving productivity of community services will impact on outpatient follow-up.

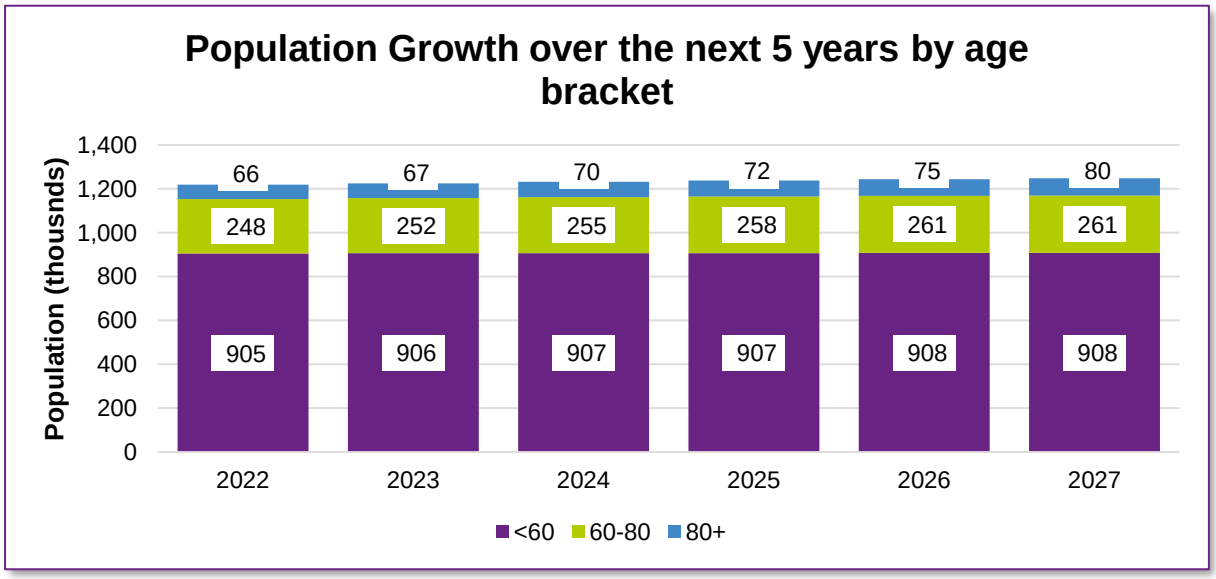
- The above findings, alongside the higher-than-average staff-vacancy levels, increase the requirement to utilise temporary staffing via bank and agency. Except for Agenda for Change bank staff, agency staff come at a premium cost to substantive staff, thus contributing to the workforce driver of our high costs.
- In the community, the review has confirmed we have varied provision of Continuing Health Care (CHC) services, and differing costs of packages. Applying a standardised approach and collating our purchasing power as one ICS will realise savings in this area.
- Our prescribing costs are higher than the national average (adjusted for demography) and variations in practice have been highlighted. Prescribing costs in relation to Opioids has been identified as having significant opportunity to realise efficiencies.

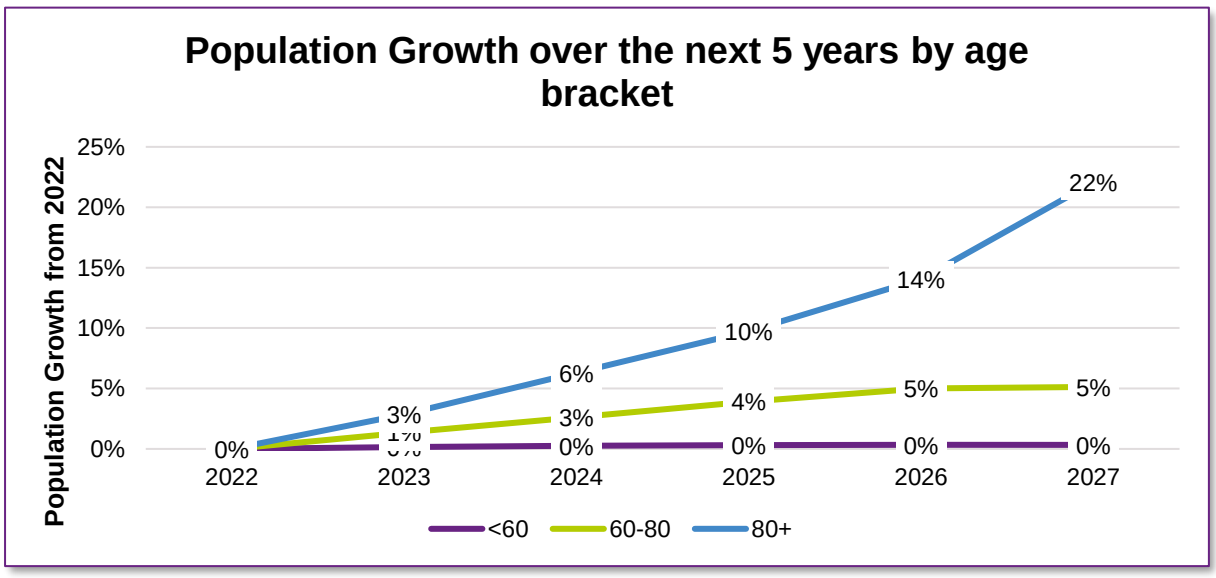
It is key we work collaboratively as a system to make sure that where costs are moving between organisations so that they are in the correct place, we work together to address any financial impact this has on the system as a whole.

5. Future Financial Outlook

There is an underlying deficit in the system now, and if we do nothing this position is expected to deteriorate in the coming years. However, based on actions the system is taking, by the end of the strategy horizon the system expects to manage and mitigate risks that would result in this position deteriorating and using innovation and transformation expect the position to improve.

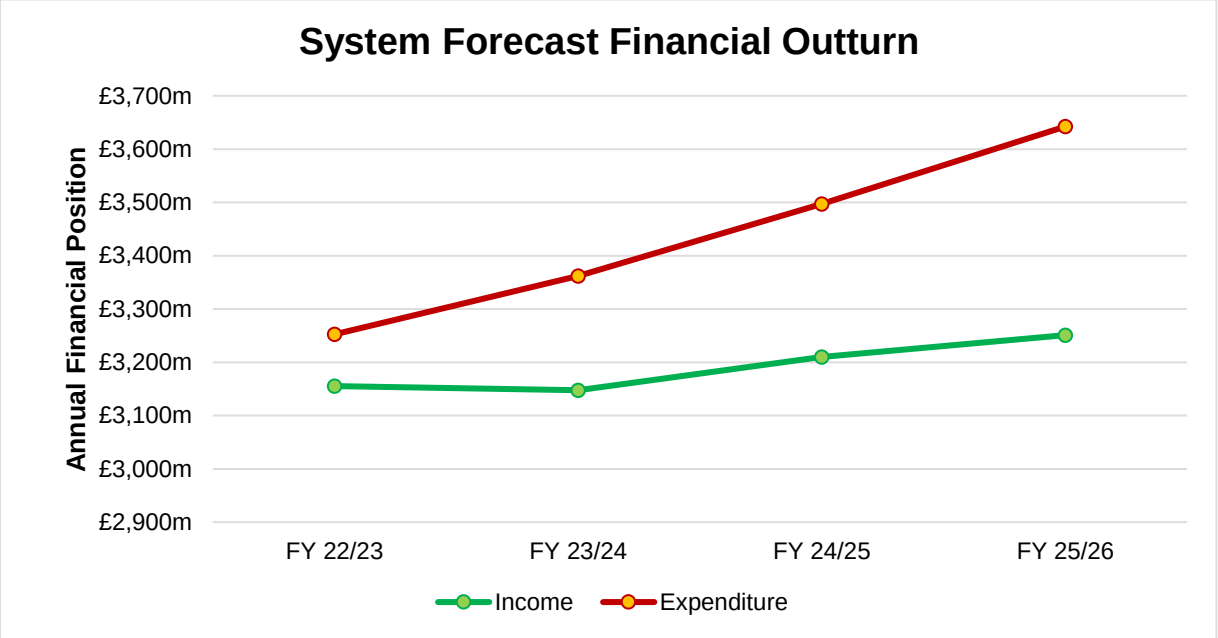
People are living longer increasing the demand of our resources, with our overall population expected to grow by 2.5% over the next 5 years, the number of over 60s expected to grow by 6%, and the number aged 80+ growing by 25%.





With this growing demand, the question of how we continue to deliver everything that we have for our population becomes increasingly important.

The increase in demand coupled with changes to funding and increased cost pressures will see our expenditure grow far quicker and greater than the income for the system. If we take no actions to deal with these factors, then in the “do nothing” scenario, the underlying deficit in the system is expected to grow by an additional £300m over the next 4 years.



Health and care partners are required to balance their budget each year and so savings will need to continue to be identified to balance budgets.

We have a huge amount of resources already at our disposal to try and support our population, but if we do nothing now, within the next 5 years we won’t have the resources to support everyone we need to. We need to change our approach now.

Framework for Aligning Future Resources

6. Financial Leadership

The finance leaders across system partners are uniquely placed to model behaviours essential to these core principles and support clinical leaders in developing their own skills so together we can achieve the shared ambition.

We are committed to work together as equal partners. At the start of our Integrated Care Partnership journey local government's regulatory and statutory arrangements are separate from those of the NHS and therefore financial control and risk managed independently. As our partnership develops and we gain further understanding of how to unlock the benefits of collaboration for our population, we aspire to manage the partnership pound as one, maturing from these separate arrangements.

Whilst financial arrangements are independent, partners across mid & south Essex have agreed to align relevant planning, investment, and performance improvement to reflect our ICS design principles to benefit our local population most effectively.

Covering areas such as:

- Revenue
- Capital
- Asset Management
- Digital
- Costing to ensure value for money in the purchase of healthcare

We will develop the skills across our workforce to increase understanding of each of our roles in achieving the 'triple aim' ensuring appropriate stewardship in the management of, and accountability for, our system resources. This will be achieved through the development of a thriving community of skilled specialists from across the system, with expert in areas such as finance, analytics, digital, legal, commercial and estate, who will support the capabilities of our stewards, with a shared goal to improve our population health.

Our vision can be summarised into some financial principles which we are committed to displaying across our system:

The principles underpinning our ambition

Transparency

We will take an open book approach, simplify processes and make information accessible. New investments will be coordinated through the system and will be in line with the system priorities and decisions regarding investment will be open and shared with everyone.

Acting as one

We are collectively 'in it together' and will work as a single system, managing opportunities, resources and risks as one

Clinically led

Through the development of the stewardship programme we will support our stewards to manage the resources available to deliver care in a way that will improve population health, optimise response and ultimately reduce inequalities.

Impactful

We will use our resources in a way which maximises the impact we have on our population

Ambitious

We will develop our staff to achieve their ambitions and the ambitions of the system

7. System Allocation

Through the ICB, MSE are allocated a healthcare resource to secure the provision of healthcare services for the local population. The ambition is for this resource to be used in a way that achieves the best outcomes for patients, securing the maximum amount of care within the available resources.

At the time of drafting the System Finance Strategy the allocations for ICS for 2022/23 have been published, although acknowledged that there will be allocation changes during the financial year especially for additional transformational programmes. For 2022/23 the total recurrent allocation is £2,123bn and the non-recurrent allocation is £109bn. In addition to this allocation, there are other income streams received into MSE through NHS provider partners where care is provided beyond the system envelope which generates a revenue. This is currently planned for 2022/23 to be £0.6bn. In addition to this local authority income relating to the residents of MSE is a further c£1bn.

Included within the responsibilities of an Integrated Care System is the management of resource across the system. The system reviewed a paper in January 2021 considering the approach of healthcare resource allocation. This concluded that whilst MSE maintains an underlying deficit the ability to create a pace of change for investment to target improvements in population health would be challenging. The system operating budget and financial framework was endorsed as the direction of travel. The basis of the financial framework is that system budgets for services are based on primary cost incurred to provide care, effectively managing delivery on the basis of ‘open book’ accounting. The financial sustainability review has identified areas where costs could be reduced within the system and the principle of budgeting for cost means that the system will effectively be moving budgets in a way that is in a transparent and risk shared way. It will also facilitate the ability for new resources to be directed to priority areas on the basis that primary cost of delivery care has been budgeted for transparently across the system.

The considerations of a system allocation approach also highlighted the need for a clearer picture of what the optimum resources should be if it was to achieve a targeted level of resource to optimize population health by disease (service) area. Operating through a stewardship model will enable insights to be gained and actions to be taken to improve this understanding.

8. Financial Sustainability Strategy

Finance transformation alone will not address the underlying deficit across health partners. In order to successfully address the financial challenge across the System, the delivery of substantial transformational savings is required. There are three strands to the strategy:

- Transformation delivery from opportunities identified within the Financial Sustainability review (£106m excluding the £6m relating to residential long-term placements)
- 'Business as usual' (BAU) efficiency requirements through productivity realisation against baseline budgets from 2021/22;
- Council resource allocation plans being realised to ensure system wide resilience; and
- Continued receipt of national Sustainability Funding (c£100m) aligned to MSE.

Transformation

The financial sustainability review has highlighted a number of opportunities. The delivery of this transformation will be a multi-year programme and requires transparency and collaboration of system partners. A System Efficiency Programme Board co-ordinate the delivery of the financial sustainability programmes, including targeted transformational productivity and is accountable to the System Oversight Assurance Group.

The expectation is that the delivery through transformation will be achieved over the 3 years by the end of 2024/25 with an ambition of releasing health net costs of between £100m - £106m.

On the basis that clinically led stewardship groups across the system manage budgets within the approved envelope, it is expected that budgets will roll forward to deliver, as a minimum, the same levels of service with a continued drive for improvement. This approach would expect budget reductions from the delivery of the transformational finance sustainability work to be transacted transparently.

From a cross council and health perspective, opportunities to explore collaborative working and joint savings initiatives will be progressed, particularly in areas where there are clear dependencies or where a change to a more integrated approach would deliver system wide benefits.

In year 'Business as Usual'

The system will co-ordinate the planning of resources on the basis of a System Operating Budget. This approach will facilitate partners to operate in a transparent way and to understand and manage the financial risks of delivery. This methodology

relies on the collaboration of partners to affect the means to achieve this, but also requires system partners to manage the resources in line with the approved plan. This is essential to avoid undermining the ability to manage system financial risk.

In-year efficiency requirements will take the form of improvement in general productivity and sound financial management to mitigate the need for continued unplanned growth in investments which, as a system that holds an underlying deficit, cannot be sustained. It is planned to move away from the traditional 'salami slice' approach to savings and consolidate our delivery into a single system transformation, whilst at the same time individual partners deliver improvements in responsiveness through local productivity and sound financial management. Service changes will be impact assessed as a system.

Beyond reductions from finance transformation programme delivery, system partner budgets will only be adjusted for material stepped changes in activity in a planned way, for example procurement savings, or decommissioning/varying of services. Investments will require a business case to be signed off through system governance. This approach is on the basis that partner budgets will equal contract values budgets being set as part of the system planning phase. Reductions will result in a budget movement across the system in line with the principles of the System Operating Budget. Budgets will be reviewed annually according to Budget Setting Principles, which will increasingly be aligned across system partners.

The ambition is that marginal budget reductions will no longer be applied generically across services in the future. Efficiency programmes will be targeted and managed on a service line basis through a Stewardship programme approach, led by clinical stewards across the system.

Sustainability Funding

Prior to COVID the system was advised that £89m of Financial Recovery funding and £10.7m of Marginal Rate Elective Threshold (MRET) funding would be available totalling c£100m. This resource is an essential part of the sustainability plan. As demonstrated from the independent financial sustainability review, even with the maximum benefits identified through transformation and the system managing in year growth, there remains a gap of c£100m.

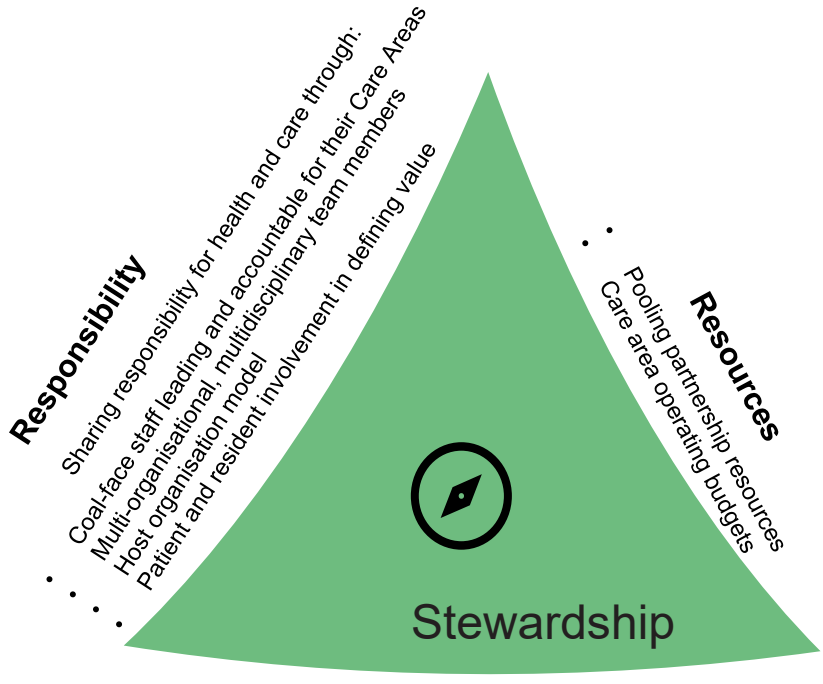
The 2022/23 Financial Framework has supported the system in addressing this strand of the sustainability strategy. As part of the system allocation the 'Top up' funding (previously MRET and Financial recovery funding) has now been baked into the allocations. Over time systems are expected to move into spending against a redefined target allocation for each system nationally. For 2022/23 mid and south Essex has been determined to be 5.5% above target for core allocations and 0.7% above target for Primary Medical Care services. As a result, a 'convergence' reduction of 1.0% and 0.2% respectively has been deducted from 2022/23 allocations. This adjustment will continue annually until the system funding is aligned to target allocations.

9. Stewardship supported by the System Financial Framework

Stewardship is a model being initiated across MSE which focussed on multi-professional, cross-organisational frontline teams, working together to get the best out of health and care resources.

It was initiated through learning that occurred during COVID, bringing together partners to deliver care for residents without the barriers of organisational boundaries. The concept initially started by looking at how we could consider joining up resources and changing accountability structure to remove barriers and inefficiencies. This sparked a programme to engage with clinical leaders across organisations to consider how we could adopt the concepts set out in in an article "Developing a culture of stewardship: how to prevent the Tragedy of the Commons in universal health systems"

The aim is for stewards to take on collective responsibility, on behalf of all Partnership organisations, for stewarding resources within their care area e.g., Stroke, Ageing Well, Cancer etc. The goal is to deliver on the Triple Aim.



Intelligence

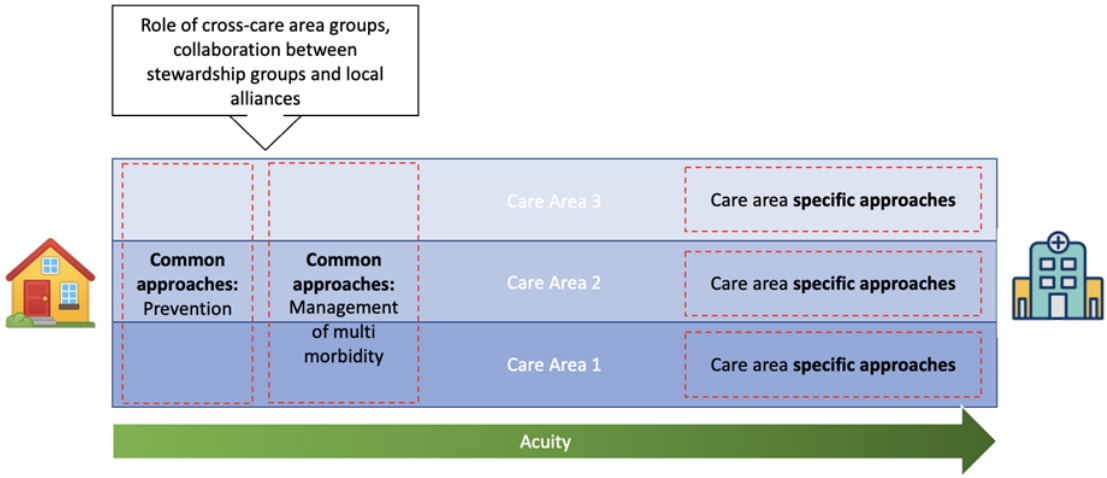
- Population health management – using integrated data to improve health and wellbeing
- Evidence based practice

The narrative that we set out with stewards reflects that Health and Care Partnership resources are like that 'Common Land', underpinning the way in which our population can lead healthy lives. Together as a Health and Care Partnership, we will adopt a culture of Stewardship, taking collective responsibility for how that common resource ((e.g., funding, workforce, and infrastructure) is used and applied in a fair and transparent way to the maximum benefit of our population.

From experience the shared resource is often fragmented, divided and sub-divided into smaller plots, down to departmental or sub-specialty level. The sense of shared, wider responsibility and potential to flexibly align and/or re-align resources with evolving population needs are lost in the competition for plots – the 'Tragedy of the Commons'.

A culture of Stewardship, sharing responsibility for ensuring that our Partnership's common resource is used for the common good, is required to release its potential and to re-focus resource use on addressing our residents' greatest needs.

There is commitment to ensure that Stewardship Teams can identify opportunities to improve how resources are used, including specifying common clinical standards and policies across the system. This commitment requires our system to connect information, not just financial related, but all information relating to the delivery of the service areas, in a transparent way, so that we can collectively optimise the delivery and improve outcomes for our residents.



In July 2021 we published the first edition of our system budget book, which has set out by service line indicative budgets and other key metrics. Reporting arrangements are maturing to facilitate this information being shared regularly to provide necessary insights to inform, influence and impact change behaviours.

Work is actively underway with the six pilot areas to ensure accurate alignment of costs to the most appropriate stewardship area, as well as developmental work for stewards to understand the breadth of resources that would be at their disposal under new ways of working.

All six areas are identifying specific pathways within their care areas – i.e. Early Supported Discharge for Stroke and Asthma within Respiratory – to focus on improvements across the triple aim during this development period.

We will be developing this work through the support of host organisations from within mid and south Essex to move to practical implementation with an ambition to have 25 care areas operational by 2025.

10. System Reporting and Accountability

Governance includes regular collective oversight and assurance via the System Oversight & Assurance Group (SOAG) enabling areas of rising risk to be identified, agree necessary recovery actions required and, where necessary, to redirect or secure additional resources to enable course correction.

Detailed accountability and assurance will happen through specific subject-matter groups (including, but not limited to, the Mental Health Partnership Board, Elective Care Board, People Board, Cancer Board, Urgent and Emergency Care Board, Primary Care Transformation Board, our Alliance Boards, System Quality Group and System Finance Leadership Group), enabling SOAG to take a risk-based and proportionate governance approach to oversight and assurance. Senior finance officers from across the system will support these subject matter groups to ensure consistent alignment and understanding regarding resource implications.

The principles supporting joint accountability arrangements are underpinned by effective collaboration, transparency, and trust between all partners, and between the ICS and its residents. Each part of the ICS (system, alliance, and neighbourhood) and each statutory organisation will have its own arrangements for gaining assurance regarding the management of resources as approved through the ICS planning process. As a system we are committed to managing risks across the system, either rising risks from within partner organisations or emerging system wide risks both requiring collective management as a system.

Transparent reporting will be undertaken at a system level, recognising accountability to the public. The use of resources and the financial implications of decisions will be a core part of expected reporting.

Aside from the System role of resource allocator, there are two other roles that will operate in the system; Resource Consumer or Resource Manager.

The distinction between the two roles has been made as follows:

- Resource consumer: will be measured on the level of resources consumed of services provided by others. Management reporting for resource consumption will provide a view of the level of resource that has been used – it is not the transfer of cash, and the aim of reporting will be to understand the variation of resources use to improve population health.
- Resource manager is the direct manager of a budget for resources, incurring the costs for the delivery of care and is linked with cash transactions. Management reporting will provide insight into the performance against budget and is a hard measure for the financial success of the ICS against the System financial envelope

As consumers of resource Alliances neighbourhoods will both be supported to understand the resources consumed by their populations and how this links to the services which are provided.

As the stewardship programme matures, accountability for delivery across a service area, underpinned by a data driven evidence base will be overseen by SOAG.

The relationship between the new Integrated Care Partnership and the Health & Well Being Board and continuing joint forums will be critical to ensure consistency of reporting and accountability against system priorities.

11. System Capital and Investment

Operating as a system in deficit will require choices to be made, at both care area and system level. We will identify where resources are being used sub-optimally and redirect or refocus this into areas that deliver greater value. These choices will need to be reflected in how the system utilises any future growth funding, ensuring this is targeted either at service deficits or identifiable needs. Such decisions will be based upon evidence where available, using tools such as Model Hospital and GIRFT, as well as population health projections, to identify where best investments will be made.

We are committed to prioritising capital & investments to reflect the needs of our population in line with our ICS strategy. We are at the start of the journey to leverage the collective benefits of operating as a system, particularly exploiting the opportunities of local authority partners regarding housing and planning as one of the wider determinants of health.

The first priority on funding is to equalise national expected inflation pressures on the basis that productivity will be the key to mitigating the need for growth investment. Any excess growth funding we are committed to prioritise within the system to maximise population health improvement and gain the best benefits from the partnership pound through an ambition to achieve a positive return on investment on all future investments.

The capital funding arrangements in health are evolving and we expect greater autonomy within the ICS to manage, utilise and direct capital funding within the limitations of CDEL.

Our financial planning submission includes a 3-year capital programme although our local investment plans will be considered over longer time horizons (5-10yrs) than current operational planning. We have developed draft System pipeline schemes linked to Estates and Digital strategies and are mindful these plans will need to balance the requirements of System and single partners.

Our Estates investments are underpinned by a single Estates strategy reflective of jointly agreed principles for transformation of the estate and supporting new models of care. We are already recognising Estate rationalisation opportunities and our ambition will be to maximise and accelerate these opportunities, including consideration of asset ownership transfers to optimise the benefits for our population.

Our investment decisions will follow a capital prioritisation process which will ensure a consistent risk-based approach to investment proposals. Early on the System Finance Leadership Group recommended an investment matrix (below) to the HCP Board to support the considerations and prioritisation of investment. Due to the over subscription in available capital and long pipeline of legacy commitments limited new investments have proceeded unless they are linked with national capital investment

programmes. We will continue to ensure plans are clinical and operationally led and as clinical strategies develop our plans will adapt.

We will widen the scope of our capital reporting arrangements to be inclusive of all partners beyond local NHS partners. We will continue to work with our commercial partners.

We recognise the importance of continued strong relationships with all NHS departments to ensure all Capital resource opportunities are identified and, where applicable submit appropriate bids to maximise capital resources. This will include obtaining resources to support the Elective Recovery Programme and restoration agenda at a quick pace.

Factor	Detail	Scale			Weighting %
		Low (0-3)	Mid (4-7)	High (8-10)	
Strategic Fit	Supports delivery of STP Board agreed priorities	Does not address the objectives of the STP Board priorities. Low risk to reputation or other imperative if not delivered.	Partially addresses one or more of the objectives of the STP Board priorities. Some risk to reputation or other imperatives if not delivered.	Fully supports one or more of the objectives of the STP Board priorities. High risk to reputation of other imperatives is not delivered	**25**
Addressing health Inequalities	Reduces identified health inequalities.	Little contribution towards reducing health inequalities.	Some contribution towards reducing health inequalities.	Significant contribution towards addressing health inequalities.	**15**
Quality and Outcomes	Clinical Evidence base, patient experience, measurable outcome on health and well-being, life expectancy or other population health outcomes	Limited benefit to patients is demonstrated	Some benefits demonstrated; and/or significant benefits, but difficult to measure/evidence	Significant and measurable benefit.	**20**
Deliverability	Deliverability within resource, time, workforce, or other constraints	Significant unmitigated risks to deliverability.	Some unmitigated risks to deliverability.	Clear evidence that risks to deliverability have been adequately mitigated.	**20**
Cost Effectiveness	Return on investment expected (quantitative or qualitative assessment can be used)	Limited evidence of return on investment, or significant risks that claimed returns will not be delivered	Some evidence of return on investment. Some questions re value for money. Some risk that claimed returns will not be delivered	Clear evidence of return on investment. Clear benefits and value for money.	**20**
					100

12. Risks and Opportunities

We recognise that to achieve this vision, there will be a number of risks and opportunities along the journey. We will need to prioritise and make the best use of existing resources and prioritising any investment into future resources.

Workforce

The frontline workforce who delivers heath and care to our citizens has been stretched and fatigued over the past 2 years. We know that we need to attract and retain our staff, provide excellent development, and career pathways matching the ambition of our workforce to ensure we have a stable, motivated, and highly skilled workforce.

We have a huge, talented, and motivated volunteering community that we need to recognise and utilise alongside our frontline workforce, supporting and complimenting each other's skillsets to support out population.

COVID Impact on the delivery of our services

It's harder to work effectively and efficiently across and within service areas due to the pandemic and our limited resources now must be more targeted than ever. The gap between health inequalities has grown and we know that we must implement our stewardship model and review how we deliver all our services immediately to ensure we are using our resources now and, in the future, as effectively as possible for our citizens. This will free up the capital needed to invest now for the future.

Infrastructure and Estates

Our infrastructure and estates are old, and investment is required to consolidate modernise our estate. We know the older the estate the greater the financial burden, and so we must innovate and work with third parties to find the resources and solutions needed to invest now for the future whilst balancing the need to prioritise investments across the system.

Market constrains and cost of living impact

The Ukrainian conflict alongside national inflationary pressures have seen the cost of care rise rapidly over the past 18 months. The provider care market and workforce who support our population, are stretched with capacity but also financially. We need to work with the market to find solutions to deliver the right care at the right time that is sustainable for everyone.

Capacity in the right settings

Expansion of Primary care capacity has been limited with growth in population and demand. Capacity in the right setting is essential as well as development greater

opportunities to facilitate self-care, reducing the demand downstream in more resource heavy settings.

Social Care Funding Announcement

In September 2021 the Prime Minister announced proposals to tackle NHS backlogs, reform adult social care and bring the health and social care system closer together. This was set out in "Build Back Better: Our Plan for Health and Social Care".

The main announcement highlighted:

- There will be a cap on care costs from October 2023, which local authority partners will need to administer and fund individuals' costs once the cap is exceeded;
- There will be a more generous means-test, resulting in an increase in people being eligible for council funding support (including those who currently fund the entirety of their care);
- Self-funders will be able to ask local authority partners to arrange their care for them with a view to doing so at better rates for the individual.

Whilst the 2021 funding announcement promoting greater integration between Health and Social Care was welcomed, local government partners are still unclear how this will impact the system financially. LAs currently rely on income from client contributions, which will reduce after the new arrangements are introduced. Care home providers will be required to increase their charges following the announcement to lift National Insurance by 1.25%. It is anticipated that Central Government expect local authority partners to bridge the additional funding gap caused by these proposals, through increasing the social care precept and council tax. Unless there is greater flexibility in the rules on the level of uplift allowed, no additional income can be generated. This poses a significant risk to our system in an already volatile market.

Managing the Transition

13. Approaching managing funding across sectors

As we move towards new ways of working, and adopting a stewardship approach, we do not want to destabilise any of the partner organisations within the system. As such transition to new models, which will likely require the movement of funding, or resource, across organisations and sectors will require careful management.

It is essential however that processes exist to enable this to occur, particularly to enable the implementation of a stewardship approach and to empower front-line staff to make best use of available resource.

Through this finance strategy it is the aim to:

- Improve outcomes for residents;
- Achieve sustainable management of resources;
- Focus resource on delivering service line and system priorities;
- Allow clinical SROs / provider's flexibility to reconfigure services; and
- Seek joint solutions to issues that arise.

For this to occur we will adopt the following behaviours:

- Act with openness and transparency;
- Adopt regular collective reporting and an open book approach to problem solving to enable:
    - Clinically led solutions which generate best outcomes for the population and the system as a whole
    - reduction or elimination of stranded costs where possible
    - an approach that ensures no single organisation incurs a cost pressure as a result of an overall system gain

We will achieve change in the management of funding across sectors through phases:

- Phase 1:
    - Align budgets and reporting and establish a single operating budget to avoid destabilising any one part of the system
    - Proof of concept Stewardship
- Phase 2
    - Target investment into priority areas and drive cost reduction through transformational changes in the areas that have identified opportunities – instead of blanket/ generic cost reductions across all partners
    - Shadow Stewardship
- Phase 3:
    - Using stewardship as a vehicle, alignment of accountability with the resources available through provider led models so that accountability for the end to end clinical and financial governance

14. Approach to Efficiency

Significant focus was given to undertake the Financial Sustainability review across MSE in 2021, providing a transparent understanding of the opportunities.

The approach to system operating budgets provides a framework for organisations to transparently manage the potential destabilising risk of historic adjustments which bear no resemblance to the true cost of delivering care to the population (primary cost of delivery).

Sustainable delivery for our system requires a relentless focus on managing the primary costs, which makes the approach to delivering efficiency in MSE ICS ambitious and stand out in comparison to other ICS.

A System Efficiency Programme Board has been established which draws together partners to oversee the delivery of the Financial Sustainability review. This approach drives a programme structure, aligning finance partner support from across the system, to support the Senior Responsible Officers for the programmes set out in the review. The financial sustainability programme is expected to deliver stepped changes in finance transformation across the following work streams over a 3-year period 2022 – 2025.

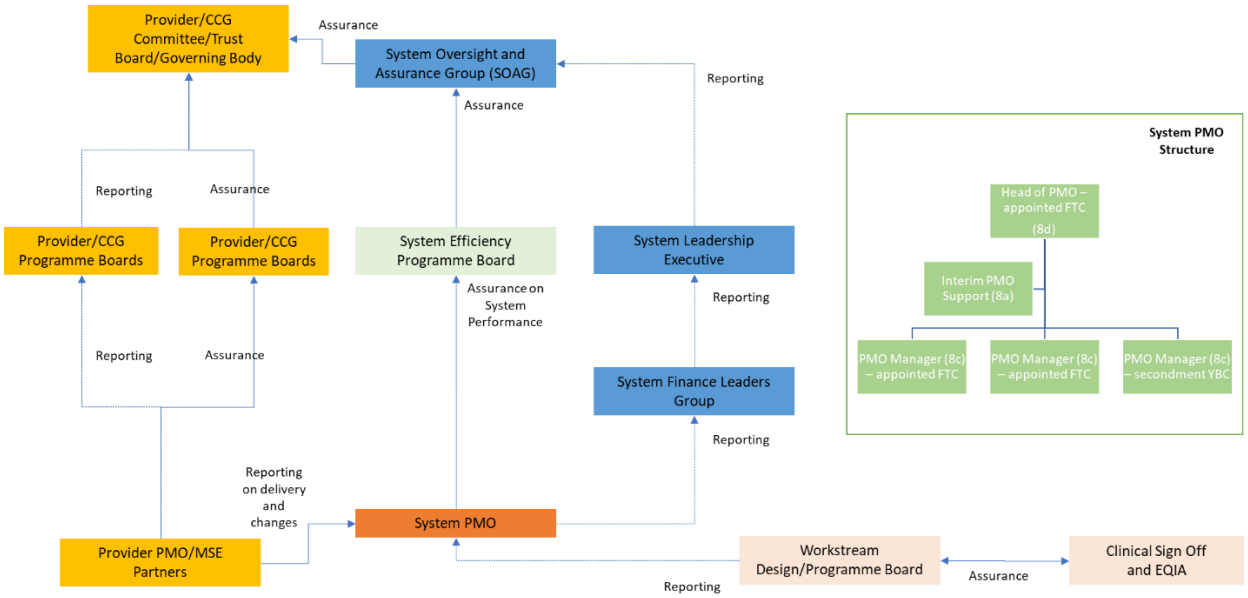
Table 2

High Cost Drivers	Workstream	Ref	Tactical Interventions	Theme	Net Releaseable Costs (£m)	SRO
Activity Flows	Referrals (elective)	P1	Develop services delivered by specialists/GPs in the community	Delivering the right care at the right time to improve pathway efficiency	£22.8	William Guy
		P2	Introduce GP peer review and feedback			
		P3	Expand clinical triage and assessment			
	Referrals (outpatient)	P4	Introduce GP peer review and feedback			A&G - Trust Karen Wesson
		P5	Expand clinical triage and assessment			
		P6	Consistent application of the straight to test pathway			
	Non-elective flows	P7	Improve the Same Day Emergency Care (SDEC) pathway			Sam Goldberg
		P8	Improve access to primary care	Effectively supporting the management of population health in lower cost settings	£11.8	William Guy
		P9	Education and support for self-management for patients with long term conditions*			
Workforce	Bank and Agency spend	R1	Implement a robust workforce strategy*	Moving towards system-wide corporate services to remove duplication	£12.5	Ruth Jackson (Heather Golding MSE FT)
		R2	Reduce barriers for rapid employment of substantive staff*			
		R3	Improve cost control measures*			
		R4	Offer more flexible working options*			
	Corporate services	R5	Consolidate back office functions across the System			Dawn Scrafield

Table 3

Provider Productivity	Length of Stay	S1	Improve discharge pathway consistency*	Improving productivity to deliver activity at a lower cost	£39.2	Andrew Pike
		S2	Patient flow improvement program*			
	Outpatients**	S3	Give patients more control of their care*			Andrew Pike
		S4	Improve outpatient booking process*			
	Theatres	S5	Improve engagement with pre-operative patients*			
		S6	Introduce real time theatre updates*			Andrew Pike / Jane Farell
		S7	Improve effective use of management information*			
	PoLCE	S8	Reduce the number of interventions being undertaken*			Andrew Pike
	Sub-scale services	S9	Assess and implement reconfiguration of services*			Charlotte Williams
	Readmissions	S10	Expand rehab community services	Effectively supporting the management of population health in lower cost settings		Michelle Stappleton
		S11	Improve patient education*			
		S12	Introduce a discharge follow up service			
System Producitivty	CHC	S13	Align CHC commissioning and unit costs with peers	Improving productivity to deliver activity at a lower cost	£25.7	Alyson Taylor/ Viv Barker / Phillip Clark/Stephen Mayo
		S14	Review CHC referral eligibility across the System			
		S15	Improve out of hospital care			
	Prescribing	S16	Prescribing efficiency programme			Simon Williams
		S17	Align prescribing unit costs across CCGs			
	Local Authorities	S18	Align residential unit costs			Matt Williamson (ECC), Benedict Leigh (SBC) and Ian Wake (TCC)

To ensure we have the right programme delivery the following governance has been established to realise the multi-year financial improvement plan.



15. Approach to Costing

The NHS in England has invested substantially in costing to implement the National Costing Transformation Programme, though locally this has not been the case with all local providers. The reality is that while NHS trusts are putting some funding into supporting costing, local health systems are not reaping the potential huge benefits. The majority of Costing teams time is spent on the annual National Cost Collection NCC). As a result, there is little time to support clinical and operational teams to use the cost data to improve value. The potential for costing is substantial particularly supporting the stewardship process, but unlocking the potential requires a fundamental reset of the approach to costing locally.

In order to have a clear understanding of the costs, and cost drivers, of care within our system we will open up a wealth of opportunities for partners to better harness and manage the resources available.

The expertise of costing experience and capability locally currently rests within MSEFT, primarily driven by the mandatory annual requirements of cost collections and reporting to support model hospital. Other partners also have some costing capabilities, however the resilience and maturity in the development of these functions reflects the relative focus that nationally has been on services outside the acute sector.

An ambition within our ICS is to take the costing capabilities and strength of the team to build capacity and capability to stretch across the system, facilitating the development of world class costing knowledge to improve the understanding and accessibility of information for our stewards.

The costing strategy ambition is to have a single costing hub, centred around the expertise and experience based at MSEFT, with a single costing system to support this.

The costing strategy will provide a structured training plan for developing the technical skills of costing staff, to support the recruitment and retention of highly skilled costing professionals.

The strategy will embed costing and benchmarking into stewardship, clinical leadership, and operational meetings and in the long term should not be limited to health services.

The medium-term costing strategy will develop a structured clinical engagement programme which educates and supports clinicians and service managers to understand costing information, reduce clinical variation, support business cases, drive cost efficiencies and help to develop efficient patient pathways, working alongside all partners.

Along with the key challenge of retention on highly skilled and ‘niche’ costing expertise within the system are the significant challenges regarding both Business Intelligence (BI) and Information Technology (IT) requirements and support. A single costing ‘hub’

servicing the system would need an investment in the short-term to increase the bandwidth of the current team, but also in IT and BI around this.

System Information Governance is an important factor as the single hub will need access to data over several organisations.

The key measures of success based on health costing requirements are as follows:

- Local system cost information is regularly used in decision-making to drive improvements in value;
- There is a single version of cost data that can be used both locally;
- Compliant annual National Cost Collections 'NCC' to NHSEI by all required to submit;
- Model hospital costing data provided to suitable quality from all partners;
- Outcome of National Cost Collections reviewed and discussed at Finance & Performance and System Financial Leaders Group;
- Retention of experienced staff;
- Dedicated IT and Business Improvement resource;
- Cloud based costing system;
- Single costing system implemented across mid and south Essex;
- Use of patient level costing within financial management reporting;
- Costing information influencing clinical decision making; and
- Costing and related finance/activity training programme in place (primarily group training/on-line).

Our longer-term ambition is to be one of the leading ICSs in the country helping to shape the future direction of costing and benchmarking practices in the NHS.

16. Approach to Financial Risk Management

The system needs to develop and agree a financial risk management framework, which then underpins this financial strategy.

System partners understand the need to manage risk and the financial consequences. Through the memorandum of understanding partners are committed to robust financial risk management including:

- Commitment to operating on the basis of a "System operating Budget" as the basis of the ICS Finance Framework, which will include a system budget structure to co-ordinate resources across and on behalf of the system according to approved plans;
- Reporting routinely and on a timely basis to meet the financial reporting needs and expectations of the ICS;
- Providing well-formed and open insights into financial performance and risks to facilitate an open approach to delivering the financial commitments of the ICS;
- Commitment to the delivery of the Financial Sustainability Programme, following the approval of the Financial Sustainability Review in August 2021. This forms the basis of the system financial strategy which is to address the underlying financial deficit;
- Prioritisation of future discretionary system resources to improve the benefit of population health;
- Agreeing to support system-based recovery plans where necessary in year. From time to time, this will also require partners to risk share; and
- Commitment to collate all partner and organisation risks.

Acknowledging the risk in volatility relating to demand for services across Health & Care, the ambition is to mature our predictive capabilities to proactively manage risk and associated financial consequences.

17. Approach to Cash Management and System Contracting

Whilst each provider within the system has a contract which sets out the minimum delivery and quality requirements, this has not been the basis of relationship between providers in mid and south Essex. The relationship between providers has always been to work collectively together to support our population in the best way. This approach will continue going forwards, but we recognise the importance and responsibility of managing cashflow in the system:

- We need to manage cash effectively across the system to ensure reduced interest payments, and not create transaction inefficiencies
- Will need to respond to external ICS contracts and transactions/challenge to ensure value for money and governance and transparency are maintained.
- Best practice standards such as Public Sector Payment Policy (pay within 30 days) and minimising loans and interest are adopted by all partners

18. Skills and Capability to deliver the transition

As a finance community we recognise the importance on investing in our finance community to ensure we develop strong skills and opportunities for succession planning. As a System Finance Leadership, we are committed to the development of a Finance Staff Development plan to support the growth of integration across our system.

The use of the following tools, networks and principles will be considered in the development of this plan.

Finance Teams across the system will be instrumental in delivering our ambition as part of the wider Integrated Care System. We want to be able to provide our population and our staff with the confidence that resources are being used transparently, supporting the benefit of population health improvement, and fulfilling our statutory obligations and duties.

By establishing clear and transparent funding arrangements within our system we aim to support the collective understanding of how resources are allocated across the system for both revenue and capital.

We want to ensure value for money across the whole system by supporting our Integrated Care Partnership in the establishment and management of integrated fund arrangements, (such as the Better Care Fund) at place and across Health and Wellbeing Boards.

We will further support our places to understand the resource consumption of their populations and how to utilise available funding in accordance with ICB priorities and national policies.

The implementation of a model of Finance Business Partnering will enable expert leadership on all aspects of financial management and reporting for a specific spend area within the ICB. Becoming the financial expert for their area they will work openly and supportively with clinical and operational managers as required supporting and upskilling the capabilities of teams outside of finance.

Adopting a consistent model of financial management, and an ethos of collaboration at all levels, across partner organisations will enable development opportunities across sectors for finance professionals

Working beyond professional boundaries is pivotal in delivering our vision of financial transparency and sustainability for our population.

Conclusion

As the MSE system we are committed to achieving the triple aim. As a system we have the ambition to prioritise the prevention of ill health through evidence-based investment and to develop systems to support ‘well people’ proactively take control of their health.

This finance strategy will underpin how we innovate and continuously improve over the coming years so we can maximise the benefit our partnership pound can offer to improve health and care for our residents across Mid & South Essex.

Mid and South Essex Integrated Care System

Appendix B

NHS

Mid and South Essex

Our Finance Strategy for Health and Care

Why we need to change?

We have a huge amount of resources already at our disposal to try and support our population, but if we do nothing now, within the next 5 years we won't have the resources to support everyone we need to.

Our current position:

44,000

professionals in our workforce who deliver care and health to our population

£3.2bn

is spent supporting our population with their health and care needs, which is already £300m above our allocation

1.2 million

live in mid and south Essex and last year we supported them through 1.5 million outpatient & inpatient activity, meeting 100,000 new requests for care and over 6 million GP appointments

Where will we be in 5 years time if we do nothing?

People are living longer increasing the demand of our resources, with the number of **over 60s** expected to grow by **6%** in the next 5 years, and the number aged **80+**

growing by 25%

We know the best place to receive support is in the community but

1 in 2 GPs plan to retire in the next **5 years** and

2 in 5 nurses in the next **10 years**

reducing our primary care capacity and resulting in people attending other services

If we do nothing, our could deficit could grow by

£400m due to changes in national funding, increased demand and workforce challenges

Our vision

As the MSE system we are committed to achieving the triple aim:

- **Better population health;**
- **Better quality of care; and**
- **Financially sustainable services**

Our Ambition

- As a system we have the ambition to **prioritise the prevention of ill health through evidence-based investment.**
- We have the ambition to develop systems and resources to support people to proactively **take control of their health** through self-help resource to prevent further ill health.
- Using innovation and continuous improvement we have the ambition to maximise the benefit our partnership pound can offer in care for our residents across mid and south Essex.
- We have the ambition to **align future resources to the system priorities** and will only invest where there is no resource improvement potential.
- Over the next 3 financial years we have the ambition to recurrently **release more than £100m through efficiency**.
- We have the ambition to **maintain financial balance** through a healthy combination of cash release and productivity efficiency measures.

What do we need to do to achieve our ambition?

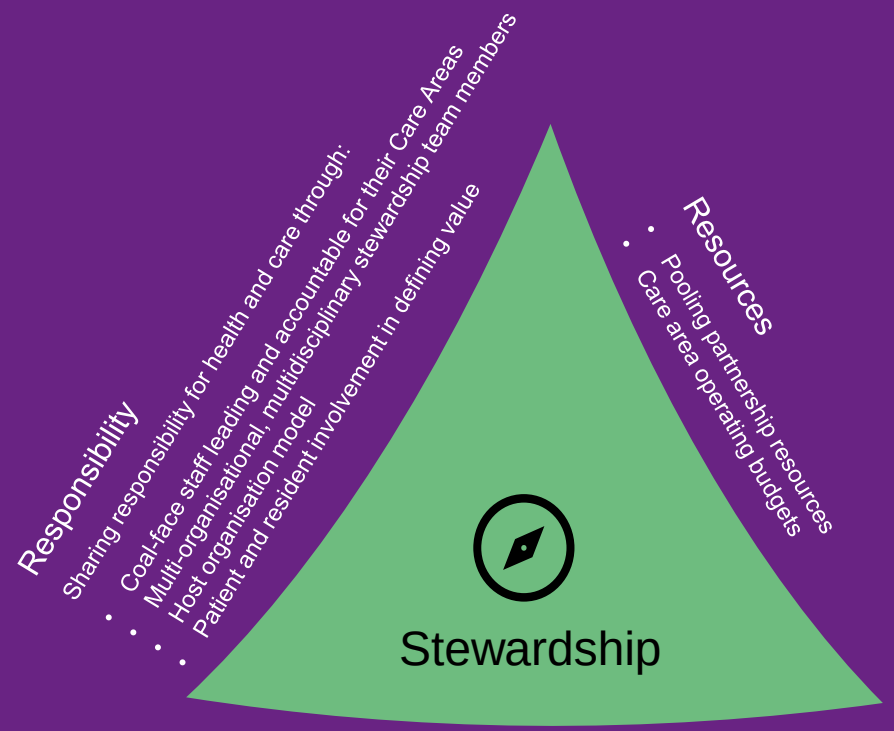
- Stewardship
- Financial leadership
- Financial framework /strategy
- Reporting and accountability
- Capital and Investment

313

What do we need to do to achieve our ambition?

Stewardship is a model being initiated across MSE which focusses on Multi-professional, cross-organisational frontline teams, working together to get the best out of health and care resources.

We will pool our resources and take a collective responsibility on how this resource is used. We will integrate our data combining it with intelligent analysis and clear visualisation to ensure everyone has the right information in front of them to make the best decisions for our population



Intelligence

- Population health management – using integrated data to improve health and wellbeing
- Evidence based practice

Stewardship

Financial leadership

Financial framework /strategy

Reporting and accountability

Capital and Investment

What do we need to do to achieve our ambition?

The finance leaders work together inclusively and have done so across MSE for many years. They are uniquely placed to model behaviours essential to the core principles required to make stewardship a success.

We have agreed to align relevant planning, investment and performance improvement in order to most effectively benefit our local population and align them to our stewardship teams

Using the specialist skills of our thriving community of professionals from across the system; expert in areas such as finance, analytics, digital, legal, commercial and estate, we will develop the skills across our workforce to support the effectiveness of resource management.

Stewardship

Financial leadership

Financial framework /strategy

Reporting and accountability

Capital and Investment

315

What do we need to do to achieve our ambition?

In order to achieve the triple aim and address the growing deficit across the system, the delivery of substantial transformational savings is required. The core strands to deliver our sustainable finance strategy are:

- Year on year ‘Business as usual’ improvements through realising ways our teams and organisations could be more efficient and eliminate waste;

- Delivering transformation savings by changing how we work individually and collectively as a system, based on opportunities identified

- Continue to align system funding to the target allocations as previous and current funding levels have differed, particularly due to COVID over the past few years.

Stewardship

Financial leadership

Financial framework /strategy

Reporting and accountability

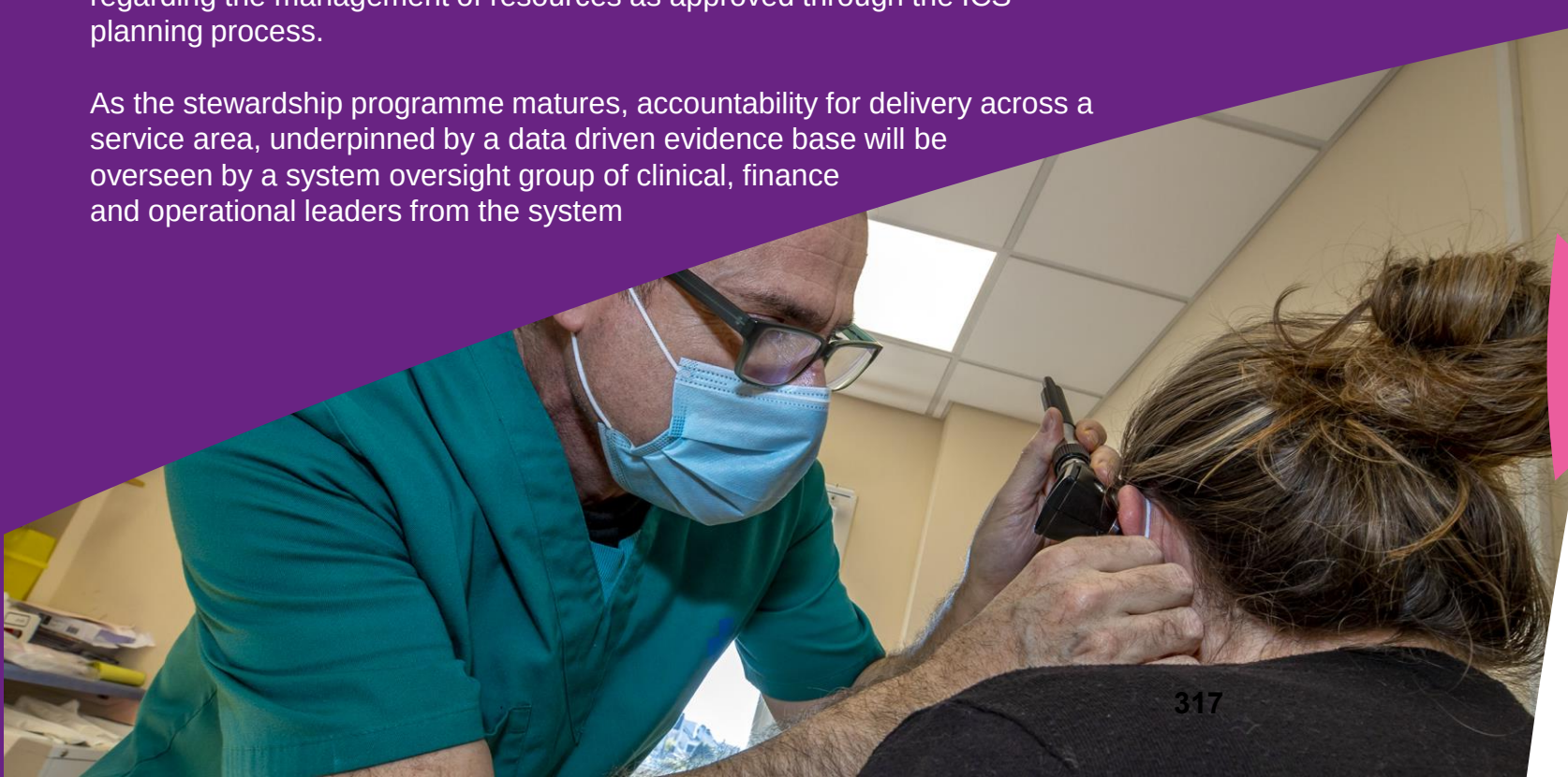
Capital and Investment

What do we need to do to achieve our ambition?

The principles supporting joint accountability arrangements are underpinned by effective collaboration, transparency and trust between all partners, and between the ICS and its residents.

Each part of the ICS (system, alliance and neighbourhood) and each statutory organisation will have its own arrangements for gaining assurance regarding the management of resources as approved through the ICS planning process.

As the stewardship programme matures, accountability for delivery across a service area, underpinned by a data driven evidence base will be overseen by a system oversight group of clinical, finance and operational leaders from the system



- Stewardship
- Financial leadership
- Financial framework /strategy
- **Reporting and accountability**
- Capital and Investment

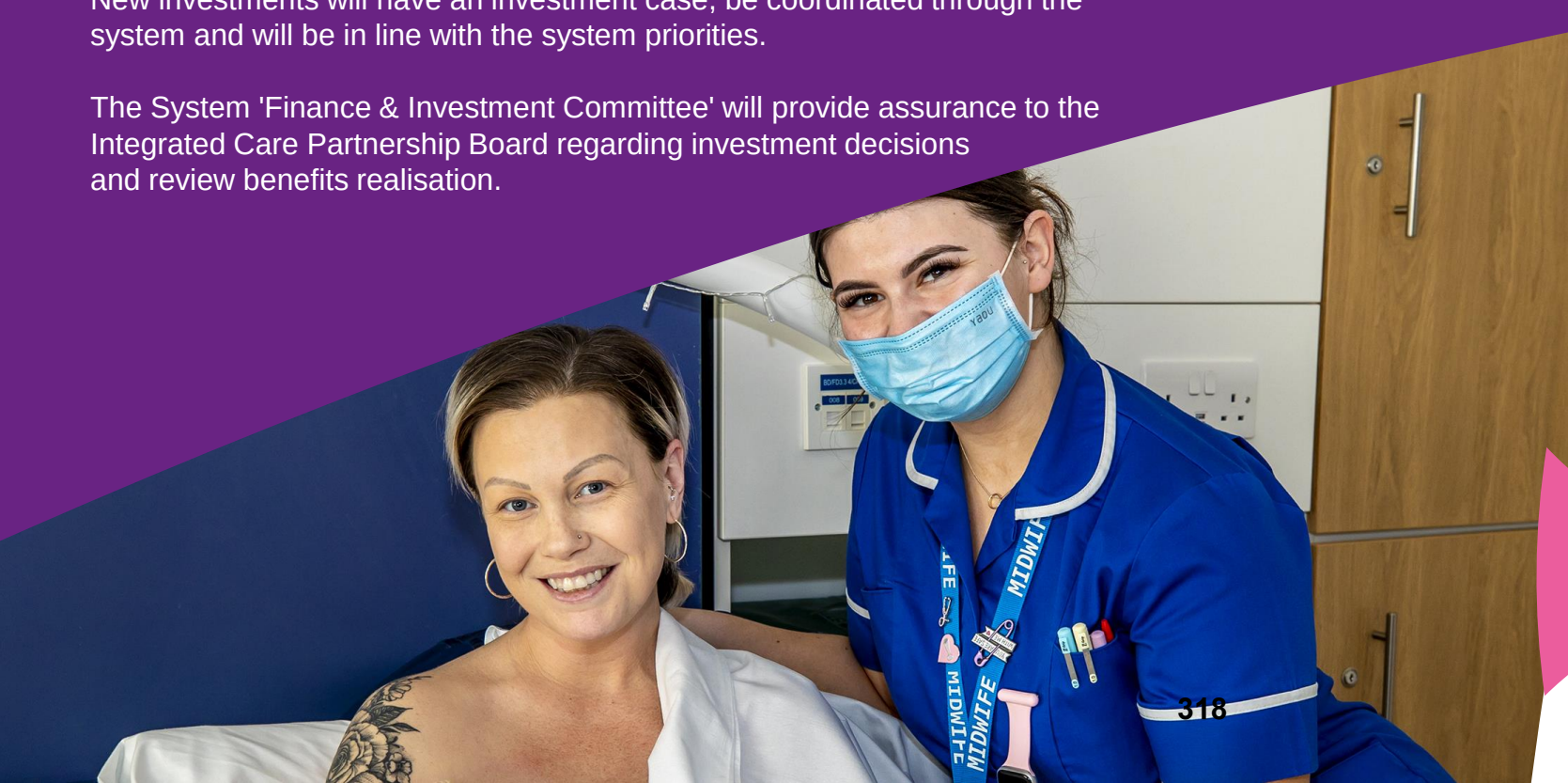
What do we need to do to achieve our ambition?

We have the ambition to align future resources to the system priorities and will only invest where there is no resource improvement potential.

Our estates, infrastructure and digital offering needs to be modernised and we need to be innovative in how we invest to do this given our constraints.

New investments will have an investment case, be coordinated through the system and will be in line with the system priorities.

The System 'Finance & Investment Committee' will provide assurance to the Integrated Care Partnership Board regarding investment decisions and review benefits realisation.



Stewardship

Financial leadership

Financial framework /strategy

Reporting and accountability

Capital and Investment

The principles underpinning our ambition

Transparency

We will take an open book approach, simplify processes and make information accessible. New investments will be coordinated through the system and will be in line with the system priorities and decisions regarding investment will be open and shared with everyone.

Acting as one

We are collectively 'in it together' and will work as a single system, managing opportunities, resources and risks as one

Clinically led

Through the development of the stewardship programme we will support our stewards to manage the resources available to deliver care in a way that will improve population health, optimise response and ultimately reduce inequalities.

Impactful

We will use our resources in a way which maximises the impact we have on our population

Ambitious

We will develop our staff to achieve their ambitions and the ambitions of the system

What risks will we face and what opportunities are there?

We recognise that to achieve this vision, there will be a number of risks and opportunities along the journey. We will need to prioritise and make the best use of existing resources and prioritising any investment into future resources.

Workforce

The frontline workforce who deliver heath and care to our citizens has been stretched and fatigued over the past 2 years. We know that we need to attract and retain our staff, provide excellent development and career pathways matching the ambition of our workforce to ensure we have a stable, motivated and highly skilled workforce

Infrastructure and estates

Our infrastructure and estates are old and investment is required to consolidate modernise our estate. We know the older the estate the greater the financial burden, and so we must innovate and work with third parties to find the resources and solutions needed to invest now for the future whilst balancing the need to prioritise investments across the system

Digital Transformation

The digital services on offer across the health and care system are not in-line with the digital offering across the private sector. We know that we need to invest in digital transformation to be accessible for our citizens of all ages but with the limited resources we have, we need to be smart and innovative on how we transform our digital services

COVID impact on delivery of our services

It's harder to work effectively and efficiently across and within service areas due to the pandemic and our limited resources now have to be more targeted then ever. The gap between health inequalities has grown and we know that we must implement our stewardship model and review how we deliver all our services immediately to ensure we are using our resources now and in the future as effectively as possible for our citizens.

Market constraints cost of living impact

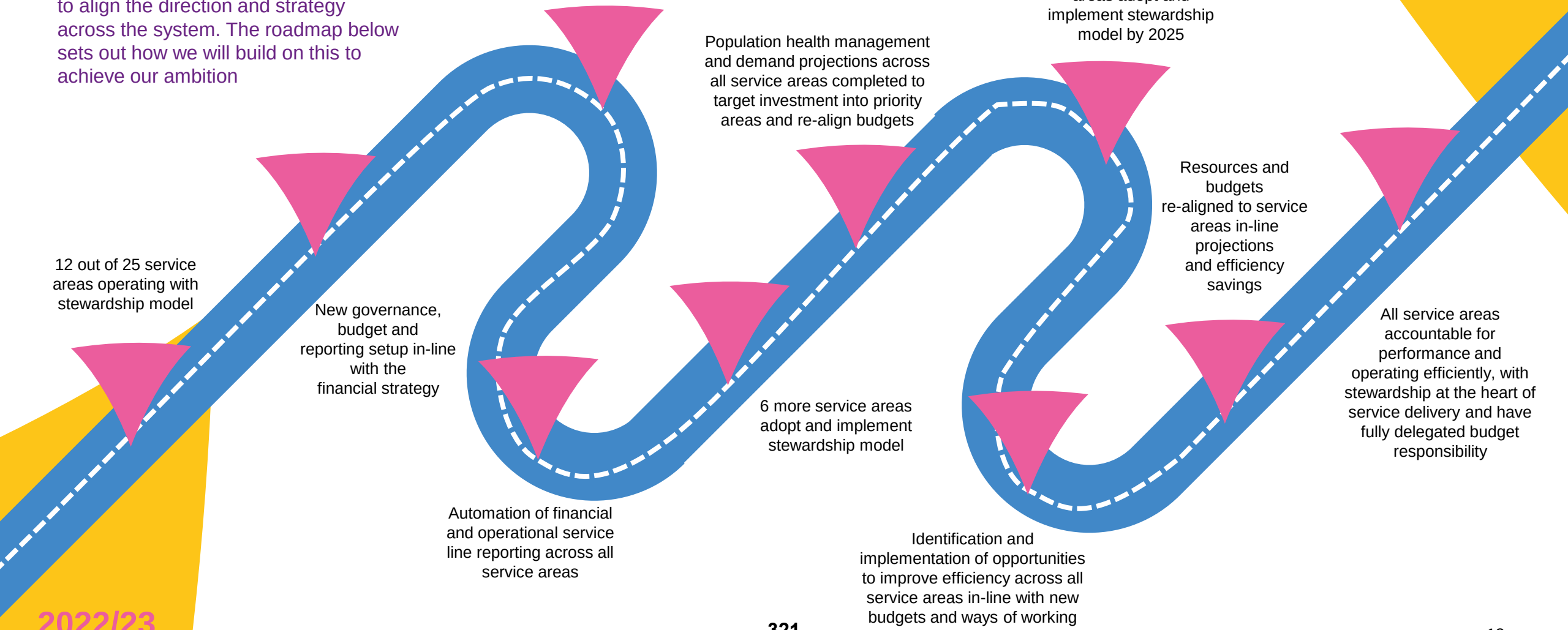
With the introduction of new legislation, increasing cost of care and national inflationary pressures, the provider care market and workforce to support our population, are stretched with capacity but also financially. We need to work with the market to find solutions to deliver the right care at the right time that is sustainable for everyone

Capacity in the right settings

Expansion of Primary care capacity has been limited with growth in population and demand. Capacity in the right setting is essential as well as development greater opportunities to facilitate self care, reducing the demand down stream in more resource heavy settings

Our roadmap

We are starting from a position of strength, working cohesively together to align the direction and strategy across the system. The roadmap below sets out how we will build on this to achieve our ambition



321

The information contained in this document can be translated, and/or made available in alternative formats, on request.

Part I Meeting

Date of meeting	1 July 2022
Agenda item number	12
Title of report	Working with People and Communities Strategic Approach
Purpose of report.	To describe the work undertaken to date to develop a draft strategic approach to engagement with people and communities on the ICB's work and to build a full strategy. I
Executive Lead	Jo Cripps, Executive Director Strategy and Partnerships
Report Author	Claire Hankey, Director of Communications and Engagement
Impact Assessments	
Financial implications	None identified
Details of patient or public engagement or consultation.	Work undertaken with Healthwatch Essex as outlined in the report
Conflicts of Interest:	None identified
Recommendation(s)	The Board is asked to note the report and continued work to further develop the strategy.

Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

Working with People and Communities Strategic Approach

1. Introduction

Public involvement and engagement are an essential part of making sure that effective and efficient health and care services are delivered.

The Integrated Care Board is required to have a strategy and delivery plan to describe how it will engage with people and communities on its work, and meet the statutory responsibilities placed on it by legislation. This paper and associated documents describe the work undertake thus far to develop a draft strategic approach and to build a full strategy.

2. Main Report

As they establish, all Integrated Care Boards have been asked by NHS England to develop a draft Strategic Approach for Working with People and Communities.

Our approach in mid and south Essex has a strong focus on working in partnership and builds on the adoption of the Partnership wide engagement framework back in 2020.

There is clear evidence and agreement that strong engagement and communications is crucial to achieving the best outcomes with, and for, our communities.

This brings with it the recognition that our methods of engagement must adapt to the changing landscape in which we now operate. We need to move from an internal facing approach where we expect residents to come to us, to a much more external approach - meeting our communities where they are whether in person or virtually.

This has been proven no more so than through the experience of the COVID-19 pandemic and vaccination programme which saw the development of new and innovative means of working with our communities. Our legacy is to maintain the commitment to continue to expand the reach of our engagement to better reflect our population, alongside the desire to make better use of new technology.

The draft approach at Appendix A, describes a set of principles to enable us to meet our statutory duties, and outlines the ways in which we will engage with our residents and use this insight in our work.

Work over the next period includes the development of a system wide co-production framework through a facilitated workshop where we will come together with various co-production plans and ideas to create an agreed way of working for the health and care agenda across the mid and south Essex area.

Delivery of our commitment to working with people and communities is further supported through working closely with the Director of Community Mobilisation and Transformation who is developing several innovative and citizen -led channels and mechanisms to embed an asset-based approach, some of which outlined towards the end of the approach document.

To inform our draft approach, we worked with our three Healthwatch organisations, led by Healthwatch Essex, to understand and promote the perspectives of residents and stakeholders to help us shape our thinking – the research findings and recommendations are provided at Appendix B (circulated as a separate attachment).

The subsequent draft approach document was submitted as required to NHS England on 27 May 2022 for review and we await the outcome of that process. It was also endorsed by the Health and Care Partnership board at its meeting on 9 June 2022.

The Board is asked to note that NHS England concluded a public consultation on its draft guidance for Working in Partnership with People and Communities on 20 May 2022.

This will become statutory guidance and will be adopted as policy by NHS England. The guidance will apply to newly formed Integrated Care Boards, NHS trusts and NHS foundation trusts to support how they build effective, positive, purposeful, and enduring partnerships with communities to improve services and outcomes for people and meet their public involvement legal duties.

In the interim as part of developing the draft approach The ICB Communications Director and Head of Insight and Engagement met with The Consultation Institute to ensure our approach was on track to meet the new guidance.

3. Conclusion

The draft strategic approach attached has been developed with insight from a range of partners and stakeholders and seeks to support the ICB to meet its expected responsibilities regarding how it works with people and communities.

As a draft approach it will continue to evolve as statutory guidance is implemented and will form the basis of a full strategy, underpinned by a series of frameworks to support delivery.

4. Recommendations

The Board is asked to note the draft approach and the intention to develop a full strategy and supporting frameworks, for how the ICB will work with people and communities, ensuring it is in line with the likely statutory requirements placed upon it.

5. Appendices

Appendix A –Draft Working with People and Communities Strategic Approach.
Appendix B – Healthwatch Essex: Developing how we work with people and communities report (circulated separately and available to members of the public on request).

Mid and South Essex Integrated Care System

Appendix A

NHS
Mid and South Essex

DRAFT

People and Communities Strategic Approach

2022-2023

Mid and South Essex Integrated Care System

Public Insight and Engagement
– the strategic approach

Introduction

Engagement and the involvement of our residents is an essential part of making sure that the best possible health and care services are delivered; by reaching, listening to, involving and empowering our people and the communities they live in. These people and their communities are at the heart of the decision-making process – as an Integrated Care System – **we start with people.**

We will be taking the learning gained over the past two years from the Covid pandemic and embed it into this Working with People and Communities approach. We now have the opportunity to create a new 'deal', whereby people are active and engaged partners in the development of healthy places, not merely consumers of NHS services. We want to create a new relationship based on meaningful resident engagement, informed by community insights and underpinned by trust.

We will be re-establishing our engagement steering group so that public involvement across the system is as focused and co-ordinated as possible.

Our plan, over the next two years will be to co-design, embed and deliver a full Working with People and Communities strategy that will fall from this approach.

Purpose and aim of this strategic approach

We have created this document to outline the Mid and South Essex Integrated Care Board's strategic approach to public involvement, and the key principles that will underpin our ways of working and supports the ICS Communications and Engagement Strategy. It lays out the plan on how we will collaboratively work with our partners to ensure that how we involve people, how we respond to their views and experiences, and how we identify and share the impact of involvement, are aligned. This is underpinned by a number of frameworks and toolkits which will support key areas to ensure consistency and alignment across the system. These can be found on page 11 of this document.

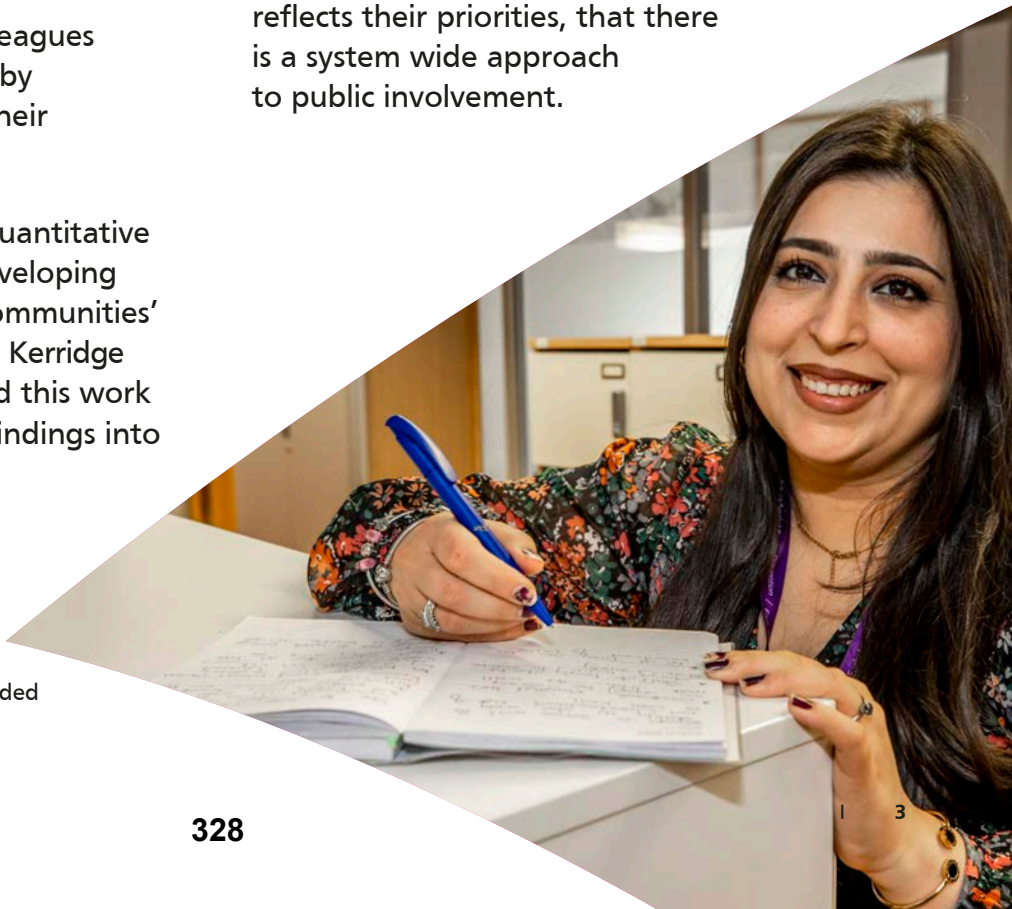
Developing our approach

We have worked closely with colleagues in our three Healthwatches – led by Healthwatch Essex - to draw on their insight and best practice.

The subsequent qualitative and quantitative research and outcome report 'Developing how we work with people and communities' by Dr Kate Mahoney with Dr Tom Kerridge and Lorna Orriss-Dib has supported this work and we have incorporated their findings into this **Working with People and Communities Approach.**

Legislation and requirements of system partners

Current legislation[1] requires Clinical Commissioning Groups (CCGs) to involve the public in commissioning, and requirements of CCGs under **the public sector equality duty - Equality Act 2010, Accessible Information Standards** and the related duty to reduce health inequalities between people in terms of access to care and outcomes achieved, also highlight the need for effective involvement of those with protected characteristics in order to fulfil the required duty. In addition, wider system partners – local authorities and NHS Foundation Trusts – have similar obligations to involve the public. It is expected that the current statutory duties of the CCG relating to public involvement will be assumed by the Integrated Care Board (ICB) from July 2022. It is, therefore, essential for both reasons of alignment and good practice, but also to ensure that the population's views and experiences are sought and responded to in a systematic way that reflects their priorities, that there is a system wide approach to public involvement.



[1] Section 14Z2 of the NHS Act 2006, as amended by the Health and Social Care Act 2012

Public involvement guidance

The ICS Design Framework (2021) sets the expectation that partners in an ICS should agree how they listen consistently to, and collectively act on, the experience and aspirations of local people and communities. This includes supporting people to sustain their health and wellbeing, as well as involving people and communities in developing plans and priorities, and continually improving services. The ICS implementation **guidance on working with people and communities (September 2021)** highlights the following key points:

- A strong and effective ICS will have a deep understanding of all the people and communities it serves.
- The insights and diverse thinking of people and communities are essential, enabling ICSs to tackle health inequalities and the other challenges faced by health and care systems.
- The creation of statutory ICS arrangements brings fresh opportunities to strengthen work with people and communities, building on existing relationships, networks and activities.

Gathering insight from our diverse population about their experiences of care, their views, suggestions for improvement and their wider needs in order to ensure equality of access, is therefore a key component of an effective and high performing ICS. There is a clear expectation in the guidance that this will be implemented in a range of ways, including embedding co productive purposes.

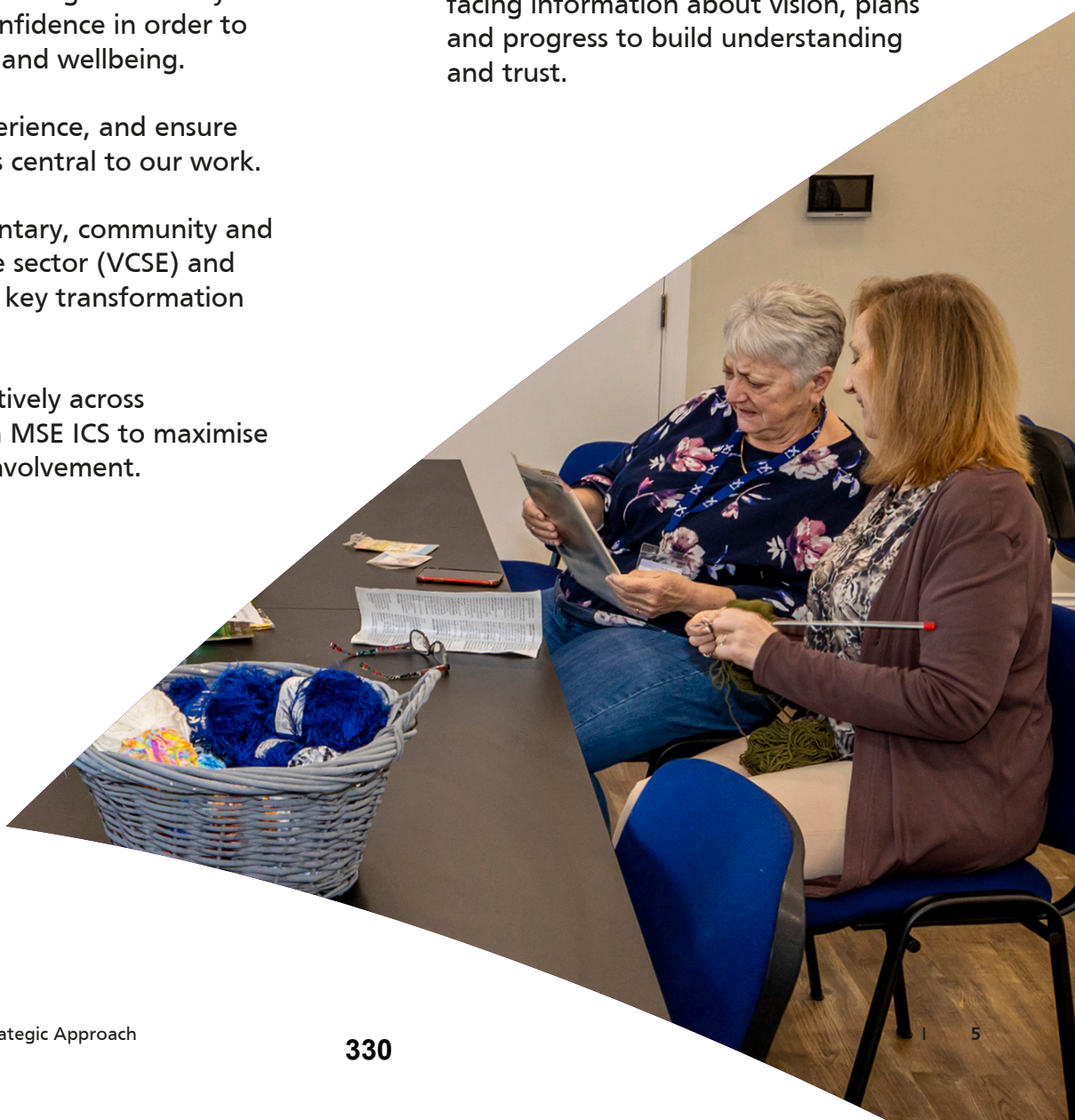
The creation of statutory ICS arrangements will bring new opportunities in how we work with people and communities, that build on our existing work, networks and relationships.

> “The partners within the ICS will be expected to agree how to listen consistently to, and collectively act on, the experience and aspirations of people and communities.

Principles

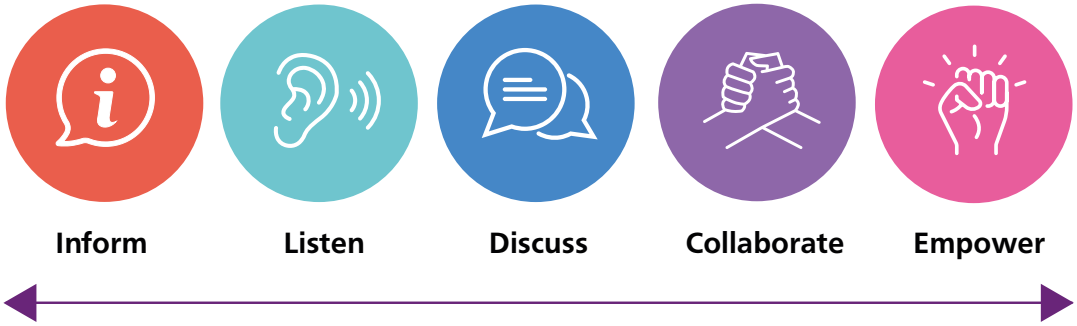
Our principles for effective public involvement across our system are:

- Understand our people and communities' experiences and aspirations for health and care.
- Ensure that insight from groups and communities who experience health inequalities is sought continuously and effectively and then used to make changes in order to reduce inequity in, and barriers to, health and care services.
- Use community development approaches that empower people and communities, building community capacity and confidence in order to improve health and wellbeing.
- Value lived experience, and ensure co-production is central to our work.
- Work with voluntary, community and social enterprise sector (VCSE) and Healthwatch as key transformation partners.
- Work collaboratively across organisations in MSE ICS to maximise the impact of involvement.
- Use public engagement and insight to inform decision-making and ongoing service improvement.
- Redesign models of care and work relating to system priorities in partnership with staff, people who access care and support, and family and friend carers.
- Demonstrate clearly the actions taken as a result of insight and involvement, and be open and when changes cannot be made.
- Provide clear and accessible public facing information about vision, plans and progress to build understanding and trust.



Public involvement – the ways we work to gain insight

There is not one way to deliver public involvement, but a range of activity that involves different methods and approaches. We recognise the need to use a range of varied but complimentary ways to reach out to our communities to inform and listen to them.



Inform

We will provide residents with clear information, in a format that is appropriate to them, on how they can be involved in our work – this can range from ways to feed in views and experiences, to working in partnership with us. Information will be delivered in a range of ways including; a new website, feedback via Virtual Views, our residents panel, newsletters and briefings (written/online/face to face). We will also cascade information through key partners and our staff.

Listen

We will actively listen to what people want to talk to us about. We will do this by providing ways for people to talk to us – face to face or online and through trusted partners such as the VCSE, Healthwatch, and Virtual Views and we will also collate views that come through enquiry routes, patient experience and complaints.

Discuss

We will discuss how we plan, design and deliver the best possible services with people, and ensure that their experiences, feedback, views and suggestions help shape our work. We will do this by talking to our residents, and involving people with lived experience or through representatives of a wider community. We will build relationships with people and communities and have continuing conversations, so we know how effective the changes we have made have been as a result of insight.

Empower

We want to empower people and communities to take control of their own health and wellbeing in ways that work for them. We will do this by understanding what they need to make informed choices about their health and wellbeing. We will work closely with our partners in primary care, VSCE sector and others to provide opportunities to access resource and support.

Collaborate

Once we agree our collaboration principles and standards, we will embed them throughout our work and within the ICS. We will make sure that involvement and collaboration are centred around people and communities, not around our structures and ways of working. We aspire to develop a range of frameworks to support our collaboration including; frameworks for co-production, lived experience and individual involvement which will help embed this approach across the ICS. We will also share examples of good collaboration across our programmes and projects.

Ways we can deliver effective public involvement

We recognise that public engagement, with careful planning and preparation will be a key factor in all decision-making processes for the ICS. We will incorporate a wide range of residents in our work and ensure that we are truly inclusive and the people match our demographic diversity. This will ultimately lay the groundwork for future quality outcomes for the people of mid and south Essex.

We want to work together across the partnership in collaboration and with a shared purpose. We will support and encourage everyone to work together to advance the common good.

Building trust will be an important aspect of the Working with People and Communities approach but it will only be achieved by being clear and open about the process and feeding back to the community as part of our sustained engagement and involvement culture.

Communication

We will develop long-term communication strategies that maintain engagement and share information about our work, priorities and future plans in a way that is clear, engaging and tangible to people and communities. We will ensure that we communicate clearly how people can become involved, including support to be able to do so. We will clearly communicate the impact of involvement.

Inclusion engagement

We will promote and demonstrate an inclusive involvement ethos and will use appropriate ways of reaching and hearing from communities who experience health inequalities, or barriers to accessing care, considering intersectionality throughout. We will work collaboratively with our diverse communities to co-design interventions and solutions to issues identified. We will go out to our communities and not wait for them to come to us.

Individual involvement

We will develop a framework for individual involvement, including Community Ambassadors, lived experience roles and champions. We will embed lived experience in our work in a systematic and supportive way.

Formal public consultation

We will develop and support systematic and effective delivery of formal public consultation ensuring that legal requirements are adhered to and that the views of our communities are sought and considered appropriately.

Co-production

We will work in collaboration with charity sector organisations and community groups to champion opportunities to embed co-production at all levels of the system, sharing learning and good practice. We will use an agreed co-production framework as a basis for a consistent approach, and will audit how co-production impacts our work and the individuals involved.

Residents panel

We will work to develop our residents panel, Virtual Views, which will strive to match the demographics of the ICS. We will hold ongoing discussions with members of the public to inform our priorities and approach some of our most difficult issues. We will draw together insight from a range of partners across our system, including VCSE and Healthwatch, developing a robust approach to capture, collation and sharing though an Insight Bank. We will ensure that insight is used to inform Health Inequality Impact Assessments, and ongoing service change.

Placed based networks

Our approach will recognise the emotional implications involved in learning lessons and developing accessible, inclusive, and culturally competent engagement strategies. Therefore, we will grow and develop our place-based networks, to increase reach and active involvement across our diverse communities, to ensure we hear from and involve people in our work and to work with our partners to develop collaborative solutions to issues and barriers highlighted.

Governance

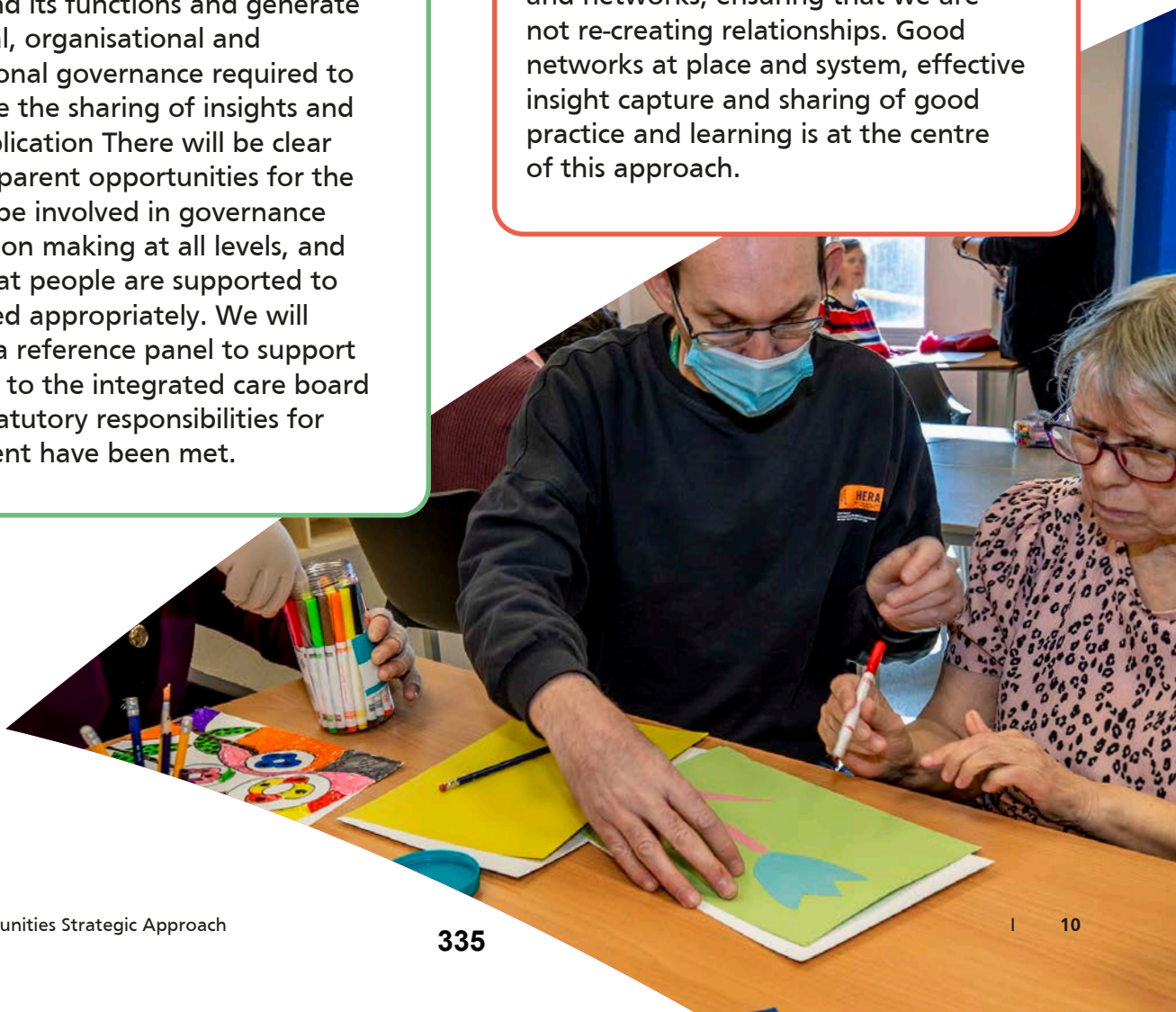
We will ensure that members of the public are suitably informed about the ICS and its functions and generate the clinical, organisational and informational governance required to encourage the sharing of insights and avoid duplication There will be clear and transparent opportunities for the public to be involved in governance and decision making at all levels, and ensure that people are supported to be involved appropriately. We will establish a reference panel to support assurance to the integrated care board that its statutory responsibilities for involvement have been met.

Embedded involvement

We will support our workforce and partners to understand the benefits of effective public involvement. We will embed involvement in programmes, projects and initiatives through a network of 'champions' across the ICB and its partners and will facilitate the ethos of 'we start with people'.

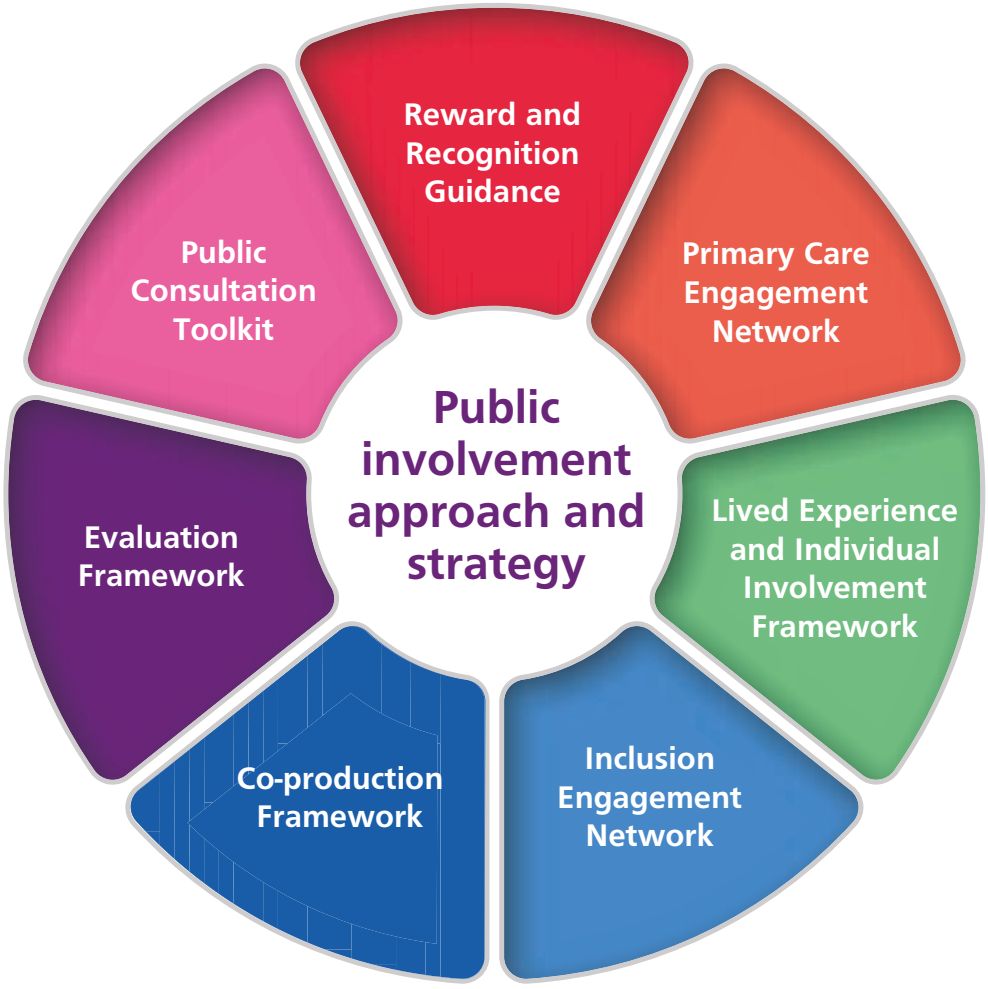
Delivering an integrated approach

By facilitating cross-organisational training in community development and integrated approaches, including asset-mapping, we will consistently build on existing insight, involvement and networks, ensuring that we are not re-creating relationships. Good networks at place and system, effective insight capture and sharing of good practice and learning is at the centre of this approach.



Toolkits and frameworks to help us deliver public involvement

It is our aspiration to create range of toolkits and frameworks to ensure a systematic approach in delivering public involvement across our system. All the ICS partners will use the frameworks as overarching principles and ways of working but include scope for local variation. Our initial list is not exclusive and will be reviewed regularly.



How we will work to deliver effective public involvement

The following outlines our ways of working to ensure we deliver effective public involvement that will avoid duplication across the system.

Advising – In order that the public involvement is delivered in a consistent way we will be providing an expert advice function across the ICS to support improved outcomes to our residents.

Empowering – Public involvement will empower our communities, by showing that we have heard people's voices and taken action as a result. Empowering communities especially those who experience the greatest inequity in access, experience and outcomes to health and social care, will mean their experiences will be heard, which help us to shape those services and support our overall aspiration to reduce health inequalities.

Embedding – we will ensure that excellent public involvement is embedded throughout our work and across all levels of the ICS. This includes making sure our partners and colleagues see involving our residents as 'business as usual' and that the value of public involvement is truly understood and integral to our ways of working.

Enabling – We will support our partners to effectively involve our residents. This may be through existing methods or supporting them to develop bespoke ways of engaging. Importantly the collation of insight from our residents in a systematic way will ensure partners are able to get public views without over engaging.

Aligning – Good public involvement will not be achieved in a silo. We will succeed by working across both the 'system and place', sharing insight and best practice, joining up areas of work where appropriate to do so, and supporting partners to consider a journey across services and sectors and the interdependencies.

Demonstrating – It is very important that we demonstrate to our residents, with quality feedback, on how their involvement has improved services and ultimately improved outcomes and access to health and care across the Mid and South Essex ICS.

Evaluating – to continually improve our public involvement work we need to regularly evaluate. We will consistently review how we involve people and see how well this works for the ICS and the residents.

Public Involvement

Working across mid and south Essex

PCN/neighbourhood level

Populations at a local and hyper-local level

- Working with people and communities where they live; reaching and hearing from local people and collaborating to develop local solutions.

Place

Aligned to one or more local authority; health and care organisations working collaboratively with other partners, including the voluntary and community sector

• Thurrock • South East Essex • Basildon and Brentwood • Mid Essex •

- Drawing on insight from people across 'place'
- Shaping place-based health and care priorities, plans and service delivery
- Public involvement governance linking to system structures

One integrated care system (ICS)

Across mid and south Essex covering a population of 1.2 million people

- A strategic approach, and key principles to guide good practice
- Ensuring the 'public voice' influences and shapes system wide priorities and plans, and programmes of work
- Public involvement governance linking to structures at Place
- Evaluation of public involvement
- Sharing insight and best practice

How our ICS works

PCN/ Neighbourhood Level

Working with people and communities where they live

Examples of community assets

- Primary Care Network
- Residents and neighbourhood group
- Practice based participation groups
- Voluntary sector
- Local service providers
- Local council(s) - parish / district / borough / county / unitary
- Housing providers
- Police
- Fire services

Place

Shaping place-based health and care priorities, plans and service delivery

Examples of community assets

- Community groups
- Voluntary sector and local health forums
- Healthwatch Essex, Southend and Thurrock
- Local service providers
- Local council(s) – district / borough / unitary
- Housing providers
- Care providers
- Police
- Fire services
- Alliance

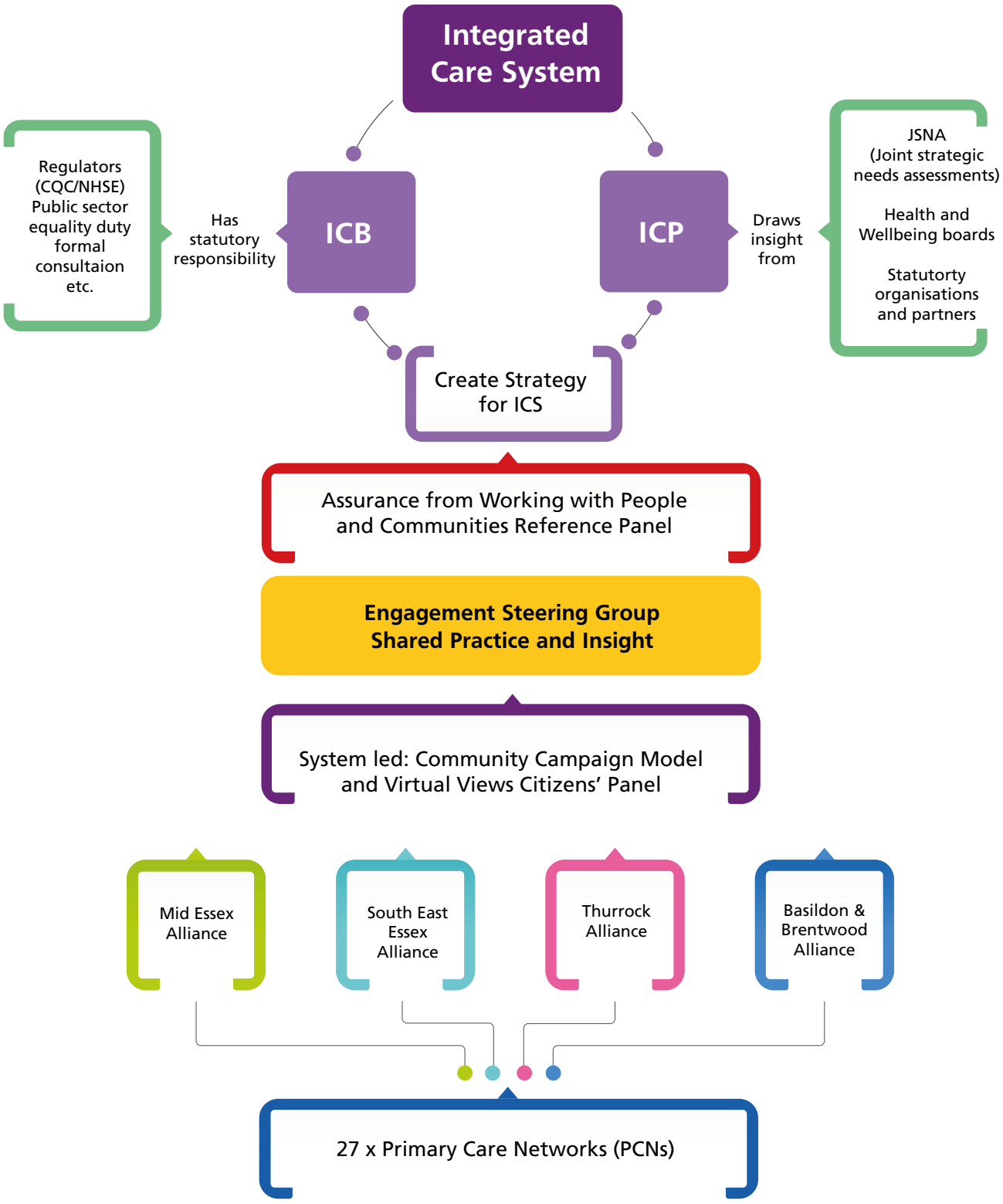
MSE ICS

Strategic approach ensuring the public voice influences and shapes system wide priorities, plans and work

Examples of community assets

- Virtual views
- Healthwatch Essex, Southend and Thurrock
- Voluntary and community sector
- Alliance
- ECC, SCC and Thurrock Council
- Care provider collaboratives
- Housing provider collaborative
- Police
- Fire services

Governance



Linking with community assets for example: social prescribers, local networks of interest or experience, community and support groups, patient participation groups, residents associations, faith groups, community leaders

Working with People and Communities into the future

The knowledge and experience we gained before and during the COVID pandemic recognises that connecting more deeply with our communities brings a much richer insight to our work. The recommendations reflected in the report by Healthwatch Essex, highlighted the need and the value of adopting an engagement approach that involves going out to communities, rather than waiting for communities to contact health and care services. We need to deliver a truly integrated approach to engagement that requires collaborative training, long-term communications, an openness and honesty on behalf of staff, plus a bottom-up strategy that is underpinned by a range of engagement tools and frameworks, including co-production and asset-mapping.

Vision: Towards an asset based resident led social movement for the ICS

As a hallmark of our ICS we are seeking to create a whole systems model that enables the opportunity to connect face-to-face and virtually around universal and societal challenges, that are important not only to communities of place, purpose and interest but also supports the objectives of our ICS. We are creating the foundations of resilient, resident-led communities that can support exceptional health and care outcomes that matter to everyone.

We recognise that the route to our communities exists not only within our voluntary sector partners and groups, but also through developing relationships within communities themselves to address health inequalities, meeting people where they are using a narrative and common language that resonates with our communities.

Community Campaign Model

As well as mapping and activating a group of 700 digital community leaders of place, building trust through working with them to deliver training that increases community resilience and supporting the development of microgrant programmes to build trust and amplify purposeful communities, in Essex we have developed the Community Campaign Model that is digital first, whilst seeking to move the needle from digital to physical social action around thematic social movements.

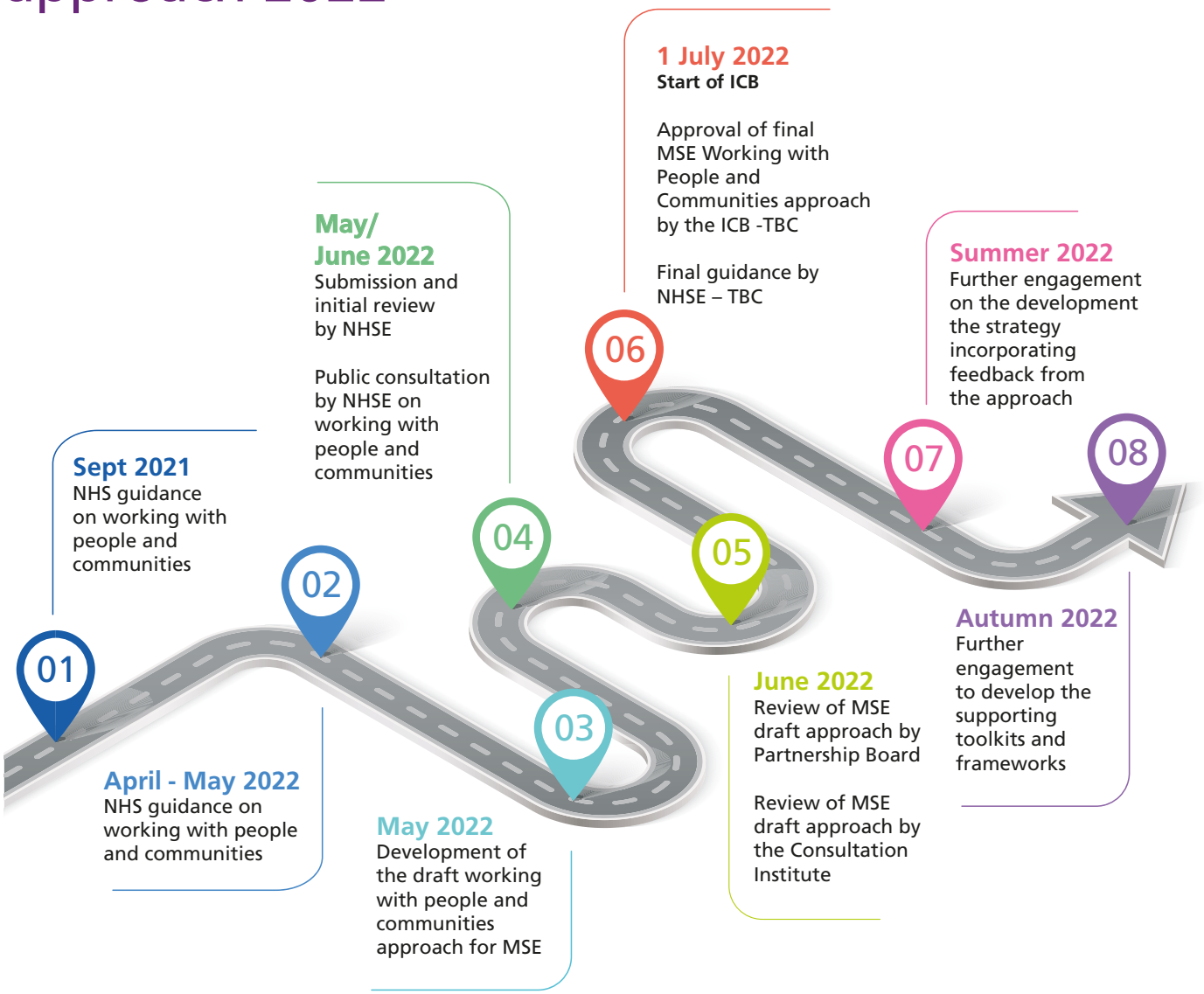
The Community Campaign Model can be implemented for communities of interest, place or purpose working alongside local, national and international influencers. It is a new approach to civic infrastructure which seeks to align the wants and needs of the community with the objectives of the public sector.

It creates a social movement around societal issues (such as Access to Services, Careers, Covid-19 dementia, social isolation, climate action etc.) which **engage and mobilise resident to provide solutions for themselves** with the support of the ICS.

We are the first ICS to broker a Community Partnership with Meta, who are the owners of Facebook, to support us in delivering an approach that allows us to reach people organically each month across the pillars of inform, prevent and assist where they are in existing online communities.
We meet communities where they are to enable us to provide volunteer recruitment, management, support emergency response, community mutual aid, support and advocacy, driving tangible behavior change with our communities around shared social missions of purpose. The model has been evaluated for efficacy by Public Health England, the National Institute of Health Research (NIHR), Manchester University and GovLab at University of New York (NYU).

The Community Campaign Model

Mid and south Essex roadmap to our working with people and communities approach 2022



Further information

For further information about our 'Working with People and Communities Approach', please contact the communications and engagement team by emailing msepartnership.comms@nhs.net, or telephone 01268 594534.

If you wish to be involved in helping develop and plan our integrated health and care services by being a member of our citizens panel 'Virtual Views' by visiting **www.midandsouthessex.ics.nhs.uk/get-involved/how/virtual-views** or if you do not have internet access, please ring the engagement team on the number above and we will discuss the options available.

Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

Part I Board Meeting

Date of meeting	1 July 2022
Agenda item number	13
Title of report	ICB 2022/23 Financial Plan and Budgets
Purpose of report.	To set out the financial planning process and final position for the Mid & South Essex System and, within that position, the ICB commissioning position for the 2022/23 financial plans.
Executive Lead	Dawn Scrafield, Director of Resources
Report Author	Jason Skinner, Director of Finance System Planning & Reporting Jennifer Kearton, Director of Finance Operations & Delivery
Link to the ICB's Strategic Objectives	Financial Sustainability
Impact Assessments	Not Applicable
Financial implications	None
Details of patient or public engagement or consultation.	None
Conflicts of Interest:	None Identified
Recommendation(s)	The Board is asked to: • Approve the 2022/23 financial plans for the ICB.

ICB 2022/23 Financial Plan and Budgets

1. Introduction

1.1. For 2022/23 planning, national guidance was issued on 24 December 2021 with planning templates and detailed technical guidance issued in January 2022. In line with the national timetable draft plans were submitted on 17 March 2022 and final submissions on 28 April 2022

1.2. Post submission, NHS England (NHSE) released funding to contribute to non-pay inflationary cost pressures which exceeded the original planning assumptions. As a result, a subsequent submission was made on 20 June 2022 to account for this additional allocation. Please see 2.3 below for further details.

1.3. System partners collectively developed the plan in line with guidance. It should be noted that this planning process is for NHS partners only and includes the Integrated Care Board (ICB) and the full income and expenditure plans for Mid & South Essex NHS Foundation Trust (MSEFT) and Essex Partnership Universities NHS Foundation Trust (EPUT). It should further be noted that for the first quarter of the 2022/23 financial year, the ICB allocation has been disaggregated to Clinical Commissioning Group (CCG) level to ensure the appropriate reporting of CCG Closure Accounts at month 3.

1.4. The draft system plan was developed in line with initial guidance that anticipated the delivery of a balanced financial plan. Mid and south Essex has planned to operate within its available resource, however the system has identified risks to achieving this position and these will be closely managed and reported on throughout the year.

1.5. The ICB allocations and provider income external from the system make up the total resources available for the system partners to deliver services for M&SE population plus other services commissioned from EPUT and MSEFT. The total system turnover is £2.88bn. This baseline funding also includes some additional allocations for 2022/23 - maternity services funding of £2m to address the Ockenden review is now included through the system budget for providers and Health inequalities funding £3.3m has also been received non recurrently.

1.6. The summary position is a balanced financial plan for both the system and each NHS partner individually, with an efficiency programme of £84m and unmitigated risks of £86m.

1.7. The following paper provides an overview of the system plan at section 2 and the ICB Plan at section 3.

2. M&SE System Financial Plans

2.1. The full system planning analysis has been reviewed by the System Finance Leaders Group (SFLG) and System Leaders Executive Group (SLEG) and following paper presents the key points of detail for the Boards review.

2.2. System resources are identified in 3 areas:

Table 1

M&SE System Allocation	£m
Core allocation	1,926.0
Convergence adj (1.0%)	-18.6
Revised core allocation	1,907.4
Primary Medical Services	191.3
Convergence adj (0.2%)	-0.4
Revised PMS allocation	191.0
Ockenden funding	2.0
Running Costs	22.8
Additional inflationary funding	21.0
Recurrent allocation	2,144.2
Covid	34.6
Health inequalities	3.4
Elective Services Recovery Funding	37.0
Additional inflationary funding	6.3
Total system allocation	2,225.5
SDF	43.8
Total system allocations	2,269.2
External trust income	611.7
Total system resources	2,880.9

2.2.1. Recurrent allocations (£2.1bn); core and primary medical services allocations, running costs (management costs) allocations and an additional recurrent allocation relating to outcomes from the Ockenden report.

2.2.2. Non-recurrent allocations (£125m); Covid, health inequalities and Elective Recovery Funding (ERF) funding along with SDF which funds new transformational investments.

2.2.3. External income (£0.6bn) from purchasers outside the system for services provided by MSEFT and EPUT. It should be noted that this covers all services provided by EPUT outside of the mid and south Essex geography.

2.3. Further detail on system allocations is as follows:

2.3.1. The system core allocation is based on underlying 2021/22 recurrent funding, adjusted for the new allocations for maternity Ockenden funding and an element of the additional inflationary funding received this year.

2.3.2. It has been assessed that mid and south Essex are 5.5% above target for core allocations and 0.7% above target for primary medical care services. As such, reductions of 1.0% and 0.2% respectively have been made to 2022/23 allocations to “converge” the system closer to our fair share target funding. This has resulted in a total reduction in allocation of £19m.

2.3.3. The approach adopted by the system was to use growth funding for inflationary cost pressures and to offset the impact of the convergence reduction. Any further increased costs due to activity growth are required to be contained by system organisation’s productivity.

2.3.4. In recognition of increasing inflationary pressures the system received £27.3m between the April plan submission and the June plan submission. The funding was provided to specifically support non-pay inflation and was received with

clear direction on how it should be distributed. As a result, £10.9m was used to support contracts with providers in and out of system, £3.0m was provided directly to East of England Ambulance service and £5.9m was provided to support cost pressures relating to Continuing Health care and Property services. As a result the system has £6.3m remaining which is being held in mitigation of the risks already identified in the system position.

2.3.5. System Development Funding (SDF) funding totals £45.8m of which £2.0m for maternity funding (Ockenden) is within core allocations and the remaining £43.8m provided as additional funding on a non-recurrent basis. This funding supports a range of transformational programmes across the system, and further detail by programme is provided in appendix A.

2.3.6. As set out in the planning guidance, systems will be expected to deliver 10% additional elective activity compared to 2019/20. Additional elective funding (£37m) has been allocated to the System to fund 104% of 2019/20 levels of value-based activity across elective ordinary, day case, outpatient procedures with a published tariff price and first and follow-up outpatient attendance activity.

2.3.7. The additional elective funding allocation will be adjusted up or down if actual activity delivered (combined across all in scope activity) is above or below the 104% baseline value (adjusted by 75% of the tariff value both ways). In line with national planning guidance, our system financial plans include full receipt of this funding and the associated expenditure needed to deliver these services. However, our risk profile includes the potential clawback of up to 75% of this funding if activity is not delivered as set out above.

2.3.8. The System receives a specific allocation for covid spending, which for 2022/23 is £34.6m. The 2021/22 allocation was £87.4m and as such the 2022/23 allocation is c.60% of the level of 2021/22 funding.

2.4. Without the efficiency programme of £84m within the plan, the current run rate of our expenditure would exceed the available resource.

2.5. The phasing of delivery increases during the year. The system profile for financial performance expects a £12.4m deficit in Q1, with improvement in the remainder of the year to deliver surplus positions in Q2 of £1.4m, in Q3 of £5.3m and in Q4 of £5.8m.

Table 2

Efficiency summary		2022/23		
		ICB £'000	Trusts £'000	NHS System £'000
System efficiencies		**15,497**	**68,524**	**84,021**
Of which:				
- Recurrent		14,738	56,346	71,084
- Non recurrent		759	12,178	12,937
% system allocation				**3.7%**
% expenditure		**0.7%**	**3.8%**	**2.1%**
% expenditure (exl intra-group)		**1.4%**	**3.8%**	**2.9%**

Table 3 below excludes intra-group trading and thus shows the net expenditure incurred in delivering services both to the mid amd south Essex population and to all other users of services provided by EPUT and MSEFT.

Table 4 below presents the system risks and mitigations. Our original plan highlighted risks valuing £142.6m of which £34.6m could be mitigated, leaving unmitigated risks of £108.1m.

Following receipt of the additional non-recurrent inflationary funding, the System net unmitigated risk is £85.8m and will be closely monitored throughout the year.

Table 3

	£m
System allocation	
Recurrent	2,144.2
Non-recurrent	125.1
External trust income	611.7
Total resources	2,880.9
ICB commissioned services	-565.2
Primary care	-436.1
Other ICB programme costs	-85.6
ICB running costs	-22.8
Trust pay	-1,099.8
Other trust operating expenses	-634.2
Non-operating expenses	-37.3
Total expenditure	-2,880.9
Net system position	0.0

Table 4

System risks & mitigations	£m
Planning risks	-100.3
Planning identified mitigations	34.6
Net risks	-65.7
Adidtional risks:	
Covid	-20.4
Non-pay inflation	-19.8
Alignment with other systems	-2.1
Other risks	-0.8
Net risks	-108.9
Unidentified mitigations	108.9
Further non-pay allocation	23.1
Final unidentified mitigations	85.8

It should be noted that while the overall financial position does not allow for the creation of a contingency reserve, there are several planned investments totalling £141m that are funded within the system financial plans, *Table 5* aside provides a summary of the System Investment funding.

Table 5

System investment funding		£m
System Development Funding (SDF)	Non-Rec	43.8
Health Inequalities funding	Non-Rec	3.4
Ockenden maternity funding	Recurrent	2.0
Community non-demographic fundi	Recurrent	4.0
Covid funding	Non-Rec	34.6
ERF funding	Non-Rec	37.0
Capacity funding	Recurrent	4.0
System investment reserve	Non-Rec	11.8
System contingency	Non-Rec	0.0
		140.6

3. ICB Financial Plan

3.1. Within the system position, the plans are identified for the ICB. Plans have been developed in line with the national guidance and represent a full year. Delay to ICB establishment to 1st July, required systems to disaggregate allocations by CCG for Q1. Any utilisation of this allocation in Q1 by the five CCGs will be deducted from the system annual allocation and the residual allocation available to the ICB for the remainder of the financial year. As such, any underspend in Q1 will be available to the ICB from July and similarly any overspend in Q1 will result in a reduced allocation for the ICB for the remainder of the financial year.

3.2. The allocations for the ICB for the full year are included in section 2 of this paper.

3.3. The delivery of a balanced financial plan for 2022/23 is reliant on the delivery of efficiencies within the ICB. This is £15.5m for the financial year. Delivery is summarised below:

Table 6

ICB Efficiencies Planned for 2022/23	Mid & South Essex ICB
	£'000
ICB Area of Efficiencies	
Acute	2,554
Primary Care (inc. Primary Co-Commissioning)	8,403
Continuing Healthcare	3,300
Running Costs	481
Other Programme Services	759
Total ICB Efficiencies	**15,497**
Recurrent / Non-Recurrent Split:	
Recurrent	14,738
Non-recurrent	759
Total ICB Efficiencies	**15,497**

3.4. The breakdown of the ICB expenditure plan is shown below, including the expected element of delivery by the five CCGs for Q1 within the overall annual position.

Table 7

ICB Expenditure 2022/23	Mid & South Essex ICB Full Year	Mid & South Essex ICB Q1
	£'000	£'000
Acute	1,246,655	311,664
Mental Health	209,908	52,477
Prescribing	198,444	49,611
Other Primary Care	45,700	11,425
Primary Care Co-commissioning	192,903	48,226
Continuing Care Services	106,673	26,668
Community Health Services	160,551	40,138
Other Programme Services	37,973	(8,089)
Other Commissioned Services	47,622	11,906
Running costs	22,796	5,699
Total ICB Expenditure	**2,269,225**	**549,724**
Confirmed / Indicative allocations		
Confirmed	2,257,264	546,734
Indicative	11,961	2,990
Total ICB Expenditure	**2,269,225**	**549,724**

3.5. For the CCGs/ICB, the net risks for the financial year were £32.8m prior to the receipt of additional funding which has reduced the unidentified mitigations to £20.6m. It should be noted that this position includes £6.3m of non-recurrent inflationary funding support from NHSE/I.

Table 8

ICB risks & mitigations

Description (all figures in £m)	Risk ICB	Mitigation ICB	**Net ICB**
System identified			
• Effiencies under-delivery	-3.1	3.1	**0.0**
• Continuation of services funded by HDP	-4.3	4.3	**0.0**
• ICB set-up / other cost pressures	-10.1	3.7	**-6.4**
• EEAST Ambulance contract cost pressure	-4.1		**-4.1**
• Provide cost pressure	-1.7		**-1.7**
• Other cost pressures	-2.0		**-2.0**
• ERF Income reduction for under activity	-9.3		**-9.3**
• Further stretch efficiencies and actions to recover lost ERF	0.0	11.6	**11.6**
	-34.5	22.8	**-11.7**
NHSE/I updated risks			
• Additional covid costs	-9.1		**-9.1**
• Known non-pay impact linked to RPI	-0.3		**-0.3**
• Expected energy inflation	-0.5		**-0.5**
• Other non-pay inflation	-11.1		**-11.1**
• System non-pay inflationary funding		12.2	**12.2**
	-21.0	12.2	**-8.9**
Total net ICB risks	**-55.5**	**34.9**	**-20.6**

4. Recommendation

The Board are asked to approve the 2022/23 financial plan for the ICB.

5. Appendices

Appendix A – System Development Funding

Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

Appendix A – System Development Funding

2022/23 SDF allocations - mid and south Essex

	Within allocation	Additional - confirmed	Additional - indicative	Total
Ageing Well		1.5		**1.5**
Cancer		0.7	1.9	**2.6**
CVD, Respiratory & Stroke				**0.0**
CYP		0.2		**0.2**
Diabetes				**0.0**
Diagnostics Programme		3.2	3.2	**6.4**
Emergency & Elective Care			1.1	**1.1**
Health Inequalities				**0.0**
IT & Tech				**0.0**
LD & Autism		1.3		**1.3**
Maternity	2.0	0.7	0.3	**3.1**
Mental Health		11.6		**11.6**
Other SDF / Other Pressures		1.3	2.7	**4.0**
People				**0.0**
Personalised Care		0.3		**0.3**
Prevention		0.1	0.4	**0.5**
Primary Care		10.6	2.3	**12.9**
SCN				**0.0**
SDF Reserve (not used in 22/23)				
System Transformation		0.2		**0.2**
TOTAL SDF	**2.0**	**31.8**	**12.0**	**45.8**
Total Addiitonal Allocation		*31.8*	*12.0*	*43.8*

Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

Part I Board Meeting

Date of meeting	1 July 2022
Agenda item number	14
Title of report	Harmonisation of Commissioning Policies
Purpose of report.	To highlight to the Board to a required programme of work to harmonise currently different commissioning policies over the course of 2022/23.
Executive Lead	Dr Ronan Fenton, Medical Director
Report Author	Jo Cripps, Executive Director, Strategy & Partnerships Dr Pete Scolding, Assistant Medical Director, ICS
Impact Assessments	None, as yet. The completion of impact assessments will be a key part of this work.
Financial implications	An assessment of the financial implications will be a key part of this work.
Details of patient or public engagement or consultation.	This will require pre-consultation engagement as part of developing the pre-consultation business case, including early engagement with Health Overview and Scrutiny Committees.
Conflicts of Interest:	None
Recommendation(s)	The Board is asked to: • Note and approve the work required to address differences in the commissioning policies adopted from predecessor Clinical Commissioning Groups in the context of the ICBs statutory responsibilities to: ○ Improve outcomes in population health and healthcare. ○ Tackle inequalities in outcomes, experience and access ○ Enhance productivity and value for money ○ Help the NHS support broader social and economic development.

Harmonising Commissioning Policies

1. Introduction

As the Integrated Care Board is established, it assumes the functions and responsibilities of the five predecessor Clinical Commissioning Groups (CCGs). There has been a detailed programme of work to transition from the CCGs to the ICB. As part of this work, it was noted that, while the CCGs' commissioning policies were almost fully aligned, there were six clinical treatment areas where the service offer differed. These are:

- Bariatric Surgery
- Breast asymmetry
- Breast reduction
- Female Sterilisation
- Vasectomy
- Tertiary Fertility Services –including
    - Intra-uterine insemination (IUI)
    - In vitro fertilisation (IVF), with or without intra-cytoplasmic sperm injection (ICSI)
    - Donor Insemination (DI)
    - Sperm, oocyte and embryo cryopreservation
    - Sperm and oocyte donation
    - Surgical sperm retrieval

This paper outlines the work required to harmonise these polices over the course of 2022/23.

The Board will be supported in taking decisions about future arrangements through:

- Multi-professional clinical and professional advice.
- Engagement and consultation with residents.
- An assessment of the financial consequences of any decision made.
- An assessment of service capacity and capability to deliver any future changes to commissioning policies.
- Equality and health inequality impact assessments.

2. Main Report

The five CCGs in Mid and South Essex had different commissioning policies. As work commenced to bring the CCGs closer together, most of the commissioning policies, particularly those related to treatments and procedures carried out by the main acute provider, were aligned. However, CCGs at the time agreed to maintain local policies in relation to the six clinical areas described above. These decisions were taken by individual CCGs based on their local population needs, financial position and capacity of local services to respond.

As a starting point the ICB will need to adopt the policies of the five preceding CCGs and note that there is some misalignment as described above. However, as the ICB has taken

on the functions of CCGs, it is now required to harmonise policies which consider the needs of the population of Mid and South Essex as a whole.

The Board is asked to note that the absence of provision in some areas needs to be addressed and to observe a commitment to address disparities while ensuring the ICB can commit to its four key, nationally stated, purposes:

- Improve outcomes in population health and healthcare.
- Tackle inequalities in outcomes, experience and access.
- Enhance productivity and value for money.
- Help the NHS support broader social and economic development.

The Board is asked to note that there is no earmarked funding to address historical disparities.

- As it commences this work the ICB will want to ensure that it:
- Benefits from strong clinical and multi-professional leadership advice.
- Ensures high quality services for the population.
- Is financially sustainable and offers value for money for taxpayer funding.
- Can offer fair and equitable access to services.
- Addresses health inequalities.

Proposed Plan to Resolve Discrepancies

The following steps are outlined to describe, at high level, the plan to enable the ICB to take decisions on resolving the above differences. This will be a complex programme of work.

In order to resolve the historical differences:

- The ICS Clinical and Multi-professional Congress will assess and review each of the six clinical areas above. This work is underway and will be completed by mid-August. A description of this process is provided at Appendix 1.
- The ICB Finance team will complete a financial impact assessment in response to the Congress' findings. This will be completed by the end of August.
- The ICB Communications and Engagement Team will gather existing insight on these areas of policy (e.g. from previous engagement and consultation with residents conducted via CCGs) by the end of July and prepare to undertake pre-consultation engagement.
- Over the summer, colleagues from across the ICB directorates will work together to develop a 'pre-consultation business case' outlining the potential recommendations arising from the above work, and a delivery plan for consultation.
- Work will also be undertaken with providers to review the potential impact of any decisions on provider capacity (for example, in the context of our waiting lists, independent sector provider capacity and specialist provider capacity).
- In September 2022, a pre-consultation business case will be brought before the ICB, including the need to formally consult with residents on the recommendations under consideration, as appropriate.
- If required, a public consultation will be launched by 1 October, running until 24 December (12 weeks).

Teams will prepare a decision-making business case for the ICB to agree at its meeting in February 2023, with adoption from 1 April 2023.

Risks and Mitigations

This is a complex programme of work requiring coordination and support from across the Integrated Care Board directorates. The following risks and mitigations are provided for information:

Risk	Mitigation
Resources required to undertake this work within the above timescale (e.g. across all ICB directorates, including clinical, quality, finance, communications, purchase of healthcare, etc) are significant and need to be planned and resourced.	Resource plan to be agreed by ICB Executives.
For the intervening period between now and decision-making, residents will continue to experience a differential in service offer.	Residents will continue to be subject to the policy according to the location of their registered GP (eg. if registered to a practice in Basildon and Brentwood, the service offered for the registered population by the predecessor CCG would be observed). Adopt an agreed process of dealing with concerns and queries from residents.
Potential delays in the above timeline due to unforeseen circumstances (e.g. the need to observe pre-election periods if a local or general election were to be called)	Watching brief on external factors.

3. Conclusion

The harmonisation of predecessor CCG policies will need to be undertaken. The above plan provides a framework to address these differences while ensuring the ICB fulfils its stated core purposes.

4. Recommendation

The ICB Board is asked to note and approve the work required to address differences in the commissioning policies adopted from predecessor Clinical Commissioning Groups.

5. Appendices

Appendix 1: Clinical and Multi-Professional Congress Process for Reviewing Commissioning Policies

Appendix 1

Clinical and Multi-Professional Congress process for reviewing commissioning policies

The Clinical and Multi-professional Congress (CliMPC) has 15 members drawn from across our health and care system, bringing together experienced colleagues from across sectors, including community care, mental health, patient engagement, pharmacy, primary care, public health, secondary care, social care, urgent and emergency care.

An information pack has been prepared for each area, including:

1. Background information on the health condition concerned and procedure/treatment under review
2. Existing policy across five CCGs
3. Prevalence across system, including activity and deprivation data, with correlations as appropriate
4. The policy decision options to be considered e.g. continue with current variation, fully funded, threshold funding, individual prior approval and not routinely funded.
5. Clinical effectiveness of the treatment
6. Health impact for individuals
7. Cost effectiveness
8. Affordability
9. Health inequalities
10. Strategic fit
11. Practice in other systems where available including relevant commissioning policies.

Review and scoring:

Before a CliMPC meeting, all members will review the information pack and submit a pre-score of each for sections 5-10 above, and an overall pre-session recommendation on a funding option from those listed in section 4.

At a CliMPC session, each section will be discussed to explore members' views (i.e. sections 5-10), After discussion, pre-scoring is reviewed to consider members' views prior to discussion. A decision is then taken on which funding option to recommend.

This recommendation is written up in a report for the Board, along with salient detail from the discussion at Congress.

Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

Part I Board Meeting

Date of meeting	1 July 2022
Agenda item number	15
Title of report	Board Forward Plan
Purpose of report.	To provide the Board with a snapshot of potential future items that will be received by the Board during 2022/23
Executive Lead	Anthony McKeever, Chief Executive
Report Author	Mike Thompson, Chief of Staff.
Impact Assessments	Not Applicable
Financial implications	None related to this paper
Details of patient or public engagement or consultation.	None related to this paper
Conflicts of Interest:	None identified for this paper.
Recommendation(s)	The Board is asked to: • Note the first draft of the Board Forward Plan.

MID & SOUTH ESSEX INTEGRATED CARE SYSTEM

NHS

Mid and South Essex Integrated Care Board

ICB Forward Plan

1 July 2022

	July	Sept	Oct	Nov	Dec	Jan 23	Feb	Mar
Strategy	Draft People & Communities Strategy Finance Strategy	Delegation framework (local) Draft Proposals for all age Mental Health strategy Children's Partnership Plan	NHSE Delegation for Specialised Commissioning, Dental, Optometry & Pharmacy Frameworks		Draft Integrated Care Strategy			5 Yr Plan Sign Off
		Pre Consultation Case - Community Beds Proposals		Mental Health Strategy Implementation Update	Quality Strategy Progress	Decision Making Business Case – Community Beds	Compacts/ MoU refresh 23/24	
Operational Plans		Urgent & Emergency Care winter 23/24 proposals		Winter plan (22/23)		Draft 2023/24 operational plan		2023/24 Operational Plan and budgets
		Commissioning Policies			NHSE Delegation proposals (specialised comm, dental pharmacy, optometry)			NHSE Delegation Agreements
Alliance Development		Alliance plans			Delivery Plans Progress	23/24 draft delegation framework		Delegation approval/ delegation agreements.

	July	Sept	Oct	Nov	Dec	Jan 23	Feb	Mar
People & Workforce		People Board Review	People Strategy Progress					
Population Health & Stewardship		Stewardship Update	Refreshed Population Health Management Strategy					
Inequalities			Draft Health Inequalities strategy			Inequalities Fund Progress Report		
Estates		Estates Strategy						
Business Case Approvals								
				362				