Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

Governance Handbook

February 2025

(Update in progress)

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1. Functions, Delegation and Decisions

1.1. ICB Functions Map, including Committee Structure

1.2. Scheme of Reservation and Delegation, including Schedule of Detailed Delegated Financial Limits

Residents of Mid and South Essex

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

Assurance

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.

Decision Making

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

Assurance

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.

Advisory

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

Decision Making

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.

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**

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.	Constitution 1.6.2, Standing Orders 2.1.3, 2.1.4
	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.	Constitution 1.6.2, 1.7.2, 4.4.2, Standing Orders 2.1.3, 2.1.4
	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
	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

	Decisions and functions reserved to the Board	Reference
	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.	
	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.	

	Decisions and functions reserved to the Board	Reference
The Board	**Appointments/Dismissal** Appoint the Ordinary Members of the Board, exercised by the Chair.	Constitution 2.1.5, 2.2.2, 2.2.4
	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.	Constitution 3.13
	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.	Constitution 4.6.1
	Appointment of Internal or External Auditors and the Counter Fraud officer following recommendations from the Audit Committee.	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.	Constitution 7.2.8
	Approve and publish an Integrated Care System Plan and Capital Resource use Plan.	Constitution 7.2.8, 7.4.1
	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.	Constitution 1.4.7
	Approve annually (with any necessary appropriate modification) the annual refresh of system plan.	

	Decisions and functions reserved to the Board	Reference
	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 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.	
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 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 Committee shall have oversight of and responsibility for approving the governance arrangements of the ICB (including the delegation of functions to and from the ICB). The Audit Committee shall review instances of non-compliance with Standing Orders. The Audit Committee shall approve policies for which it is the sponsoring committee. The Audit Committee shall receive a report of any decisions made using Constitutional provision for 'urgent decisions'.	Standing Orders 3.1.6 Standing Orders 4.9.6
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).	Constitution 3.14.1, 8.1.6

Committee	Decisions and functions reserved to the Committee	Reference
	- 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. The Remuneration Committee shall establish a Non-Executive Remuneration Panel to consider and agree arrangements for remuneration of Non-Executive Members. The Remuneration Committee shall approve policies for which it is the sponsoring committee.	Constitution 3.14.1
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 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, including: - Agree the financial framework including annual budgets and commissioning intentions. - Make investment and disinvestment decisions /recommendations - Receive assurance on delivery of financial performance - Investigate any activity within its terms of reference.	

Committee	Decisions and functions reserved to the Committee	Reference
	The Finance & Investment Committee shall approve policies for which it is the sponsoring committee. The Finance & Investment Committee has established sub-groups for the oversight of medicines optimisation, commissioning prioritisation and for processing appeals to procurement decisions made under the Provider Selection Regime.	
Executive Team (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: - Make investment and disinvestment decisions / recommendations in accordance with the Detailed Delegated Financial Limits - Oversee the operational functions of the ICB - Provide assurances to the ICB Board and relevant sub-committees as required - Approve minor changes to service restriction policies as recommended by the Medical Director and refer complex / controversial changes for decision at appropriate committee / ICB Board.	
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. The Quality Committee shall approve policies for which it is the sponsoring committee.	Constitution 7.4.1

Committee	Decisions and functions reserved to the Committee	Reference
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. 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. The Primary Care Commissioning Committee shall approve policies for which it is the sponsoring committee.	
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.	

Committee	Decisions and functions reserved to the Committee	Reference
	The committee has specific delegated responsibility for managing the ICB element of the Better Care Fund (BCF) and associated iBCF investment, in accordance with the schedule of detailed financial delegated limits.	
Clinical & Multi-professional Congress ("The Congress")	The Congress 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 leadership to the system as well as involvement, advice and support to service development and transformation programmes. The Congress shall lead on Stewardship. The Congress 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). The Congress shall approve policies for which it is the sponsoring committee.	
People Board	The Committee (Board) 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 strategic leadership to ensure the implementation of the People Plan and Integrated Health & Care Workforce Strategy and associate workforce plans.	
Digital, Data and Technology Board	The Committee (Board) 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 strategic leadership and oversight of overall digital delivery plan for the system.	
System Leadership / Partner Groups	The system has established the following system leadership/partner groups (for example): • Chief Executive Forum • System Finance Leaders Group	

Committee	Decisions and functions reserved to the Committee	Reference
	• Clinical Leaders Forum • Transformation & Improvement Boards • System Quality Group • System Projects, Programmes & Performance The groups have no delegated powers beyond those delegated to officers by their respective organisations, 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.	

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	Section 75, NHS Act 2006	Section 75 Agreement

	the duties set out within the Act. All governance arrangements are defined within Section 75 Agreements as if written into the SORD.		

Decisions and functions delegated by the Board to other statutory bodies

Body	Decisions and functions delegated by the Board	Legal power	Governing arrangements
Hertfordshire and West Essex Integrated Care Board	For the operational management of the following services as defined within supporting delegation agreements / memorandum of understanding, as approved by the Board as if written into the Scheme of Reservation and Delegation: - Community Pharmacy and Optometry Contract Management - Children and Young People Mental Health Services - Home Oxygen Service	S65Z5 of the 2006 Act	Memorandum of Understanding and delegation agreement. Children's Commissioning Collaborative Agreement via the Executive Children's Commissioning Collaborative Forum.
Bedfordshire, Luton and Milton Keynes Integrated Care Board	For the operational management of the following services as defined within supporting delegation agreements / memorandum of understanding, as approved by the Board as if written into the Scheme of Reservation and Delegation: - Specialised commissioning of services not retained by NHS England.	S65Z5 of the 2006 Act	Memorandum of Understanding and delegation agreement. Collaborative working agreement for specialised services.

Suffolk and North East Essex Integrated Care Board	For the operational management of the following services as defined within supporting delegation agreements / memorandum of understanding, as approved by the Board as if written into the Scheme of Reservation and Delegation: - Individual Placement Team - Contract management of the East of England Ambulance Service NHS Trust	S65Z5 of the 2006 Act	Memorandum of Understanding and delegation agreement. Collaborative working agreement for specialised services.

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
	Appoint the Vice Chair of the Board.	Constitution 3.11.8

Board Member / employee	Decisions and functions delegated by the Board	Reference
	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
	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.	

Board Member / employee	Decisions and functions delegated by the Board	Reference
	Operational Responsibilities To approve and be the signatory of delegation agreements on behalf of the ICB.	
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. 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.	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 Constitution 7.4.1

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 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. The Director of Resources may temporarily delegate functions to be undertaken in their absence to an appropriate deputy. To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	
Executive 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 and innovation); clinical and multi-professional leadership support; Stewardship; Individual Funding Requests; Quality and Governance (Clinical and Multi-Professional Congress); Clinical Pathways and Medicines Optimisation. To be the lead Executive Officer ensuring appropriate advice and explanations are provided to the Clinical & Professional Congress. To ensure that adequate processes are in place for the management of Specialised Commissioning as delegated by NHS England, providing assurance in that regard to the Board.	

Board Member / employee	Decisions and functions delegated by the Board	Reference
	To oversee, review, advise upon and recommend changes to service restriction policies for approval by the Executive Team or wider committees / Board accordingly. To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	
Executive Chief Nursing Officer (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. To be the lead Executive Officer ensuring appropriate advice and explanations are provided to the Quality & Safety Committee. To act as the Board designated lead (and supported by other Executive Officers) for: - Children and young people (aged 0-25) - Children and young people with special education needs and disabilities (SEND) - Safeguarding (all-age), including looked after children - Learning disability and autism (all-age) - Down syndrome (all-age) To act as the System Director of Infection Prevention and Control.	Constitution 1.4.7, 7.2.8, 7.4.1 Constitution 7.2.4

Board Member / employee	Decisions and functions delegated by the Board	Reference
	To manage the commissioning Teams responsible for Mental Health and Babies, Children and Young People services focussing on workstreams to oversee contractual performance (alongside the quality Team) and work collaboratively for service transformation. 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.	
Executive Chief People Officer	**Strategy, Annual Operational Plan and Budgets** Develop and present to the Board for approval, proposals for organisational development. Develop and present to the Board for approval, the Equality and Diversity Strategy; having overarching responsibility for the delivery of employer responsibilities for equality, diversity and inclusion (and associated national reporting) as well as the co-ordination of wider equality, diversity and inclusion responsibilities delivered by the Strategy and Corporate Services Directorate. **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, designed to fulfil the ten designated people functions. 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.	
Executive Director of Strategy and Corporate Services	**Regulations and Control** Ensure processes are in place to comply with Local Authority Health Overview and Scrutiny Requirements.	Constitution 7.3.4

Board Member / employee	Decisions and functions delegated by the Board	Reference
	Report urgent decisions to the Board for ratification.	Standing Order 4.9.6
	Annual Reports and Accounts Preparation of the Annual Report in accordance with relevant guidance and regulations.	Constitution 7.4.1
	Statutory Functions / Duties 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
	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.	Constitution 1.4.7, 7.2.8, 7.4.1, 9.1.1, 9.1.2, 9.1.3
	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.	Constitution 1.4.7
	Ensure systems are in place to reduce inequalities (Section 14Z35) and report on the discharge of these duties within the Annual Report.	Constitution 1.4.7, 7.2.8, 7.4.1

Board Member / employee	Decisions and functions delegated by the Board	Reference
	In accordance with section 14Z38 of the Act establish arrangements for obtaining appropriate advice.	Constitution 1.4.7
	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.	Constitution 1.4.7, 7.2.8, 7.4.1
	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.	Constitution 1.4.7
	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
	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 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.	Constitution 9.1.7

Board Member / employee	Decisions and functions delegated by the Board	Reference
	To act, on behalf of the Chief Executive, as the Gold Commander where necessary. To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice: Community Pathways; Acute Delivery; Performance and Analytics; Emergency Planning; and Operations and Resilience.. 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. **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.	Constitution 7.2.8 Constitution 7.2.8
Executive Chief Digital and Information Officer	**Operational Responsibilities** To undertake the role of Chief Information Officer. To ensure the ICB complies with legislation and guidance related to the protection of data, working alongside the SIRO and Caldicott Guardian. Establish adequate arrangements to discharge ICB duties in relation to the Freedom of Information Act 2000 and Information Commissioner Office requirements. To provide the operational services for Corporate IT and Primary Care Digital Services. To work collaboratively with partners to deliver the digital transformation agenda and national asks. To provide ongoing assurance of cybersecurity, business continuity, privacy, and data protection. To ensure the efficient collection, and the timely and appropriate distribution	Constitution 7.2.5

Board Member / employee	Decisions and functions delegated by the Board	Reference
	of information to support operational and strategic decisions.	
Alliance Directors	**<u>Operational Responsibilities</u>** 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 with responsibility for tackling health inequalities at a local level. Be accountable for delivery of Alliance Plans and the ICB element of the Better Care Fund and the way in which BCF funds are utilised. To be the lead Executive Officer ensuring appropriate advice and explanations are provided to their respective Alliance and the ICB. Being responsible for local partnership working, engagement with communities and the delivery of public health, early intervention models of prevention. The Basildon and Brentwood Alliance Director has specific responsibility for Primary Care Development and the management of Primary Care Commissioning including GPs, Pharmacy, Optometry and Dental Services (Primary Care Delegated functions and Primary Care Networks Development); 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. To act as the Freedom to Speak Up 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.	
Budget Holders	To fulfil budget holder duties as set out within the Standing Financial Instructions and in accordance with the delegated limits set out within.	

Board Member / employee	Decisions and functions delegated by the Board	Reference
	To be accountable for and sign contracts within their budgetary remit (Directors and above), where approval for the contracted service is complete in accordance with this scheme of reservation and delegation e.g. The Director of Primary Care signing primary care contracts.	

Decisions and functions delegated to the Board by other statutory bodies

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, Pharmacy, Optometry and Dentistry and Specialised 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, Pharmacy, Optometry and Dentistry. • Planning Primary Medical Services, Pharmacy, Optometry and Dentistry in the Area, including carrying out needs assessment. • Undertaking review of Primary Medical Services, Pharmacy, Optometry and Dentistry 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, Pharmacy, Optometry and Dentistry with other health and social care bodies in respect of the Area where appropriate; • For the operational management of those specialised services delegated by NHS England; 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 (Primary Care). Delegation Agreement for Specialised Services.

Schedule of Detailed Delegated Financial Limits

Provision	Who can authorise	Notes
1. Virements *Movements between care areas to be signed off by the Medical Director or Executive Chief Finance Officer*		
a. Within cost centre	Budget Holders	Note 1
b. Between cost centre in same directorate and care area	Budget Holders	Note 1
c. Between directorates but in same care area	Executive Directors	Or nominated deputy
d. Between care areas	Executive Chief Finance Officer and Medical Director	
e. New allocations (specified use)	Executive Directors	Or Senior Finance Manager
f. New allocations (general)	Executive Directors	Or nominated deputy

Provision			Who can authorise	Notes
2.	**Approval Limits for committing expenditure and service contracts, including variation of contracts, but excluding staff pay costs (see notes 2 & 3)**			*Business cases to be presented in accordance with the Decision Making Policy.*
	a.	**Within existing agreed budgets**		
	i.	< £100,000 (and within budget holder limits)	Budget Holders	Note 1
	ii.	< £250,000	Executive Director	
	iii.	£250,000 - £5,000,000	Executive Team	
	iv.	£5,000,000 - £10,000,000	Finance and Performance Committee	
	v.	> £10,000,000	ICB Board	
	b.	**In-year proposals with no budgetary provision**		
	i.	< £100,000 (and within budget holder limits)	Executive Team	
	ii.	£100,000 - £2,500,000	Finance and Performance Committee	
	iii.	> £2,500,000	ICB Board	
	c.	**Approval of invoices within approved contract values:**		
	i.	< £1,000,001	Budget Holders	Note 1
	ii.	£1,000,001 - £10,000,000	Executive Director	
	iii.	£10,000,000 - £25,000,000	Executive Chief Finance Officer	Or Deputy Director of Finance
	iv.	> £25,000,000 to NHS providers with MSE system	Executive Chief Finance Officer	Or Deputy Director of Finance
	v.	> £25,000,000 with other providers	Executive Chief Finance Officer	
	d.	**Approval of expenditure greater than tender price / business case. Subject to remaining within approval and tender limits identified above**		
	i.	< 10% of approved tender	Chief Executive Officer or Executive Chief Finance Officer	
	ii.	> 10% of approved tender or business case would require review of need and affordability in accordance with the business case process identified in 2 (above).	Follow the limits as per business case section 2. Above.	

Provision	Who can authorise	Notes
3. Quotation, tendering and contract procedures for expenditure / income proposals, whether capital or revenue, purchases or disposals of non-clinical services / products procured in accordance with the Public Contract Regulations (2015)	*To clarify, these limits relate to contracts where the ICB is the contracting authority. Where another system partner is the contracting authority, that organisations 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 of 2 verbal quotations)	Budget Holders	Note 1
b. £5,001 - £50,000 (minimum 3 written quotations)	Budget Holders	Note 1
c. NON-CLINICAL GOODS / SERVICES (inc VAT)		
i. £50,001 - £213,447	Executive Director	
ii. > £213,447	Executive Director	
d. CLINICAL GOODS / SERVICES (inc VAT)		
iii. £50,001 - £663,540	Executive Director	Note 1
iv. < £663,540	Executive Director	
e. Waiving of quotations and tenders subject to SOs and SFIs	Executive Chief Finance Officer	All waivers to be reported to Audit Committee.

Provision	Who can authorise	Notes
4. Arrangements for the discharge of responsibilities under the Health Care Services (Provider Selection Regime) Regulations 2023.	*All provisions set out below may be authorised in accordance with the thresholds set out under section 2.*	
a. Complete and approve direct award without competition	Executive Directors	Or Budget Holders or Attain
b. Approval of 'most suitable provider'	Executive Directors	Or Budget Holders or Attain
c. Approval of PSR competitive process	Executive Directors	Or Budget Holders or Attain
d. Review and response to Provider representations	Provider Selection Regime Review Group	
e. Secondary review subsequent ICB response to Provider representations	NHS England Independent Panel	

Provision		Who can authorise	Notes
5. Management of Budgets/Expenditure for Staff Pay, Agency and Consultancy			
a.	Engagement of staff not on the Establishment (within available budget and full year cost) – costs per employee:		
i.	> £50,001	Executive Director	
ii.	£50,001 - £100,000	Chief Executive Officer or Executive Chief Finance Officer	Prior approval required from NHSE for contract appointments
iii.	£100,001 - £250,000	Chief Executive Officer AND Executive Chief Finance Officer	Prior approval required from NHSE
iv.	> £250,001	Chief Executive Officer AND Executive Chief Finance Officer Reported to Remuneration Committee for information and scrutiny EXCEPT, if the appointment relates to CEO or CFO (in iii or iv above) the process will be reviewed by Remuneration Committee and recommended to the ICB Board for approval.	Prior approval required from NHSE
v.	IN ADDITION, for the recruitment agency / contract staff, all contract with either a total value of £50,000 or above, a day rate of £600 or greater and/or contracts that exceed 6 months.	> £600 per day – NHSE Regional Rep > £800 per day – NHSE CFO > £900 per day – NHSE Regional & National	Require NHSE prior approval.

Provision	Who can authorise	Notes
6. Signing of Contracts and contract variations		
a. Signing of contracts (including Grants, MOUs and LOAs) where due process has been followed i.e. procurement / funding approved / business case processes (as evidence in the contract governance form).	Budget Holders, or Executive Directors, or Executive Chief Finance Officer, or Chief Executive Officer.	Note 1
b. Signing of contracts or documentation related to services that are delegated to another ICB to deliver on behalf of Mid and South Essex ICB.	Executive Directors	

Provision		Who can authorise	Notes
7. Primary Care Commissioning			
a. Investment in Primary Care Contractors (General Medical Services, Pharmacy, Optometry and Dentistry) within existing budgets or nationally defined entitlement:			
i.	< £250,000	Executive Director	Director of Primary Care
ii.	£250,000 - £1,000,000	Executive Team or Executive Chief Finance Officer of Chief Executive Officer	
iii.	£1,000,000 - £5,000,000	Primary Care Commissioning Committee	
iv.	£5,000,000 - £10,000,000	Finance and Performance Committee	
v.	> £10,000,000	ICB Board	
b. Investment in Primary Care Contractors (General Medical Services, Pharmacy, Optometry and Dentistry) outside of existing budget:			
iv.	< £250,000	Executive Team or Executive Chief Finance Officer or Chief Executive Officer	
v.	£250,000 - £1,000,000	Primary Care Commissioning Committee	
vi.	£1,000,000 - £5,000,000	Finance and Performance Committee	
vii.	> £5,000,000	ICB Board	
c. 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 Primary Care Commissioning Committee.	

Provision		Who can authorise	Notes
8. Better Care Fund (see note 4)			
a. Approval of the ICB element of BCF investment within existing budgets:			
	i. < £250,000	Executive Directors	Alliance Director
	ii. £250,000 - £1,000,000	Executive Directors	2 x Alliance Directors
	iii. £1,000,000 - £3,000,000	2 x Executive Directors **AND** Executive Chief Finance Officer or Chief Executive Officer	
	iv. > £3,000,000	To follow section 2 above.	
b. Approval of the ICB element of BCF investment outside of existing budgets.		To follow section 2 above.	

Provision	Who can authorise	Notes
9. Continuing Healthcare		
a. Approving Continuing Healthcare packages of care:		
i. Up to agreed standard rate per week	CHC Business Manager	
ii. Up to annual equivalent £100,000	Operational Lead	
iii. Up to annual equivalent £150,000	Head of CHC / Deputy Chief Nurse	
iv. Over annual equivalent £200,000	Executive Chief Nursing Officer	
b. Patient Transport (journeys outside of contract)	Any posts identified in 9a.	

Provision	Who can authorise	Notes
10. Losses, Write Off and Compensation		
a. Losses due to theft, fraud, overpayment, fruitless payments, non-contracted activity, compensation payments:		
i. < £5,000	Executive Chief Finance Officer **OR** Chief Executive Officer	
ii. £5,000 - £25,000	Executive Chief Finance Officer **AND** Chief Executive Officer	
iii. £25,000 - £100,000	ICB Board	
iv. > £100,000	ICB Board	And reported to NHSE 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 20 days):		
i. < £10,000	Chief Executive Officer **OR** Executive Chief Finance Officer **AND** Executive Chief Nursing Officer	
ii. > £10,000	Chief Executive Officer **AND** Executive Chief Finance Officer **AND** Executive Chief Nursing Officer	
c. Write off of non-NHS debtors:		*All instances of losses or write off will be reported to the audit committee.*
i. < £500	Executive Directors	
ii. > £500	Chief Executive Officer **OR** Executive Chief Finance Officer	
d. Special severance or retention payments	Reserved by NHS England	

Notes:

1. Limits for Budget Holders will be set on a case-by-case basis up to the maximum limits shown in the schedules.
2. Approval limits include commitment of expenditure (approval of business cases), authorising requisitions / order / invoice and the signing of contracts and grants.
3. Approval of commitment of expenditure relates to the total and aggregate value of any contracts over its full term.
4. Approval of BCF investments for Essex will need to be signed by at least two Ads to reflect the arrangements of the Essex BCF impacting on three Alliances.

Definitions:

Full Title	Short Title	Description
Executive Directors	Exec Dir	All Executive Directors of the ICB with a line report to the Chief Executive Officer
ICB Chief Executive Officer	CEO	The ICB Chief Executive Officer
Executive Chief Finance Officer	CFO	The ICB Executive Chief Finance Officer
Medical Director	MD	The ICB Executive Medical Director
Executive Chief Nursing Officer	CN	The ICB Executive Chief Nursing Officer
Deputy Director of Finance	DDoF	Named Directors and Deputy Directors of Finance within the Finance and Estates Directorate
Director of Primary Care	Dir PC	Director of Primary Care
Deputy Director for Primary Care Development	DD PC	Deputy Director for Primary Care Development
Alliance Director	AD	Alliance Directors for Basildon & Brentwood, Mid Essex, South East Essex and Thurrock
Deputy Chief Nursing Officer	Deputy CN	The ICB Director of Nursing reporting to the CN.
Head of Continuing Healthcare	Head of CHC	The Deputy Director for All Age Continuing Care
Continuing Healthcare Business Manager	CHC Business Manager	Nominated CHC Business Managers, CHC team to maintain register.
Operational Lead	Operational Lead	Nominated CHC Operational Leads. CHC team to maintain a register.
Budget Holder	Budget Holder	Any nominated budget holder. The limits in this SoDDFL 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	Deputy Directors of Finance or their line reports. For allocation of new budget allocations (virements) where the use is specified and thus no decision on which are area the funding is to be allocated to is needed.
Nominated Deputy	ND	A deputy can be nominated by the authorising officer.

Committee Name:	
The ICB Board	Board
Finance and Performance Committee	FPC
Audit Committee	Audit
Primary Care Commissioning Committee	PCCC
Remuneration Committee	RemCom
Executive Team	Exec

2. Terms of Reference (TOR) and Management of Meetings

Mid & South Essex Integrated Care Board

Executive Team

Terms of Reference

1. Constitution

1.1 The Executive Team (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 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 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 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 purpose of the Committee is as follows:

3.2.1 To provide oversight and assurance to the Board regarding the operational management of the ICB and delivery of its strategic objectives.

3.2.2 To contribute to the overall delivery of the ICP's objectives to create opportunities for the benefit of 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 proposed business cases / decisions ensuring support of system recovery
- Recommending the strategic direction
- Robust decision making (approval of/providing support for investment /disinvestment/decommissioning decisions in line with the ICB Scheme of Reservation and Delegation)
- Identify key issues and 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 Committee has no executive powers, other than those delegated in the SoRD and specified in these ToR and those held by the individual attending the meeting.

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 11 members of the Committee who shall directly report to the Chief Executive Officer.

4.4 Membership will comprise:

- Chief Executive Officer
- Executive Chief People Officer
- Executive Chief Finance Officer
- Executive Chief Nurse
- Executive Medical Director
- Executive Director of Strategy and Corporate Services
- Executive Director of System Recovery
- Chief Digital Information Officer
- Alliance Director, Basildon and Brentwood
- Alliance Director, Mid Essex
- Alliance Director, South East Essex
- Alliance Director, Thurrock

Chair and vice chair

4.6 The Chair of the Executive Committee will be the Chief Executive Officer.

4.7 The Chair of the 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:

- Director of Communications and Partnerships
- Chair of ICB Oversight Group (IOG).

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

5. Meetings Quoracy and Decisions

5.1 The Committee will meet at least 12 times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Meetings will be planned weekly subject to there being necessary business to transact.

5.3 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.

5.4 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

5.4 For a meeting to be quorate a minimum of 6 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 a virtual meeting (either via email, video or conference call) of at least 6 members to reach a quorate decision.

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 To ensure appropriate multi-professional diligence, scrutiny, and strategic alignment over the operation of the ICB and the delivery of its objectives

- To ensure our people our empowered to deliver the projects and programmes that support the achievement of objectives.
- To be responsible for the ICB Equality, Diversity, Inclusion and belonging agenda, ensuring compliance with legislation and best practice, and creating an inclusive culture.
- To support and contribute to financial sustainability through robust decision making as delegated through the SORD.
- To ensure consistent message across the ICB in relation to its strategic direction and the delivery of financial turnaround.
- Review and collective ownership of finance, quality, performance, and operations ahead of formal scrutiny by Board sub-committees.
- To oversee and own the corporate risk register ensuring it is regularly updated and actions are being taken to address identified risks.
- To provide advice, guidance and clear decision making to the Senior Leadership team.
- To support the Board and other sub committees of the board to discharge their responsibilities effectively.
- To set the standard and example for matrix working across the ICB
- To oversee the response to regulatory review (e.g., NHSE, CQC).

6 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.

7 Accountability and reporting

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

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

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 decisions 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.

8.8 The ICB Operational Group (IOG) shall be accountable to the Executive Committee and ensure that proposals to the Executive Committee have completed all relevant due diligence and are supported by key stakeholders.

8.9 The ICB Inclusion and Belonging Group shall be accountable to the Executive Committee and ensure that proposals to the Executive Committee have completed all relevant due diligence and are supported by key stakeholders.

8 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.
- Notes of the meeting are taken (the meeting will not be formally minuted), but a robust register of decisions will be maintained, and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept, in accordance with the standing orders.
- 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.

9 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: 11 July 2024

Date of review: 11 July 2025

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.
- Establish sub-committees/groups for the discharge of functions associated with the audit committee responsibilities e.g. Information Governance Steering Group and Health and Safety Committee.
- 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 transform 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 Member 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 and 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:

- Non-Executive Member, Audit Committee Chair (Chair)
- Partner Board member
- Associate Non-Executive Member

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

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.

The Associate Non-Executive Member shall be the Vice Chair. Although not a member of the ICB Board, the Associate Non Executive member shall attend the Board alongside the Partner Board Member to provide feedback on audit committee business where the Audit Committee Chair was absent for a 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:

- Executive Chief Finance Officer 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 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 and 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 that the ICB acts consistently with the principles and guidance established in HM Treasury's Managing Public Money.

To seek reports and assurance from directors and managers as appropriate, concentrating on the ICB's systems of 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. This will be undertaken by reviewing 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 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 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, counter fraud self-review assessment submissions and discuss NHSCFA quality assessment reports.

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, including those relating to IT security and the annual Data Security & Protection toolkit audit.

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 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 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:

- Integrity of the Financial Statements of the ICB.
- 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.

The Committee shall receive reports on compliance with the training requirements for conflicts of interest at least twice annually and ensure that processes are operating effectively that staff are adequately trained.

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.

Health and Safety

The Committee shall receive assurances from the Health and Safety Group that the ICB fully complies with the Health and Safety Act and all other associated legislation.

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 reduce the environmental impact of its services, including progress against the NHS Net Zero strategy.

Management

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

To receive reports on compliance with mandatory training.

Delegated Authority

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

- Approving 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.

Policies and procedures

The policies and procedures approved as the sponsoring committee for those associated with its remit of work, shall be reported to the Board.

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.

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: 11 July 2024

Date of review: April 2025

Appendix 1

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's policy on pay 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:

- Executive Chief People Officer 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 bi-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 via 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 The committee has delegated authority via the Scheme of Reservation and Delegation to approve on behalf of the ICB Board or endorse new and/or significant amendments for the Board, of policies and procedures within its remit.

6.1.6 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.

Policies and procedures

7.6 The policies and procedures approved by Remuneration Committee as the sponsoring committee for those associated with its remit of work, shall be reported to the Board.

Confidentiality

7.7 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.

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. 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 Board approval: 11 July 2024

Date of next review: April 2025

Mid and South Essex Integrated Care Board

Finance and Performance Committee

Terms of Reference

1. Constitution

1.1 The Mid and South Essex Integrated Care Board (MSE ICB) Finance and Performance 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 and Performance Committee is a formal committee of the MSE ICB, which has delegated authority from the MSE ICB details of which are set out in the Scheme of Reservation and Delegation (SoRD). The Committee holds only those powers as delegated in these Terms of Reference as determined by the 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 MSE 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 to take forward specific programmes of work as considered necessary by the Committee's members, to support the discharge of their duties. 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 SoRD but may not delegate any decisions to such groups.
- Establish sub-committees to support the discharge of relevant or related ICB functions.

2.3 At the point of review of these terms of reference (June 2024) the Finance and Performance Committee has the following sub-committees:

1) Integrated Pharmacy Medicines Optimisation Committee (IPMOC) - this group will report quarterly to the Committee unless there is a need to escalate between times.
2) Provider Selection Regime (PSR) Review Group – this group will only report as required to the Committee as it only meets if there is representation from Providers on a decision that has been made.

2.4 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 oversee the performance of MSE ICB in delivering its finance and performance national targets and objectives, ensuring the effective and efficient use of resources, whilst working towards/delivering financial balance.

3.2 The Committee will contribute to the overall delivery of the ICB objectives and Integrated Care Partnership (ICP) strategy through the oversight and assurance of:

1. Annual system and ICB finance and performance planning, including appropriate scrutiny of provider partner plans to the extent that they form part of the overall system finance and performance plan. Monthly finance and performance monitoring, including quarterly system deep dives.
2. Medium-term financial and performance planning including the development and performance against the System Financial Recovery Plan.
3. Providing regular assurance updates to the ICB Board via the Chair's finance and performance report and minutes of the committee.
4. The committee may be requested by the Board, or Chief Executive, to undertake specific oversight and assurance, related to their role within the overall ICB and system governance structure.

3.4 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.

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 7 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 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 matters.

4.4 Membership will comprise:

- Non-Executive Member of the Board (Chair) or External Chair

- Two Associate Non-Executive Members or Chairs of Finance Committees from intra-system NHS Foundation Trusts
- A third independent Associate Non-Executive Member
- Chief Executive, MSE ICB
- Executive Chief Finance Officer, MSE ICB
- Executive Director of Strategy & Corporate Services, MSE ICB
- System Medical Director, MSE ICB
- Executive Director of System Recovery
- Local Authority Partner Member

4.5 On a quarterly basis the Executive Chief Finance Officers from MSEFT and EPUT will attend for 'deep dive' sessions on system financial sustainability and performance.

Chair and vice chair

4.6 The Committee will be chaired by a Non-Executive Member of the Board with the relevant skills and experience to chair the Finance and Performance Committee, appointed by the Chair of the ICB.

4.7 The 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:

- Executive Chief Finance Officer, MSEFT (or nominated Deputy)
- Executive Chief Finance Officer, EPUT (or nominated Deputy)
- ICB Executive Directors, including the Chief Digital Information Officer
- Local Authority Partner Member Finance Officers
- MSE ICB Director of Oversight & Assurance
- MSE ICB Director of Commercial
- MSE ICB Director of Finance
- MSE ICB Deputy Director of Finance – Analytics and Performance
- Director of Pharmacy and Medicines Optimisation (ref: IPMOC)
- Deputy Director of Contracting (ref: PSE Review Group)

4.11 The NHSE Regional Chief Finance Officer (or nominated deputy) may attend meetings periodically when the System is in escalation owing to its financial performance.

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 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 matter including representatives from health partners.

Attendance

4.14 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.

4.15 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 Finance and Performance Committee is not a meeting held in public. 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 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 of the Committee are required, including the Chair or Vice Chair of the Committee and the Executive Chief Finance Officer 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 or their nominated deputy 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 by 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 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 known as 'Chairs Action' 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 Oversight Framework

- To receive assurance regarding the arrangements for discharging and implications of the ICBs responsibilities in respect of the following themes under the NHS System Oversight Framework (SOF):
  - Finance – including use of resources.
  - Performance – including access and outcomes.
  - Local – strategic priorities.

6.1.2 System financial management framework:

- To oversee the joint obligation to achieve financial balance/agreed financial plan in line with published guidance and collaborative in whole system balance.
- To oversee and monitor delivery of the financial performance of the ICB and providers partners, through regular reporting on all aspects of the ICB and system financial performance.
- 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 considered in financial decision-making and that all impact assessments have been appropriately completed and considered.

6.1.3 Resource allocations (revenue)

- To agree the approach for distribution of the resource allocation via agreement of the ICB Budgets on an annual basis.
- To receive regular reports and planning updates regarding the deployment of system-wide transformation funding and one-off resource provided to the ICB on behalf of the system.
- The committee can seek the advice of the Senior Finance Leadership Group (SFLG) on any matters it feels necessary.

6.1.4 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.

6.1.5 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 identify and agree common approaches across the system such as financial reporting, estimates and judgements.
- 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 oversee the development of financial and activity modelling to support the ICB priority areas.
- 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 ensure the appropriate information is available to manage financial issues, risks, and opportunities across the ICB.
- To review financial and associated risks against the system financial target and the ICBs own financial targets and made recommendations to address risks that are not tolerable to the ICB and wider system.
- To agree key outcomes to assess delivery of the ICBs financial strategy (including financial recovery programme).
- 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 considered when assessing the financial position.

6.1.6 Performance:

- To receive regular contract performance reports (covering contract management, activity, cost, and quality) for each of the ICB's' main areas of commissioning expenditure.
- To review assurance on performance against the delivery of the relevant core ICB's Strategies and Operational Plan through regular reporting on delivery and the ICB Board Assurance Framework, providing recommendations to SOAC where rectifying actions are required.
- To review assurance on progress and achievement against key national, regional, and local targets for service improvement, with a particular focus on

delivery of the annual planning requirements.

- To make recommendations to the Board on developments to the System Performance Assurance Framework.
- To receive and review in year monitoring reports covering all national constitutional standards, any additional national or regional performance requirements as specified by NHSE, local priorities targets, patient outcome measures and inequality performance.
- To provide assurance on system performance improvement plans and recovery trajectories, making recommendations to SOAC in-year on corrective actions, and oversee progress on performance against such plans on a regular basis, seeking SOAC escalation to the Board in relation to any serious concerns or deviation from plan.
- To review assurance on progress and achievement against outcomes and targets agreed with partner organisations.
- To oversee the management of the system financial target and the ICB's own financial targets (as set out above).
- 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 considered when assessing the financial position.

6.1.7 System efficiencies:

Given the governance arrangements for financial recovery, the following items will be managed through separate governance and reported through to the committee:

- 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.
- Agreeing strategies to reduce variation and improvement outcomes by maximizing efficient and effective use of non-financial and financial resources.
- To review exception reports on any material breaches of the delivery of agreed efficiency improvement plan including the adequacy of proposed remedial action plans.

6.1.8 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.

- To scrutinse and support capital business cases to ensure alignment with system objectives, efficiency expectations and affordability of on-going revenue consequences.

6.1.9 Board Assurance Framework:

- Review and monitor those risks on the BAF and Corporate Risk Register which relate to finance and performance 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.

6.1.10 Investment & Procurement:

- To oversee procurement and contracting activity (business cases / service proposals) of the ICB, providing assurance to the Board that these activities have been conducted in a manner that meets the legal, statutory, regulator and other obligations of the ICB whilst also delivering best value for patients and taxpayers.
- The committee will approve investments and procurements within its delegated financial limits.
- To review procurement outcomes and approve the award of contracts and/or make recommendations to the ICB, in accordance with the Scheme of Reservation and Delegation.
- To review and monitor the procurement programme and pipeline in line with the ICB Commissioning Intentions.
- 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 on behalf of the ICB Board or endorsing new and/or significant amendments for the Board, of policies and procedures within its remit.
- Approving business cases / financial spend up to the limits specified in the detailed delegated financial limits within the Scheme of Reservation and Delegation.
- Approving updated policies for which the Committee is a sponsor.

7 Behaviours and Conduct

ICB values

7.1 Members will be expected to conduct business in line with the ICB values, objectives, the Nolan Principles 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 and are responsible for declaring interests relevant to agenda items as soon as they are aware of an actual or potential conflict. Committee members must consequently comply with the Committee Chair's decision on the necessary action to manage the interest in accordance with the ICBs Conflict of Interest 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.

Policies and procedures

7.7 The policies and procedures approved as the sponsoring committee for those associated with its remit of work, shall be reported to the Board.

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 Committee will escalate issues of continued non-compliance or non-delivery of expected plans to the SOAC or Board as necessary.

8.3 The Committee will advise the Audit Committee on the adequacy of assurance available and contribute to the Annual Governance Statement.

8.4 Regular reports on the delivery of plans will be submitted to the ICB for assurance.

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

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

8.7 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. It is noted that commercially sensitive or other confidential / sensitive information may be noted in the meeting that cannot be reflected in minutes

that are available to the public (i.e., submitted to the public Board meetings). Where this is the case, those items will be minuted 'confidentially', and a note made within the minutes of this fact. Confidential minutes are then reported to the Part II confidential meeting of the ICB Board.

8.8 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.

8.9 The Integrated Pharmacy Medicines Optimisation Committee and Provider Selection Review Group shall report and be accountable to the Finance and Performance Committee.

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: 11 July 2024

Date of review: 1 April 2025

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.
- Establish sub-committees for the contractual management and transformation of primary care services.
- Create task and finish sub-groups 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 providing oversight and assurance to the ICB Board on the following areas:

- Objective oversight and scrutiny of the management of primary care services.
- Setting the strategic direction for the use of primary care funds
- Approval of investment decisions within its authority as set out within the ICB Scheme of Reservation and Delegation.
- Identify key risks and issues requiring discussion or escalation to the Board.

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 premise of the PCCC is to look at the needs of the community in a fair and transparent way through consensus, enabling Provider colleagues to rely on the work of the PCCC to deliver assurance that primary care issues are dealt with appropriately.

3.4 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 7 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:

- Associate 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 or nominated deputy
- Director of Pharmacy and Medicines Optimisation
- NHS Alliance Directors or Deputy 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 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 (LMC, LOC, LPC, LDC)
- Healthwatch
- Representative from Primary Care Collaborative
- Representative from the Communications Team
- Other attendees invited to present agenda items.

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 10 times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

5.2 Meetings will be arranged monthly [subject to being business to transact], ordinarily we will conduct the meeting for strategic items and then operational items on a bi monthly basis.

5.3 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.

5.4 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 4 Members of the Committee are required, including the Chair or Vice Chair of the Committee and a clinician.

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 using 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 two other members, 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:

NB: references to Primary Care shall include Primary Medical, Dental, Optometry and Community Pharmacy services.

- To monitor delivery of primary care strategies, across the whole system and within each of the four "Alliances".
- Provide oversight and scrutiny of the management of primary care services (Provider Contracts). The majority of the specific actions will be undertaken through officer delegation and the sub-group structure. The Primary Care Commissioning Committee will consider all significant contractual actions.
- Provide objectivity, transparency and fairness in the commissioning of primary care services.
- To oversee the delivery of equitable access to primary care across Mid and

South Essex.

- Promoting and encourage the reduction of health inequalities through primary care.
- To consider and decide upon primary care system wide work programmes, bids or returns on behalf of the ICB e.g. estates/capital submissions.
- To maintain an overview of, challenge and scruitinse the financial position for primary care in mid and south Essex in order to achieve the financial targets set.
- 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 oversight of Primary Care Strategy and delivery of intended outcomes. This will be achieved by review of reporting on qualitative metrics and quantitative data (including patient experience) for primary care services; providing assurance that action plans and risks relating to primary care quality are being addressed and that practices are being supported to improve quality.
- To be accountable for primary care risks and hold to account risk owners or appropriate management of risks.
- To promote the integration of primary care within the wider system.
- To receive assurances or escalations from the People Board regarding primary care workforce.

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

- Approving on behalf of the ICB Board or endorsing new and/or significant amendments for 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.

Policies and procedures

7.7 The policies and procedures approved as the sponsoring committee for those associated with its remit of work, shall be reported to the Board.

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.

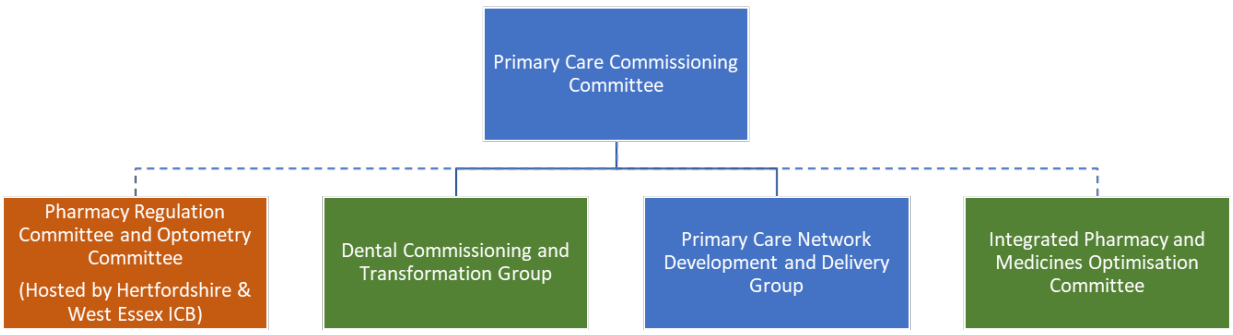
8.2 The Chair of the committee may be invited to attend the ICB as requested by the Chair of the ICB.

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 following sub-group structure will support the workings of and report into the Committee:



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: 11 July 2024

Date of review: April 2025

TERMS OF REFERENCE

Mid & South Essex Integrated Care Board
Quality Committee

1 Constitution

1.1 The Quality Committee (the Committee) is established by the Mid and South Essex 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 TOR 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.

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 To fulfil the ICB's quality statutory objectives the Board has developed 2 distinct quality committees as mandated through NHSE guidance. The first being the Quality Committee whose overall remit is to provide the Board with accountability and assurance and the second being the System Quality Group whose remit and focus is centred on surveillance and learning.

3.3 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.

3.4 The System Quality Group (SQG) provides a strategic forum to facilitate engagement, intelligence-sharing, learning and quality improvement across the ICS. SQGs are not statutory bodies, but members will be accountable to their own statutory body and SQGs will help to ensure that quality as a statutory function is supported and delivered in an integrated way and in support of the Quality Committee as appropriate.

3.5 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.

3.6 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 6 members of the Committee, including at least 1 Independent Non-Executive Member of the Board, based on their specific knowledge, skills and experience. Other members of the Committee need not be members of the Board.

4.3 The membership will comprise:

- Non-Executive Member of the Board (Chair)
- Associate Non-Executive Member of the Board (Deputy Chair)
- ICB Executive Chief Nursing Officer (Executive Lead)
- ICB Executive Medical Director
- At least 2 ICB Alliance Directors
- ICB Patient Safety Partners
- MSEFT Chief Nurse or Medical Director
- EPUT Executive Nurse or Medical Director
- Essex Community Collaborative Chief Nurse/Director of Nursing
- Primary Care Representative
- Senior Healthwatch Representative
- Director level representation from Local Authority partners
- Third Sector/Voluntary representative at Director level

- NHSE Regional Director of Nursing

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 vote on behalf of the absent Committee member.

Chair and Vice Chair

4.5 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.

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

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 Terms of Reference.

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 where appropriate:

- ICB Directors of Nursing/Deputy Director of Nursing
- Director of Pharmacy and Medicines Optimisation
- Relevant members of the ICB Nursing and Quality directorate to present reports as per agreed Committee work plan
- Relevant members of the wider stakeholders when appropriate to present reports where there is an overlap in agendas, eg.:
  - ICB Medicines Optimisation Team
  - ICB Mental Health, Learning Disabilities and Neurodiversity team
  - ICB Babies, Children's and Young People's team
  - ICB Clinical Leadership and Innovation Directorate
  - ICB People Directorate
  - ICB Corporate Services
  - Public Health Directors
  - ICB Consultant Midwife for the LMNS Board
  - Directors of Adult Social Services
  - Directors of Children's Social Care

4.10 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

4.11 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.

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.

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 6 Members of the Committee are required, including the Chair or Vice Chair of the Committee, the ICB Executive Chief Nurse or Medical Director.

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 accordance 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 or their nominated deputy (as per 4.4 above) 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 delivery of all elements, standards and outcomes 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.
- To review information collected from relevant partner quality dashboards, spotlight reports, thematic reviews, and surveillance themes to identify areas of concern that may require further analysis, intervention, or escalation. This includes a review of themes and learning arising from incident reporting and investigation, compliance benchmarking and patient experience.
- Oversee, monitor, and scrutinize the delivery and compliance of the ICB key statutory requirements including those relating to:
    - safeguarding of children and adults
    - infection prevention and control
    - equality and diversity as it applies to service users
    - medicines optimisation and safety
    - All Age Continuing Care provision in the system
    - Primary Care (General Practitioners, Pharmacy, Optometry and Dental)
    - the nursing/residential care sector
    - the quality of local maternity services
    - the Learning Disability and Autism improvement programme
    - the Neurodiversity improvement programme
    - Special Educational Needs and Disabilities (SEND) improvement programme
    - Mental health care (all ages)
- Review and monitor those risks on the Board Assurance Framework (BAF) and Operational Risk Registers which relate to quality, and high 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 directorates.
- 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 drawing on the work, intelligence and assurances received from the System Quality Group. SQG discussions and scheduled reports will inform the process of assurance for the Committee.
- Receive assurance that the system has a framework that 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 triangulated, disseminated and embedded.
- Receive assurance that the ICB has effective and transparent mechanisms in place to monitor mortality from partners and that they learn from deaths (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 through co-design and co-production.
- Have oversight of and approve the TOR and work programmes for the groups reporting into the Quality Committee (e.g., Infection Prevention and Control, Safeguarding Boards, System Quality Group (SQG)).
- Report and escalate to the System Oversight and Assurance Committee (SOAC) to ensure any quality related performance issues eg. Undertakings or regulatory interventions are co-ordinated effectively between committees and deliver the intended outcomes via SOAC's oversight.
- Oversee the process for completion of Quality Impact Assessments and where appropriate Equality Health Impact Assessments through the Equality Health Impact Assessment Group/Panel, and receive reports that no detriment to quality has occurred through the investment of disinvestment of services (in line with the responsibilities set out in the ICB's Decision Making Policy).

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 or approving and recommending new and/or significant amendments for ratification 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 and Standards of Business Conduct Policy.

Equality, diversity and inclusion

7.3 Members must demonstrably consider the equality, diversity and inclusion 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 will be accountable to the Chair of the ICB for the conduct of the committee.

8.3 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.

8.4 The Committee Chair and Executive Lead 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.

8.5 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 Board approval: 11 July 2024

Date of next review: April 2025

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 & 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: 1 July 2022

Date of review: 1 July 2023

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 or 'Congress') 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 The 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 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.

3 Purpose and Responsibilities

3.1 To contribute to the overall delivery of Triple Aim for Integrated Care Systems (ICSs) – better health and wellbeing for everyone, better quality of health and care services for everyone and sustainable use of health and care resources.

3.2 CliMPC has no executive powers, other than those delegated in the SoRD and specified in these terms of reference. 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 The CliMPC has delegated authority via the Scheme of Reservation and Delegation to make decisions in respect of the following:

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

3.4 The CliMPC will also 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.

3.5 CliMPC and its members' roles may include:

- Clinical and Care Strategy
    - By exploring, assessing and making recommendations on key system clinical and care priorities.
    - 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.
    - 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.
    - 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.
    - Ensure that service transformation plans are co-designed and produced with patients, service users and residents, using a robust framework for equality impact assessment of transformative change.
    - 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.

- 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.
    - Support health and care professionals to bring forward proposals on service transformation and improvement in a structured way.
    - 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.
    - Support and advise clinical work-streams in developing financially sustainable and enduringly transformative pathways of care.

- Assurance and statutory adherence
    - Make recommendations to the ICB Board on proposals developed and scrutinised

through the CliMPC.

- By supporting the ICS Medical Director in discharging such specific assurance and statutory adherence functions as may be necessary 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.

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 Executive 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 Executive 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 (minimum of one other member).

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

6 Behaviours and Conduct

Values

6.1 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.

6.2 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

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

Conflicts of Interest

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

6.5 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

6.6 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.

Policies and procedures

6.7 The policies and procedures approved as the sponsoring committee for those associated with its remit of work, shall be reported to the Board.

7 Accountability and reporting

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

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

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

7.4 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.

7.5 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.

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

8 Secretariat and Administration

8.1 CliMPC 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.
- 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 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 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.

9 Review

9.1 The CliMPC will review its effectiveness at least annually.

9.2 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 Board approval: 11 July 2024

Date of next review: April 2025

Mid & South Essex Integrated Care Board

System Oversight and Assurance Committee

Terms of Reference

1 Constitution and Context

1.1 The System Oversight and Assurance Committee (SOAC) 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.

1.4 These Terms of Reference describe the scope, function, and ways of working for the SOAC. They should be read in conjunction with the Memorandum of Understanding (MoU) and Compacts of the ICS, and the MoU with NHS England (NHSE).

1.5 The partnership approach to system oversight will be geared towards overall performance improvement and development (this includes finance, quality, performance, and workforce, hereafter referred to as overall performance). It will include an oversight of progress towards delivery of the MSEFT NOF4 exit criteria. It will be data-driven, evidence-based, and rigorous.

1.6 The SOAC will therefore be pivotal to effecting change resulting from escalations from the ICB or partners that impacts on overall performance as a system.

1.7 NHS England (NHSE) has adopted a relationship with NHS system Partners in Mid and South Essex, enacting streamlined oversight arrangements under which:

- NHS system partners will take the collective lead on oversight of providers, commissioners, and Alliances in accordance with the terms of the Partnership MoU.
- NHSE 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.
- The intention of SOAC is to support an embedded assurance approach. It remains an ICB committee and as such it is expected that region (NHSE) will work with and through the ICB to support issues raised in the committee where appropriate.

1.8 In line with principles and functions set out in the Memorandum of Understanding between NHSE and MSE, NHSE may, where appropriate, enact certain regulatory and system oversight functions through the committee. Where appropriate NHSE will utilise its role as

Co-Chair to fulfil this function. This may be conducted in a Part 2 meeting where the nature of the business requires.

2 Authority

2.1 The Committee is a formal committee of the ICB Board, which has delegated authority from the ICB details of which are set out in the Scheme of Reservation and Delegation. The 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 or within the wider system (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 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.
- Establish sub-committees to support the discharge of relevant or related ICB functions.

3 Purpose

3.1 The role of the Committee is to bring partners together for mutual accountability of system overall performance according to the requirements of relevant legislation, the NHS Constitution and NHS England (assessed through the NHSE Oversight Framework).

3.2 The committee will not duplicate the role of other ICB Board sub-committees but will receive escalation of items that are not being resolved through those sub-committees.

3.3 Partners in attendance at the committee will then take the appropriate steps required to facilitate a response to the issues identified.

3.4 The Committee will thereby ensure that system risks are being managed and mitigated appropriately.

3.5 It supports the joint accountability function for and on behalf of the partners and provides a mechanism of providing additional assurance or escalation to the ICB Board, individual Boards and Governing Bodies and committees established across statutory organisations that monitor performance.

4 Membership

4.1 The membership of the SOAC (core business) will include representation from each sector of the Partnership. 4.5 below reflects the role of NHSE in the National Oversight Framework (NOF) and details the membership of the Part II meeting for NOF 4.

4.2 The membership will comprise:

- ICB Chief Executive (Co-Chair)
- Lead Director NHSE (Co-Chair)
- Lead Recovery Support Programme (RSP) Director, NHSE (Co-Chair for the RSP part of the meeting)
- Chief Executive, Mid and South Essex NHS Foundation Trust (MSEFT)
- Chief Executive, Essex Partnership University NHS Foundation Trust (EPUT) (also a member representing the Mid and South Essex Community Collaborative.
- Executive Chief Nurse, MSE ICB
- Nominated Director, East of England Ambulance Service NHS Trust (EEAST)
- Alliance Director Representative, MSE ICB
- Executive Chief Finance Officer, MSE ICB
- Executive Director of Strategy and Corporate Services, MSE ICB
- Directors of Oversight and Assurance (link to NHSE Multi-Disciplinary Team (MDT)), MSE ICB and/or Trust
- Executive Chief People Officer, MSE ICB
- Upper Tier Local Authority Partner Representative

4.3 If a member is unable to attend a SOAC meeting, they 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.

4.4 Additional attendees may include (dependent on agenda items):

- Executive Director of System Recovery
- Executive Medical Director, MSE ICB
- Executive Chief Digital Information Officer, MSE ICB
- Senior Responsible Officers (SROs) for identified areas such as workforce, quality, finance, and performance
- SROs and programme leads for transformation programmes
- Director of Communications and Engagement, MSE ICB

4.5 Membership of the NOF4 Part II meeting include:

- Lead Recovery Support Programme (RSP) Director, NHSE (Co-Chair for the RSP/NOF4 part of the meeting)
- ICB Chief Executive
- Lead Director, NHSE
- Senior Workforce Lead, NHSE
- Chief Executive, Mid and South Essex NHS Foundation Trust (MSEFT)
- Chief Executive, Essex Partnership University NHS Foundation Trust (EPUT)
- Executive Chief Finance Officer, MSE ICB
- Executive Chief Finance Officer, MSEFT

4.6 Additional attendees for the NOF4 Part II meeting may include by invitation:

- Executive Director of System Recovery
- Executive Chief Finance Officer, EPUT
- Executive Chief Nurse, MSE ICB
- Executive Director of Strategy and Corporate Services, MSE ICB
- Executive Chief People Officers, MSE ICB, MSEFT, EPUT

Chair and vice chair

4.7 The Chair of the ICB will appoint a Member of the Board, with the relevant skills and experience, to co-chair the Committee alongside the representative from NHS England. With the Lead RSP Director from NHSE Chairing the NOF4 Part II meeting.

4.8 In the absence of both Co-Chairs, 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.

5 Meeting Quoracy and Decisions

5.1 The SOAC does not have formal delegated functions from the ICB Board other than in relation to its function as an oversight committee as outlined in section 6 below and has no authority for the approval of financial commitment. The Committee will operate based on joint accountability and consensus and through the delegation to individual members.

5.2 The full SOAC meeting will normally occur bi-monthly, with a minimum of six meetings held per financial year. However, *NOF4* and *undertakings* discussions initially be established monthly, with frequency to be adjusted on the recommendation of the NOF4 Chair from NHS England. Arrangements and notice for calling meetings are set out in the Standing Orders.

5.3 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.

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 6 Members of the Committee are required, including:

- At least one Co-Chair/nominated Chair
- 2 x ICB Executives
- Representation from both Provider Executives (MSEFT and EPUT)
- NHSE representative

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 Where a recommendation or decision is made this will be through consensus. When this is not possible the Chair may call a vote. Under exceptional circumstances any substantive difference of views among members will be reported to the Integrated Care Board.

5.9 Only members of the Committee or their nominated deputy 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 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 using telephone, email, or other electronic communication.

Urgent Decisions

5.12 If 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 to capture a transparent audit trail.

5.13 Where this is not possible an urgent decision may be exercised by the Committee Chair and relevant lead ICB Executive 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 ratification.

6 Responsibilities of the Committee

6.1 To ensure that appropriate escalations are received and where appropriate acted upon to address the realisation of risks or performance issues affecting the system (i.e., issues that affect more than one organisation within the partnership). Appropriate escalations are defined as matters referred to SOAC by sub-committees of the ICB Board where risks or issues are not being addressed sufficiently or in a timely manner. Matters relating to individual partner organisations will be escalated through sovereign organization governance. Matters relating to system working across the partnership will be escalated through appropriate system forum governance or ICB sub-committees as appropriate. Only once other governance routes have been exhausted and SOAC escalation deemed appropriate, will it be addressed by the Committee.

6.2 To ensure that the system partners are working together to deliver required standards of overall performance and where this is not the case, govern how issues are resolved or escalated accordingly.

6.3 Be the forum under which preparations are made for NHS England quarterly and annual assurance review meetings, and where accountability sits for delivery of actions arising from those meetings.

6.4 To decide on issues that need to form part of the workplan of SOAC for a period of time where traction and progress is stalled and is posing an increased risk to the system in delivering its statutory responsibilities and functions.

6.5 To receive requests from assurance committees to take enhanced oversight for delivery, where cross-provider/cross-system risks are identified and are unable to be managed within the sovereign organisations' governance arrangements, or where the committees are not assured of the mitigations of said risks.

6.6 To bring together the triangulation of activity, finance, quality, and workforce data where issues exceed the remit of individual committees.

6.7 To provide feedback to the ICB Board and where appropriate the Chief Executive's Forum.

6.8 To have oversight that the partners in the system are supporting the delivery of the Joint Forward Plan.

6.9 To maintain oversight of progress towards the delivery of the agreed MSEFT NOF4 exit criteria.

6.10 To maintain oversight of progress towards delivering the undertakings requirements placed on MSEFT.

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 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 SOAC will formally report and provide assurance, through the Chair, to the Integrated Care Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board of require action. It will make recommendations, where appropriate to the ICB Board, the Chief Executive Forum (Health) and partner organisations as required.

9 Secretariat and Administration

9.1 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. They will ensure:

- 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 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. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

10.2 The Committee will review its effectiveness at least annually.

Date of approval by ICB Board: 11 July 2024

Date for review: July 2025

Mid & South Essex Integrated Care Board

People Board

Terms of Reference

1. Constitution

1.1 The People Board 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.

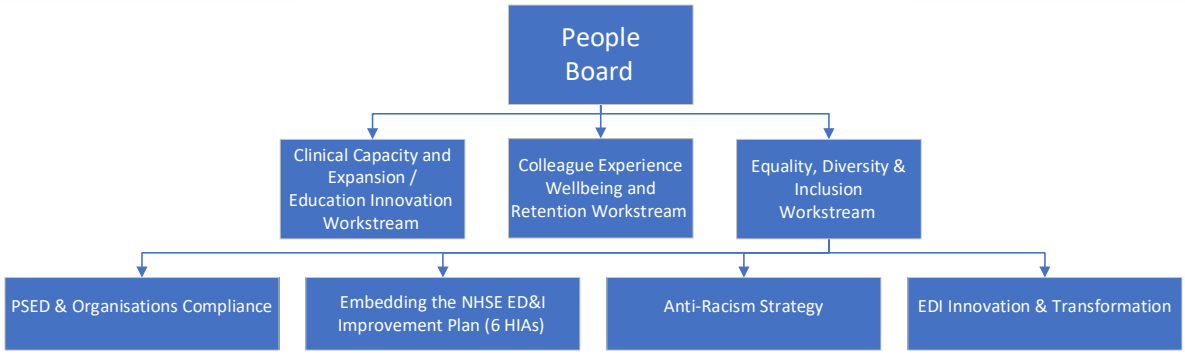
1.3 The People Board is a non-executive chaired committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. Authority

2.1 The People Board 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 People Board 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 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. The sub-structure of the People Board workstreams are shown below:



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 People Board has been established to provide the ICB with assurance that it is delivering its functions and undertaking its responsibilities to deliver the workforce related activities that are carried out by the ICB as an employer itself and to work collaboratively with other partners across the Integrated Care System (ICS). 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.

3.2 The People Board will agree system implementation of people priorities including delivery of the People Plan, People Promise and Workforce Plan (2023) by aligning partners across the ICS to develop and support 'one workforce', including through closer collaboration across the health and care sector, with local government, and the voluntary, community, faith, and social enterprise (VCFSE) sector.

3.3 The People Board will ensure that the ten people functions are delivered and that the ICB and system partners are meeting the strategic workforce priorities in the NHS, as set out in the People Plan. These include improving people's experience of working within the NHS, enabling them to provide the best possible care and health outcomes for patients and citizens; transforming and growing the workforce to make use of the skills of staff and meet changing health needs; and developing a compassionate and inclusive culture that drives positive change for staff.

3.4 The People Board will provide regular assurance updates to the ICB and system partners, in relation to activities and items within its remit and linked to the areas above as well as identifying any key system issues and/or risks requiring discussion to escalation to the Board.

3.5 The duties of the People Board 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.

3.6 The People Board has no executive powers, other than those delegated in the SoRD and specified in these ToR or by virtue of its attending Members.

4. Membership and attendance

Membership

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

4.2 The ICB Board will appoint no fewer than 8 members, including at least one independent Non-Executive Member who shall be the Chair of the People Board. Other members of the Committee need not be members of the Board.

4.3 When determining the membership of the People Board, active consideration will be made to equality, diversity and inclusion.

4.4 Membership will comprise:

- Non-Executive Member (Chair)
- ICB Chief People Officer (Vice Chair)
- ICB Executive Chief Nursing Officer
- NHS Provider Chief People Officers x3 (MSEFT, EPUT and Provide CIC)
- NHS Provider Chief Nurses x3 (MSEFT, EPUT and Provide CIC)
- Local Authority Workforce / People Director(s) x3 (Southend, Essex and Thurrock)
- MSE Hospice Collaborative Representative
- Primary Care Lead
- Staff Side Representative
- System EDI Senior Responsible Officer (SRO)

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 People Board.

4.7 The People Board 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:

- Workstream Chairs (or members)
- Heads of Service
- EDI Leads across the system

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 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 ICB 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 of the Committee are required, including the Chair or Vice Chair of the Committee and a Chief People Officer and two members who are representing other organisations or sectors within the Integrated Care System.

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 People Board will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

5.8 Only members of the People Board 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 People Board 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 ratification.

6. Responsibilities of the Committee

6.1 The People Board's duties are to ensure that strategies and delivery plans are in place to:

- Support the health and wellbeing of staff across the Integrated Care System
- Build / develop the workforce for the future and enable adequate workforce supply, ensuring that the 'one workforce' across the Integrated Care System is representative of the local communities served.
- Support inclusion and belonging for all and create a great experience for staff across the Integrated Care System, addressing issues of inequality and inequity.
- Value and support leadership at all levels and lifelong learning, ensuring that leaders at every level live the behaviours and values set out in the People Promise
- Lead workforce transformation and new ways of working.
- Educate, train and develop our people and manage our talent.
- Drive and support broader social and economic development, leveraging roles as anchor institutions and networks, and supporting all ICS partners to address the wider determinants of health and inequalities.
- Transform our people services and support the people profession.
- Lead on coordinated workforce planning using analysis and intelligence, aligning this to the needs to our current and future population, and our service and workforce needs.
- Support system design and development, using organisational and cultural development principles to support the establishment and evolution of the ICB and the Integrated Care Partnership.

6.2 The People Board will:

- Review and monitor those risks on the BAF and corporate risk register which relate to people and identify operational risks which could impact on care.
- Ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner.
- Ensure oversight, and implementation, of national policy developments relating to the health and care workforce.
- Have oversight of, and approve the Terms of Reference and work programmes for, any groups reporting into the People Board.

6.3 The People Board must be assured that:

- There are robust processes in place for the effective delivery of a high-quality people function for the ICB.
- There are robust processes in place to ensure effective collaborative working across partners.
- A culture which considers Equality, Diversity and Inclusion (EDI) is embedded and actively promoted, and that consideration of EDI is demonstrably present across the ICB and its partners.

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. This could mean excluding an individual from access to or participation in an agenda item or meeting, at the discretion of the chair.

Confidentiality

7.6 Issues discussed at People Board 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 People Board is accountable to the ICB Board and shall report to the Board on how it discharges its responsibilities.

8.2 The Chair of the People Board may be invited to attend the ICB Board 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 People Board 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 People Board will have regard to the Integrated Care Strategy and the Joint Forward Plan. It will take direction and provide relevant updates to the ICP in this regard.

9. Secretariat and Administration

9.1 The People Board 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 People Board will review its effectiveness at least annually and 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 People Board will utilise a continuous improvement approach and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Date of approval: 14 Nov 2024

Date of review: 14 Nov 2025

Mid and South Essex Integrated Care System

Integrated Care Partnership
Terms of Reference

Purpose

The Integrated Care Partnership (herein referred to as the ICP) is a partnership across Mid and South Essex, established by the Mid and South Essex Integrated Care Board and the three upper tier local authorities (Southend City Council, Essex County Council and Thurrock Council) as equal partners, with a focus on aligning purpose and ambitions to support the residents of Mid and South Essex. It is formed as a joint committee between the Mid and South Essex ICB and the upper tier local authorities.

The ICP will facilitate joint action to improve health and care outcomes, to influence the wider determinants of health and broader social and economic development.

Together, the Mid and South Essex Integrated Care Board (ICB) and the Mid and South Essex ICP forms the new statutory Mid and South Essex Integrated Care System (ICS).

The ICP has specific responsibility for developing the Mid and South Essex Integrated Care Strategy for the whole population. The strategy will take forward the health and wellbeing strategies of our upper tier health and wellbeing boards, use the best available evidence and data, covering health and social care (both children's and adult's social care), and seek to address the wider determinants of health and wellbeing. The strategy will be built bottom-up from local assessments of needs and assets identified through our four Alliances, district, borough, and city councils. The strategy will be focused on improving health and care outcomes, reducing inequalities, ensuring inclusion, and addressing the consequences of the pandemic for our communities.

While the ICP has no formal delegated powers from its constituent organisations, it will provide leadership, oversight, and support for system-wide activities, playing a key role in ensuring joint accountability to our population.

The ICP builds on the existing Health & Care Partnership and will therefore be underpinned by the existing Partnership Memorandum of Understanding (MoU), which will need to be slightly amended in light of the agreed new membership of the ICP and these ToRs should be read in conjunction with that modified MoU.

The existing Health and Care Partnership 5-year Strategy (December 2019) describes the following high-level ambitions which will support the ICP in its definition of the integrated care strategy:

We will reduce health inequalities by:

- Creating opportunities for our residents, through education, employment, and socio-economic growth
- Support health and wellbeing, with a focus on prevention, self-care, and early identification
- Bring care closer to home, where safe and possible
- Transform and improve our services

This will be underpinned by:

- Strong clinical and multi-professional leadership
- Meaningful engagement with our communities to ensure true coproduction

1 Our Beliefs and Values as an Integrated Care Partnership

- **Subsidiarity -** devolving planning and delivery to the lowest possible level.
- **Respect for sovereignty** of statutory organisations
- **Collaboration** to bring about improved Standards, Outcomes and the application of Common Clinical Policies
- **A shared agenda** driven and owned by partners working together with a focus on **reducing health inequality**
- **Data Driven:** serving the individual needs of our population, not organisations
- **Delivery of integrated care,** with meaningful engagement with our communities
- **Asset and strengths-based approaches**, delivering care according to people's preferences
- **A focus on healthy lives –** prioritising prevention and self-care
- **Clinical and Care Professional engagement** at the earliest opportunity
- **Empowering front line staff to do the right thing** – through distributed leadership
- **Pragmatic pluralism** –differing needs across our populations require different approaches. Not a one size fits all approach
- **Innovative - trying** new and innovative approaches, test and learn

2 Our Responsibilities as an Integrated Care Partnership

The ICPs responsibilities are to:

1. Develop the integrated care strategy for the population of Mid and South Essex.
2. Design and oversee a joint accountability framework to ensure delivery of the integrated care strategy.
3. Ensure the integrated care strategy:
    a) Is focused on reducing the inequalities that our population faces
    b) Uses the best available evidence and information, including the joint strategic needs assessments and health and wellbeing strategies of local authorities
    c) Is built 'from the bottom up' taking account of health inequalities, challenges, assets and resources locally at neighbourhood and Alliance level.
    d) Expands the range of organisations and partners involved in strategy development and delivery.
    e) Is underpinned by insights gained from our communities.
    f) Benefits from strong clinical and professional input and advice.
4. Agree and monitor delivery of Alliance plans (Basildon and Brentwood; Mid-Essex, South-East Essex and Thurrock), with a focus on shared learning and support.
5. Agree and have oversight of the statutory ICS health inequalities strategy.
6. Consider recommendations from partners and reach agreement on:
    - Priority work programmes and workstreams that would benefit from a cross-partnership approach
    - The apportionment of transformation monies from national bodies aligned to the ICP
    - The need to take joint action in relation to managing collective issues and challenges.
7. Commission specific advice from established groups – including but not limited to, the Clinical and Multi-professional Congress, our Population Health Management function, our Engagement Network, Healthwatch organisations, Stewardship groups, our Digital, Data and Technology Board, our People Board, our System Finance Leaders' Group, and our Estates function, in order to obtain subject matter expertise, leadership, advice and support in setting the strategic direction of the ICP.
8. Provide active support to the development of the four Alliances across Mid and South Essex, enabling local partnership arrangements, engagement and co-production, bringing together Local Authorities, voluntary and community groups, NHS partners and residents. Facilitate and support cross-Alliance working and sharing of best practice where this would benefit the population or provide efficiencies in our approach.
9. Ensure that the ICP has a greater focus on population health improvement, integration of health and care services around the needs of residents, and a focus on care provided in primary and community settings.
10. Provide a mechanism for joint action and joint decision-making for those issues which are best tackled on a wider scale.

For the avoidance of doubt, it is not a function of the ICP to duplicate the statutory functions of constituent organisations.

The Mid and South Essex ICP will not perform a health scrutiny function and will itself be subject to scrutiny by the Health Scrutiny Committees as appropriate of Southend City Council, Essex County Council and Thurrock Council.

3 Chair and Vice Chair Arrangements

3.1 The Mid and South Essex will appoint a Chair and three vice-Chairs annually. The Chair and vice-chairs will hold office until they resign, cease to be a member of the Mid and South Essex ICP, or cease to be a member of the organisation that appointed them to the ICP.

3.2 If a vacancy arises for any position within the Municipal Year, an appointment will be made for the remainder of the Municipal Year.

3.3 For the first year of operation, the Chair of Mid & South Essex ICB will act as Chair of the ICP. The chairs of the three upper tier local authorities Health and Wellbeing Boards (Southend City Council, Essex County Council and Thurrock Council) will act as vice chairs.

4 Membership

4.1 The founding membership of the Mid and South Essex ICP will be one member nominated by the ICB, and one member nominated by each of Southend City Council, Essex County Council, and Thurrock Council.

4.2 Subject to the agreement of the Mid and South Essex ICP, the membership will be as set out in Appendix 2.

4.3 In addition to the membership outlined in Appendix 2, the Mid and South Essex ICP may appoint such additional persons as it sees fit, either as co-opted voting members or as observers who shall be entitled to participate in discussion at meetings of the Mid and South Essex ICP but shall not be entitled to vote.

4.4 Where a member is to be appointed other than by an upper tier local authority or the ICB then the ICP will invite nominations via any fair process determined by their appointing organisations and the agreed nominee will be co-opted on to the ICP at a meeting of the ICP. In the event that there is no clear nominee or if there is a dispute as to the identity of the nominee, the ICP may co-opt as it thinks fit.

4.5 Southend City Council, Essex County Council, and Thurrock Councils will not exercise Health and Wellbeing Board activity through the Mid and South Essex ICP.

5 Deputies

5.1 If a member is unable to attend a meeting of the ICP, 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, Alliance, or group effectively. Deputies will be eligible to vote if required. The Chair of the Mid and South Essex ICP must be informed in advance of the relevant meeting of the identity of a substitute

6 Additional Attendees

6.1 At the discretion of the Chair, additional representatives may be requested to attend meetings from time to time to participate in discussions or report on particular issues.

7 Term of Office

7.1 The term of office of members shall end:

a) if rescinded by the organisation by whom they are appointed; or
b) if a Councillor appointed by a Council cease to be a member of the appointing Council.
c) if an ex officio member cease to be appointed in that role
d) if the individual changes role within an organisation and is no longer in the role that led to their appointment to the ICP.

8 Quorum

8.1 The quorum for meetings of the Mid and South Essex ICP shall be the chair plus 1 voting member representing each of Southend City Council, Essex County Council, and Thurrock Council and the Mid and South Essex ICB.

8.2 If there is no quorum at the published start time for the meeting, a period of ten minutes will be allowed, or longer, at the Chair's discretion. If there remains no quorum at the expiry of this period, the meeting will be abandoned, and no business will be transacted.

8.3 If there is no quorum at any stage during a meeting, the Chair will adjourn the meeting for a period of ten minutes, or longer, at their discretion. If there remains no quorum at the expiry of this period, the meeting will be closed, and no further business will be transacted.

8.4 The Quorum provisions shall apply equally to virtual meetings.

9 Member Conduct

9.1 Members of the Mid and South Essex ICP who are not Councillors shall comply with any code of conduct applicable to their professional body and/or the organisation they represent.

9.2 If a member persistently disregards the ruling of the Chair, or person presiding over the meeting, by behaving improperly or offensively or deliberately obstructs business, the Chair, or person presiding over the meeting, may move that the member be not heard further. If seconded, a vote will be taken without discussion.

9.3 If the member continues to behave improperly after such a motion is carried, the Chair, or person presiding over the meeting, may move that either the member leaves the meeting or that the meeting is adjourned for a specified period. If seconded, a vote will be taken without discussion.

10 Conduct of Business

10.1 The Mid and South Essex ICP shall hold at least four meetings each year. Special meetings may be called at any time by (i) the Chair or (ii) by a written notice requiring a meeting to be called being served on the Chair of the ICB by Southend City Council, Essex County Council or Thurrock Council specifying the business to be transacted.

10.2 In the absence of the Chair at a meeting of the Mid and South Essex, one of the three Vice Chairs will preside over that meeting.

10.3 The Mid and South Essex ICP may hold any meeting remotely using Zoom, Microsoft Teams, or any other suitable platform and may live stream the meeting.

10.4 The manner of voting will be determined by the person chairing the meeting.

11 Notice of and Summons to Meetings

11.1 At least five clear working days before a meeting, a copy of the agenda and associated papers will be sent to every member of the ICP and made available to the public for meetings held in public. The agenda will give the date, time and confirmation regarding whether the meeting is in person or virtual and specify the business to be transacted and will be accompanied by such details as are available.

11.2 A minimum of five working days' notice will be given when calling an extraordinary meeting.

12 Participation at the Mid and South Essex ICP

12.1 All members of the Mid and South Essex ICP are entitled to speak and where necessary to vote (unless they have been co-opted as a non-voting member by the Mid and South Essex ICP).

12.2 At the discretion of the Chair, co-opted non-voting members may be permitted to speak and participate at meetings of the Mid and South Essex ICP.

13 Public Questions

13.1 At a meeting of the Mid and South Essex ICP any member of the public who is a resident or a registered local government elector of Southend City Council, Essex County Council, or Thurrock Council may ask a question about any matter over which the Mid and South Essex ICP has power, or which directly affects the health and wellbeing of the population.

13.2 A member of the public who wishes to ask a question under 14.1 above shall give written notice, including the text of the proposed question, within 2 working days of the meeting. Questions from the public should be sent to mse.midsouthessexstp@nhs.net

13.3 Unless the Chair otherwise agrees and subject to 14.5 below, a member of the public may only ask one question.

13.4 Questions shall be put orally at the meeting in the order in which notice of the question has been received. At the end of each reply, the questioner may ask one supplementary question arising from the answer. A member of the Mid and South Essex ICP nominated by the Chair will either give an oral reply to the question and/or any supplementary question orally or will indicate that a written reply will be sent to the questioner within 5 working days. There shall be no debate about the question or any supplementary question between members of the Mid and South Essex ICP.

13.5 The period allocated to questions under 14.1 shall be limited to 20 minutes unless the Chair agrees to extend this time. Any questions remaining after that period has elapsed shall be subject to a written reply within 5 working days.

13.6 Answers given orally at the meeting shall be included in the Minutes. Written replies shall be copied to all members of the Mid and South Essex ICP.

13.7 For the purposes of 14.1 to 14.6 above and for the avoidance of doubt a County Councillor, or a District Councillor for a District Council in Essex, or a councillor of

Southend City Council or Thurrock Council who, in either case, is not a member of the Mid and South Essex ICP shall be regarded as a member of the public.

14 Voting

14.1 The ICP will generally operate on the basis of forming a consensus on issues considered and will attempt to resolve in good faith any issues between partners, as per the principles of the Partnership MoU. It will seek to make any decisions on a "Best for Mid and South Essex" basis.

14.2 On the rare occasion that a vote is required to support a decision, for example, should that become necessary in respect of priorities for investment or apportionment of transformation funding, the ICP may make a decision provided that it is supported by a simple majority of ICP members present at the meeting. If notwithstanding a consensus decision cannot be achieved, the issue resolution process outlined in the MoU will be followed.

14.3 In the case of an equal number of votes the Chair (or in his/her absence the Vice Chair presiding at the meeting) shall have a casting vote.

15 Accountability and Reporting

15.1 Minutes, and a summary of key messages arising from each meeting will be submitted to all members after each meeting and made available on the ICS website.

15.2 The ICP has no formal powers delegated by Partner organisations.

16 Conflicts of Interest

16.1 Members of the Mid and South Essex ICP are required to declare any interests they have in respect of matters being discussed by the Mid and South Essex ICP.

16.2 Where any ICP member has an actual or potential personal conflict of interest (in other words, one which is not related to the role they undertake for the partner organisation) in relation to any matter under consideration at any meeting, the Chair shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that member may participate and/or vote in meetings (or parts of meetings) in which the relevant matter is discussed.

16.3 Where the Chair decides to exclude a member, the relevant organisation represented by that member may send a deputy to take the place of the conflicted member in relation to that matter.

16.4 Each member must abide by the policies of the organisation they represent in relation to conflicts of interest.

17 Professional & Administrative Support

17.1 The secretariat function for the ICP will be provided by the Mid & South Essex ICB in partnership with upper tier local authorities. A member of the team will be responsible for arranging meetings, recording notes and actions from each meeting and preparing agendas and ensuring these are agreed by the Chair and Vice Chairs.

17.2 The Mid and South Essex ICP may establish Programme Boards/Advisory Sub-Groups to oversee specific work programmes or broader thematic areas as required. Programme Boards/Sub-Groups, reporting into the Mid and South Essex ICP, will be

managed in accordance with separate terms of reference as agreed by the Mid and South Essex ICP

17.3 The role, remit and membership of Programme Boards/Advisory Sub-Groups will be reviewed regularly by the Mid and South Essex ICP to ensure they remain flexible to the demands of ongoing and new programmes of work.

18 Minutes

18.1 The Chair will sign the minutes of the proceedings at the next suitable meeting after they have been agreed as a correct record at that meeting. The Chair will move that the minutes of the previous meeting be signed as a correct record.

18.2 The minutes will be accompanied by a list of agreed action points, which may be discussed in considering the minutes of the previous meeting should they not be specifically listed as items on the agenda for the meeting.

19 Interpretation of Terms of Reference

19.1 The ruling of the Chair of the Mid and South Essex ICP as to the interpretation of these Terms of Reference shall be final.

20 Suspension of Terms of Reference

20.1 As far as is lawful, any of these Terms of Reference may be suspended by motion passed by the majority of those members present and entitled to vote.

21 Review

21.1 The terms of reference and the membership of the ICP will be reviewed at least annually.

Appendix 1

East of England Leadership Compact

In working together as a leadership community, we will adopt the following behaviours and hold each other to account for upholding these:

- We will put people first – our patients, staff, and citizens.
- We will support each other to deliver excellence in quality and performance.
- We will respect and trust each other and share important information, so there are no surprises
- We will have inclusive robust, honest, and realistic conversations where all voices are heard, views respected, and differences resolved for the greater good of our population.
- We will be compassionate and caring, supporting each other, especially in difficult times.
- We will value each other's contributions, celebrate successes collectively and learn from failure
- We will ensure our collective decisions are transparent and inclusive and we will abide by them.
- We will agree expectations and hold each other to account.
- We will be ambitious to improve health and wellbeing, sharing expertise, talent, knowledge, best practice, innovation and learning for the benefit of our patients, staff, and citizens
- We will work together to have a strong, united external voice for our region.

Mid and South Essex Integrated Care System

Appendix 2

Mid & South Essex ICP Membership

	Name
1.	Chair, Mid & South Essex ICB (Chair)
2.	Chair, Southend City Council Health & Wellbeing Board (Vice Chair)
3.	Chair, Essex County Council Health & Wellbeing Board (Vice Chair)
4.	Chair, Thurrock Council Health & Wellbeing Board (Vice Chair)
5.	CEO, Mid & South Essex ICB
6.	Chair of the Mid & South Essex Foundation Trust
7.	Chair of the Essex Partnership NHS Foundation Trust
8.	Chair of Provide CIC
9.	Chair of the North East London NHS Foundation Trust
10.	Lead Non-Executive Director of the East of England Ambulance Services Trust
11.	Director of Public Health, Southend City Council
12.	Director of Public Health, Essex County Council
13.	Director of Public Health, Thurrock Council
14.	Director of Adult Social Services, Southend City Council
15.	Director of Adult Social Services, Essex County Council
16.	Director of Adult Social Services, Thurrock Council
17.	Director of Children's Services, Southend City Council
18.	Director of Children's Services, Essex County Council
19.	Director of Children's Services, Thurrock Council
20.	Clinical Lead, Basildon & Brentwood Alliance
21.	Alliance Director, Basildon & Brentwood Alliance
22.	Clinical Lead, Mid-Essex Alliance
23.	Alliance Director, Mid-Essex Alliance
24.	Clinical Lead, South East Essex Alliance
25.	Alliance Director, South East Essex Alliance
26.	Clinical Lead, Thurrock Alliance
27.	Alliance Director, Thurrock Alliance
28.	Lead Officer, Basildon Council
29.	Lead Officer, Braintree District Council
30.	Lead Officer, Brentwood Council
31.	Lead Officer, Castle Point Council
32.	Lead Officer, Chelmsford City Council
33.	Lead Officer, Maldon District Council
34.	Lead Officer, Rochford Council

Name
35. CEO, Essex Local Medical Committee
36. CEO, Healthwatch Southend
37. CEO, Healthwatch Essex
38. CEO, Healthwatch Thurrock
39. Representative of Mid & South Essex Community & Voluntary Sector Organisations
40. Representative of Hospice Sector
41. Representative of Anglia Ruskin University
42. Representative of University of Essex
43. Representative of Writtle University College
44. Chief Constable, Essex Police
45. Locality Director, NHS England & Improvement
46. Executive Director of Strategy & Partnerships, Mid & South Essex ICB
47. Director of Communications & Engagement, Mid & South Essex ICB
48. Chief People Officer, Mid & South Essex ICB
49. Chief Finance Officer, Mid & South Essex ICB
50. Director of Strategic Partnerships, Mid & South Essex ICB
51. Medical Director, Mid & South Essex ICB

Reviewed: 28 September 2022

Agreed: 28 September 2022

Mid & South Essex Integrated Care Board

Digital Data and Technology Board (DDaT)

Terms of Reference

1. Constitution

1.1 The Digital Data and Technology Board (DDaT) 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.

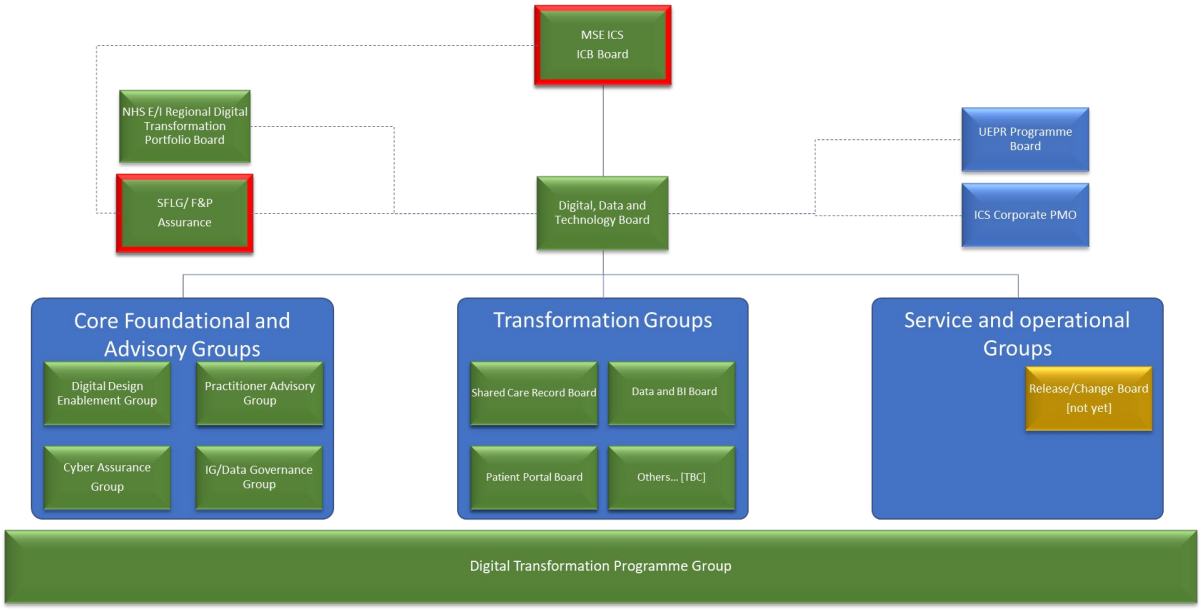
1.3 The Committee is an executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. Authority

2.1 The DDaT Board 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 DDaT Board 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.
- Establish sub-committees.
- Create task and finish sub-groups 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 purpose of the Committee is as follows:

3.2.1 To provide oversight and assurance to the Board in the development and delivery of DDaT 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:

- Providing the strategic oversight for all ICS Priority Digital Programmes.
- Objective oversight and scrutiny of DDaT and decisions.
- Review system performance against digital priorities.
- 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 DDaT Board's remit is to align the strategic goals of the ICS (in line with national and regional priorities) to the appropriate use of digital and business intelligence systems, and the deployment of technology, enabling partner organisations to maintain effective programmes and services to support the reduction in health inequalities across MSE.

3.5 DDaT will further ensure that information standards and sharing of information for the purpose of health and social care within MSE ICS function is undertaken in accordance with relevant legislation. DDaT will be held to account for compliance

with the standards and as part of the Digital and Data 'What Good Looks Like' requirements issued on the 31 August 2021.

3.6 The DDaT Board will oversee and ensure achievement of the overall digital delivery plan and services (including risk management) for the system. It will bring together digital and data/BI leads, executive leads, communications and other relevant individuals to enable delivery from across the M&SE system.

3.7 The Committee will create assurance links with other digital and data local care systems governance as required.

3.8 The DDaT Board has no executive powers, other than those delegated in the SoRD and specified in these ToR or by virtue of its attending Members.

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 16 members of the Committee, including at least 1 Member of the ICB Board/external Chair, based on their specific knowledge, skills and experience. Other members of the Committee need not be members of the Board.

4.4 Membership will comprise:

- ICB Partner Member (External Chair)
- ICS Chief Digital Information Officer (Vice Chair)
- ICS Practitioner Advisory Group Chair
- NHS and Partner Executive Digital Lead/Chief Information Officer x 4 (MSEFT, EPUT, NELFT, Provide CIC
- Local Authority Digital Lead x 3 (Southend, Essex, and Thurrock)
- ICS Finance Lead
- ICS Information Governance Lead
- ICS Communications Lead
- Primary Care Digital Lead
- ICB Strategy / Transformation Lead
- NHS England Regional Digital Representative

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 Member of the ICB Board, with the relevant skills and experience, to chair the DDaT Board. This will be the ICB Partner Member.

4.7 The DDaT Board may appoint a Vice Chair of the Committee from amongst its members. This shall be the ICS Chief Digital Information Officer.

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:

- Emergency Preparedness, Resilience and Response Lead
- Digital Contracts Lead
- Procurement Lead
- Programme Leads
- Local Authority Leads
- Head of Assurance and Oversight
- ICS Programme Director Data and Digital
- Data and BI Board Chair/Deputy Chair

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 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 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 5 Members of the Committee are required, including the Chair or Vice Chair of the Committee, Information Governance Lead, one representative from the Local Authority and one Chief Information Officer from a Provider.

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.

5.11 Any agenda items that have a wider ICS implication will need to obtain approval and recommendations from the Finance and Performance Committee prior to it being discussed at DDaT.

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 ratification.

6. Responsibilities of the Committee

6.1 The Committee's duties are as follows:

- focus on ensuring the implementation of the Digital and Data Strategies, including the prioritisation of system work/projects across the ICS based on capacity.
- Offer a forum where change, escalation of issues and risks can be discussed and managed.
- test and ensure there is a robust framework that endorses, enables and supports delivery of the ICS Digital and Data strategies.
- Through its members prioritise resources with partner organisations to support key system wide programmes and objectives.
- offer a horizon scan for external influences and strategic initiatives which the

system may need to consider not manage the detail of projects.

The following areas are not within the scope of the DDaT

- Specific locally commissioned technical and digital projects undertaken by individual organisations will not be delivered through this mechanism but will be subject to its governance.
- Digital programmes that are delivered outside of the pre-agreed priorities.
- Detailed delivery of projects.

6 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.

7 Accountability and reporting

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

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

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.

8 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.

9 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: 14 Nov 2024

Date of review: 14 Nov 2025

Mid & South Essex Integrated Care Board

Provider Selection Regime (PSR) Review Group

Terms of Reference

1. Constitution

1.1 The PSR Review Group (the Group) is established by the Integrated Care Board (the Board or ICB) in accordance with its Constitution as a sub-group of the Finance and Investment Committee.

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 Group and may only be changed with the approval of the Board.

1.3 The following ICBs have agreed to set up mirroring Groups within their governance to support with a pool of independent colleagues providing members for this Group, when required. This arrangement supported by a Memorandum of Understanding and is intended to mitigate against either perceived or direct conflict from those who have been involved in the original decision and supports an independent majority for reviews by this group:

- NHS Hertfordshire and West Essex ICB
- NHS Norfolk and Waveney ICB
- NHS Bedfordshire, Luton and Milton Keynes ICB
- NHS Suffolk and North East Essex ICB
- NHS Cambridgeshire and Peterborough ICB

1.4 For the purpose of clarity, where the term 'Relevant Authority' is used within these terms of reference, it means the original ICB that published a notice containing its intention to award the contract to a chosen provider.

2. Authority

2.1 The PSR Review Group is authorised by the Board to:

- Investigate any activity within its terms of reference.
- Commission independent procurement or legal advice or other advice as required in the course of its duties.
- 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 Group) within its remit as outlined in these terms of reference.
- Work collaboratively with the ICBs listed above to ensure the independence of the Group and support those within other ICBs in the region.

2.2 For the avoidance of doubt, the Group will comply with the ICB Standing Orders, Standing Financial Instructions, and the SoRD. Furthermore, that in the event of any conflict, the Relevant Authority's Standing Orders, Standing Financial Instructions

and the Scheme of Reservation and Delegation will prevail over these terms of reference other than the Group being permitted to meet in private.

2.3 The Group holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

3. Purpose

3.1 The purpose of the Group is to provide local independent scrutiny for representations made against intention to award notices described in section 6 below.

3.2 Where the ICB PSR Review Group finds that a representation has merit (e.g. it identifies that the process has not been correctly followed or brings to light information that has a bearing on the decision reached), the recommendations reached must be considered by the Relevant Authority over whether this impacts on the intention to award a contract to the selected provider. The Relevant Authority must then decide to:

- enter into a contract or conclude the framework agreement as intended
- go back to an earlier step in the selection process, either to the start of the process or to where a flaw was identified, rectify this, and repeat that step and subsequent steps
- abandon the provider selection process.

3.3 The Relevant Authority must communicate the decision described above promptly and in writing, to:

- the provider that made the representation
- the provider to which the Relevant Authority at the beginning of the standstill period to award the contract, or all providers with which the Relevant Authority intended at the beginning of the standstill period to conclude the framework agreement.

3.4 If the provider continues to remain unsatisfied about the Relevant Authority's response, the provider may request the NHS England PSR review group to consider their representation further. They must submit their request through the PSR website within five working days of receiving the Relevant Authority's decision following the relevant authority's review of their representation. If the provider submits a request for advice from the PSR review group, the Relevant Authority will be notified, and the relevant authority should:

- keep the standstill period open for the duration of the group's review
- make a further decision once it has considered the independent expert advice.

3.5 If the provider does not submit their request to the PSR review group within the five working day period, or the PSR review group does not accept the request for advice, then at any point after the end of that period, the Relevant Authority can bring the standstill period to an end and proceed to award the contract to their chosen

provider.

4. Membership and attendance

Membership

4.1 The Members of the group shall be appointed by the Chair of Group at the time it is required to meet.

4.2 The Membership of the Group will remain flexible to accommodate varying PSR representations, but will appoint no fewer than three members being independent and not involved in the original decision from the following:

- Associate Non-Executive Member (Chair)
- Non-Executive Member (Vice Chair)
- Independent Procurement Advisor (nominated super-user)
- Director of Commercial
- Executive Chief Nursing Officer or Executive Medical Director
- Alliance Director
- Independent co-opted Member

4.3 This may include Members drawn from the ICBs listed in 1.3, as appropriate and required.

Chair and vice chair

4.4 The Chair of the ICB will appoint a Non-Executive Member of the Board, with the relevant skills and experience, to chair the Group.

4.5 The Group may appoint a Vice Chair from amongst its members.

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

4.7 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

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

- Contract Manager
- Commissioner
- Alliance representative
- Procurement advisors

4.9 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 and when making decisions.

4.10 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.

5. Meetings, Quoracy and Decisions

5.1 The Group will meet as required, within five working days of receipt of Provider Representations.

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

Quorum

5.3 For a meeting to be quorate a minimum of three Members are required, including the Chair or Vice Chair.

Decision making and voting

5.4 Decisions will be taken in accordance with the Standing Orders. The Group will reach conclusions by consensus.

6. Responsibilities of the Group

6.1 The Group's duties are as follows:

1. Consider representations made against intention to award notices process under C, most suitable provider process, competitive process or a modification issued through the use of provisions set out in the Health Care Services (Provider Selection Regime) Regulations 2023 (the Regulations).
2. The Group may call upon the ICBs listed in section 1.3 above to substitute their members when the Relevant Authority does not have sufficient individuals to trigger an independent review and/or the contract is deemed to by the relevant authority to be of significant reputational risk.
3. Where a representation is received within the 8 working days of the notice published by the Relevant Authority – with its intention to award the contract to the chosen provider and observe the standstill period, the Relevant Authority through this group must:
    a. Ensure that the provider is afforded an opportunity to explain or clarify its representation(s) if these are not clear.
    b. Is expected to provide an indicative timeframe for when the representation might be considered by, and when the provider might reasonably expect a decision to be made.
    c. Must provide any information requested by the provider that the Relevant Authority is required to keep under the regime as soon as possible, except where this:
        i. would prejudice the legitimate commercial interests of any person, including the Relevant Authority
        ii. might prejudice fair competition between providers
        iii. would otherwise be contrary to the public interest.

d. Must review the evidence and information used to make the original decision, taking into account the representations made.

c. Must consider whether the representation has merit (e.g., it identifies that the process has not been correctly followed or brings to light information that has a bearing on the decision reached.

4. The provider that made the representations is expected to respond promptly and concisely to questions from the Relevant Authority about the points it has made, and if it cannot respond within a reasonable timeframe then it is expected to provide a justification.

5. Sufficient time and opportunity will be allowed for the provider that made the representations to respond to questions from the Relevant Authority. In the event that the provider fails to respond/communicate, then it is for the relevant authority to decide whether to complete its assessment of the representations and communicate their decision to the provider.

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, 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 Group 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 Group members' interests and those of staff and representatives from other organisations who regularly attend Group meetings will be produced for each meeting. Group 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 Group Chair can decide on the necessary action to manage the interest in accordance with the Policy.

Confidentiality

7.6 Issues discussed at Group 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 Group is accountable to the Finance and Investment Committee and shall report to the FIC on how it discharges its responsibilities.

8.2 The Chair of the Group will be accountable to the Chair of the ICB for the conduct of the Group.

8.3 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.

8.4 The Group Chair will provide assurance reports to the Finance and Investment Committee as appropriate.

9. Secretariat and Administration

9.1 The Group shall be supported with a secretariat function 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.
- 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 Finance and Investment Committee.
- Action points are taken forward between meetings and progress against those actions is monitored.

10. Review

10.1 The Group 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: 18 January 2024

Date of review: January 2025

Summary of Meeting Protocols, Conduct & Etiquette
For ICB Board Meetings

Role of Members, Attendees and Observers

Members as listed within the ICB Constitutions (for ICB Board meetings) or in the Terms of Reference of the Committee are the individuals who will provide quoracy of the meeting and will be responsible for making decisions, if necessary, by voting in accordance with the Constitution and Standing Orders.

Deputies – With the permission of the Chair of the meeting, Executive Directors and the Partner Members of the Board may nominate a suitable deputy to attend if they are unable to. The deputy may speak but may not vote on their behalf.

Participants/Attendees are invited by the Chair for either one off attendance or as a regular attendee and do not participate in decision making but may be invited to present papers or be asked to provide explanations and further information in relation to items for discussion.

Observers are members of the public and others not required to be present, but who are welcome to attend the meeting on the basis that they will respect the proceedings and the Chair's authority. Observers may ask questions where this is appropriate and at the discretion of the Chair as set out below.

Questions from the Public or Individual who are not 'Members'

ICB Board meetings are 'meetings held in public' not 'public meetings'. The arrangements are intended to promote transparency over the Board governance and decision-making processes. [However, the requirements of the Board and the conduct of its business are paramount]

Members of the public may be given an opportunity to pose questions at a specific point during the meeting, which should be submitted in writing three working days in advance of the meeting. The agenda time given over to Questions from the public will normally be confined to fifteen minutes. no individual question together with its response is expected to exceed five minutes.

A question should relate to an item considered by the Board Directors at the relevant meeting. Questions on matters not on the agenda of the Board can be resolved by letter or email to the Chief Executive's office. The ICB postal address is NHS Mid and South Essex ICB, PO Box 6483, Basildon, SS14 0UG and Chief Executive Office email address is ceooffice.mseics@nhs.net.

To support the good conduct of business, each member of the public is requested to pose only one question and the number of questions responded to during the meeting will be at the discretion of the Chair. Where the Chair deems necessary, a written response to questions raised will be provided where a substantive response cannot be provided immediately. Questions dealt with at meetings will be documented within the relevant minutes.

Behaviour

- The Chair reserves the right to call the meeting to a stop and discharge the public in attendance where individuals' conduct is inappropriate or distracting.
- Aggressive behavior or abusive language (including heckling) will not be tolerated. Such behaviour will automatically result in the exclusion of any person(s) involved from the Board's meeting(s).

Petitions[1]

Members of the public are permitted, by agreement in advance, to formally present petitions to the Board. A petition is the expression of the views of the people who sign it and is an important mechanism for local people to have a voice on local health matters. [Such petitions may take digital or electronic form so long as they offer free and unfettered access to local residents]. To ensure that a range of voices are heard and in order to avoid giving undue prominence to particular or active lobby groups, petitions will be viewed as one piece of evidence and information contributing to an overall picture of public opinion.

Accordingly, the ICB will follow best practice and use a fair, transparent, and consistent approach to responding to petitions where decisions of the ICB Chair shall be deemed final. A valid petition must be signed by the person initiating the petition, plus at least five other supporting individuals, it may be in relation to an item of Board business or in relation to the provision of services for which the ICB is responsible for commissioning.

Meeting etiquette protocols

We ask participants and those in attendance at Board meetings to observe the following meeting etiquette:

- Please identify yourself and address the Chair when asking a question.
- Respect the decisions of the Chair in conducting the meeting.
- Please avoid interrupting anyone or talking over someone else, even if you disagree strongly.
- When contributing to proceedings, allow others to have their say. It is unfair to continue to address the meeting at the expense of others who would like to contribute.
- Avoid holding side conversations when someone else is talking.

Mobile Phone Protocol

The Board has responsibility for the health and care of 1.2m residents and public funding of £3b. It is essential therefore that Board and committee meetings have the full and focussed attention of members so that they can discharge their duties effectively and transparently. It is recognised that many Board members have senior responsibilities including clinical and professional accountabilities and/or on-call / emergency response duties; therefore, it is acceptable for phones to be present at

[1] A valid petition must be signed by the person initiating the petition, plus at least five other supporting individuals, it may be in relation to an item of Board business or in relation to the provision of services for which the ICB is responsible for commissioning.

meetings. Our policy is that any board member who is likely to be to be required to attend to a call or a message should avoid disrupting meetings by ensuring that:

- phones are always kept on silent/vibrate mode
- If an urgent call/message is received that requires immediate attention that this is signalled to the Chair and the member leaves the meeting room for the period required.

This will ensure that fellow Board members are not distracted, that the business of the Board can be conducted without interruption and to reassure the public that each and every member is focussed on their Board responsibilities during the meetings.

Members of the public or other attendees are also asked to turn mobile phones and other devices off or to vibrate.

Those in attendance have a responsibility to respect the role of Chair and to assist them in the delivery of the above. The underlying principles of the all the above reflect good manners, courtesy and consideration.

Mid and South Essex Integrated Care System

NHS
Mid and South Essex

Process to establish a new committee/sub-committee or other forum

Document Control Information	Details
Document Name	Process for establishing a new committee or other group
Reference Number	SOP003
Version	1.0
Status	Approved
Author / Lead	Sara O'Connor, Senior Manager Corporate Services
Responsible Executive Director	The Chief Executive has delegated responsibility to the Director of Corporate Services for the management of governance procedures.
Responsible Committee	Executive Committee
Date Approved by Responsible Committee	January 2025
Next Review Date	January 2026, unless a prior review is necessary.
Target Audience	All ICB Board staff and Board members when setting up new committees/groups.
Stakeholders engaged in development of Policy (internal and external)	• Director of Corporate Services • Associate Director of Corporate Services • Executive Committee
Impact Assessments Undertaken *(State if not-applicable)*	Not applicable.

Version History

Version	Date	Author (Name and Title)	Summary of amendments made
0.1	21/2/22	Sara O'Connor	Draft process for approval by Executive Team.
1.0	28/1/25	Jane King	V1.0 document finalised.

Process to establish a new committee/sub-committee or other forum

1. Introduction

1.1. Effective arrangements to establish and manage committees/sub-committees and other forums is a key component of effective corporate governance. This document sets out the process that must be followed when establishing a new Mid and South Essex (MSE) Integrated Care Board (ICB) committee/sub-committee or other forum. A flowchart summarising the process is provided at **Appendix A.**

1.2. Within this document, committees/sub-committees and other forums are generally referred to as a 'group'. In simple terms, a group will consist of people who come together to make recommendations or decisions, undertake monitoring or work together on a project or task within a specific area of responsibility.

1.3. The principles within this process will be applied when undertaking any future review of the ICB's corporate governance structure.

2. Purpose

2.1 To ensure that the establishment of committees and groups is undertaken in a consistent manner to ensure:

- new groups are only established if it can be demonstrated that the business of the new group cannot be effectively conducted by any existing group(s)
- the work of other groups is not duplicated
- all groups have clear terms of reference (ToR) setting out their scope/purpose/objectives, appropriate membership/quorum, frequency of meetings and accountability arrangements
- ToR are approved by the relevant responsible committee (or in the case of main committees, by the ICB Board)
- escalation of risk and/or triangulation of information occurs between groups
- an up-to-date record of the ICB's committee structure is maintained.

3. Scope of this procedure

3.1 The process applies to all formal committees/sub-committees/boards and other groups established by the ICB that have delegated authority or responsibility for one or more of the following:

- decision making within designated limits
- monitoring of a designated area (i.e. finance, performance, quality, internal control, or the commissioning of services)
- management or monitoring of a time-limited project or task (i.e. programme boards / task and finish groups)
- management of risk within a specific area / specialty.

3.2 External groups (i.e. those set up by partner organisations) attended by ICB staff and ICB internal directorate/team meetings are outside the scope of this process.

3.3 If there is any doubt whether this process applies, please contact the governance team via mseicb-thu.icbgovernanceteam@nhs.net.

4. Definitions

4.1 For the purpose of this process, the following definitions are used:

- **ICB Board –** the governing body of the ICB as set out in the ICB's Constitution (often referred to as 'the Board').

- **Committee** – committees of the ICB Board (often referred to as 'main committees') as set out in the ICB's Constitution. These are currently Audit Committee, Clinical and Multi-Professional Congress, Executive Committee, Finance & Performance Committee, Quality Committee, Primary Care Commissioning Committee, Remuneration Committee and the four Alliance Committees. Their terms of reference, and any subsequent amendments, must be approved by the ICB Board.

- **Committees in Common*** - a means by which two or more organisations can come together to make quasi-shared decisions, by working through a shared agenda. Each participating organisation uses its statutory powers to establish a statutory committee with delegated functions or decision-making powers in respect of the parent organisation only.

- **Joint Committee*** - a statutory, reciprocal arrangement between two or more bodies, usually established for the purpose of joint decision-making. Under this arrangement, the participating organisations set up a formal committee which is a joint committee of all of them, to take responsibility for one or more of their statutory functions. The constituent organisations are bound by the decisions made by the committee, which is established by agreement between the participating organisations.

- **Responsible Committee** – with the exception of main committee committees reporting to the ICB Board**, every group will have a 'responsible committee' to which it reports and is accountable to. The role of 'responsible committee' is set out in section 5 below.

- **Sub-committee** – a group reporting directly to a main ICB committee.

- **Programme Board** – a group set up to support the Senior Responsible Officer for the programme in making decisions and providing challenge and approval on issues affecting the progress of the programme.

- **Project Board** – a group set up to agree the project deliverables and objectives and monitor the work of the project team, to ensure the project remains on track to achieve the identified benefits.

- **Task and Finish Group** – a group set up to undertake a specific time limited task, usually focusing on an existing operation, routine or a piece of work within a project.

- **Working Group** – a group appointed to study and report on a particular question and make recommendations based on its findings.

- **Steering Group** – a group that decides on the priorities or order of business of the organisation or specific area of work, and manages the general course of its operations.

*For further advice on whether it is appropriate to set up Committees in Common and Joint Committees, please contact the Associate Director of Corporate Services or Senior Manager Corporate Services.

5. Roles and Responsibilities

5.1 The Chief Executive Officer (CEO) has overall responsibility for implementation of this procedure.

5.2 The Executive Director of System Recovery is the Executive Lead with delegated responsibility for ensuring this process is adhered to and regularly reviewed.

5.3 The Director of Corporate Services, supported by members of the ICB Governance Team, has operational responsibility for ensuring this process is followed, providing advice, ensuring that all groups are logged and that annual reviews of committee effectiveness are undertaken for all main ICB committees.

5.4 Managers must follow this process when setting up new groups within their remit.

5.5 The 'responsible committee' to which each group will report is responsible for:

- establishing groups which report to it, including approving the terms of reference
- dissolving groups which report to it
- receiving updates from groups reporting to it (via formal minutes, or update reports), and
- is the escalation route for any issues discussed by the groups which report to it that require resolution, or approval, at a higher level.

5.6 The Chair of each group must ensure that ToR are adhered to and reviewed at least annually.

6. Process to establish a new group

6.1 A new ICB group may only be established if it can be demonstrated that the business of the new group cannot be effectively conducted by any existing group.

6.2 Before establishing a new group, contact relevant managers and/or the governance team to check if an existing group might be able to take on additional responsibilities. Where appropriate, explore this possibility with the relevant lead/committee Chair.

6.3 Advise the governance team of the decision so corporate records can be updated and take action as per one of the options set out in Section 6.4 or 6.5 below.

6.4 Amendment of an existing group's ToR

If the additional business can be conducted by an existing group, amend the existing Group's ToR as follows:

i. Include additional scope/responsibilities and consider if the frequency of meetings is sufficient.

ii. Review membership, including the Chair of the committee, to ensure that members have the appropriate knowledge, skills and capacity to discharge the additional responsibilities.

iii. Invite comments on the revised ToR from existing / new group members and the ICB's Operational Group (IOG). Once these comments have been considered, submit an updated draft to the existing group for its approval.

iv. Submit a final draft of the ToR to the group's 'responsible committee' for approval.

v. Provide a copy of the final approved ToR to group members and the governance team to save within corporate records.

vi. Review the ToR at least annually (add the review to the group's workplan).

6.5 Establishment of a new group

If an existing group cannot conduct the additional business, follow the process below:

i. For new groups, advise the governance team of the proposed name of the group; its 'responsible committee'; a brief summary of its remit; and Chair/Executive Lead/responsible manager, so that this can be logged. Keep the governance team updated on progress of establishment of the new group.

ii. Membership of the group, including the Chair, must be appropriate to its purpose and objectives.

iii. All main committees of the Board will be chaired by a Non-Executive Member (NEM), Associate NEM or, in the case of Executive Committee, the CEO.

iv. The ToR, to be developed using the template attached at **Appendix B,** must state the group's:

- clearly defined purpose in line with the ICB's strategic aims and objectives.
- level of delegated authority (if any) in accordance with the Scheme of Delegation and Reservation (SoRD) and its duties and responsibilities.
- clearly defined reporting lines (i.e. its 'responsible committee') for the escalation of issues, risks and triangulation of information.

v. Submit a first draft of the ToR to proposed members of the new group, relevant leads/managers, and to IOG, for comment.

vi. Consider comments received and then submit a final draft of the ToR to the responsible committee (or in the case of a new main committee, the Board) for approval.

vii. A copy of the final approved ToR must be forwarded to the governance team to save in corporate records. This also applies to any subsequent amendments to the ToR.

viii. Develop an annual workplan for the group which should be approved by members and reviewed annually. A template is provided at **Appendix C**.

ix. Implement appropriate arrangements to inform the responsible committee of the group's work, e.g. sharing minutes/action notes or providing regular exception reports. (NB: The Board receives approved minutes of its main committees).

x. Consideration must be given to managing conflicts of interest in accordance with the ICB's Management of Conflicts of Interest Policy (Ref 018). Any potential, actual or perceived conflicts of interests must be managed by the Chair in accordance with the policy and noted in the minutes. Each meeting agenda must include an item entitled "Declarations of Interest" at the start of the agenda. Members must declare any interests relevant to items on the agenda.

7. Escalations

All groups must have clear channels for escalating significant risks and issues.

i. Escalation should be undertaken when the group has concluded it is not able to manage the risk or issue within its delegated authority, and will normally be via the responsible committee.

ii. Escalations must be recorded within minutes of the escalating group and the responsible committee (or other group(s) receiving the escalation).

iii. Agendas must include a standing item at the end of the meeting entitled "Matters for Escalation to [*name of responsible group or other relevant forum(s)*]".

iv. The group should consider whether any escalated issues or risks should be recorded on the appropriate level of ICB risk register maintained on the RLDatix DCiQ database (and/or in due course, on the PMO's new project management database, currently being implemented). For further advice in this regard, please contact the Senior Manager Corporate Services or Datix Administrator.

8. Disestablishment of a Group

8.1 Time bounded groups, such as Task and Finish Groups, will automatically be disestablished once the relevant task has been completed. The responsible committee must be informed if the group needs to meet longer than envisaged.

8.2 For all other groups, the responsible committee should be advised of the intention for the group to be disestablished, with reasons, to provide an opportunity to raise any concerns in this regard.

8.3 The governance team must be informed when a group has been disestablished so corporate records can be updated.

8.4 Managers must ensure that records of the disestablished group are maintained in accordance with the ICB's Records Management and Information Lifecycle Policy (Ref 012).

9. Related Policies and Guidance

- Records Management and Information Lifecycle Policy (Ref 012)
- Management of Conflicts of Interest Policy (Ref 018)

10. Review of Procedure

This procedure will be reviewed every two years, or sooner if required.

11. Links to Appendices

Appendix A – Flowchart summarising the process within this document.

Appendix B – Terms of Reference template.

Appendix C – Workplan for committees and other groups.

Appendix A

Summary of process for establishing new ICB committees/sub-committees or other groups.

Can the relevant business be conducted by another group?

See Sections 6.1 to 6.3 of this process for more information.

YES	NO
See sections 6.4 and 7 of this process: Update the Terms of Reference (ToR) of the existing group, including its scope, responsibilities, membership. Inform governance team of the proposed changes. Share updated ToR with existing group members, any other relevant managers and ICB Operational Group (IOG) for comment. Consider comments received and submit an updated draft ToR to the existing group for its approval.	See sections 6.5 and 7 of this process: Develop Terms of Reference (ToR) for the new group, including its scope, responsibilities, membership, and how it will report to its 'responsible committee'. Inform the governance team of the proposed new group. Share draft ToR with proposed group members, any other relevant managers and ICB Operational Group (IOG) for comment. Consider comments received and submit an updated draft ToR to the existing
Submit a final draft of the ToR to the existing group's 'responsible committee' for approval.	Submit a final draft of the ToR to the group's 'responsible committee' for approval.
Submit the final approved version of the ToR to the governance team for saving in corporate records.	Submit the final approved version of the ToR to the governance team for saving in corporate records.
Review the ToR at least annually (add 'ToR review' to the committee/group's workplan (see template at **Appendix C**)	Review the ToR at least annually (add 'ToR review' to the committee/group's workplan (see template at **Appendix C**)
Time-bounded 'task and finish' groups will automatically be disestablished once the relevant task is complete. Should the group need to meet longer than anticipated, inform the responsible committee.	Time-bounded 'task and finish' groups will automatically be disestablished once the relevant task is complete. Should the group need to meet longer than anticipated, inform the responsible committee.

Disestablishment of Group - See Section 8 of the process.

For all other groups, the responsible committee must be advised of the intention for its disestablishment, with reasons, to provide an opportunity to raise any concerns in this regard.

Inform the governance team when a group is to be disestablished so corporate records can be updated.

Maintain records of the disestablished group in accordance with the ICB's Records Management and Information Lifecycle Policy (Ref 012).

Guidance for meeting administration

Group	Formal TOR *	Project TOR	Agenda	Note CoIs	Formal minutes	Informal Notes	Short bullet notes	RAID Log	Decision Log	Action Log	Escalation to SOAC	Attendance
Board and main committees (sub-committees of the Board), except for Executive Committee.	✓		✓	✓	✓				✓	✓	✓	✓
Executive Committee	✓		✓	✓		✓			✓	✓	✓	✓
Statutory groups (i.e. Health & Safety) Contractual meetings (e.g. performance meetings) - Gold HR investigation / Tribunal MDT for AACC		✓	✓	✓	✓				✓	✓		✓
Contractual meetings – Silver & Bronze		✓	✓	✓					✓	✓		✓
Working Groups / Task and Finish Groups		✓	✓	✓			✓	✓ (or separate logs)	✓	✓		✓
Team / Directorate Meetings			✓ (informal)	✓						✓ (if required)		

* denotes formal terms of reference that needs to be approved by the Board.

3. Financial Management

3.1. Standing Financial Instructions

Mid and South Essex Integrated Care System

NHS
Mid and South Essex
Integrated Care Board

Standing Financial Instructions

Document Control:

Policy Name	Standing Financial Instructions
Policy Number	093
Version	2.0
Status	Approved Final Version
Author / Lead	Finance Team
Responsible Executive Director	Executive Chief Finance Officer
Responsible Committee	Audit Committee Finance & Performance Committee
Date Ratified by Responsible Committee	11 January 2024
Date Approved by Board/Effective Date	18 January 2024
Next Review Date	January 2026
Target Audience	All Staff
Stakeholders engaged in development of Policy (internal and external)	Finance Team Governance Team Internal Audit External Audit
Impact Assessments Undertaken *(State if not applicable)*	Equality and Health Inequalities Impact Assessment

Version History

Version	Date	Author (Name and Title)	Summary of amendments made
0.1	Feb-June 22	Finance Team	First draft
1.0	01/07/22	Finance Team	Final version approved by ICB Board
1.1	07/01/24	Kevin Edwards, Attain Nicola Adams, Associate Director of Corporate Services	Amendment to account for new Provider Selection Regime Regulations. Transferring policy into corporate template, accessibility and changes resulting from organisational restructure.
2.0	18/01/24	Helen Chasney, Corp Svcs & Gov Support Officer	Approved Final Version.

Contents

1. Introduction

1.1. 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.

1.2. 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**.

1.3. 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.

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

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

1.6. 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.

2. Purpose and Statutory Framework

2.1. 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.

2.2. 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.

2.3. 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.

2.4. 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.

2.5. 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.

2.6. 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.

2.7. 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.

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

2.9. 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.

3. Scope

3.1. 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.

3.2. 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.

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

3.4. 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.

3.5. E.g., This policy applies to all ICB Board members and staff (including temporary/bank/agency/work experience staff, students, and volunteers).

4. Definitions

There are no definitions to include.

5. Roles and Responsibilities

5.1. Integrated Care Board

5.1.1. The ICB Board remains accountable for the financial stewardship of the ICB and ensuring it complies with legislation and statutory requirements.

5.2. Audit Committee

5.2.1. 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.

5.3. Chief Executive

5.3.1. 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.

5.3.2. The CFO reports directly to the ICB chief executive officer and is professionally accountable to the NHS England regional finance director.

5.3.3. The chief executive will delegate to the CFO 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 CFO 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.

5.4. Executive Chief Finance Officer (CFO)

5.4.1. The CFO is responsible for operational financial management and stewardship and as such is accountable to the Chief Executive Officer and the ICB Board.

5.5. All Staff

5.5.1. 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.

6. Policy Detail

6.1. Management accounting and business management

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

6.1.2. The CFO will delegate the budgetary control responsibilities to budget holders through a formal documented process.

6.1.3. The CFO 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.

6.1.4. In addition, the CFO 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.

6.1.5. The CFO 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.

6.2. Income, Banking Arrangements and Debt Recovery

Income

6.2.1. 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.

6.2.2. The CFO 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.

Banking

6.2.3. The CFO 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.

6.2.4. The CFO 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.

Debt Management

6.2.5. The CFO is responsible for the ICB debt management strategy.

6.2.6. 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.

6.3. Financial Systems and Processes

Provision of Finance Systems

6.3.1. The CFO 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.

6.3.2. 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.

6.3.3. 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.

6.3.4. The CFO 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 CFO shall periodically seek assurances that adequate controls are in operation.

6.4. Procurement and Purchasing

6.4.1. The CFO 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.

6.4.2. The ICB must ensure that procurement activity is in accordance with the Public Contracts Regulations 2015 (PCR) for non-healthcare services as defined by the Common Procurement Vocabulary (CPV) codes and associated statutory requirements whilst securing value for money and sustainability.

6.4.3. The ICB must ensure that healthcare services procurement is in accordance with the Health Care Services (Provider Selection Regime) Regulations 2023 (PSR) as defined in Schedule 1 and section 150(1) of the Health and Social Care Act 2012.

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

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

6.4.6. 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.

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

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

6.4.9. Undertake any contract variations or extensions in accordance with PCR 2015 for non-healthcare services, PSR for healthcare services and the ICB procurement policy.

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

6.5. Staff Costs and Staff Related non-Pay Expenditure

Executive Chief People Officer

6.5.1. 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.

6.5.2. 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.

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

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

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

6.5.6. Insert text. Additional headings can be added instead of subheadings if this aids comprehension.

6.6. Annual Reporting and Accounts

6.6.1. The CFO 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.

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

6.6.3. 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.

6.7. Internal Audit

6.7.1. 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 CFO to ensure that:

- all internal audit services provided under arrangements proposed by the CFO 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, and
- 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.

6.8. External Audit

6.8.1. The CFO 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.

6.9. Losses and Special Payments

6.9.1. 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.

6.9.2. The CFO 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.

6.9.3. 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.

6.9.4. 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.

6.9.5. 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.

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

6.10. Fraud, Bribery and Corruption (Economic Crime)

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

6.10.2. The ICB CFO 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.

6.11. Capital Investments & Security of Assets and Grants

6.11.1. The CFO 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 CFO is responsible for ensuring there are processes in place to ensure that a business case is produced.

6.11.2. 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.

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

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

6.11.5. 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.

6.11.6. 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.

Grants

6.11.7. The CFO 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.

6.11.8. 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.

6.12. Legal and Insurance

6.12.1. 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.

6.12.2. 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.

7. Monitoring Compliance

7.1. Compliance with this policy will be monitored by the finance team and reported to the Audit Committee and the Finance & Performance Committee according to their terms of reference.

7.2. Both Internal and External Auditors will also review compliance with the policy and provide feedback to respective committees via their audit reports.

8. Staff Training

8.1. There is no general staff training required. However, finance staff will be professionally qualified as required by their role description.

8.2. This policy will be shared with staff to ensure their understanding and ‘on the job’ support will be provided by the finance team where needed.

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.

9.2. 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

Associated Policies

- Scheme of Reservation and Delegation
- Standing Orders
- Decision Making Policy
- Procurement and Contracting Policy

11. References

- ICB Constitution
- National Health Service Act 2006, as amended by the Health and Care Act 2022.

12. Equality Impact Assessment

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 and version number: Standing Financial Instructions	**Directorate/Service**: Finance
Assessor's Name and Job Title: Nicola Adams	**Date:** 07/01/2024

OUTCOMES
Briefly describe the aim of the policy and state the intended outcomes for staff
To govern financial processes. This documents ensures that staff follow statutory guidance and ICB Policy.
EVIDENCE
What data / information have you used to assess how this policy might impact on protected groups?
General assessment.
Who have you consulted with to assess possible impact on protected groups? If you have not consulted other people, please explain why?
This is a financial procedure that has no impact on protected characteristics.

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	
Disability (Physical and Mental/Learning)			X	
Religion or belief			X	
Sex (Gender)			X	
Sexual Orientation			X	
Transgender / Gender Reassignment			X	
Race and ethnicity			X	
Pregnancy and maternity (including breastfeeding mothers)			X	
Marriage or Civil Partnership			X	

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?
The impact of financial decisions are monitored as per individual decisions and not as part of this policy.

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

4. Policy Management Framework

4.1. Policy for developing policies (including Policy Template)

4.2. Policy Framework (Register of Policies)

4.3. Risk Management Policy

4.4. Conflicts of Interest Policy

4.5. Standards of Business Conduct Policy

4.6. Decision Making Policy

4.7. Patient and Public Engagement Framework [to follow]

Mid and South Essex Integrated Care System

NHS
Mid and South Essex
Integrated Care Board

Policy for the development, ratification and implementation of policies (Policy for Policies)

Document Control:

Document Control Information	Details
Policy Name	Policy for the development, ratification and implementation of policies
Policy Number	MSEICB 016
Version	2.0
Status	Approved ICB policy
Author / Lead	Sara O'Connor, Senior Manager Corporate Services
Responsible Executive Director	The Chief Executive has delegated responsibility to the Director of Corporate Services for the management of policies
Responsible Committee	Audit Committee
Date Approved by Responsible Committee	23 July 2024
Date Ratified by Board	12 September 2024
Next Review Date	July 2026
Target Audience	All ICB Board members and staff (including temporary/bank/agency/work experience staff, students and volunteers)
Stakeholders engaged in development of Policy (internal and external)	• Governance Leads • Executive Committee • Audit Committees
Impact Assessments Undertaken *(State if not-applicable)*	• Equality and Health Inequalities Impact Assessment - completed • Quality Impact Assessment – N/A • Privacy Impact Assessment – N/A

Version History

Version	Date	Author (Name and Title)	Summary of amendments made
0.1	21/2/22	Viv Barnes, Governance Lead	Draft ICB Policy
0.2	25/2/22	Viv Barnes, Governance Lead	Amended to reflect feedback from Governance Leads
0.3	3/6/22	Viv Barnes, Governance Lead	Final amends prior to adoption
1.0	7/7/22	Viv Barnes, Governance Lead	Formatting review prior to uploading
1.1	09/07/24	Sara O'Connor, Senior Manager Corporate Services	Updated to reflect organisational change.
1.2	22/07/24	Sara O'Connor, Senior Manager Corporate Services	Policy checklist (Appendix C) updated to include reference to review of draft policy by Local Counter Fraud Specialist where necessary.

Version	Date	Author (Name and Title)	Summary of amendments made
2.0	23/07/24	Helen Chasney, Corporate Services & Governance Support Officer	Final Approved version.

Contents

1. Introduction

1.1. To ensure robust governance, organisations need formal written documents, such as policies, which communicate standard corporate organisational ways of working. These help to clarify strategic and operational requirements and ensure consistency within day to day practice. In addition, they can improve the quality of work, increase the successful achievement of objectives and support patient safety, quality and experience. It is recognised that systems need to be in place to ensure policies are user friendly, up-to-date and easily accessible.

1.2. A common format and approval structure for policies will reinforce corporate identity. More importantly, this will help to ensure that policies and related procedures in use are current and reflect an organisational approach. It will also avoid confusion and assist employees to readily access information within the document in a consistent manner.

2. Purpose

2.1. Mid and South Essex Integrated Care Board (the ICB) intends that its organisational policies should provide a clear understanding of what is expected of employees and Board members.

2.2. Whilst this document is particularly relevant to staff who are responsible for writing or reviewing policies, it is equally important that all Board members and employees understand the relevance of having these in place.

2.3. Occasionally policies will be developed through partnership working and may have a different format than that described here. In these instances, the policy itself will be adopted but will still be quality-assured against the criteria of this document to ensure that when presented for final approval it meets the ICB's requirements.

2.4. This document outlines the process for policy development from inception through to ratification, implementation and evaluation.

2.5. A flow chart detailing this process is shown at Appendix B.

3. Scope

This policy applies to all ICB Board members and staff (including temporary/bank/agency/work experience staff, students and volunteers).

4. Definitions

- **Policy** - an organisation wide corporate policy is a ratified plan of action which applies to all relevant staff as a 'must do' requirement.

The formal policy document is legally binding between employer and employee. A policy says '*what you must know or do*.'

- **Procedure** - an organisation wide procedure is a standardised series of actions taken to achieve a task in an agreed and consistent manner to attain a safe and effective outcome. A procedure is a formal document that must be complied with as it may be used to support an individual or the ICB during legal action. A procedure tells you '*how it must be done*.'
- **Strategy** - a strategy is a document that defines a process of moving towards an ideal situation, generally over the long-term, implementing actions or compliance with a policy. A strategy tells you '*how we will get from A to B*.'

5. Roles and Responsibilities

5.1. Integrated Care Board

5.1.1. The ICB Board has overall responsibility for ensuring that the organisation has a robust system in place for the development, approval and regular review of policies covering all of its corporate activities.

5.1.2. The ICB Board will receive formal confirmation from the committee sponsoring the policy that it meets the requirements of the Policy for Policies. The ICB Board is responsible for providing formal approval of all new ICB policies and those which have been subject to substantial or significant revisions, having received this assurance.

5.2. Audit Committee

5.2.1. The responsibility of this Committee is to review and ratify corporate, Health and Safety, Information Governance and emergency planning related policies that are new or have been subject to substantial or significant revisions since the previous version.

5.2.2. Provided the Audit Committee is satisfied with the content and presentation of the policy, they will ratify it and recommend it for final approval by the ICB Board. The Audit Committee has delegated authority to give final approval to any policies that have been subject to no revisions or only minor changes from the previous version.

5.3. Quality Committee

5.3.1. The Quality Committee has the same responsibilities as detailed in section 5.2 above but in relation to clinical policies.

5.4. The Finance and Performance Committee

5.4.1. The Finance and Performance Committee has the same responsibilities as detailed in section 5.2 above but in relation to procurement and investment policies.

5.5. Chief Executive

5.5.1. The Chief Executive Officer of the ICB has overall accountability for implementing the Policy for Policies.

5.6. Director of Corporate Services

5.6.1. The Chief Executive has delegated operational responsibility for implementation of this policy to the Director of Corporate Services.

5.7. Policy Authors

5.7.1. Policy authors are responsible for reviewing and updating the policies within their remit on an annual basis or should legislation, guidance, organisational change or other circumstances necessitate an earlier review.

5.8. Governance Lead

5.8.1. The Associate Director of Corporate Services supported by the Senior Manager of Corporate Services (referred to in this policy as the Governance Lead) will provide support with policy development by:

- Offering support and advice to policy authors.
- Testing the rationale for the need for an ICB policy.
- Logging the policy on the relevant policy register.
- Identifying possible overlap/conflict with any other policies that have been ratified or are in development.
- Identifying whether the document is a policy or a local procedure or guidance.
- Identifying and confirming the correct ratification route.
- Confirming that a draft policy meets the requirements of the Policy Development Checklist (Appendix C) before it is submitted to the ratifying committee.
- Uploading ratified policies to the intranet and internet.
- Maintaining the register of active policies.
- Archiving old policies.
- Advising policy leads when policies are due for review.

5.9. Line Managers

5.9.1. Line Managers are responsible for:

- Identifying when a new or amended policy may be required for the areas within their remit.
- Ensuring that new members of staff are made aware of key policies as part of their induction.
- Highlighting new and amended policies within their team briefings.
- Monitoring the implementation of policies within their team and addressing any failures to follow agreed processes.

5.10. All Staff

5.10.1. All staff need to ensure they are aware of the system for policy development, ratification and implementation. This includes a requirement on receipt of new policies to review their contents and assess the relevance to their role.

5.10.2. All staff should be aware that wilful or negligent disregard of any policy will be investigated and potentially treated as a disciplinary offence.

6. Policy Detail

6.1. Style and format

6.1.1. All policies and any related procedures should be developed using the Policy Template appended to this policy (Appendix D). Requirements in respect of style and format are detailed on the template itself.

6.1.2. The Policy Template has been designed to be accessible in accordance with the requirements of the Equality Act 2010 and the Public Sector Bodies (Websites and Mobile Applications) Accessibility Regulations 2018. It is imperative, therefore, that policy authors use the template provided and do not attempt to modify its format. Accessibility checks must be performed by the policy author and any issues addressed prior to approval of a new or revised policy.

6.2. Key features of a well-written policy

6.2.1 Each policy must be compliant with all current legal and statutory requirements that are relevant to their development. A well written policy should:

- Be clear, concise, jargon free and written in straightforward language.
- Explain abbreviations or acronym the first time they are used.
- Take account of the relevant views of stakeholders where appropriate.
- Be sound / evidence based.
- Have clear objectives.
- Specify how it will be implemented, monitored and audited.
- Describe a consequence of any breaches.

6.3. Development of new and revised policies

6.3.1 It is important that the development of policies and related procedures are linked to service priorities and that they do not duplicate other work either nationally or locally. Therefore, the author must ensure that they have researched the background and available evidence prior to consultation and ratification.

6.3.2 An author may be requested to develop a new policy based on ICB needs, changes in legislation or national requirements.

6.3.3 An author who is reviewing an existing policy is expected to review the contents of the current version for their continued relevance and maintaining continuity between versions. The author will also be responsible for checking that any hyperlinks remain valid and undertaking a new Equality Impact Assessment.

6.3.4 Whilst writing the policy, the author should use the Policy Development Checklist (Appendix C) to confirm whether it meets all necessary requirements.

6.4. Consultation

6.4.1 Consultation should be undertaken to secure the support and experience from all relevant individuals and groups.

6.4.2 It is vital to the success of the implementation of any policy that the expertise and experience of all relevant parties has been considered, particularly those who will be expected to implement its requirements.

6.4.3 The consultation process is an opportunity to influence the policy content and should not be considered only as an exercise to satisfy the checklist requirements.

6.4.4 A draft policy when sent out to stakeholders should be as near to the 'final' draft version as possible and include all relevant references with details of associated documentation. This will help to ensure that the stakeholders are able to review and make appropriately informed comments. Sufficient time should be given to enable a thorough review by stakeholders.

6.4.5 A list of all staff and stakeholders consulted during the policy development should be included in the relevant section.

6.5. Preparation for approval

6.5.1. Once the policy has been fully consulted upon and comments considered it is ready for formal agreement and ratification.

6.5.2. It is the author's responsibility to contact the Governance Lead to request that the policy be added to the agenda of the next most convenient and appropriate committee meeting, although the governance team will track and remind policy authors when policies are due for review.

6.5.3. The author should submit the draft policy, completed Policy Development Checklist and a summary of the purpose of the policy (if new) or of the key changes that have been to the existing policy (if amended) to the Governance Lead.

6.5.4. The Governance Lead will review the policy and associated documents and advise the policy author if any changes or additional information is needed before it is submitted to the ratifying committee.

6.5.5. The policy author may be invited to attend the committee meeting to present the policy and respond to any queries.

6.5.6. If the policy is not deemed to be ready for formal ratification, the committee will agree with the author where amendment or clarification is required. The author will then re-submit to the next meeting if appropriate. If the policy is deemed ready for final approval (with or without minor amendments), then it will be approved by the relevant committee(s) and ratified by the ICB Board, or, in the case of new or significantly amended policies, approved by the ICB Board.

6.6. Fastrack policy approval process

6.6.1. There will be occasions due to urgency or immediacy where the process of formal ratification needs to be accelerated, but this should be on an exceptional basis only. In these circumstances, committee Terms of Reference allow for urgent decisions to be taken outside of their normal meeting schedule. If necessary, the policy can then be formally approved by the ICB Board under the exercise of Emergency Powers.

6.7. Dissemination and communication to staff and the public

6.7.1. The Governance team will arrange for all ratified policies to be added to the staff intranet page and staff will be notified of all policy activity through the ICB's internal communication system.

6.7.2. Policies must be provided in alternative formats upon request, such as larger print, easy read, braille, audio format and different languages.

6.8. Document control including archiving arrangements

6.8.1. The Governance team will hold a central register of all current policy documents, together with a master file of electronic copies, including archived documents.

7. Monitoring Compliance

7.1. Performance indicators will be used to monitor effectiveness of this policy. These will include complaints, claims and incidents to identify where failure to follow policy may have impacted on commissioning, service delivery, regulatory compliance or corporate governance.

7.2. The relevant sponsoring committee will be responsible for ensuring that policies submitted to them for approval are compliant with this policy.

8. Staff Training

8.1 There is a requirement as part of local induction to ensure that staff are made aware of the importance of policies and procedures and their adherence to them.

8.2 All policies must identify the training requirements associated with them and the frequency with which this training is required.

9. Arrangements for Review

9.1. 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.

9.2. If only minor changes are required, the sponsoring 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 The author is required to provide details of supporting or linked strategy, policy, procedural or other documents within the ICB that may need to be read in conjunction with the policy or for staff to be aware of their existence.

10.2 For this policy the associated documentation is:

- Policy Template.
- Policy Checklist.

Associated Policies

This policy is relevant to all ICB Policies.

11. References

11.1. The author should provide references to any documents that have been used to develop the policy as evidence that it has been based on best practice and guidance.

11.2. For this policy the references are:

- Equality Act 2010.
- Public Sector Bodies (Websites and Mobile Applications) (No. 2) Accessibility Regulations 2018.

12. Equality Impact Assessment

12.1. An Equality Impact Assessment (EIA) of this policy has been undertaken and it has identified no equality issues.

12.2. The EIA has been included as Appendix A.

Appendix A - Equality Impact Assessment

INITIAL INFORMATION

Name of policy: Policy for Policies **Version number (if relevant):** 2.0	**Directorate/Service**: CEO's office / Governance
Assessor's Name and Job Title: Sara O'Connor, Senior Manager Corporate Services	**Date:** 9 July 2024

OUTCOMES
Briefly describe the aim of the policy and state the intended outcomes for staff
This policy provides a framework for the development of staff and public policies to ensure that they are user friendly, up-to-date and easily accessible.
EVIDENCE
What data / information have you used to assess how this policy might impact on protected groups?
This policy acknowledges that at least 1 in 5 people in the UK have a long term illness, impairment or disability and many more have a temporary disability. The policy template has therefore been developed to meet the accessibility requirements of the Equality Act 2010 and the Public Sector Bodies (Websites and Mobile Applications) Accessibility Regulations 2018.
Who have you consulted with to assess possible impact on protected groups? If you have not consulted other people, please explain why?
• Governance Leads • Human Resources • Audit Committee

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*

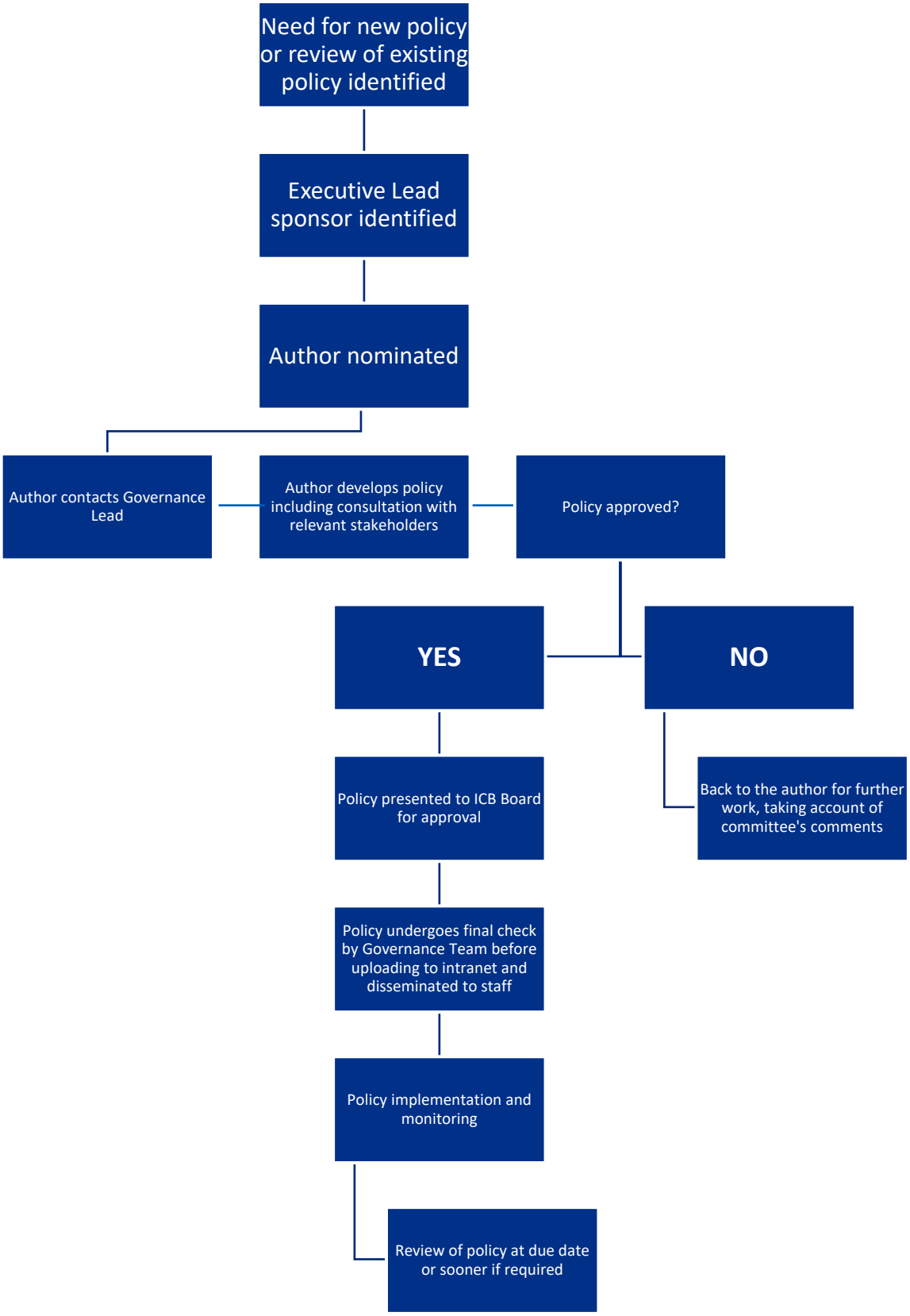
Please tick to show if outcome is likely to be positive, negative or neutral. Consider direct and indirect discrimination, harassment and victimisation.

Protected Group	Positive outcome	Negative outcome	Neutral outcome	Reason(s) for outcome
Age			X	No impact identified
Disability (Physical and Mental/Learning)			X	No impact identified. Policies will be made available in alternative formats on request. All final policies undergo website accessibility checks.
Religion or belief			X	No impact identified
Sex (Gender)			X	No impact identified
Sexual Orientation			X	No impact identified
Transgender / Gender Reassignment			X	No impact identified
Race and ethnicity			X	No impact identified. Policies will be made available in alternative formats on request.
Pregnancy and maternity (including breastfeeding mothers)			X	No impact identified
Marriage or Civil Partnership			X	No impact identified

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?
Performance indicators will be used to monitor effectiveness of this policy. These will include complaints, claims and incidents to identify where failure to follow policy may have impacted on commissioning, service delivery, regulatory compliance or corporate governance. Sponsoring committees which review new/revised policies often query issues relating to equality and request policy authors to update policies to address any issues identified.

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 – Key Stages of the Policy Process



Appendix C - Policy Development Checklist

Policy title:			
Criteria for Compliance	**Author Yes/No**	**Author's Comments**	**Reviewer's Comments**
Could this policy be incorporated within an existing policy?		If no explain why	
If a new policy, has the Governance Team been notified so a policy reference can be allocated?			
Does this policy follow the style and format of the agreed template?			
Has the Document Control table been completed?			
Has the Version Control table been completed?			
Is there an appropriate review date?		Explain if less or more than 2 years	
Have key performance indicators (or other arrangements) been identified to monitor effectiveness of the policy?			
Have all relevant associated policies and references been listed?			
Have all appropriate stakeholders (including where necessary the Local Counter Fraud Specialist) been consulted and identified on the stakeholder list?			
Has an Equality Impact Assessment (EIA) been undertaken? (included within Policy template)			
Has the policy been amended to address any negative impacts identified from the EIA?			
Is a Quality Impact Assessment (QIA) or required?			

Policy title:			
Criteria for Compliance	**Author Yes/No**	**Author's Comments**	**Reviewer's Comments**
NB: Seek advice from Quality Team if required.			
Is there a clear indication of how the policy will be implemented?			
Have job titles/responsibilities been updated to reflect the current ICB structure.			
Has a website accessibility check been undertaken and any issues addressed?			

Appendix D – Policy Template

SEE OVERLEAF

Mid and South Essex Integrated Care System

NHS
Mid and South Essex
Integrated Care Board

XXXX Policy Name

Document Control:

Document Control Information	Details
Policy Name	
Policy Number	
Version	
Status	
Author / Lead	
Responsible Executive Director	
Responsible Committee	
Date Ratified by Responsible Committee	
Date Adopted by the ICB Board/Effective Date	
Next Review Date	
Target Audience	
Stakeholders engaged in development of Policy (internal and external)	
Impact Assessments Undertaken *(State if not applicable)*	• Equality and Health Inequalities Impact Assessment • Quality Impact Assessment • Privacy Impact Assessment

Version History

Version	Date	Author (Name and Title)	Summary of amendments made

Contents

1. Introduction

1.1. Insert text

2. Purpose / Policy Statement

2.1. Insert text Insert statement of policy

2.2. Insert narrative for bullet list:

- Bullet list (remove if not using)

3. Scope

3.1. E.g. This policy applies to all ICB Board members and staff (including temporary/bank/agency/work experience staff, students and volunteers).

4. Definitions

- State Word – Provide Definition
- State Word – Provide Definition
- State Word – Provide Definition

5. Roles and Responsibilities

5.1. Integrated Care Board

5.1.1. Insert narrative for ICB Board responsibilities.

5.2. XXXX Committee

5.2.1. Insert narrative for Committee responsibilities.

5.3. XXXX Committee

5.3.1. Insert narrative for XXX Committee responsibilities (if applicable – repeat as necessary).

5.4. Chief Executive

5.4.1. Insert narrative for what the Chief Executive is accountable for.

5.5. Director of XXX

5.5.1. Insert narrative for what the Executive Director lead is accountable for.

5.6. Policy Authors

5.6.1. Insert narrative for what the Policy Authors are accountable for.

5.7. Arden and GEM Commissioning Support Unit (AGEMCSU)

5.7.1. Insert narrative for relevant AGEMCSU responsibilities (if applicable)

5.8. Governance Lead

5.8.1. Insert narrative for what the Governance Lead is accountable for (if applicable).

5.9. Line Managers

5.9.1. Insert narrative for what Line Managers are accountable for.

5.10. All Staff

5.11. Insert narrative for what all staff are accountable for.

6. Policy Detail

6.1. Subheading

6.1.1. Insert text. Additional headings can be added instead of subheadings if this aids comprehension.

7. Monitoring Compliance

7.1. Insert text regarding KPIs or other ways of monitoring compliance with the policy.

7.2. Insert text regarding Committees responsible for monitoring compliance.

8. Staff Training

8.1. State training requirements

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.

9.2. 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

- List supplementary documents (if applicable)

Associated Policies

- List here the relevant associated ICB policies

11. References

- Provide a list of references of the documents that have informed or contributed to this policy.

12. Equality Impact Assessment

12.1. State either – the EIA has identified no equality issues with this policy OR Issues identified in the EIA were XXX and they have been addressed by XXX.

12.2. The EIA has been included as Appendix A.

Appendix A - Equality Impact Assessment

INITIAL INFORMATION

Name of policy and version number:	**Directorate/Service**:
Assessor's Name and Job Title:	**Date:**

OUTCOMES
Briefly describe the aim of the policy and state the intended outcomes for staff
EVIDENCE
What data / information have you used to assess how this policy might impact on protected groups?
Who have you consulted with to assess possible impact on protected groups? If you have not consulted other people, please explain why?

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				
Disability (Physical and Mental/Learning)				
Religion or belief				
Sex (Gender)				
Sexual Orientation				
Transgender / Gender Reassignment				
Race and ethnicity				
Pregnancy and maternity (including breastfeeding mothers)				
Marriage or Civil Partnership				

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?

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

Implementing the Policy/Service

Negative outcomes – action plan

If there are no negative outcomes, please remove this section.

An Equality Impact Assessment cannot be signed off until negative outcomes are addressed. What actions you have taken/plan to take to remove/reduce negative outcomes?

1. Action taken/to be taken	2. Date	~~3.~~ Person Responsible

If a negative outcome(s) remain explain why you think implementation is justified.

Insert response here

Appendix B – Title XXX

Insert other appendices as appropriate

Ref Number:	Policy Name
001	Media Policy
002	Social Media Policy
003	Procurement and Contracting Policy
004	Accounting and Financial Management
005	Patient Choice Policy **(NEW)**
006	Banking and Cashflow Management Policy
007	Creditors and Purchase Policy
008	Debtors and Sales Order Policy
009	Financial Allocations and System Reporting
010	Information Governance Management & Framework Policy
011	Information Sharing Policy
012	Records Management & Information Lifecycle Policy
013	Access to Information Policy
014	Information and Cyber Security Policy
015	IT Equipment Refresh and Disposal Policy
016	Policy for Policies
017	Risk Management Policy
018	Conflicts of Interest, Gifts and Hospital and Commercial Sponsorship
019	Standards of Business Conduct Policy
020	Lone Working Policy
021	Health & Safety Policy (including Fire Safety, First Aid and Manual Handling)
022	Legal Services Policy
023	FTSU (Whistleblowing) Policy
024	Incident Reporting Policy
025	Management of Violence and Aggression and Vexatious Behaviour Policy
026	Counter-Fraud, Bribery & Corruption Policy
027	Forensic Readiness Policy
029	Security and Lockdown Policy
030	Business Continuity Policy
031	On Call Director Policy
032	Health Inequalities Impact Assessment Policy and Guidance
033	Equality in Employment Policy
034	Recruitment & Selection Policy
035	Job Matching and Evaluation Policy
036	Disclosure and Barring Policy
037	Nurse Revalidation Policy
038	Professional Registration Policy
039	Probation Policy
040	Stress Management Policy
041	Flexible Working Policy
042	Grievance Policy
043	Managing Performance Policy
044	Absence Management Policy
045	Disciplinary Policy
046	Hybrid Working Policy
047	Annual Leave Policy
048	Special Leave Policy
049	Maternity, Paternity & Adoption Leave Policy
050	Parental Leave Policy

051 Shared Parental Leave Policy
052 Fostering Policy
053 Learning & Development Policy
054 Appraisal Policy
055 Organisational Change Policy
056 Dignity at Work Policy
057 Lease Car Scheme Policy (NEW)
058 Management of Leavers Policy
059 Pandemic People Incidents Policy
060 Close Personal Relationships at Work Policy
061 Domestic Violence and Abuse Policy
062 Complaints, Compliments and Concerns Management Policy
063 Safeguarding Adults and Children (including Children in Care/Looked After Children) Policy
064 Safeguarding Supervision Policy
065 Management of Allegations against staff, volunteers and people in positions of trust who work with adults and children Policy
067 Serious Incidents Process Policy
068 All Age Continuing Care Policy
069 Personal Health Budgets: Ethos, Practice and Guidance Policy
071 Prevent Policy
072 Quality Assurance Visits Policy
073 Mental Capacity Act 2005 and Deprivation of Liberty Policy
074 Communicable Disease Outbreak and Incident Management Policy
075 Bariatric Surgery
076 Individual Funding Request Policy
077 Tertiary Fertility Serices
078 Reimbursement of Staff Expenses Policy (including Travel).
079 Parachute Policy (NEW) Urgent contract for primary medical care provision or caretaking policy
080 Defining Boundaries between NHS and Private Healthcare
081 Vasectomy
082 Breast Asymmetry Corrective Surgery
083 Breast Reduction Surgery
084 Female Sterilisation
085 Commissioning Policy (Service Restriction)
086 Under / Overpayments Policy
087 Pay Protection Policy
088 Decision Making Policy and Procedure
089 Patient Safety Incident Response Framework (PSIRF) Policy
090 Cycle to Work Policy (NEW)
091 Menopause at Work Policy
092 Provider Accreditation Policy
094 Volunteering Policy (NEW)

Mid and South Essex Integrated Care System

NHS
Mid and South Essex
Integrated Care Board

Risk Management Policy

Document Control:

Policy Name	Risk Management Policy
Policy Number	MSEICB 017
Version	2.0
Status	Final ICB Policy
Author / Lead	Head of Governance and Risk
Responsible Executive Director	The Chief Executive has delegated responsibility to the Chief of Staff for risk management
Responsible Committee	Audit Committee
Date Ratified by Responsible Committee	20 June 2022
Date Approved by Board/Effective Date	20 July 2023
Next Review Date	1 July 2025
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. • MSE ICB Audit Committee
Impact Assessments Undertaken	• 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	July 2022	Sara O'Connor / Viv Barnes	Policy Reference number added to final draft and final formatting reviewed prior to uploading.
2.0	July 2023	Sara O'Connor, Head of Governance and Risk	Amended to reflect new ICB Board Assurance Framework, mandatory risk management training for staff Band 8a and above, changes to job titles and other minor amendments.

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

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:

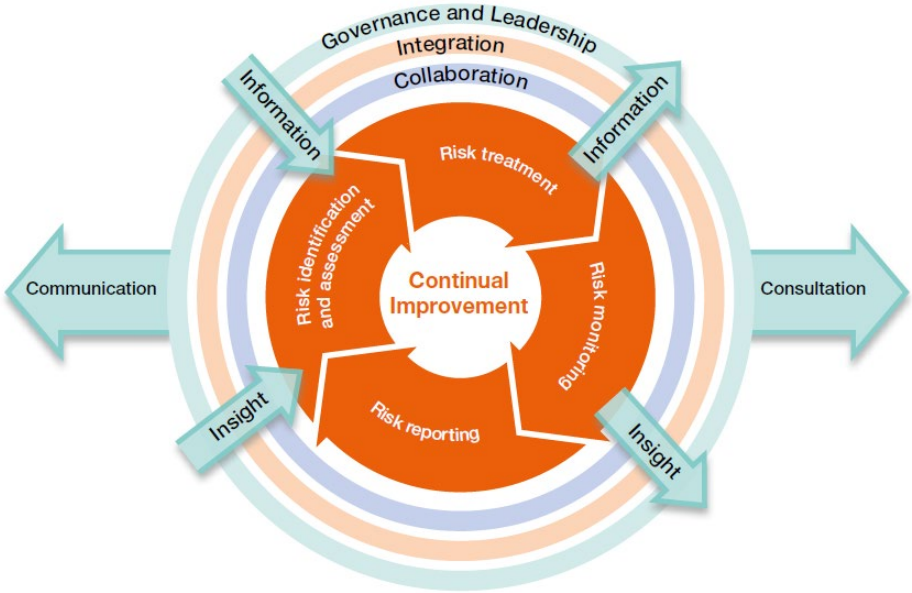
- Supports the ICB in achieving its strategic objectives and realising the significant safety, quality, financial and other organisational benefits from effectively managing risk.
- Ensures processes are based on best practice, national guidance and take account of organisational needs.
- Promotes an 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 Board Assurance Framework (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 BAF. Recommendations for strategic risks will usually be made by the Chief Executive Officer in conjunction with the relevant Responsible Executive Director(s) and ICB Chair or by the relevant ICB Committee. 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.

5.2.3. The BAF will be updated bi-monthly and presented to each publicly held Part I ICB Board meeting.

5.2.4. Strategic risks on the BAF will be cross-referenced against relevant risks on the operational risk register.

5.2.5. The BAF will include a summary of the ICB's main providers' top rated (red) risks.

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, supported by the Deputy Director of Governance and Risk 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. Executive 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 Executive Director of Resources also acts as the ICB Senior Information Risk Owner.

5.7. Executive Chief Nurse

5.7.1. The Executive 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 Executive 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 Executive 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. Head of Governance and Risk

5.10.1. The Head of Governance and Risk, reporting to the Deputy Director of Governance and Risk has responsibility for managing the risk management process, including liaising with risk leads for updates, production of the BAF and 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).

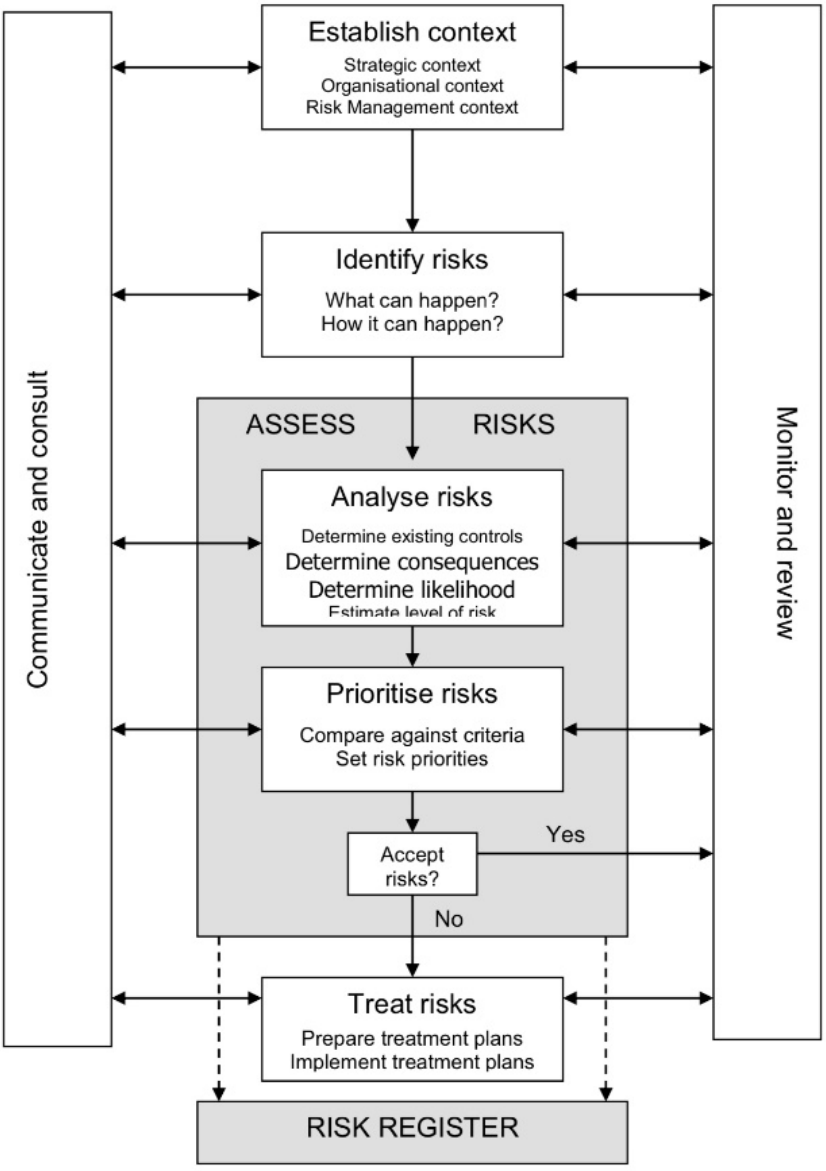
6. Policy Detail

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 work life balance 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 'red/extreme' will be recommended by the Responsible Executive Director/Committee to the ICB Board for inclusion on the BAF where appropriate (see section 5.2.2.), noting that strategic risks on the BAF may cover one or more risk on the risk register.
- **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 considering 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.**

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 mandatory risk management training for staff at Band 8a and above 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:** 1.1	**Directorate/Service**: Corporate / Chief Executive's Office
Assessor's Name and Job Title: Sara O'Connor, Head of Governance and Risk MSE ICB.	**Date:** 18 February 2022 and reviewed 14 June 2023.

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 work life (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

1. Reducing Health Inequalities
2. Creating Opportunities
3. Supporting Health and Wellbeing
4. Bringing Care Close to Home
5. Improving and Transforming Our Services

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 –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	Low	5	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.

Mid and South Essex Integrated Care System

NHS
Mid and South Essex
Integrated Care Board

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	2.0
Status	Final - Approved
Author / Lead	Sara O'Connor, Senior Manager (Corporate Services), Mid Essex CCG
Responsible Executive Director	The Chief Executive has delegated responsibility to the Executive Director of Strategy and Corporate Services for the management of conflicts of interest
Responsible Committee	Audit Committee
Date Ratified by Responsible Committee	16 April 2024
Date Approved by Board/Effective Date	July 2024
Next Review Date	April 2025
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 latest version of Policy (internal and external)	• Governance Team • Kevin Edwards, Associate Director, Attain. • MSE Staff Engagement Group. • ICB Executive Team • Audit Committee
Impact Assessments Undertaken	• Equality and Health Inequalities Impact Assessment

Version History

Version	Date	Author (Name and Title)	Summary of amendments made
1.0	01/07/22	Sara O'Connor / V Barnes	Final approved version following review against policy checklist.
1.1	20/06/23	Sara O'Connor	Review date amended to 1 December 2023 as agreed by Audit Committee (20 June 2023).
1.2	22/01/23	Sara O'Connor	Review date extended to 30 April 2024 as agreed by Audit Committee, 16 January 2024

Version	Date	Author (Name and Title)	Summary of amendments made
			(awaiting outcome of annual internal audit and policy to be updated to reflect new mandatory training requirements).
1.3	29/01/2024	Sara O'Connor	Updated to reflect new mandatory Conflicts of Interest Training for ICBs and job titles due to organisational change.
2.0	July 2024	Helen Chasney	Final – Approved version

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. ICBs are designed to bring together partners from across the ICS in the interests of the local population, including through all ICB boards having local authority, Trust/Foundation Trust and general practice nominated board members. The ICB's approach to the management of conflicts of interest should ensure these benefits of partnership are not lost.

1.3. 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 and training 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.

1.4. 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.

1.5. 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.

1.6. 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.

1.7. 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.

1.8. Interim Guidance on the functions and governance of the ICB was 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.

1.9. 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.

1.10. Partner Members will be expected to act in accordance with paragraph 1.9 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.

1.11. 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.

1.12. 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 6.6 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]

[1] This may be a financial gain, or avoidance of a loss.

from the consequences of a decision they are involved in making.

4.3. **'Material interest'** – is an interest reported and which is assessed as appropriate for inclusion in the ICB's register of interests.

4.4. **Non-financial professional interest** - Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.

4.5. **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.

4.6. **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.

4.7. **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.

Improper Performance – Under the Bribery Act 2010 improper performance is defined in summary as 'performance which amounts to a breach of an expectation that a person will act in good faith, impartially, or in accordance with a position of trust.' The offence applies to bribery relating to any function of a public nature, connected with a business, performed in the course of a person's employment or performed on behalf of a company or another body of persons. Therefore, bribery in both the public and private sectors is covered by the Act.

[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.

NB: It is an offence for a person to offer, promise or give a financial or other advantage to another person in one or two cases:

Case One applies where that person intends the advantage to bring about the improper performance by another person of a relevant function or activity or to reward such improper performance.

Case Two applies where the person knows or believes that the acceptance of the advantage offered, promised, or given in it constitutes the improper performance or a relevant function or activity.

Openness – Means that there should be transparency about NHS activities to promote confidence between the ICB and its employees, service users and the public.

Probity – Means that there should be an absolute standard of honesty in dealing with the assets of the NHS. Integrity should be the hallmark of all personal conduct affecting service users, employees, and suppliers and in the use of information acquired in the course of NHS duties.

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 and is responsible for:

- ensuring that the ICB has processes in place to enable individuals to declare and manage conflicts of interest.
- creating a culture in which ICB employees feel able and supported to report any conflicts of interest concerns as part of their day-to-day activities.

Executive Director of Strategy and Corporate Services. The Chief Executive has delegated responsibility to the Executive Director of Strategy and Corporate Services for managing conflicts of interest.

5.2. 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.
- Report any suspicions of fraud, bribery, or corruption in accordance with the ICB's Counter Fraud, Bribery, and Corruption Policy by referral to the ICB's Local Counter Fraud Specialist (LCFS), Executive Chief Finance Officer, or to the NHS Counter Fraud Authority (NHS CFA).

5.3. Audit Committee

5.3.1. The Audit Committee will have responsibility for monitoring the ICB's compliance with this policy.

5.4. Conflicts of Interest Guardian

5.4.1. 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.
- Be a safe point of contact for employees or workers of the ICB to raise any concerns in relation to this policy, ensuring that concerns are treated with appropriate confidentiality and that explanations are provided for any decisions taken.
- 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.
- Provide advice on minimising the risks of conflicts of interest.

5.4.2. Contact details for the Audit Committee Chair/Conflicts of Interest Guardian are at **Appendix D**.

5.5. Policy Author

5.5.1. The policy author will have responsibility for reviewing and updating the policy in line with Section 8.

5.6. ICB Governance Lead

5.6.1. 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.

5.7. Line Managers

5.7.1. 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 understand their responsibilities and are supported to 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.

5.7.2. Line managers should be the first point of contact if a member of staff is unsure whether to declare an interest or to accept/decline a gift and should work with their staff to ensure their declarations of interests and declarations of gifts and hospitality are up-to-date.

5.8. Local Counter Fraud Specialist

In line with the ICB's Counter Fraud, Bribery and Corruption Policy, the LCFS is responsible for investigating allegations of fraud, bribery, and corruption. In consultation with the Executive Chief Finance Officer, the LCFS will report any case to the NHS Counter Fraud Authority and / or the police, as agreed, and in accordance with the NHS Counter Fraud

manual. The LCFS is responsible for taking forward all counter fraud work locally in accordance with national standards and in consultation with the Executive Chief Finance Officer.

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, or as a member of an ICB committee/sub-committee or other group/forum – the ICB will implement appropriate arrangements to facilitate this.
- Annually when prompted by the ICB – because of its role in spending taxpayers' money, the ICB will ensure that, at least annually, staff are prompted to update their declarations of interests or make/confirm a nil return where there are no interests or changes to declare.
- During meetings by inclusion of declarations of interest as a standing item each meeting's agenda.
- 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 or become evident(e.g. during a meeting when it becomes apparent that interests individuals have 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 cause the member of staff or somebody else substantial damage or distress or put a member of staff at risk of harm, with the agreement of the Conflicts of Interest Guardian (who will seek appropriate legal advice where required), 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. In these circumstances a confidential unredacted record will be maintained.

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. A gift means 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.

6.8.2. Staff should not accept gifts that may affect, or be seen to affect, their professional judgement.

6.8.3. Gifts from suppliers or contractors:

- Gifts from suppliers or contractors doing business (or likely to do business) with the organisation should always 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. The £6 value has been selected with reference to existing industry guidance issued by the Association of the British Pharmaceutical Industry (ABPI).

6.8.4. 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.

6.8.5. 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).

6.8.6. 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.

6.8.7. 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 an estimate that a reasonable person would make as to its value).

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, vaping, 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.

This list is not exhaustive and if there is any doubt, please contact your line manager and/or a senior member of the Governance Team.

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.

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.

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[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

[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)

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.
- 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.

6.19.6. The Chair of a meeting has ultimate decision-making responsibility regarding how conflicts of interest are managed.

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. Prevention of Fraud and Bribery

The ICB is committed to preventing fraud and bribery and encourages staff with concerns or reasonably held suspicion about potentially fraudulent activity or practice to report these immediately to the ICB's Local Counter Fraud Specialist (LCFS), whose contact details can be obtained via the ICB's intranet. Suspicions may also be reported to the Executive Chief Finance Officer to the ICB Chair or ICB Chief Executive Officer where it would not be appropriate to report to the Executive CFO.

Suspicions of fraud can also be reported directly and confidentially to the NHS Fraud and Corruption Reporting Line on 0800 028 4060 or via https://cfa.nhs.uk/reportfraud.

6.22. Identifying and Reporting Breaches

6.22.1. 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'.

6.22.2. 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 (who is the first point of contact for any genuine suspicions or concerns regarding fraud or bribery, as per the ICB's Counter Fraud, Bribery and Corruption Policy)

6.22.3. 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 Freedom to Speak Up Policy.

6.22.4. 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.

6.22.5. 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.

6.23. Taking Action in Response to Breaches

6.23.1. 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.

6.23.2. 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.

6.23.3. 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.

6.23.4. 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.
- Civil/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.

6.24. Learning and Transparency Concerning Breaches

6.24.1. Anonymised reports on breaches, the impact of these, and actions taken will be considered by the Audit Committee and any other relevant committee/group.

6.24.2. 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. All ICB 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). The module is also available to individuals without an ESR account at Managing-conflicts-of-interest-online-training-for-ICBs.

8.1.2. The ICB will also implement arrangements to ensure that non-ICB staff who are members of the Board or its committees have undergone suitable training on the management of conflicts of interests.

8.1.3. Those staff with responsibility for decision-making or 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. .

8.1.4. 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.

8.1.5. 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 annually. 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

- Managing Conflicts of Interest Mandatory Training for ICBs.
- 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 (2021)
- ABHI Code of Ethical Business Practice https://www.abhi.org.uk/membership/code-of-ethical-business-practice/
- NHS Code of Conduct and Accountability (July 2004)

10.2. Associated ICB Policies

- MSEICB 003 Procurement and Contracting Policy
- MSEICB 019 Standards of Business Conduct Policy
- MSEICB 023 Freedom to Speak Up Policy
- MSEICB 026 Counter-Fraud, Bribery and Corruption Policy
- MSEICB 045 Disciplinary Policy

11. References

This policy is based on:

Managing Conflicts of Interest in the NHS (Model Policy for Organisations) April 2017

Managing Conflicts of Interest: online training for ICBs – Module 1 (January 2024).

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:** 29/01/24

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	The onus is on every individual to declare their interests. However, there is a risk that staff from protected groups may be reluctant to use the policy to raise concerns 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 Freedom to Speak Up 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 reported 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?
Annually

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 even if a 'Nil' Return

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 and 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 (except where they are Board members).

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 I may be committing an offence under the Fraud Act 2006, which may result in civil, criminal, and / or internal disciplinary investigation and action, including prosecution.

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 I may be committing an offence under the Fraud Act 2006, which may result in civil, criminal, and / or internal disciplinary investigation and action, including prosecution 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 <u>if accepting them might give rise to perceptions of bias or favouritism</u>, 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	**<u>Sponsorship</u>** Line manager and governance advice must be sought <u>before</u> 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

Corporate Governance Team contacts – Nicola Adams, Sara O'Connor or Helen Chasney

Audit Committee Chair George Wood

Conflicts of Interest Guardian: George Wood

Executive Chief Finance Officer – Jennifer Kearton

Local Counter Fraud Specialist – Hannah Wenlock, Anti-Crime Specialist (ACS).
Email: hannah.wenlock@nhs.net, Telephone: 07919 595930

Mid and South Essex Integrated Care System

NHS
Mid and South Essex
Integrated Care Board

Standards of Business Conduct Policy

Document Control:

Policy Name	Standards of Business Conduct Policy
Policy Number	MSEICB 019
Version	V2.0
Status	Final - Approved
Author / Lead	Senior Manager Corporate Services
Responsible Executive Director	The Chief Executive has delegated responsibility to the Executive Director of Strategy and Corporate Services
Responsible Committee	Audit Committee
Date Ratified by Responsible Committee	16 April 2024
Date Approved by Board/Effective Date	July 2024
Next Review Date	April 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)	• Governance Team • Audit Committee
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
1.0	10/07/22	Viv Barnes	Final formatting review following adoption
1.1	20/06/23	Helen Chasney	Review date amended to 31 December 2023 as agreed by Audit Committee (20 June 2023)
1.2	16/01/24	Helen Chasney	Review date extended to 30 April 2024 as agreed by Audit Committee, 16 January 2024.
1.3	10/04/24	Sara O'Connor	Update of guidance, references and job titles following completion of ICB organisational change process.
2.0	July 2024	Helen Chasney	Final – Approved version.

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
- Guidance on the Fit and Proper Persons Test
- Professional Standards Authority: Standards for members of NHS Boards and CCG Governing bodies in England (2012).
- ABHI Code of Ethical Business Practice
- 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

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 Deputy Director of Governance Risk / Senior Manager Corporate Services.

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. **Bribery** - includes 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.
- **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 Executive Director of Strategy and Corporate Services.

5.4. **Executive Director of Strategy and Corporate Services**

5.4.1. The Executive Director of Strategy and Corporate Services is responsible for the oversight and management of Standards of Business Conduct.

5.5. **Policy Author**

5.5.1. 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.

5.6. **Deputy Director of Governance and Risk**

5.6.1. The Deputy Director of Governance and Risk, supported by the Senior Manager Corporate Services, 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.

5.7. **Local Counter Fraud Specialist (LCFS)**

5.7.1. In line with the ICB's Counter Fraud, Bribery and Corruption Policy, the LCFS is responsible for investigating allegations of fraud, bribery, and corruption. In consultation with the Executive Chief Finance Officer, the LCFS will report any case to the NHS Counter Fraud Authority and / or the police, as agreed, and in accordance with the NHS Counter Fraud manual. The LCFS is responsible for taking forward all counter fraud work locally in accordance with national standards and in consultation with the Executive Chief Finance Officer.

5.8. **Line Managers**

5.8.1. 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.

5.9. **All Staff**

5.9.1. 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 Deputy Director of Governance and Risk / Senior Manager Corporate Services.
- They report any suspicions of fraud, bribery, or corruption in accordance with the ICB's Counter Fraud, Bribery and Corruption Policy. Individuals suspected of committing an offence of fraud or bribery may be subject to criminal and / or disciplinary investigation which could result in criminal and / or disciplinary action being taken, including prosecution and / or dismissal. For more information, please refer to the Counter Fraud, Bribery, and Corruption Policy.

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 Deputy Director of Governance and Risk / Senior Manager Corporate Services.

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. The introduction of the Bribery Act 2010 places responsibility on the ICB to ensure robust procedures are in place to prevent bribery and corruption taking place within the ICB and it is an offence under the Bribery Act to fail to prevent bribery. It is the responsibility of all employees to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests or benefits and their NHS duties.

6.2.3. All individuals within healthcare organisations are capable of being prosecuted for taking or offering a bribe. There is no maximum level of fines that can be imposed, and an individual convicted of an offence can be imprisoned for up to ten years.

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's Local Counter Fraud Specialist whose contact details can be obtained via the ICB's intranet. Suspicions may also be reported to the Executive Chief Finance Officer (CFO) or to the ICB Chair or ICB Chief Executive Officer where it would not be appropriate to report to the CFO.

6.2.5. Suspicions of fraud can also be reported 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 Deputy Director of Governance and Risk / Senior Manager Corporate Services 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 Deputy Director Governance and Risk. 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 individual's Executive Director, taking advice from the Deputy Director of Governance and Risk if required..

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 Procurement 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 Deputy Director of Governance and Risk / Senior Manager Corporate Services

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, 2018. 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's Governance Team 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 Audit Committee with the support of the Human Resources Department.

9. Arrangements for Review

9.1. This policy will be reviewed annually. 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 and Guidance

- 002 Social Media Policy
- 003 Procurement and Contracting Policy
- 010 Information Governance Management and Framework Policy
- 018 Conflicts of Interest, Gifts and Hospitality and Commercial Sponsorship Policy
- 023 Freedom to Speak-Up Policy
- 026 Counter-Fraud, Bribery and Corruption Policy
- 034 Recruitment Policy
- 036 Disclosure and Barring Policy
- 045 Disciplinary Policy
- 078 Reimbursement of Staff Expenses and Travel Policy
- 080 Defining the Boundaries between NHS and Private Healthcare
- IG Resource Guide

11. References

- The Bribery Act 2010
- Fraud Act 2006
- Data Protection Act 2018
- 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)
- NHSE/I Interim Guidance on the Functions and Governance of the Integrated Care Board
- ABHI Code of Ethical Business Practice
- Code of Ethics of the Chartered Institute of Procurement and Supply.

12. Equality Impact Assessment

12.1.1. 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 Freedom to Speak-Up (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.

Mid and South Essex Integrated Care System

NHS
Mid and South Essex
Integrated Care Board

Decision Making Policy and Procedure

Document Control:

Document Control Information	Details
Policy Name	Decision Making Policy and Procedure
Policy Number	MSEICB 088
Version	1.0
Status	Final
Author / Lead	Michelle Angell / Nicola Adams
Responsible Executive Director	Director of Resources
Responsible Committee	Finance & Investment Committee
Date Ratified by Responsible Committee	14 September 2023
Date Approved by ICB Board/Effective Date	28 September 2023
Next Review Date	September 2025
Target Audience	All MSE ICB Staff
Stakeholders engaged in development of Policy (internal and external)	• Executive Team • Finance & Investment Committee
Impact Assessments Undertaken *(State if not applicable)*	• Equality and Health Inequalities Impact Assessment

Version History

Version	Date	Author (Name and Title)	Summary of amendments made
0.1	15/06/2023	Michelle Angell, Portfolio Director, MSEP, ICB	First draft
0.2	15/06/23	Karen Wesson, Interim Oversight and Assurance Director	Amendments included
0.4	21/06/23	Linda Moncur, Director of Nursing for Safeguarding, ICB	Amendments included
0.4	28/06/23	Janette Joshi, Deputy Director of System Healthcare Purchases Jenny Davis, Commercial Director, MSEFT	Amendments included
0.5	13/07/23	Nicola Adams, Deputy Director of Maggie Pacini, Consultant in Public Health	Amendment included – Policy and Procedure
0.6-0.9	11/08/23	Nicola Adams, Deputy Director of Governance and Risk	Amendments included
0.10	12/09/23	ICB Executive Team	Amendments included
0.11	14/09/23	Finance and Investment Committee	Amendments included
1.0	28/09/23	ICB Board	Final version approved.

Contents

1. Introduction

1.1. The Mid and South Essex Integrated Care Board (ICB), as part of the Integrated Care System (ICS) receives a fixed budget from NHS England to enable it to fulfil its statutory functions, duties and the health aspect of the Integrated Care Strategy set by the Integrated Care Partnership (ICP). The ICB has a statutory responsibility to maintain financial balance and, as part of discharging this obligation, must decide how and where finite local resources are allocated.

1.2. The need for health care is always greater than the resources available to a society to meet demand. Therefore, it is evident that it will not be possible for the ICB to commission all the health care that is needed or wanted by the population it serves and, as a result, it will need to prioritise its commissioning intentions based on the needs of the local population.

1.3. In carrying out these functions, the ICB will act with a view to securing health services that are provided in a way which promotes the NHS Constitution among patients, staff, and members of the public. Patients have a right to expect that the ICB will assess and prioritise the health requirements of the local community and commission the services to meet those needs as considered necessary.

1.4. Those with the responsibility for health care budgets must make decisions about priorities at three levels: when developing strategic plans (the main priorities), when deciding year on year which investment and disinvestments to make, and at the individual patient level.

1.5. The Decision-Making Policy and Procedure is to be applied when making both clinical and non-clinical (e.g., IT) decisions.

1.6. The ICB will ensure that procurement decisions in relation to our clinical services are fully informed and based on health outcomes data by utilising all reliable data sources combined with population health data and clinical analysis.

2. Purpose / Policy Statement

2.1. The purpose of this policy is to set out an ethical framework that underpins and applies to the priority setting processes required to enable the ICB to discharge its statutory functions within the financial envelope it is set by NHS England. In particular, providing the basis for decision-making in:

- The development of strategic plans for individual services
- making investment and disinvestment decisions during the annual commissioning cycle
- making in-year decisions about service developments or disinvestments
- management of restricted services, including individual funding requests.

2.2. The purpose of setting out the principles and considerations to guide priority setting is to:

- provide a coherent framework for decision-making (both investments, disinvestments, and decommissioning).
- promote fairness and consistency in decision-making.
- ensure that there is a clear and comprehensive rationale for decisions.
- enable the ICB to discharge its functions and deliver the health aspects of the strategy set by the ICP in a safe, fair and transparent manner.

2.3. Decommissioning and investment decisions impact on patients and providers therefore requires a formal process, which provides an evidence trail and ratification by a decision-making authority in the face of potential appeals and legal challenge by an affected party. This policy therefore sets out the governance process for decision-making as well as the evaluation criteria used when appraising investment and disinvestment cases.

3. Scope

3.1. This policy and procedure applies to all staff working within MSE Integrated Care Board and covers all contractual agreements utilised by the ICB.

4. Definitions

4.1. For the purpose of this policy the following definitions have been applied:

- **Investment:** Funding allocated to support service provision across MSE ICS.

- **Commissioning:** Commissioning is the continual process of planning, agreeing, and monitoring services. Commissioning is not one action but many, ranging from the health-needs assessment for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment.

  There is no single geography across which all services should be commissioned: some local services can be designed and secured for a population of a few thousand, while for rare disorders, services need to be considered and secured nationally.

- **Decommissioning**: This relates to the withdrawal of funding from a provider organisation that is subsequently re-commissioned in a different format.

- **Disinvestment:** This relates to the withdrawal of funding from a provider organisation and the subsequent stopping of the service.

4.2. In the event that decommissioning, or disinvestment is proposed, the ICB recognises that a number of steps will be required prior to a final decision being taken by the ICB Board. These include consideration as to whether a consultation exercise is required with partner organisations, patients, public and the Health Overview and Scrutiny Committees.

5. Roles and Responsibilities

5.1. Integrated Care Board ('the Board')

5.1.1. The Board retains overarching responsibility for decision-making and sets out is framework for delegating authority for the approval of decisions within the Scheme of Reservation and Delegation

5.1.2. The Board will oversee the approval of all investment /disinvestment decisions over **£5,000,001** within existing agreed budgets and over **£2,500,000** where there is no budgetary provision. The scrutiny of such proposals will generally be held in public, for which supporting papers will be available on the ICB's website. The ICB Constitution sets out provision for meetings to be held 'in camera' where there is a legal requirement to uphold confidentiality, or it is not in the public interest to discuss in a public meeting.

5.1.3. The Board is also responsible for ensuring the ICB meets its statutory responsibilities such as involving and engaging with the public over decision-making within the ICB.

5.2. Chief Executive Officer

5.2.1. As set out in the Scheme of Reservation and Delegation the Chief Executive Officer can approve business cases up to the value of **£1,000,000** within existing agreed budgets and between **£100,001 and £250,000** with no budgetary provision**.**

5.2.2. Business cases <£250,000 can be approved by the Executive Director identified as the Senior Responsible Officer for the programme.

5.3. ICB Executive Team

5.3.1. The ICB Executive Team are responsible for the delivery of ICB objectives, including performance, quality, and financial plans. It will delegate activities, tasks, and mitigations of risks to the SLT and receive escalations and responses from SLT in respect of business case proposals.

5.3.2. The Executive Team must be sighted and 'support' all ideas/projects recommended by the SLT prior to them progressing through to business case development and formal approval.

5.3.3. All proposals will need to have and ICB Executive sponsor in order to progress through decision-making.

5.4. ICB Senior Leadership Team (SLT)

5.4.1. The SLT functions as the operational "engine room" of the ICB. All expenditure exceeding £50k must be 'supported' by the SLT before proceeding to any formal approval stages.

5.4.2. The SLT includes representatives from Executive Officer direct line reports from all Directorates across ICB, providing insight and guidance to the development of

ICB business and achievement of ICB objectives. As such, the SLT facilitates operational delivery as directed by the ICB Executive Team.

5.4.3. SLT contributes to the decision-making process by ensuring that any projects/ideas include consideration of all aspects for which the ICB are responsible (i.e. clinical, quality and corporate governance).

5.5. Finance and Investment Committee

5.5.1. The Finance and Investment Committee will approve all investment / disinvestment decisions between £1,000,000 and £5,000,000 within existing agreed budgets and **£250,000 and £2,500,000** where there is no existing budgetary provision.

5.5.2. The Finance and Investment Committee is the sponsoring committee responsible for monitoring compliance with the Decision-Making Policy.

5.6. The Quality Committee

5.6.1. The Quality Committee is responsible for overseeing continued improvement in the quality of services, quality governance and oversight of Equality/Health Inequality Impact Assessments e.g., in support of business cases, ensuring they are adequately governed.

5.6.2. The Quality Committee will be made aware of all investment / decommissioning / disinvestment proposals that impact upon clinical services and seek assurance that all concerns have been addressed prior to approval.

5.7. Primary Care Commissioning Committee (PCCC)

5.7.1. The PCCC is the decision making committee in relation to the ICB's delegated functions for Primary Care (GP, Pharmaceutical, Ophthalmic and Dental services). Approval of core contractual investments (including Primary Care estate) will be presented to the PCCC for approval in accordance with the ICB Scheme of Reservation and Delegation, and be escalated accordingly where the financial envelope exceeds the authority of PCCC (i.e. exceeding £1,000,000).

5.8. Clinical and Multiple-Professional Congress (CLiMP)

5.8.1. The Clinical and Multiple-Professional Congress is an advisory Committee responsible for driving the identification and delivery of transformation programmes across the ICS; providing clinical and professional scrutiny; acting as a sounding board of multi professionals across health and care sectors; providing clinical advice to major investment and disinvestment cases and amendments to the Procedure of Limited Clinical Effectiveness (POLCE).

5.8.2. All ideas/proposals with a clinical impact should be scrutinised by the CLiMP, or an appropriate clinical expert, who will ensure that decisions are clinically sound, and any resulting impact of service changed identified in impact assessments are appropriately mitigated or managed.

5.9. System Transformation and Investment Group (STIG)

5.9.1. The STIG provides a gateway for transformation programmes (Business Cases requiring approval of the Finance & Investment Committee or investments that have cross-system implications). The group ensures that there is strategic alignment, cross system outcomes and benefits realisation.

5.9.2. Although there is similar representation on the STIG compared to the System Financial Recovery Working Group, the STIG has a more strategic rather that operational / functional role.

5.10. Stewardship Groups

5.10.1. Stewardship Groups bring together small teams of frontline health and care staff and managers to collaborate as 'stewards' using their different perspectives, skills, and knowledge alongside population-level data, to take a fresh look at the value delivered from our shared resources.

5.10.2. Stewardship Groups are aligned around 'care areas' such as cancer care or stroke and through their innovative work may propose ideas, projects, or changes in care pathways, that will be processed through this policy.

5.10.3. Additionally, ideas generated from other forums; impacting on care areas will need to be routed to the Stewardship Groups to ensure there is a cohesive approach to new ways of working for the benefit of our residents.

5.11. Central Programme Management Office (CPMO)

5.11.1. The CPMO will ensure that all investment / disinvestment proposals have complied with the necessary governance requirements e.g., completed, and approved Equality Health Inequalities Impact Assessment, Quality Impact Assessment, Data Protection Impact Assessment and Digital Technology Assessment Criteria (DTAC) where relevant, prior to submission to the SFRG.

5.11.2. The CPMO will maintain a central registry of ideas/proposals as well as projects in progress.

5.12. System Financial Recovery Working Group

5.12.1. The System Financial Recovery Working Group is responsible for ensuring a collaborative approach to decision making. It will ensure that decisions are in the best interest of the system as a whole and contribute to financial recovery, whilst ensuring that sovereign organisations continue to operate in accordance with their statutory duties. The group will bring together the ICB with system partners to ensure that system partners are sighted on proposals and contribute to 'system ownership' in the best interests of our residents. The group will review all proposals for investment/disinvestment/decommissioning, including all relevant Impact Assessments to inform decisions as to whether a project should proceed through 'gateway 0' as an idea/project that should progress to formal consideration for approval.

5.13. Investment and Disinvestment Committee (IDC)

5.13.1. The Investment and Disinvestment Committee will guide the commissioning cycle of the ICB, considering the strategic direction of decision making across the ICB. It will meet twice per annum. Firstly, in March, to consider and guide how commissioning proposals meet the needs of the ICB operational plans. Secondly, in September to consider any in-year changes that reflect the changing needs of residents and regulators.

5.13.2. The role of this Committee is to ensure that:

- Proposals are not considered in silo. A holistic overview will provide a consistent approach to decision-making ensuring that all decisions fully support the achievement of system priorities within the overall financial envelope.
- Decision-making is fair and equitable throughout the commissioning cycle.
- The diversion of funds to treatments which are of low priority are prevented, as all cases are considered equitably against the funding available.
- Investment and disinvestment cases are reviewed alongside population health analytics to ensure that the needs of our population are met.
- The health economy and local communities are sufficiently aware of or consider opportunity costs.
- The failure to address disinvestment and redirection of resources is mitigated.
- Clinical and public engagement is at the centre of ICB planning processes.

5.13.3. Formal decision-making groups will check that the IDC has supported the direction of commissioning decisions and where this is not the case (i.e. investment and disinvestment case proposals fall outside of this planning cycle) will be submitted for system-wide review to the Financial Recovery Working Group, prior to the Chief Executive Officers' Forum, who will act as the IDC where urgent decision making is required that cannot wait until the mid-cycle IDC review.

5.14. Chief Executive Officers' Forum

5.14.1. The Chief Executive Officers' Forum is a meeting of Chief Executive Officers from system Partners who together are accountable for performance improvement across the system.

5.14.2. Each Chief Executive Officer is responsible for a portfolio of work to address specific areas of priority e.g. workforce. Together they will act as the IDC where urgent decisions are required and therefore must support decisions that fall outside of the planning cycle for them to progress to formal approval.

5.15. Director of Resources

5.15.1. The Director of Resources is responsible for ensuring systems are in place to deliver the financial duties of the ICB. Including establishing the annual budget and budget management processes. As such the Director of Resources is

responsible for making sure that financial decision-making within the ICB is robust; consequently, they are the Executive Sponsor for this policy.

5.15.2. They are also responsible for the development of the Capital Resource Use Plan for approval by the Board and reporting how the ICB has exercised its functions in accordance with the Plan within the Annual Report.

5.15.3. As set out in the Scheme of Reservation and Delegation the Director of Resources can approve business cases up to the value of **£1,000,000** within existing agreed budgets and between **£100,001 and £250,000** with no budgetary provision**.**

5.16. Chief Nurse

5.16.1. The Chief Nurse is the Executive Director responsible for ensuring that the required quality and patient safety considerations have been undertaken prior to any investment / decommissioning / disinvestment in a clinical service.

5.16.2. The Chief Nurse is the lead Executive Officer ensuring appropriate advice and explanations are provided to the Quality and Safety Committee.

5.17. Identified Operational Lead

5.17.1. The Operational Lead responsible for the service is required to undertake the following actions when considering investment / disinvestment / decommissioning of a service:

- Follow the decision-making policy, ensuring that all advice, engagement and due process is followed in progressing a decision and that approvals are sought in accordance with the Scheme of Reservation and Delegation.
- Seek advice of the governance team to navigate decision-making processes.
- Be pro-active within the commissioning cycle to ensure that the IDC is sighted on proposals.
- Develop robust business cases in line with the Decision-Making Policy.
- Secure legal advice through our legal framework where appropriate.
- Establish a robust benefits realisation process to assess the potential and realisable benefits to improve the effectiveness of the service.
- Inform the CPMO and the relevant department of the benefits identified and plan with them how to obtain valid evidence of positive progress.
- Review, with the CPMO, the monitoring of the benefits realised.
- Undertake impact analysis assessments.
- Keep a risk log of issues identified.
- Prepare a case to be considered by the relevant Committee in respect of investment / disinvestment / decommissioning of a service.
- Notify the provider of the 10-day appeals process (see point 6.17 below).

5.18. Policy Authors

5.18.1. The Policy Author and the Quality Committee is responsible for:

- ensuring that all key stakeholders have been consulted in the development of this policy, adhering to ICB governance arrangements.
- ensuring that all staff are aware of the purpose and aims of this policy and that the appropriate governance arrangements are in place to support compliance.

5.19. Governance Lead

5.19.1. The ICB Governance Lead is responsible for ensuring that this policy remains up to date and included within the suite of policies and procedures communicated to all ICB staff.

5.20. Line Managers

5.20.1. All line managers are responsible for ensuring that their staff are aware of this policy and that this is adhered to when making any investment / decommissioning / disinvestment decisions.

5.21. All Staff

5.21.1. All ICB staff are responsible for adhering to the content of this policy.

6. Policy / Procedure Detail

6.1. Commissioned Services

6.1.1. The ICB commissions services for our population in Primary Care (including GP, Pharmacy, Optometry and Dental services), in our community, in mental health services and in our acute hospitals. There are services the ICB does not commission, which remain the responsibility of NHS England, such as some specialised services.

6.1.2. In some cases, the ICB must make the difficult decision to 'not' commission a service or only commission a service in certain circumstances. These services are therefore subject to a 'Service Restriction Policy' that describes the circumstances under which that service might or might not be provided.

6.1.3. Healthcare and the needs of our patients are sometimes complex and exceptional. It is the responsibility of the ICB to ensure consideration is given to those circumstances when making decisions and therefore has established an 'Individual Funding Request (IFR) Policy'.

6.1.4. Both the Service Restriction and Individual Funding Request Policies support the decision-making process within the ICB but sit outside the domain of this policy.

6.1.5. There are circumstances in which the ICB may change a previous decision to commission a service; to either decommission or disinvest in a service for example:

- Where a service is not clinically effective and other services exist to serve

the needs of the population, the ICB may disinvest in the service.

- Where the quality of services of a provider does not meet the standards required of the ICB the service may be decommissioned.
- Where the innovative work of our Stewardship and other Groups suggests that there may be more benefit from changing the way a service is provided.
- Where, due to financial constraints, the ICB can no longer afford to provide a service, that is then moved to a 'restricted service' or a services that is no longer provided at all (a non-commissioned service).

6.1.6. The decommissioning and disinvestment process is subject to this decision-making policy and is described in more detail from section 6.13.

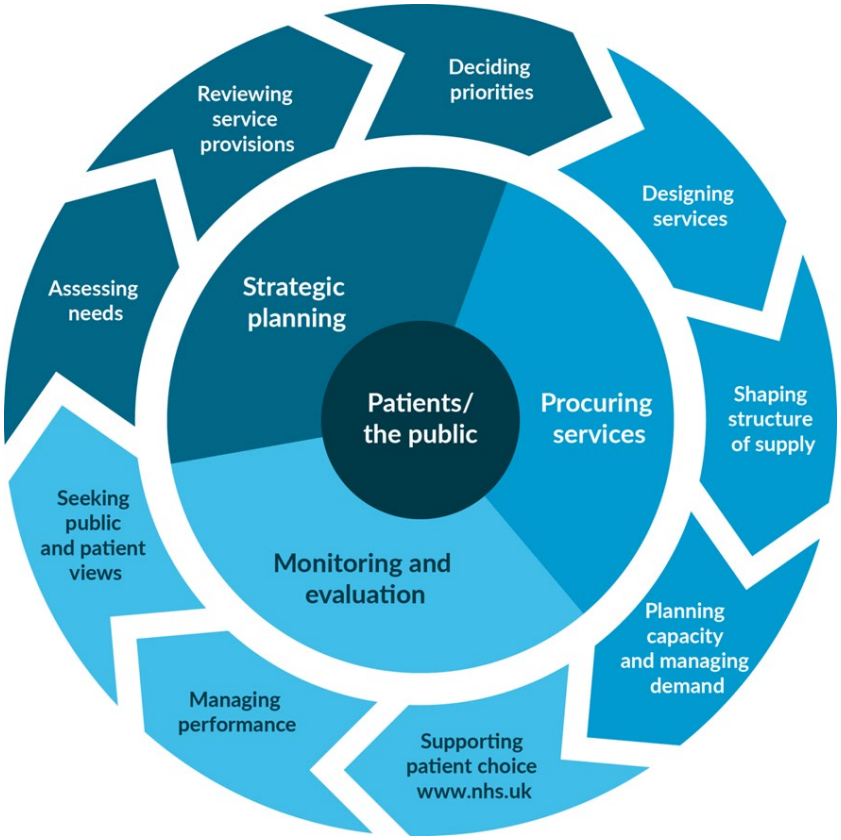
Principles of Decision Making

6.2. The ICB Planning Cycle

6.2.1. The ICB is responsible for developing a plan for meeting the health needs of our residents (as set out in the Integrated Care Strategy established by the ICP), managing the NHS budget and arranging for the provision of health services in a geographical area. Nationally, the expectation is that the ICB will:

- Improve outcomes in population health and healthcare.
- Tackle inequalities in outcomes, experience, and access.
- Enhance productivity and value for money.
- Help the NHS support boarder social and economic development.

6.2.2. The ICB planning cycle puts patients and the public at the heart of what we do and is the framework that underpins how the ICB will achieve those national expectations, the asks of the Integrated Care Strategy and the collective ambitions and shared commitments of our partners across mid and south Essex.



6.2.3. The ICB Joint Forward Plan outlines those the joint ambitions, which both responds to, and supports the joint health and wellbeing strategies of our three upper tier local authority partners. Joint Strategic Needs Assessments inform the strategies or our local authority partners and are therefore the starting point by which the needs of our population are assessed.

6.2.4. As described in section 1 of this policy, the ICB must plan and prioritise its resources within the financial envelope set by NHS England; a challenging task that has competing asks and opportunity cost.

6.2.5. The Investment and Disinvestment Committee (IDC) is responsible for balancing those asks, reviewing service provision and deciding priorities at the outset of the year. As such, groups with responsibility for designing, re-designing and innovating new services must present their proposals and plans to the IDC at the outset of the year. The IDC will then consider how those asks fit with the priorities of the ICB and the wider system and decide how the finite resources of the ICB will be spent.

6.2.6. All decisions, throughout the year, will then be made of the basis of the direction set by the IDC. The IDC will meet again mid-year to consider whether priorities, national direction or local need has changed that may require amendment and therefore consideration of further cases mid-year.

6.2.7. The business case process (section 6.7 and Appendix B) established within this policy will ensure that the route to designing and procuring services is robust and

that informed decisions are made by those with authority set out within the Scheme of Reservation and Delegation.

6.2.8. Monitoring and evaluation of services is the primary responsibility of the identified operational lead (at service level) who will ensure that the intended benefits of decisions are realised and where this is not the case, corrective action will be taken to ensure the original need it met. The outcome of this will be overseen by both the Quality Committee and the System Oversight and Assurance Committee, as well as informing the next planning round.

6.3. Collaborative Commissioning

6.3.1. We will continue to explore opportunities to collaboratively procure services both to achieve value for money and develop markets e.g., NHS, Local Authority and Third Sector partners.

6.4. Record Keeping

6.4.1. An auditable record/trail of decision making and all communication relating to each decommissioning decision and contract termination must be kept by the identified Operational Lead. This is vital, both to demonstrate that the decision-making process (both investment and decommissioning / disinvestment) was robust and transparent, and as evidence in the event of any challenge, legal or otherwise.

6.5. Prioritisation Framework

6.5.1. Making good decisions regarding health care priorities involves the exercise of fair and rational judgement and discretion. Although there is no objective or infallible measure on which such decisions can be based, a Prioritisation Framework (see **Appendix F)** enables decisions to be made within a consistent setting which respects the needs of individuals and the community. The MSE ICB recognises that its discretion will be affected by National Service Frameworks, National Institute for Health and Clinical Excellence (NICE) technology appraisal guidance and Secretary of State Directions to the NHS.

6.5.2. The purpose of the Prioritisation Framework is to support and underpin the decision-making processes of the organisation (and decision-making bodies) and to support lawful and consistent commissioning policy.

6.5.3. This will be achieved by:

- Providing a coherent structure for discussion, ensuring all important aspects of each issue are considered prior to decisions being made.
- Promoting fairness and consistency in decision making from meeting to meeting and with regard to different clinical topics, reducing the potential for inequity.
- Providing a means of explaining the reasons behind the decisions made.
- Reducing risk of judicial review by implementation of robust decision-making processes that are based on evidence of clinical and cost effectiveness and an ethical framework so that the decisions are made in a manner which is

fair, rational and lawful.
- Ensuring the values and strategic aspirations of the organisation are reflected in business decisions.

6.5.4. Providing a consistent approach for the development of strategy and plans across the whole system.

6.6. Prioritisation Criteria

6.6.1. Our prioritisation criteria are the means by which the ICB and our officers can assess submitted development proposals in a clear and transparent way. The Prioritisation Framework attached at **Appendix F** was developed based on our Strategic Plan and the key priorities and outcomes agreed by our Integrated Care Board.

Decision-Making

6.7. Stages of decision-making

6.7.1. **Appendix B** sets out the decision-making process. There are four stages:

- Planning (as described in section x) and 'Gateway 0'
- Business Case Development
- Formal Approval
- Monitoring, Review and Validation

6.7.2. All decisions will follow the decision-making process outlined herein. However, those for decommissioning or disinvestment will be subject to further consideration set out in from section 6.13.

6.8. Stage 1 - Planning and Gateway 0

6.8.1. Each planning team within the ICB reports into a workstream responsible for either overseeing performance or service transformation. These may be mid and south Essex system groups (e.g., workstreams reporting into portfolio groups led by the system Chief Executives or a stewardship group) or regional groups such as the 'Cancer Board'.

6.8.2. These workstreams are responsible for the generation of proposals for new investment, changing commissioning models or patient pathways or for decommissioning / disinvestment.

6.8.3. The System Investment and Disinvestment Committee will consider proposals from the ICB planning teams in terms of their commissioning intentions either at the outset of the year or during the mid-year review meeting.

6.8.4. Gateway 0 is a process established to ensure that firstly proposals accord to the approved commissioning intentions set by the IDC, that it is affordable within the financial constraints of the system and that they support a cohesive patient pathway across the system.

6.8.5. Groups involved in Gateway 0 are representative of system partners to ensure that there is a collaborative approach to any proposal for investment, decommissioning or disinvestment.

6.9. Stage 2 - Business Case Development

6.9.1. Business cases must be produced for new proposals or when a change to existing commissioning arrangements is proposed. The ICB template business case is to be followed unless there is a national requirement that a specific template be used e.g. when bidding for NHS England ringfenced funds or Estates related business cases.

6.9.2. Business cases are not required for:

- The re-procurement of an existing service where there is no significant change to the existing model and financial envelope.
- Use of ringfenced monies obtained via a bidding process.

6.9.3. It is important to ensure that all relevant experts (e.g. clinical or technical) are consulted and contribute to the development of a business case to ensure that it is a sound and robust proposal. This may include both the initial development of the case and presenting the case to appropriate forums or ICB advisory or assurance committees/groups. A summary of the groups that may be consulted and their role in decision making is included at Appendix G.

6.9.4. To ensure that all proposal comply with governance, legal and technical requirements, each element of the business case checklist must be completed, this will demonstrate:

- Alignment to the Integrated Care Strategy and strategic priorities (including those relating to health inequalities).
- Support from the relevant Stewardship Group, Senior Leadership Team, Executive Team, Financial Recovery Working Group, System Transformation and Investment Group and the Investment and Disinvestment Committee.
- Financial commitment.
- Engagement and co-production.
- Equality and Health Inequality Impact Assessments are undertaken and actions to address any impact have been identified.
- Compliance with legal requirements and procurement regulations.
- Compliance with digital and information security standards.
- Clinical, HR, Estates and governance requirements have been met.
- There is a commitment to the realisation of benefits as part of a cycle of continuous improvement.

6.9.5. The ICB has a legal duty to engage, outlined within its communications and engagement strategy, which will be following throughout the development of the business case proposal.

6.10. Stage 3 - Formal Approval

6.10.1. The Scheme of Reservation and Delegation sets out the roles and decision making that the Board has either retained or delegated to committees or individuals within or outside of the ICB. All cases requiring the commitment or withdrawal of funding must be approved in accordance with that scheme.

6.10.2. All cases must be supported by the Executive Team prior to being presented to either an Executive Director, CEO / Director of Resources, the Finance & Investment Committee or the Board (depending on the financial value involved).

6.11. Stage 4 - Monitoring, Review and Validation

6.11.1. The ICB recognise the need to ensure that we apply best practice performance and contract management principles to all contracts and subsequently reviews whether commissioned services are meeting the needs of the population (as identified through the Joint Forward Plan and demand analysis) 'and' are of high quality and best value for money.

6.11.2. On-going review of performance and the realisation of proposed benefits will be undertaken as part of a continuous cycle of contract management supporting the principles of continuous improvement and ensuring that services remain clinically relevant and viable.

6.11.3. The process for identifying potential services for decommissioning needs to be systematic and there are a number of mechanisms utilised by our staff to evidence the need for review such as benefits analysis working groups, complaints, public health needs assessments etc.

6.12. Principles of the Decision-Making Process

6.12.1. The Decision-Making Flow Chart is depicted in **Appendix B**.

6.12.2. The ICB acknowledges that all investments involve a degree of risk. In deciding whether to invest, the ICB will take into account the risk and return of the proposed investment.

6.12.3. Having made the decision to invest, the ICB will actively monitor and manage its investment to minimise the probability and impact of adverse outcomes.

6.12.4. If the ICB decides to approve the project, it will implement controls to minimise the probability and severity of loss associated with the project.

Decommissioning and Disinvestment

6.13. Reasons for decommissioning or disinvesting.

6.13.1. The drivers for proactively decommissioning a service include:

- A persistent and serious risk to patient safety.
- The service represents poor value for money.

- There is insufficient need/demand to warrant the current volume of service and/or number of providers.
- The service model is out-dated i.e., the outcomes have not changed but new evidence on the model of delivery has developed which cannot be met via a variation of the existing contract.
- The service is no longer a clinical priority – reassessment of priorities may mean that investment is required elsewhere and so certain 'non-essential' services may be decommissioned.
- A mismatch between need and the current profile of provided services is identified as one of the outcomes of e.g., Equality Health Inequalities Impact Assessment, and/or Joint Strategic Needs Assessments.
- The provider is not demonstrably delivering on agreed outcomes following mutually agreed remedial action.
- As part of a commissioning or market management strategy.

6.13.2. The drivers for reactively addressing decommissioning are:

- Advance mitigation of impact prior to natural expiry of a time-limited contract.
- Notice of termination of contract from the provider.
- Breach of contract served due to irreconcilably poor performance, poor patient experience, governance and/or risks to patient safety.

6.13.3. As the net impact of both actions is a cessation of a service, the following principles are universal.

6.14. Decommissioning / Disinvestment Principles

6.14.1. The process outlined below is guided by the following principles.

- Initiation of a decommissioning proposal must be based on tangible evidence.
- Appropriate stakeholders must be consulted before the decommissioning decision is made.
- The provider and commissioner obligations in relation to termination and expiry, resulting from decommissioning, is outlined within the respective contract.
- Detailed consideration must be given to the broad-ranging adverse impact of the decommissioning decision.
- The provider must be consulted as early as possible, and in line with contractual notice periods.
- Where the service is identified as being a requirement / priority area, alternative provision must be available or commissioned before decommissioning is enacted.
- Once decommissioning is agreed and/or is inevitable, and where adverse impact is anticipated a detailed implementation plan is required which clearly shows the actions and accountabilities including those to mitigate adverse impact.

- A smooth transition between outgoing and replacement provider (where relevant) is in the best interests of patients. Contractual terms are available to ensure exit arrangements and succession plans (where relevant) are conducted appropriately.

6.15. Criteria for disinvestment / decommissioning

6.15.1. The following points will be considered when making the decision to disinvest a service.

- The patient experience and health need must be paramount and gaps in service provision minimised once the service ceases.
- The potential destabilising effect on other organisations e.g. third sector, of a decision to decommission/disinvest should be considered.
- Equity of service provision across MSE ICS.

6.16. The Decommissioning or Disinvestment process

6.16.1. This decommissioning process will be followed unless an event as specified under the terms and conditions of the specific contract requires immediate termination. The decommissioning / disinvestment process is documented in **Appendix C.**

6.16.2. Service Restriction Policy: For a number of commissioned procedures MSE ICB operate a Prior Approvals Scheme setting out criteria for access, based on evidence of effectiveness or relative priority for funding. Those related to procedures are included within the Service Restriction Policy; those relating to prescribing can be found on the commissioner Medicines Optimisation website. Providers must not assume that because a procedure is not included in this document or listed on the Medicines Optimisations website that by default it will be funded. The latest version of the MSE ICB Service Restriction Policy can be accessed at: 1.-JC-FP001-Mid-South-Essex-SRP-v1.3-Updated-March-2023.docx (live.com)

6.16.3. Individual Funding Request (IFR) Policy: ICBs are required to have a process for considering funding for individuals who seek NHS commissioned services outside established commissioning policies. There are, in general two types of requests (Category 1 and 2) that come before an Individual Funding Request (IFR) Panel, namely:

Category 1 – Requests for funding treatments for medical conditions where the ICB has no established commissioning policy (commonly called IFR requests), and

Category 2 – Requests for funding treatments for medical conditions where the ICB does have an established commissioning policy for that condition but where the requested individual treatment is not in the ICB policy or does not meet the criteria set out in the policy. The MSE ICB Individual Funding Request Policy can be accessed at: Individual Funding Request Policy - Mid and South Essex Integrated Care System (ics.nhs.uk)

6.16.4. The decommissioning process may, on occasion, be triggered by a contract review. These reviews are carried out with a frequency according to the perceived risks of the particular contract, and as set out in the contract. In some cases, decommissioning will be triggered by a significant event, such as a Serious Incident or a 'Never Event', failure to provide adequate assurance around policy and procedure documentation and compliance, failure to meet quality requirements within the contract or a failure to sign a contract variation for a change in service.

6.16.5. A review will be carried out by a multidisciplinary group constituted by the ICB for this purpose.

6.16.6. Using the proforma in **Appendix D**, a decision will be reached by the team as to whether to decommission or procure this service from an alternative provider. Evidence required at this stage to support the decision must be robust and provided as part of the proforma to enable the decision to be ratified and to provide detailed information for the appeals stage. Should the decision be not to decommission, then corrective action to resolve the issue must be taken.

6.16.7. In all cases the identified Operational Lead will complete an Equality Health Inequalities Impact assessment, as in **Appendix A**. This is to be supported by the prioritisation of resources framework attached at **Appendix F.**

6.16.8. The identified Operational Lead is required to ensure that appropriate consultation has taken place with all relevant stakeholders.

6.16.9. Stakeholders will include respective Health and Wellbeing Boards where relevant.

6.16.10. Should the decision be to decommission, then the decision must be reviewed by the relevant ICB Committee's to gain agreement for the decision. If the decision is regarding a service which affects more than one organisation, then approval for decommissioning must be gained from all.

6.16.11. Following approval, the decision will be communicated to the identified stakeholders to provide an opportunity for consultation. Stakeholders will include health and wellbeing boards.

6.16.12. Fifteen operational days will be allowed for this communication and queries from stakeholders to be dealt with before notice is served on the provider. The responsibility for serving notice on the provider is with the contract manager or as otherwise determined by the Chief Executive.

6.16.13. Formal public consultation in line with Health Overview and Scrutiny Committee guidelines must take place where the decommissioning of the service or contract results in a material change to the delivery of a service (except when the service is recommissioned), or where the service will not be recommissioned.

6.16.14. Following notification of decision to decommission the Commissioner and Provider (and if appropriate any successor provider) will jointly agree an Exit Plan/Succession Plan, as required under the contract for services, outlining

actions required by both parties for smooth service cessation. Where a clinical service, the plan will cover a minimum:

- Referrals, and patient transfer or discharge
- Patient continuity of care
- Patient records
- Staff
- Estate
- Equipment (also need to consider in relation to non-clinical services)
- Stock (where funded by the ICB)

6.16.15. The ICB lead will ensure mechanisms are in place where, in conjunction with the provider, execution of the Exit Plan/Succession Plan is actively managed.

6.17. Appeals Process

6.17.1. An appeal against a decommissioning decision will be accepted from the provider if the appeal is received within 10 operational days of the notice given, submitted to the following address: Phoenix House, Christopher Martin Road, Basildon SS14 3EZ, or E-mail: E-mail: mseicb.enquiries@nhs.net.

6.17.2. The appeal will be dealt with by the ICB within the required timeframe.

6.17.3. Evidence to be provided to the governing body or its designated committee or sub-committee will include copies of the relevant Contract Review Checklist and the supplementary evidence supporting this (**Appendix E**) and the Equality Health Inequalities Impact Assessment (**Appendix A**).

6.17.4. Where a service is decommissioned but the health need for a service remains, and is a priority, this should be recorded in the impact assessment and the funding ring-fenced for ongoing investment in meeting that priority health need.

6.17.5. Where decommissioning is the result of insufficient health need the funding should be identified as a financial efficiency saving and any reinvestment in alternative services as per the current investment planning and prioritisation process(es)

6.18. Assessment of Impact

6.18.1. In the event that a case for change is validated by sufficient supporting evidence, the identified Operational Lead are responsible for carrying out an impact assessment to identify the anticipated or actual impacts of the development intervention on health, social, economic and workforce factors. This impact assessment must be approved by our Quality Lead before decommissioning is undertaken.

6.18.2. The impact assessment must include:

- Health outcomes – the effect on health outcomes will be assessed to identify potential adverse consequences of decommissioning and what might to done to minimise them.

- Health inequality and equitable access implications - we believe that people should have access to health care on the basis of need. There may also be times when some categories of care are given priority in order to address health inequalities in the community. However, we will not discriminate on grounds of personal characteristics, such as age, gender, sexual orientation, gender identity, race, religion, lifestyle, social position, family or financial status, intelligence, disability, physical or cognitive functioning. However, in some circumstances, these factors may be relevant to the clinical effectiveness of an intervention and the capacity of an individual to benefit from the treatment.
- Workforce implications.
- Market implications.
- Geographic implications e.g. impact on transport links etc.
- Value for money.
- Impact on partner organisations.
- Environmental sustainability including impact on partners.

6.18.3. We will also communicate clearly, fully and continuously with ICB stakeholders before, during and following any decision by the ICB to decommission services. Decisions relating to decommissioning will follow the same approval routes as set for investment proposals.

6.19. Decommissioning / Disinvestment Assessment

6.19.1. The Decommissioning and Disinvestment Assessment document (see **Appendix D**), forms part of the auditable document trail for the decommissioning decision which may be legally challenged, therefore it must be completed factually, objectively and diligently. Decommissioning a health service will have both positive and negative impact. It is critical that the adverse impact on patients and on the wider health economy are understood and documented.

7. Monitoring Compliance

7.1. The CPMO will monitor compliance with this policy and procedure, ensuring that no service is commissioned / decommissioned without adherence to this.

7.2. The Quality and Finance and Investment Committees are responsible for monitoring compliance.

8. Staff Training

8.1. Training will be provided to all staff involved in making investment / decommissioning / disinvestment decisions, through the CPMO.

8.2. A Prioritisation Handbook has been developed to support staff to implement this policy and procedure.

9. Arrangements for Review

9.1. This policy and procedure 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 and procedure 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 and procedure will need to be ratified by the relevant committee before final approval by the Integrated Care Board.

10. Associated Policies, Guidance and Documents

- ICB Prioritisation Handbook.

Associated Policies

- Individual Funding Request Policy
- Service Restriction Policy

11. References

- Castle Point and Rochford CCG Decommissioning and Disinvestment Policy.
- North East Essex CCG Prioritisation Framework.

12. Equality and Health Inequalities Impact Assessment

12.1. The EHIIA has identified no equality issues with this policy.

13. Appendices

Appendix A - Equality Impact Assessment (EIA)

Name of policy and version number : Decision Making Policy and Procedure **Version:** 1.0	**Directorate/Service**: Corporate / Chief Executive's Office
Assessor's Name and Job Title: Nicola Adams, Deputy Director of Governance and Risk	**Date:** 28/9/23

OUTCOMES
Briefly describe the aim of the policy and state the intended outcomes for staff
The Policy will guide staff on the correct process to be followed for decision making in terms of investment, disinvestment and decommissioning.
EVIDENCE
What data / information have you used to assess how this policy might impact on protected groups?
The policy relates to all decision making and is not associated with any 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 Corporate Team, Executive Team, Public Health and other relevant ICB staff.

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.

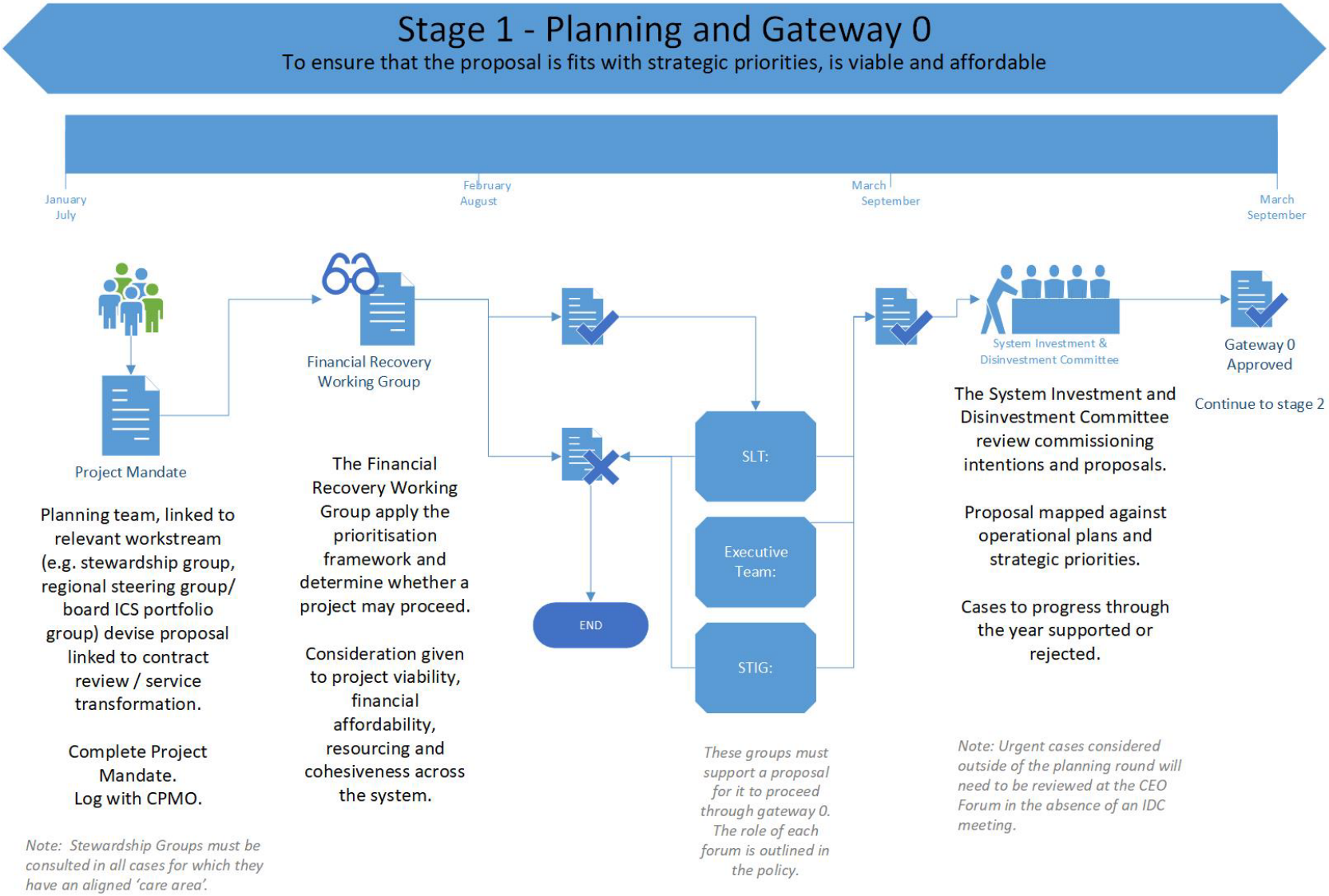
Protected Group	Positive outcome	Negative outcome	Neutral outcome	Reason(s) for outcome
Age			X	The policy sets out a consistent decision making process that will be applied consistently.

Protected Group	Positive outcome	Negative outcome	Neutral outcome	Reason(s) for outcome
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?
The policy requires impact assessments to be carried out on all decision making, which will be monitored by sponsoring/authorising committees.

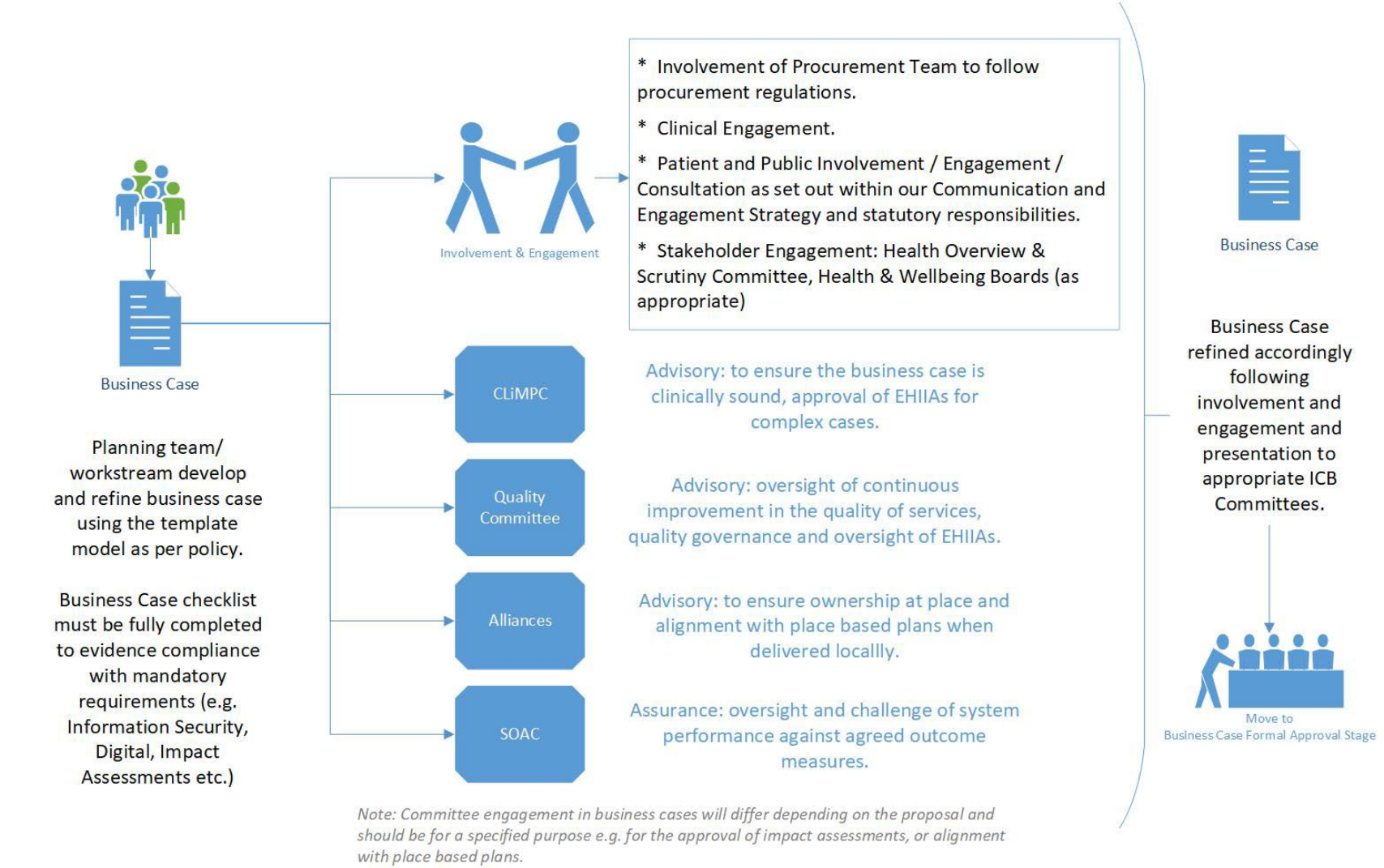
REVIEW
How often will you review this policy / service?
Every 2 years as a minimum and earlier if there are any significant changes in legislation, policy or good practice.
If a review process is not in place, what plans do you have to establish one?
N/A

Appendix B – Decision Making Flowcharts



Stage 2 - Business Case Development

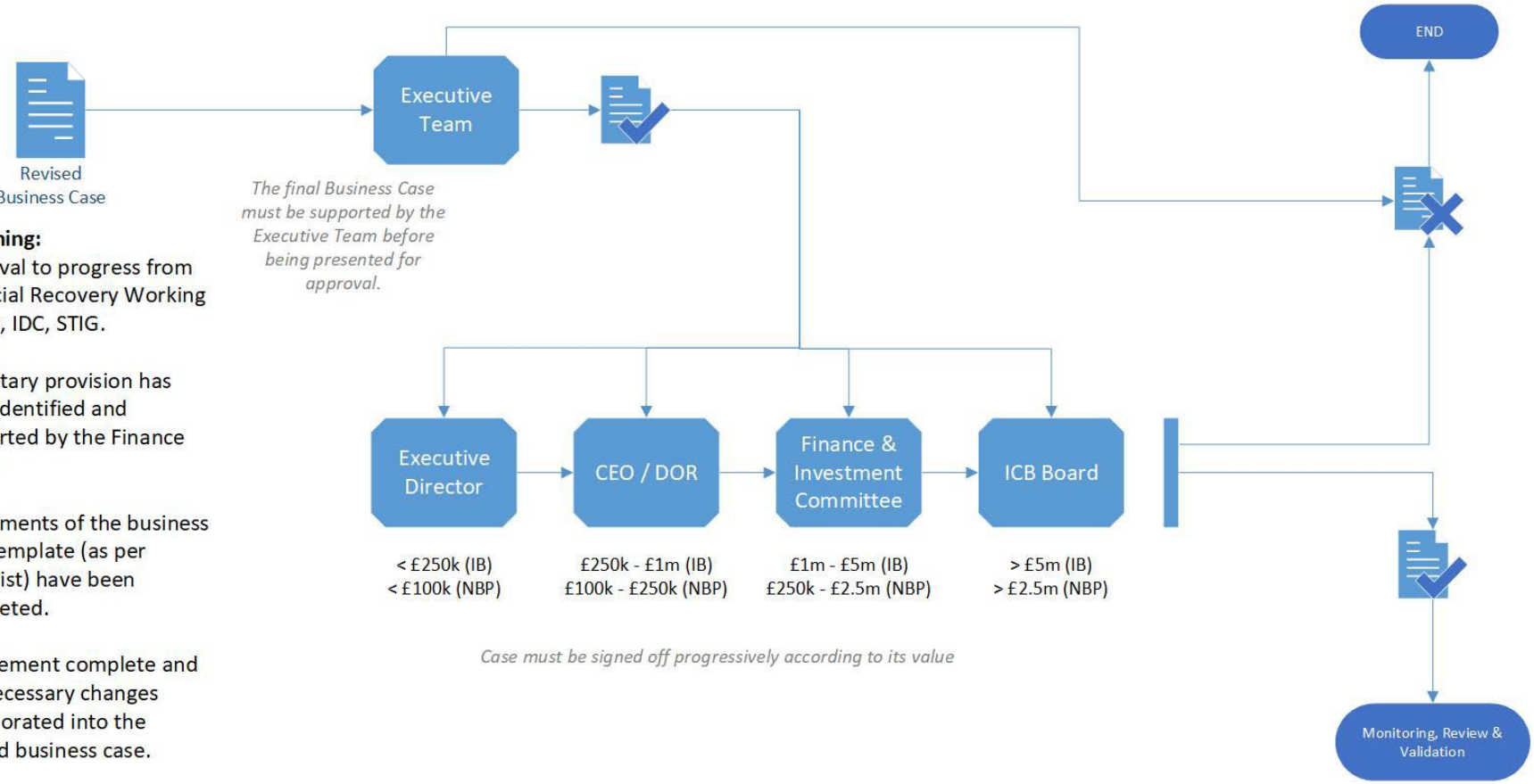
To ensure that the proposal is fits with strategic priorities, is viable and affordable



Note: Committee engagement in business cases will differ depending on the proposal and should be for a specified purpose e.g. for the approval of impact assessments, or alignment with place based plans.

Stage 3 - ICB Formal Approval Stage

In accordance with Scheme of Reservation and Delegation.



Assuming:

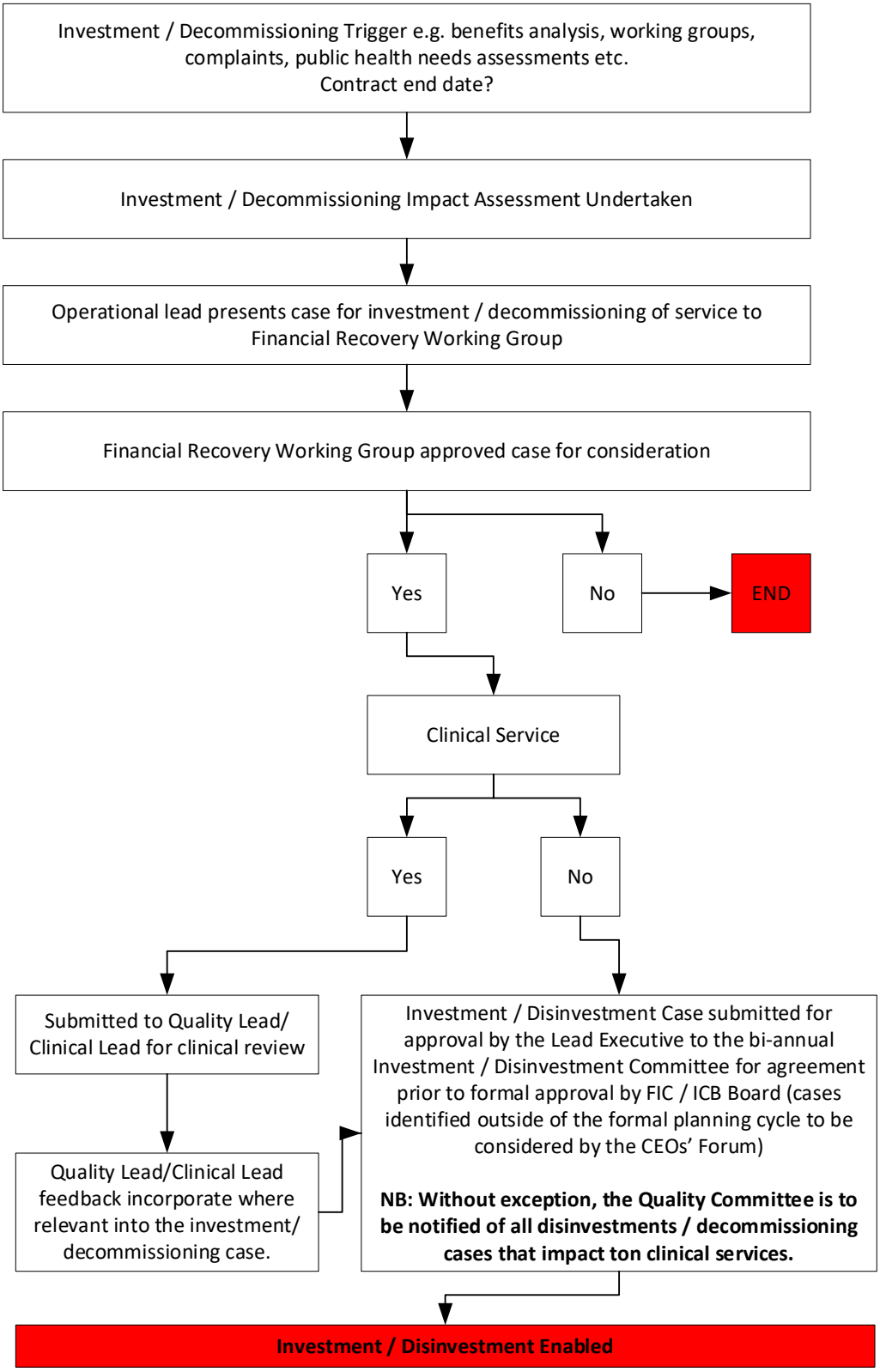
Approval to progress from Financial Recovery Working Group, IDC, STIG.

Budgetary provision has been identified and supported by the Finance Team.

All elements of the business case template (as per checklist) have been completed.

Engagement complete and any necessary changes incorporated into the revised business case.

Appendix C – Decommissioning Process Flow Chart



Appendix D – Decommissioning / Disinvestment Assessment

Service Considered for Decommissioning:	Annual Contract Value:	Approx. number of Patients Impacted:

This document forms part of the auditable document trail for the decommissioning decision which may be legally challenged, therefore it must be completed factually, objectively and diligently. Decommissioning a health service will have both positive and negative impact. It is critical that the adverse impact on patients and on the wider health economy are understood and documented.

Background – Information on Service:
Brief notes e.g. what it is, what it does, who provides etc.

Background – Procedure context and/or principle driver for Decommissioning:
DH requires that, if a variation to contract cannot be made, then terminate to enable required intervention. Otherwise, principle driver for considering decommissioning (proactive, reactive, safety, VFM, etc.).

Adverse Impact on the Patient:
Continuity of on-going care for those within service, pathway of care, access, distance travelled, is there another provider representing reasonable choice.

Positive Impact (Benefit) of Decommissioning:
The prime benefit from Decommissioning e.g. improved safety; simplified pathway; better value for money; better outcomes; market improvement; opportunity for reinvestment.

Adverse Impact on ICB including Finance:
Non-recurrent impact / one off decommissioning costs contractually borne by commissioner e.g. TUPE. Non-recurrent impact of replacement service overlapping with decommissioned service. Recurrent gross cost (cost of this service). Recurrent net cost (cost of this service less cost of any replacement or movement in demand). Transactional costs of decommissioning. Likelihood of public outcry at loss or perceived loss. Impact on ICB's reputation.

Adverse Impact on Provider:
Does the loss of this service/contract element compromise the provider's economic or physical ability to deliver other services? Fixed cost.

Adverse Impact on Health Market Economy:
Overall supply/demand balance, on upstream and downstream elements of care pathway, knock on to other providers, gap in provision, market diversity, loss of clinical skill, training opportunities etc.

Adverse Impact on Performance:
Does the cessation of service adversely impact any vital sign commitment e.g. cancer access, health inequalities, 18 weeks, access etc. (full list available on request)

Adverse Impact on Equality ***(Please complete the ICB Equality Impact Assessment proforma prior to completing this section).***
[Equality Act 2010] Does cessation of service represent unequal treatment or discrimination or inequality of access on the basis of any of the nine protected characteristics.

Adverse Impact on Quality:
Does cessation of service impact on quality of services / patient care.

Adverse Impact on Rurality:
Does cessation of service represent unequal treatment or a barrier to access to service users in a rural location – if yes, how will this be mitigated.

Health Overview & Scrutiny Committee / Consultation:
Does the recommendation(s) below and the materiality of the change indicate that HOSC will have an interest/what consultation is particularly recommended/has taken place.

Recommendations:
Recommendation to decision making authority e.g. not to be decommissioned, decommission, decommission with stipulated conditions (state them).

Completed By: Date:

Signed off by Financial Recovery Working Group: Date:

Appendix E - Contract Review Checklist

Evidence (to provide documentary evidence for questions below)	Provider Conforms? Yes	No	Data not Applicable	Data not Available
Does the provider meet the service specification and specified quality requirements?				
Actual activity v. contracted activity is significantly more or less (-/+5%)				
Activity cost v. contracted cost is significantly more or less (-/+5%)				
Are specified waiting times consistently maintained for more than 6 months.				
Does the service cost provide value for money? (if on local tariff, is it within reasonable limits, if block, is the reference cost within regional average? If QOF, within reasonable limits of regional average?)				
Have there been any significant patient safety/clinical governance issues? (such as SIs, CRB issues, breaches of policies?)				
Does the service meet current national strategy in terms of outcomes and expectations?				
Does the service conform with existing patient pathways? (i.e. part of a referral pathway to other services?)				
Does the evidence base e.g. NICE etc. identify that the service is clinically effective? (parliamentary enquiries could provide evidence?)				
If the service is provided by a single practitioner, has this impacted on service delivery during the practitioners absence?				
Does the service reduce activity and costs elsewhere in the pathway?				
Was the outcome of the service evaluation positive?				
Is there evidence of contractual breach, noting light tough approach in place since COVID, in particular with System Partners				
Has the Provider been issued with a performance notice within the current financial year?				
Is a Remedial Action Plan currently in place?				
Has the service Provider had patient concerns/complaints raised against them?				
If yes, have these concerns/ complaints been upheld by internal or external governance processes?				

Are there any other data from the review to consider? (please attach with indication below of conclusion following review of this data)				

Decision:

Recommission:		Decommission:	
Signed by ICB Quality Lead:		Date:	
Signed by Chief Finance Officer:		Date:	
Approving Committee:		Date Approved:	

Please list names of attendees ratifying this decision:

Appendix F – Prioritisation Framework

CRITERIA	MEASURE (M)				WEIGHTING	CRITERION SCORE
	None (M=0)	Low (M=1)	High (M=2)	Maximum (M=3)	(W)	(M)
1. Addresses Health Need – Addresses a health need identified in Joint Forward View Plan	Does not address a health need identified in the JSNA/HNA	Addresses a health need identified in the JSNA/HNA	Addresses a priority health need identified in the JSNA/HNA	Addresses a priority health need among >10% ICB residents OR multiple health needs	To be agreed	
2. Patient and Public Acceptability, Expectation and Involvement – Patient acceptability of treatment – Public expectation – Contribution to patient autonomy, responsibility for and involvement in decisions about their health.	Low public acceptability AND/OR no public expectation AND/OR no contribution to patient autonomy	Low public acceptability OR low public expectation OR small contribution to patient autonomy	High public acceptability OR high public expectation OR high contribution to patient autonomy	More than one of high public acceptability, high public expectation, high contribution to patient autonomy		
3. Impact on Health Inequalities – Likely contribution to reducing health inequalities	Could increase health inequalities	No impact on health inequalities	Slight reduction in health inequalities	High reduction in health inequalities		
4. Evidence of Effectiveness – Strength of evidence of benefit	No evidence of effectiveness, but no evidence of ineffectiveness	Some evidence from case series, cohort studies, unpublished data, or expert opinion.	Some evidence of effectiveness including cohort studies or non-randomised, non-blinded trials	Strong evidence of effectiveness e.g. from meta analyses/ systematic reviews, or randomised, blinded, controlled trials		
5. Benefit of Intervention – Magnitude of health improvement for patient, as	Lower magnitude of effect AND No wider benefits	Lower magnitude of effect OR	Higher magnitude of effect OR Some wider benefits	Highest magnitude of effect AND/OR Some wider benefits		

indicated by evidence on intervention – Wider benefits to services and society		No wider benefits				
6. Access – Provides care closer to home – Improves access for marginalised groups	Negative impact on access	No impact on Access	Positive impact on access	Strongly positive impact on access		
7. Strategic Alignment – With National/Regional/Local strategic priorities – With UTLA and partners' priorities; potential for shared resources – With social, political and technological developments e.g. Sustainability, Public Services (Social Value) Act	Not aligned with any	Some alignment	Reasonable alignment with multiple priorities	Strong alignment with multiple priorities		
8. Service Quality and Safety – Contribution to quality improvement e.g. effectiveness, national standards, safety, patient experience, waiting times, integration of care etc	Negative or no impact on quality	Some positive impact on quality	Strong positive impact on one quality dimension	Strong positive impact on multiple quality dimensions		
9. Patient Choice and Service Supply – Contribution to improved patient choice e.g. increased choice due to changed opening times, geography, distances travelled – Contribution to improved supply e.g. facilitates patient switching, increases provider concentration, promotes provider market entry, improves service responsiveness	Negative or no impact on choice AND supply	Positive impact on choice OR supply	Positive impact on choice AND supply	Strongly positive impact on choice AND supply		

10. **Health Economy Impact and Risk** – Risk of not doing to health economy – Impact of intervention on partners	None	Low	Medium	High		
				TOTAL SCORE		

Note: Weightings will be reviewed annually in line with priorities.

Appendix G – Role of Committees in Decision Making

Committee / Group	Type	Purpose
ICB Board	Decision Statutory	Responsible for overall governance of ICB and maintains responsibility for approving business cases/investment decisions >£5m (within agreed budgets) / >£2.5m (with no budgetary provision).
Finance & Investment Committee (F&IC)	Decision	Responsible for overseeing financial management/performance and for approving business cases/investment decisions between £1m-£5m (within agreed budgets) / £250k-£2.5m (with no budgetary provision).
Quality Committee	Assurance	Responsible for overseeing continued improvement in the quality of services, quality governance and oversight of Equality/Health Inequality Impact Assessments e.g. in support of business cases, ensuring they are adequately governed.
Clinical & Multi-Professional Congress (CLiMP)	Advisory	Advisory committee driving the identification and delivery of transformation programmes across the ICS; providing clinical and professional scrutiny; acting as a sounding Board of multi-professionals across health and care sectors. Clinical advice to major cases.
Primary Care Commissioning Committee (PCCC)	Decision	Decision making committee in relation to the ICB's delegated functions for Primary Care. Approval of core contractual investments (including Primary Care estate).
Senior Leadership Team (SLT)	Advisory Endorsement	Executive Officer direct line reports from all Directorates across ICB, providing insight and guidance to development of ICB business and achievement of ICB objectives. Functions as the operational "engine room" of the ICB. All expenditure exceeding £50k must be 'approved in principle' by the SLT.
System Transformation and Investment Group (STIG)	Advisory Endorsement	Gateway for transformation programmes (Business cases requiring FIC approval or investments that have cross-system implications). Ensures strategic alignment, cross system outcomes and benefits realisation.
Stewardship Groups	Advisory Endorsement	Targeted groups overseeing and innovating to ensure the ICB achieves the Triple Aim. Respiratory, Cardiology, Cancer, Stroke, UEC, Ageing Well – currently established. Diabetes, Dermatology, Ophthalmology, MSK, CYP, Mental Health – being developed.
Health Overview and Scrutiny Committees (HOSC)	Statutory	Statutory committee with overview / scrutiny of health decisions. To be consulted regarding significant change. Power to refer decisions to the Secretary of State.

Health & Wellbeing Boards (HWB)	Statutory	Overseeing the delivery of the Health and Wellbeing Strategy. To be consulted regarding significant change.
Audit Committee	Assurance Statutory	No decision making powers, but responsible for overseeing systems of internal control. All approved waivers must be reported to and scrutinised by the audit committee.
System Oversight & Assurance Committee (SOAC)	Assurance	Providing oversight and challenge on system performance against agreed outcome measures, constitutional standards and associate transformation programmes.
ICB Executive Team	Assurance Endorsement	Responsible for delivery of ICB objectives, including performance, quality and financial plans. It will delegate activities, tasks and mitigations of risks to the SLT and receive escalations and responses from SLT in respect of business case proposals.
Chief Executives Forum	Assurance Endorsement	Group of Health System Chief Executives/Leaders accountable for the achievement of system objectives. Will determine and agree system responses to operational, financial and performance challenges.

Appendix H – Business Case Checklist

SLT Support?		Procurement Route approved?	
Engagement complete?		Compliant with procurement policy?	
Co-produced?		Entered on procurement register?	
Meets strategic objectives?		Meets duty to reduce inequalities?	
Equality Impact Assessment complete?		Privacy Impact Assessment Complete?	
Budget available / approved?		Meets Regulator requirements?	
Committee Support?		Contributes to Net Zero sustainability requirements?	
Contributes to Social Value?		Benefits clearly set out (SMART)?	
Advice obtained from Estates?		Advice obtained from Finance?	
Advice obtained from Digital/IT/IG?		Advice obtained from HR?	
MSE Partners / Stewardship consulted?		Exec/STIG Endorse?	
Service specification included as appendix?		Impact across system assessed and addressed?	

5. Principles of Governance

5.1. **NHS Constitution – The NHS Constitution for England**

5.2. **Nolan Principles**

5.3. **Our People Promise - NHS The Promise (england.nhs.uk)**

5.4. **East of England Leadership Compact**

Department of Health & Social Care

Guidance

The NHS Constitution for England

Updated 17 August 2023

Applies to England

Contents

This publication is available at https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england

Introduction to the NHS Constitution

The NHS belongs to the people.

It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most.

The NHS is founded on a common set of principles and values that bind together the communities and people it serves – patients and public – and the staff who work for it.

This Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. The Secretary of State for Health, all NHS bodies, private and voluntary sector providers supplying NHS services, and local authorities in the exercise of their public health functions are required by law to take account of this Constitution in their decisions and actions. References in this document to the NHS and NHS services include local authority public health services, but references to NHS bodies do not include local authorities. Where there are differences of detail these are explained in the Handbook to the Constitution.

The Constitution will be renewed every 10 years, with the involvement of the public, patients and staff. It is accompanied by the Handbook to the NHS Constitution, to be renewed at least every 3 years, setting out current guidance on the rights, pledges, duties and responsibilities established by the Constitution. These requirements for renewal are legally binding. They guarantee that the principles and values which underpin the NHS are subject to regular review and re-commitment; and that any government which seeks to alter the principles or values of the NHS, or the rights, pledges, duties and responsibilities set out in this Constitution, will have to engage in a full and transparent debate with the public, patients and staff.

Principles that guide the NHS

Seven key principles guide the NHS in all it does. They are underpinned by core NHS values which have been derived from extensive discussions with staff, patients and the public. These values are set out in the next section of this document.

1. The NHS provides a comprehensive service, available to all

It is available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. The service is designed to improve, prevent, diagnose and treat both physical and mental health problems with equal regard. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.

2. Access to NHS services is based on clinical need, not an individual's ability to pay

NHS services are free of charge, except in limited circumstances sanctioned by Parliament.

3. The NHS aspires to the highest standards of excellence and professionalism

It provides high quality care that is safe, effective and focused on patient experience; in the people it employs, and in the support, education, training and development they receive; in the leadership and management of its organisations; and through its commitment to innovation and to the promotion, conduct and use of research to improve the current and future health and care of the population. Respect, dignity, compassion and care should be at the core of how patients and staff are treated not only because that is the right thing to do but because patient safety, experience and outcomes are all improved when staff are valued, empowered and supported.

4. The patient will be at the heart of everything the NHS does

It should support individuals to promote and manage their own health. NHS services must reflect, and should be coordinated around and tailored to, the needs and preferences of patients, their families and their carers. As part of

this, the NHS will ensure that in line with the Armed Forces Covenant, those in the armed forces, reservists, their families and veterans are not disadvantaged in accessing health services in the area they reside. Patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment. The NHS will actively encourage feedback from the public, patients and staff, welcome it and use it to improve its services.

5. The NHS works across organisational boundaries

It works in partnership with other organisations in the interest of patients, local communities and the wider population. The NHS is an integrated system of organisations and services bound together by the principles and values reflected in the Constitution. The NHS is committed to working jointly with other local authority services, other public sector organisations and a wide range of private and voluntary sector organisations to provide and deliver improvements in health and wellbeing.

6. The NHS is committed to providing best value for taxpayers' money

It is committed to providing the most effective, fair and sustainable use of finite resources. Public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves.

7. The NHS is accountable to the public, communities and patients that it serves

The NHS is a national service funded through national taxation, and it is the government which sets the framework for the NHS and which is accountable to Parliament for its operation. However, most decisions in the NHS, especially those about the treatment of individuals and the detailed organisation of services, are rightly taken by the local NHS and by patients with their clinicians. The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to the public, patients and staff. The government will ensure that there is always a clear and up-to-date statement of NHS accountability for this purpose.

NHS values

Patients, public and staff have helped develop this expression of values that inspire passion in the NHS and that should underpin everything it does. Individual organisations will develop and build upon these values, tailoring them to their local needs. The NHS values provide common ground for co-operation to achieve shared aspirations, at all levels of the NHS.

Working together for patients

Patients come first in everything we do. We fully involve patients, staff, families, carers, communities, and professionals inside and outside the NHS. We put the needs of patients and communities before organisational boundaries. We speak up when things go wrong.

Respect and dignity

We value every person – whether patient, their families or carers, or staff – as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest and open about our point of view and what we can and cannot do.

Commitment to quality of care

We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience – right every time. We encourage and welcome feedback from patients, families, carers, staff and the public. We use this to improve the care we provide and build on our successes.

Compassion

We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person’s pain, distress, anxiety or need. We

search for the things we can do, however small, to give comfort and relieve suffering. We find time for patients, their families and carers, as well as those we work alongside. We do not wait to be asked, because we care.

Improving lives

We strive to improve health and wellbeing and people's experiences of the NHS. We cherish excellence and professionalism wherever we find it – in the everyday things that make people's lives better as much as in clinical practice, service improvements and innovation. We recognise that all have a part to play in making ourselves, patients and our communities healthier.

Everyone counts

We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind. We accept that some people need more help, that difficult decisions have to be taken – and that when we waste resources we waste opportunities for others.

Patients and the public: your rights and the NHS pledges to you

Everyone who uses the NHS should understand what legal rights they have. For this reason, important legal rights are summarised in this Constitution and explained in more detail in the Handbook to the NHS Constitution, which also explains what you can do if you think you have not received what is rightfully yours. This summary does not alter your legal rights.

The Constitution also contains pledges that the NHS is committed to achieve. Pledges go above and beyond legal rights. This means that pledges are not legally binding but represent a commitment by the NHS to provide comprehensive high quality services.

Access to health services

Your rights

You have the right to receive NHS services free of charge, apart from certain limited exceptions sanctioned by Parliament.

You have the right to access NHS services. You will not be refused access on unreasonable grounds.

You have the right to receive care and treatment that is appropriate to you, meets your needs and reflects your preferences.

You have the right to expect your NHS to assess the health requirements of your community and to commission and put in place the services to meet those needs as considered necessary, and in the case of public health services commissioned by local authorities, to take steps to improve the health of the local community.

You have the right to authorisation for planned treatment in the EU under the UK EU Trade and Cooperation Agreement where you meet the relevant requirements.

You also have the right to authorisation for planned treatment in the EU, Norway, Iceland, Lichtenstein or Switzerland if you are covered by the Withdrawal Agreement and you meet the relevant requirements.

You have the right not to be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.

You have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible. The waiting times are described in the Handbook to the NHS Constitution.

NHS pledges

The NHS pledges to:

- provide convenient, easy access to services within the waiting times set out in the Handbook to the NHS Constitution
- make decisions in a clear and transparent way, so that patients and the public can understand how services are planned and delivered
- make the transition as smooth as possible when you are referred between services, and to put you, your family and carers at the centre of decisions that affect you or them

Quality of care and environment

Your rights

You have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality.

You have the right to be cared for in a clean, safe, secure and suitable environment.

You have the right to receive suitable and nutritious food and hydration to sustain good health and wellbeing.

You have the right to expect NHS bodies to monitor, and make efforts to improve continuously, the quality of healthcare they commission or provide. This includes improvements to the safety, effectiveness and experience of services.

NHS pledge

The NHS also pledges to identify and share best practice in quality of care and treatments.

Nationally approved treatments, drugs and programmes

Your rights

You have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if your doctor says they are clinically appropriate for you.

You have the right to expect local decisions on funding of other drugs and treatments to be made rationally following a proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain that decision to you.

You have the right to receive the vaccinations that the Joint Committee on Vaccination and Immunisation recommends that you should receive under an NHS-provided national immunisation programme.

NHS pledge

The NHS also commits to provide screening programmes as recommended by the UK National Screening Committee.

Respect, consent and confidentiality

Your rights

You have the right to be treated with dignity and respect, in accordance with your human rights.

You have the right to be protected from abuse and neglect, and care and treatment that is degrading.

You have the right to accept or refuse treatment that is offered to you, and not to be given any physical examination or treatment unless you have given valid consent. If you do not have the capacity to do so, consent must be obtained from a person legally able to act on your behalf, or the treatment must be in your best interests.

You have the right to be given information about the test and treatment options available to you, what they involve and their risks and benefits.

You have the right of access to your own health records and to have any factual inaccuracies corrected.

You have the right to privacy and confidentiality and to expect the NHS to keep your confidential information safe and secure.

You have the right to be informed about how your information is used.

You have the right to request that your confidential information is not used beyond your own care and treatment and to have your objections considered, and where your wishes cannot be followed, to be told the reasons including the legal basis.

NHS pledges

The NHS also pledges:

- to ensure those involved in your care and treatment have access to your health information so they can care for you safely and effectively
- that if you are admitted to hospital, you will not have to share sleeping accommodation with patients of the opposite sex, except where appropriate, in line with details set out in the Handbook to the NHS Constitution
- to anonymise the information collected during the course of your treatment and use it to support research and improve care for others
- where identifiable information has to be used, to give you the chance to object wherever possible
- to inform you of research studies in which you may be eligible to participate
- to share with you any correspondence sent between clinicians about your care

Informed choice

Your rights

You have the right to choose your GP practice, and to be accepted by that practice unless there are reasonable grounds to refuse, in which case you will be informed of those reasons.

You have the right to express a preference for using a particular doctor within your GP practice, and for the practice to try to comply.

You have the right to transparent, accessible and comparable data on the quality of local healthcare providers, and on outcomes, as compared to others nationally.

You have the right to make choices about the services commissioned by NHS bodies and to information to support these choices. The options available to you will develop over time and depend on your individual needs. Details are set out in the Handbook to the NHS Constitution.

NHS pledges

The NHS also pledges to:

- inform you about the healthcare services available to you, locally and nationally
- offer you easily accessible, reliable and relevant information in a form you can understand, and support to use it. This will enable you to participate fully in your own healthcare decisions and to support you in making choices. This will include information on the range and quality of clinical services where there is robust and accurate information available

Involvement in your healthcare and the NHS

Your rights

You have the right to be involved in planning and making decisions about your health and care with your care provider or providers, including your end of life care, and to be given information and support to enable you to do this. Where appropriate, this right includes your family and carers. This includes being given the chance to manage your own care and treatment, if appropriate.

You have the right to an open and transparent relationship with the organisation providing your care. You must be told about any safety incident relating to your care which, in the opinion of a healthcare professional, has caused, or could

still cause, significant harm or death. You must be given the facts, an apology, and any reasonable support you need.

You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.

NHS pledges

The NHS also pledges to:

- provide you with the information and support you need to influence and scrutinise the planning and delivery of NHS services
- work in partnership with you, your family, carers and representatives
- involve you in discussions about planning your care and to offer you a written record of what is agreed if you want one
- encourage and welcome feedback on your health and care experiences and use this to improve services

Complaint and redress

See the NHS website for information on how to make a complaint (https://www.nhs.uk/using-the-nhs/about-the-nhs/how-to-complain-to-the-nhs/) and other ways to give feedback on NHS services.

Your rights

You have the right to have any complaint you make about NHS services acknowledged within three working days and to have it properly investigated.

You have the right to discuss the manner in which the complaint is to be handled, and to know the period within which the investigation is likely to be completed and the response sent.

You have the right to be kept informed of progress and to know the outcome of any investigation into your complaint, including an explanation of the conclusions and confirmation that any action needed in consequence of the complaint has been taken or is proposed to be taken.

You have the right to take your complaint to the independent Parliamentary and Health Service Ombudsman (http://www.ombudsman.org.uk/) or Local Government Ombudsman, (http://www.lgo.org.uk/) if you are not satisfied with the way your complaint has been dealt with by the NHS.

You have the right to make a claim for judicial review if you think you have been directly affected by an unlawful act or decision of an NHS body or local authority.

You have the right to compensation where you have been harmed by negligent treatment.

NHS pledges

The NHS also pledges to:

- ensure that you are treated with courtesy and you receive appropriate support throughout the handling of a complaint; and that the fact that you have complained will not adversely affect your future treatment
- ensure that when mistakes happen or if you are harmed while receiving health care you receive an appropriate explanation and apology, delivered with sensitivity and recognition of the trauma you have experienced, and know that lessons will be learned to help avoid a similar incident occurring again
- ensure that the organisation learns lessons from complaints and claims and uses these to improve NHS services

Patients and the public: your responsibilities

> The NHS belongs to all of us. There are things that we can all do for ourselves and for one another to help it work effectively, and to ensure resources are used responsibly.

Please recognise that you can make a significant contribution to your own, and your family's, good health and wellbeing, and take personal responsibility for it.

Please register with a GP practice – the main point of access to NHS care as commissioned by NHS bodies.

Please treat NHS staff and other patients with respect and recognise that violence, or the causing of nuisance or disturbance on NHS premises, could result in prosecution. You should recognise that abusive and violent behaviour could result in you being refused access to NHS services.

Please provide accurate information about your health, condition and status.

Please keep appointments, or cancel within reasonable time. Receiving treatment within the maximum waiting times may be compromised unless you do.

Please follow the course of treatment which you have agreed, and talk to your clinician if you find this difficult.

Please participate in important public health programmes such as vaccination.

Please ensure that those closest to you are aware of your wishes about organ donation.

Please give feedback – both positive and negative – about your experiences and the treatment and care you have received, including any adverse reactions you may have had. You can often provide feedback anonymously and giving feedback will not affect adversely your care or how you are treated. If a family member or someone you are a carer for is a patient and unable to provide feedback, you are encouraged to give feedback about their experiences on their behalf. Feedback will help to improve NHS services for all.

Staff: your rights and NHS pledges to you

> It is the commitment, professionalism and dedication of staff working for the benefit of the people the NHS serves which really make the difference. High-quality care requires high-quality workplaces, with commissioners and providers aiming to be employers of choice.

All staff should have rewarding and worthwhile jobs, with the freedom and confidence to act in the interest of patients. To do this, they need to be trusted, actively listened to and provided with meaningful feedback. They must be treated with respect at work, have the tools, training and support to deliver compassionate care, and opportunities to develop and progress. Care professionals should be supported to maximise the time they spend directly contributing to the care of patients.

The Constitution applies to all staff, doing clinical or non-clinical NHS work – including public health – and their employers. It covers staff wherever they are working, whether in public, private or voluntary sector organisations.

Your rights

Staff have extensive legal rights, embodied in general employment and discrimination law. These are summarised in the Handbook to the NHS

Constitution. In addition, individual contracts of employment contain terms and conditions giving staff further rights.

The rights are there to help ensure that staff:

- have a good working environment with flexible working opportunities, consistent with the needs of patients and with the way that people live their lives
- have a fair pay and contract framework
- can be involved and represented in the workplace
- have healthy and safe working conditions and an environment free from harassment, bullying or violence
- are treated fairly, equally and free from discrimination
- can in certain circumstances take a complaint about their employer to an Employment Tribunal
- can raise any concern with their employer, whether it is about safety, malpractice or other risk, in the public interest.

NHS pledges

In addition to these legal rights, there are a number of pledges, which the NHS is committed to achieve. Pledges go above and beyond your legal rights. This means that they are not legally binding but represent a commitment by the NHS to provide high-quality working environments for staff.

The NHS pledges to:

- provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability
- provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities
- provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential
- provide support and opportunities for staff to maintain their health, wellbeing and safety
- engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families (pledge)
- to have a process for staff to raise an internal grievance (pledge)
- encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to

and, where necessary, investigating the concerns raised and acting consistently with the Employment Rights Act 1996

Staff: your responsibilities

All staff have responsibilities to the public, their patients and colleagues.

Important legal duties are summarised below.

You have a duty to accept professional accountability and maintain the standards of professional practice as set by the appropriate regulatory body applicable to your profession or role.

You have a duty to take reasonable care of health and safety at work for you, your team and others, and to co-operate with employers to ensure compliance with health and safety requirements.

You have a duty to act in accordance with the express and implied terms of your contract of employment.

You have a duty not to discriminate against patients or staff and to adhere to equal opportunities and equality and human rights legislation.

You have a duty to protect the confidentiality of personal information that you hold.

You have a duty to be honest and truthful in applying for a job and in carrying out that job.

The Constitution also includes expectations that reflect how staff should play their part in ensuring the success of the NHS and delivering high-quality care.

You should aim to:

- provide all patients with safe care, and to do all you can to protect patients from avoidable harm
- follow all guidance, standards and codes relevant to your role, subject to any more specific requirements of your employers
- maintain the highest standards of care and service, treating every individual with compassion, dignity and respect, taking responsibility not only for the care you personally provide, but also for your wider contribution to the aims of your team and the NHS as a whole
- find alternative sources of care or assistance for patients, when you are unable to provide this (including for those patients who are not receiving

basic care to meet their needs)

- take up training and development opportunities provided over and above those legally required of your post
- play your part in sustainably improving services by working in partnership with patients, the public and communities
- raise any genuine concern you may have about a risk, malpractice or wrongdoing at work (such as a risk to patient safety, fraud or breaches of patient confidentiality), which may affect patients, the public, other staff or the organisation itself, at the earliest reasonable opportunity
- involve patients, their families, carers or representatives fully in decisions about prevention, diagnosis, and their individual care and treatment
- be open with patients, their families, carers or representatives, including if anything goes wrong; welcoming and listening to feedback and addressing concerns promptly and in a spirit of co-operation
- contribute to a climate where the truth can be heard, the reporting of, and learning from, errors is encouraged and colleagues are supported where errors are made
- view the services you provide from the standpoint of a patient, and involve patients, their families and carers in the services you provide, working with them, their communities and other organisations, and making it clear who is responsible for their care
- take every appropriate opportunity to encourage and support patients and colleagues to improve their health and wellbeing
- contribute towards providing fair and equitable services for all and play your part, wherever possible, in helping to reduce inequalities in experience, access or outcomes between differing groups or sections of society requiring health care
- inform patients about the use of their confidential information and to record their objections, consent or dissent
- provide access to a patient's information to other relevant professionals, always doing so securely, and only where there is a legal and appropriate basis to do so.

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Nolan principles - The Seven Principles of Public Life

The Committee on Standards in Public Life was established in 1994, initially to deal with concerns about unethical conduct amongst MPs, including accepting financial incentives for tabling Parliamentary questions, and issues over procedures for appointment to public bodies. As an independent advisory body to the Government it monitors, reports and makes recommendations on all issues relating to standards in public life.

The seven principles are:

- **Selflessness** - Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.
- **Integrity** - Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
- **Objectivity** - In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.
- **Accountability** - Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.
- **Openness** - Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.
- **Honesty** - Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
- **Leadership** - Holders of public office should promote and support these principles by leadership and example.

NHS

People Promise

We are more than 1.3 million strong.
We are all walks of life, all kinds of experiences.
We are the NHS.

We are **compassionate** and **inclusive**

We are **recognised** and **rewarded**

We each have **a voice that counts**

We are **safe** and **healthy**

We are **always learning**

We work **flexibly**

We are **a team**

People Promise

This is a promise we must all make to each other – to work together to improve the experience of working in the NHS for everyone.

The themes and words that make up Our People Promise have come from those who work in the NHS. People in different healthcare roles and organisations have made it clear what matters most to them, and what would make the greatest difference in improving their experience in the workplace.

For many, some parts of the Promise will already match their current experience. For others, it may still feel out of reach. We must all pledge to work together to make these ambitions a reality for all of us, within the next four years.

The people best placed to say when progress has been made are those who work in the NHS. From 2021 the annual NHS Staff Survey will be redesigned to align with Our People Promise.

The NHS is an extraordinary, world-class service – thanks to every single one of us who contributes to it. Our service, training, skills and commitment are admired across the world. Together we have achieved the extraordinary – and together we continue to do so.

We feel the pressure of workload and not always having enough colleagues. We all want more time to support one another and provide great care. And we are often so busy with the daily demands of our work that we lack the time and energy to find new and better ways of doing it. But we know that the NHS always rises to the challenge, and we have seen its resilience, teamwork and innovation.

We want to continue to bring out the very best in one another – inspiring each and every person and unleashing potential. We do this by making the culture of the NHS one that's compassionate and inclusive, and addressing our workforce and workload challenges.

We are compassionate and inclusive

We are kind and respectful. We all feel the pressure at times, but we care for each other, as we care for our patients. We don't tolerate any form of discrimination, bullying or violence, and call out inappropriate behaviour.

We are open and inclusive. We understand, encourage and celebrate diversity, making the NHS a place where we all feel we belong.

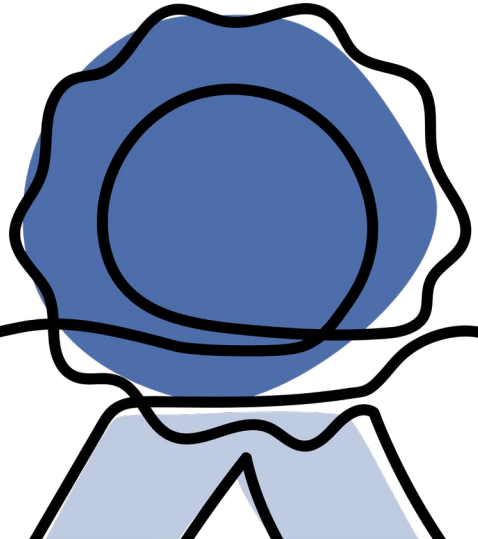
We are recognised and rewarded

We are recognised and appreciated – whether a simple thank you for our day-to-day work, or formal recognition for our dedication, such as every decade of service to the NHS.

We have a fair salary, competitive pension, and an attractive package of extended benefits, whatever our role.

We have more choices. We can buy and sell unused holiday and arrange unpaid leave, if this is what we'd prefer. We also enjoy enhanced maternity and shared parental leave.

We have access to employee assistance programmes for advice and support on issues like caring responsibilities and financial wellbeing.



We each have a voice that counts

We all feel safe and confident when expressing our views. If something concerns us, we speak up, knowing we will be listened to and supported. Our teams are safe spaces where we can work through issues that are worrying us.

If we find a better way of doing something, we share it. We use our voices to shape our roles, workplace, the NHS, and our communities, to improve the health and care of the nation.

We take the time to really listen – beyond the words – to understand the hopes and fears that lie beneath them. We help one another through challenges, during times of change, and to make the most of new opportunities.

We are safe and healthy

We're considerate of each other's time and mindful of each other's workload and the physical and emotional impact this can have. While we may choose to go the extra mile to deliver exceptional care, we still look after ourselves and each other.

Wellbeing is our business and our priority. We stay mentally and physically fit and healthy through working hour limits, healthier food choices and access to schemes to help us stay in shape.

And if we're unwell ourselves, we are supported to get the help we need, take the time to recover, and return to work at our own pace.

Our occupational health and wellbeing services are there for us when we need them, with rapid access to help with work-related mental and physical injury and illness.

We have clean safe spaces to rest and reflect, and access to hot food and drinks, including fresh water. These are the basics, but they really matter and can't be underestimated.

We have the technology and equipment we need to keep us safe, deliver the best possible care, and make the best use of our time and our skills.

We are always learning

Opportunities to learn and develop while working for the NHS are plentiful. Our management and supervision are first class – with regular reviews of workload, and opportunities for two-way feedback and appraisals – to ensure we are able to realise our potential.

We are supported to invest in our careers, through formal and informal training, to reach our personal and professional goals. We have the time, space and funding to do this.

The many career options mean we can experience a variety of health and care settings, skills and practice, and progress to different roles. There are opportunities to take advantage of shadowing and secondments, coaching and mentoring, and contribute towards research and teaching. We exchange our skills and knowledge across the local health and care system, and beyond.

We all have equal access to opportunities – with fair and transparent selection processes that attract, develop and retain talented people from all backgrounds.

We work flexibly

Our work doesn't mean we have to sacrifice family, friends or interests. Predictable working patterns and hours, that we have a say in agreeing, make a real difference to our lives and our wellbeing. That's why we have access to new rostering technology that lets us take more control over when we work.

We can work flexibly, doing whatever work pattern fits our needs, regardless of the type of role we're in. As a modern and model employer, flexible and less than full-time working isn't a barrier to progress in the NHS – it is commonplace.

As more people are recruited to the NHS across many areas, and roles are adapted to make everyone's workload more manageable, we feel better supported and the demands of work are more sustainable.

And if we have unpaid caring duties, we are supported and helped to return to work if we take time off to look after someone.

We are able to come back to the NHS even after we retire, if we still want to contribute our expertise.

We are a team

The NHS is first and foremost one huge team. Regardless of our role, experience or background, if we work for the NHS, we are part of that team. We are united by a desire to provide the very best care and support not just to those using our services, but to each other.

We're also part of a growing team, with people from many different professions and roles, working together in a flexible way to respond to the changing needs of our patients. Being in a diverse team gives us a chance to learn from each other's experience, specialisms and skills, working with a shared purpose.

Our work is fulfilling – it makes a real difference and is rewarding. We give one another the space to innovate, we support each other when times are tough, and we take time to celebrate successes, small and large.

People Promise

Together we make the
NHS the best place to work.
We are the NHS.

Cambridge University
Hospitals NHS Foundation Trust

Thank you to all our NHS people featured here.
Some of their images were captured prior to the Covid-19 pandemic.

June 2021
Publication reference: 0067

East of England Leadership Compact

In working together as a leadership community, we will adopt the following behaviours and hold each other to account for upholding these:

- We will put people first – our patients, staff and citizens.
- We will support each other to deliver excellence in quality and performance.
- We will respect and trust each other and share important information, so there are no surprises
- We will have inclusive robust, honest and realistic conversations where all voices are heard, views respected and differences resolved for the greater good of our population.
- We will be compassionate and caring, supporting each other, especially in difficult times.
- We will value each other's contributions, celebrate successes collectively and learn from failure
- We will ensure our collective decisions are transparent and inclusive and we will abide by them.
- We will agree expectations and hold each other to account.
- We will be ambitious to improve health and wellbeing, sharing expertise, talent, knowledge, best practice, innovation and learning for the benefit of our patients, staff and citizens
- We will work together to have a strong, united external voice for our region.

6. Board Nomination and Selection Process

6.1. Partner Application Pack

6.2. Nomination Letters

6.3. List of eligible nominating PMS (GMS/APMS) Providers

Designate Partner Members

Mid and South Essex Integrated Care Board

Information pack for Nominations and Selection

Contents

We value and promote diversity and are committed to equality of opportunity for all. We believe that the best boards are those that reflect the communities they serve.

We prioritise Equality, Diversity and Inclusion, team health and wellbeing and the principles of kind leadership in our 'ways of working'. All postholders will have a key role in nurturing this culture.

Appointment will be made on merit after a fair and open process so that the best people, from the widest possible pool of applicants, are appointed.

1.The opportunity

Integrated care systems (ICSs) are partnerships of health and care organisations, local government, and the voluntary sector. They exist to improve population health, tackle health inequalities, enhance productivity and help the NHS support broader social and economic development. They will take on statutory form following the implementation of proposed legislation from July 2022 and will comprise an Integrated Care Board (ICB) and Integrated Care Partnership. The Integrated Care Board will take on the CCGs' functions and broader strategic responsibility for overseeing healthcare strategies for the system. We are looking for nominees? who will work with the designate chair of ICB, and, subject to legislation, support the establishment of the system's new statutory arrangements as a designate Partner member of the ICB.

We are seeking Partner members from:

- MSE Upper Tier Local Authorities (3 members)
- NHS Foundation trusts
    - 1 Member - Acute
    - 1 Member - Mental Health
- Primary Care – 1 member

In addition to the Board partner members may be asked to join the following committees:

- Remuneration Committee
- Audit Committee
- System Oversight & Performance Committee
- Finance & Investment Committee
- Quality & Safety Committee
- (Primary Care) Commissioning Committee

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2. Role priorities and accountabilities

Please note: the following role description is dependent on legislation. Appointees will be taken on in the first instance as designate partner member(s) of the anticipated NHS ICB.

Final appointment to the role of partner member of the ICB, as described below, would be dependent on the passage of the Health and Care Bill, and any potential amendments made to that Bill.

Priorities

The partner members will:

- Work collaboratively to shape the long-term, viable plan for the delivery of the functions, duties and objectives of the ICB and for the stewardship of public money.
- Ensure that the Board is effective in all aspects of its role and appropriately focused on the four core purposes, to: improve outcomes in population health and healthcare; tackle inequalities in outcomes, experience and access; enhance productivity and value for money and help the NHS support broader social and economic development.
- Be champions of new governance arrangements (including with the ICP), collaborative leadership, joint accountability and effective partnership working, including with local government, NHS bodies and the voluntary sector.

- Support the Chair and the wider Board on issues that impact organisations and workforce across the ICS, such as integration, the People agenda, Digital transformation, Emergency Preparedness, Resilience and Response (EPRR) and Covid-19 challenges.
- Play a key role in establishing new statutory arrangements for the ICS to ensure that the ICB meets its statutory duties, building strong partnerships and governance arrangements with system partners, including the ability to take on commissioning functions from CCGs and NHS England.

Accountabilities

The partner members:

- Are accountable to the ICB Chair.
- Have designated areas of responsibilities as agreed with the ICB Chair.
- Have a collective responsibility with the other members of the ICB to ensure corporate accountability for the performance of the organisation, ensuring its functions are effectively and efficiently discharged and its financial obligations are met.

3. Role responsibilities and competencies

You will work alongside the Chair, non-executives, executive directors and other partner members as equal members of a unitary board.

As a senior leader in MSE, you will demonstrate a range of leadership competencies outlined below. Corporately, as members of a unitary board, you will contribute to a wide range of areas, including:

Strategy and transformation

- Setting the vision, strategy and clear objectives for the ICB in delivering on the four core purposes of the ICS, the triple aim of improved population health, quality of care and cost-control.
- Ensuring the reduction of health inequality becomes an organising principle of the ICB
- Aligning partners in transforming the Long Term Plan and the People Plan into real progress

Partnerships and communities

- Promoting dialogue and consensus between the NHS, local government and broader partners, to ensure effective joint planning and delivery for system working and mutual accountability.
- Supporting the establishment of the ICP, developing strong relationships between the ICB and the ICP.
- Supporting the success of the ICP in establishing shared strategic priorities within the NHS, in partnership with local government, to tackle population health challenges and enhance services across health and social care.

Social justice and health equalities

- Advocating diversity, health equality and social justice to close the gap on health inequalities and achieve the service changes that are needed to improve population health.
- Ensuring the ICB is responsive to people and communities and that public, patient and carer voices are embedded in all of the ICB's plans and activities.
- Promoting the values of the NHS Constitution and modelling the behaviours embodied in Our People Promise and forthcoming Leadership Way to ensure a collaborative, inclusive and productive approach across the system.

Sustainable outcomes

- Oversight of purposeful arrangements for effective leadership of clinical and professional care throughout the ICB and the ICS.
- Fostering a culture of research, innovation, learning and continuous improvement to support the delivery of high quality services for all.
- Ensuring the NHS plays its part in social and economic development and achieving environmental sustainability, including the Carbon Net Zero commitment.

Governance and assurance

- Collectively ensuring that the ICB is compliant with its constitution and contractual obligations, holding other members of the ICB and the ICS to account through constructive, independent and respectful challenge.
- Maintaining oversight of the delivery of ICB plans, ensuring expected outcomes are delivered in a timely manner through the proportionate management of risks.
- Ensuring that the ICB operates to deliver its functions in line with all of its statutory duties, and that compliance with the expected standards of the regulatory bodies is maintained.

People and culture

- Supporting the development of other board members to maximise their contribution.
- Providing visible leadership in developing a healthy and inclusive culture for the organisation, which promotes diversity, encourages and enables system working and which is reflected and modelled in their own and the Board's behaviour and decision-making.
- Ensuring the Board acts in accordance with the highest ethical standards of public service and that any conflicts are appropriately resolved.
- Lead in line with the NHS Leadership Compact

5. Designate partner member: person specification

Competency	Knowledge, Experience and Skills required
Setting strategy and delivering long-term transformation	• Knowledge of health, care, local government landscape and/ or the voluntary sector • A capacity to thrive in a complex and politically charged environment of change and uncertainty • Experience leading change at a senior level to bring together disparate stakeholder interests • Ability to influence partner organisations
Building trusted relationships with partners and communities	• An understanding of different sectors, groups, networks and the needs of diverse populations • Exceptional communication skills and comfortable presenting in a variety of contexts • Highly developed interpersonal and influencing skills, able to lead in a creative environment which enables people to thrive and collaborate • Experience working collaboratively across agency and professional boundaries
Leading for Social Justice and health equality	• An awareness and appreciation of social justice and how it might apply within an ICS • Record of promoting equality, diversity and inclusion in leadership roles • Life experience and personal motivation that will add valuable personal insights

Driving high quality, sustainable outcomes	• Problem solving skills and the ability to identify issues and areas of risk, leading stakeholders to effective resolutions and decisions
Providing robust governance and assurance	• An understanding of good corporate governance • Ability to remain neutral to provide independent and unbiased leadership with a high degree of personal integrity • Experience contributing effectively in complex professional meetings at a very senior level
Creating a compassionate and inclusive culture for our people	• Models respect and a compassionate and inclusive leadership style with a demonstrable commitment to equality, diversity and inclusion in respect of boards, patients and staff • Creates and lives the values of openness and transparency embodied by the principles-of-public-life and in Our People Promise

Nominees will:

- Bring the skills and experience of their sector but not act as delegates or representatives of their organisation.
- Demonstrate a proven track record of working within a complex environment to champion and effect change around equality, diversity and inclusion
- Have an understanding of the demographics of the ICB population, in order to ensure that any proposals around interventions are fit for purpose and tailored to the specific needs of the population
- Demonstrate independent and proactive leadership with confidence and integrity
- Champion open, frank and disciplined discussion and be prepared to ask the difficult questions

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

6. Nomination and Selection

The eligibility, nominations and selection process for each category of Partner Member are set out in the appendices A to C.

6.1 Assessment & Selection

Received and eligible nominations will be submitted to nominating organisations to demonstrate the requirement for joint nominations

If, as set out in the Constitution, 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 and will confirm that shortlisted nominees meet the requirements set out in the constitution.

The Chair will determine whether to approve the appointment of the most suitable nominee.

7. Timetable

- 6 May - Packs issued to eligible partners for nomination
- 18 May – Deadline for nominations to be received
- 23 May – Lists of nominations to be submitted to partner members for confirmation (jointly nominated requirement)
- w/c 30 May / 6 June – Panel interviews / Chair confirmation

Appendix A - Partner Member, NHS Trusts and Foundation Trusts (FTs)

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 health care 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).

3.5.1 These Partner Members are jointly nominated by the Partners which provide services within the area and are of essential to the development and delivery of the 5-year joint forward plan, namely:

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.

Appendix B - Partner Member, Providers of Primary Medical Services.

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 health care 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).

3.6.1 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 are Primary Medical Services (General Practice) contract holders responsible for the provision of essential services to a list of registered patients within core hours in the ICB's area.

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.

Appendix C - Partner Members, Local Authorities

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 health care 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).

3.7.1 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 Borough 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.
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.
c) 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.

Mid and South Essex
Health and Care
Partnership

TELEPHONE: 01268 594534
EMAIL: btu-tr.midsouthessexstp@nhs.net

Mid and South Essex
Health and Care Partnership
c/o Basildon Brentwood CCG
Phoenix Court
Christopher Martin Road
Basildon
Essex SS14 3HG

By email:

Chair, East of England Ambulance Service NHS Trust.
Chair, Essex Partnership University NHS Foundation Trust.
Chair, Mid and South Essex NHS Foundation Trust.
Acting Chair, North East London NHS Foundation Trust.

6 May 2022

Dear ….

MSE Integrated Care Board Partner Member Nomination

We are seeking nominations from partner organisations for each of the 6 Partner Member roles required within the MSE ICB's constitution.

Attached is a pack providing more information about these roles, including key responsibilities, the role specification, the mandatory eligibility criteria and the nomination and selection process.

As an NHS Foundation Trust you are able to make up to two nominations, one for a member who will bring a perspective of the local Acute sector and one for a member who will bring a perspective of the local Mental Health sector.

Please return your nominations to Viv Barnes (viv.barnes@nhs.net) by 18 May 2022. We will then issue a full list of received nominations by 23 May 2022 in order that these can be jointly agreed by all nominating organisations.

If more than one individual is nominated for each role, panel interviews will be held during the weeks commencing 30 May and 6 June 2022 to select the most suitable nominee. Where only one individual is nominated for a role, a confirmation process will be undertaken to ensure that the nominated individual meets the criteria for Board membership prior to any appointments being made.

If you have any queries regarding the process please do not hesitate to contact me (or Mike Thompson, mike.thompson6@nhs.net). I look forward to receiving your nomination/s by **18 May 2022** at the latest.

Yours sincerely

Professor Mike Thorne CBE
ICB Chair (designate)

Mid and South Essex
Health and Care
Partnership

TELEPHONE: 01268 594534
EMAIL: btu-tr.midsouthessexstp@nhs.net

Mid and South Essex
Health and Care Partnership
c/o Basildon Brentwood CCG
Phoenix Court
Christopher Martin Road
Basildon
Essex SS14 3HG

By email:

Leader of Essex County Council
Leader, Thurrock Council
Leader. Southend Council

6 May 2022

Dear ….

MSE Integrated Care Board Partner Member Nomination

We are seeking nominations from partner organisations for each of the 6 Partner Member roles required within the MSE ICB's constitution.

Attached is a pack providing more information about these roles, including key responsibilities, the role specification, the mandatory eligibility criteria and the nomination and selection process.

As a Local Authority you are able to make up to three nominations of individuals with knowledge and experience covering the full breadth of the ICB geography, its range of health and care services and professions.

Please return your nominations to Viv Barnes (viv.barnes@nhs.net) by 18 May 2022. We will then issue a full list of received nominations by 23 May 2022 in order that these can be jointly agreed by all nominating organisations.

If more than one individual is nominated for each role, panel interviews will be held during the weeks commencing 30 May and 6 June 2022 to select the most suitable nominee. Where only one individual is nominated for a role, a confirmation process will be undertaken to ensure that the nominated individual meets the criteria for Board membership prior to any appointments being made.

If you have any queries regarding the process please do not hesitate to contact me (or Mike Thompson, mike.thompson6@nhs.net). I look forward to receiving your nomination/s by **18 May 2022** at the latest.

Yours sincerely

Professor Mike Thorne CBE
ICB Chair (designate)

Mid and South Essex
Health and Care
Partnership

TELEPHONE: 01268 594534
EMAIL: btu-tr.midsouthessexstp@nhs.net

Mid and South Essex
Health and Care Partnership
c/o Basildon Brentwood CCG
Phoenix Court
Christopher Martin Road
Basildon
Essex SS14 3HG

By email:

To all Primary Care (General Practice) Providers in mid and South Essex

6 May 2022

Dear colleague,

MSE Integrated Care Board Partner Member Nomination

We are seeking nominations from partner organisations for each of the 6 Partner Member roles required within the MSE ICB's constitution.

Attached is a pack providing more information about these roles, including key responsibilities, the role specification, the mandatory eligibility criteria and the nomination and selection process.

As a Primary Care Provider you are able to make one nomination, seconded by another eligible practice, of an individual who will bring the perspective of the primary care sector within the ICB area.

Please return your nomination to Viv Barnes (viv.barnes@nhs.net) by 18 May 2022. We will then issue a full list of received nominations by 23 May 2022 in order that these can be jointly agreed by all nominating organisations.

If more than one individual is nominated for each role, panel interviews will be held during the weeks commencing 30 May and 6 June 2022 to select the most suitable nominee. Where only one individual is nominated for a role, a confirmation process will be undertaken to ensure that the nominated individual meets the criteria for Board membership prior to any appointments being made.

If you have any queries regarding the process please do not hesitate to contact me (or Mike Thompson, mike.thompson6@nhs.net). I look forward to receiving your nomination/s by **18 May 2022** at the latest.

Yours sincerely

Professor Mike Thorne CBE
ICB Chair (designate)

Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

List of eligible nominating PMS (GMS/APMS) Providers

Basildon and Brentwood Alliance

CLAYHILL MEDICAL PRACTICE	Vange Health Centre, Southview Road, Vange, Basildon, SS16 4HD
WESTERN ROAD SURGERY	41 Western Road, Billericay, CM12 9DX
BEECHWOOD SURGERY	Pastoral Way, Warley, Brentwood, CM14 5WF
DR GC CHAJED'S PRACTICE	Kingswood Medical Centre, Clay Hill Road, Basildon, SS16 5AD
DR DEGUN & DR MACAULAY	Knares Medical Centre, 93 The Knares, Lee Chapel, South, Basildon, SS16 5SB
MURREE MEDICAL GROUP	Murree Medical Centre, 201 Rectory Rd, Basildon, SS13 1AJ
ROBERT FREW MEDICAL CENTRE	Silva Island Way, Wickford, SS12 9NR
TILE HOUSE SURGERY	33 Shenfield Road, Brentwood, CM15 8AQ
LONDON ROAD SURGERY	Market House, Market Road, Wickford, SS12 0AA
DR N DABAS'S PRACTICE	The New Surgery, 27 Stock Road, Billericay, CM12 0AH
MOUNT AVENUE SURGERY	2 Mount Avenue, Brentwood, CM13 2NL
AEGIS MEDICAL CENTRE	568 Whitmore Way, Basildon, SS14 2ER
THE BILLERICAY MEDICAL PRACTICE	The Health Centre, Stock Road, Billericay, CM12 0BJ
DR A NAEEM & PARTNERS, THE NEW SURGERY	8 Shenfield Road, Brentwood, CM15 8AB
ROCKLEIGH COURT SURGERY	136 Hutton Road, Shenfield, Brentwood, CM15 8NN
CHAPEL STREET SURGERY	93 Chapel St, Billericay, CM12 9LR
LAINDON MEDICAL GROUP	Laindon Health Centre, High Road, Laindon, Basildon, SS15 5TR
BALLARDS WALK SURGERY	49 Ballards Walk, Basildon SS15 5HL
DR NASAH & PARTNERS	Dipple Medical Centre, South Wing, Wickford Avenue, Pitsea, Basildon, SS13 3HQ
THE NEW FOLLY SURGERY	Bell Mead, Ingatestone, CM4 0FA
FELMORES MEDICAL CENTRE	Felmores End, Basildon SS13 1PN
DEAL TREE HEALTH CENTRE	Blackmore Road, Doddinghurst, Brentwood, CM15 0HU
QUEENS PARK SURGERY	24 The Pantiles, Billericay, CM12 0UA

ARYAN MEDICAL CENTRE	Felmores End, Basildon, SS13 1PN
ROSEVILLA SURGERY	6 Rectory Park Drive, Basildon, SS13 3DW
SOUTH GREEN SURGERY	14-18 Grange Rd, Billericay, CM11 2RE
DR SHARMA & PARTNERS	Noakbridge Medical Centre, Bridge Street, Basildon, SS15 4EZ
FRYERNS MEDICAL CENTRE	Peterborough Way, Basildon, SS14 3SS
KNIGHTS SURGERY	Basildon Sporting Village, Gloucester Park North, Cranes Farm Road, Basildon, SS14 3GR
MATCHING GREEN SURGERY	49 Matching Green, Basildon, SS14 2PB
SWANWOOD PARTNERSHIP	Applewood Surgery, Wickford Health Centre, 2 Market Avenue, Wickford, SS12 0AG
THE HIGHWOOD SURGERY	Highwood Hospital Site, Geary Drive, Brentwood, CM15 9DY
DR SIMS AND PARTNERS	Dipple Medical Centre, West Wing, Wickford Ave, Pitsea, Basildon, SS13 3HQ
DR JO ARAYOMI'S PRACTICE	Dipple Medical Centre, East Wing, Wickford Ave, Pitsea, Basildon, SS13 3HQ
DR SALAKO AND PARTNERS	Langdon Hills Medical Practice, Great Berry Neighbourhood Centre, Nightingales, Langdon Hills, SS16 6SA
BB HEALTHCARE SOLUTIONS	Fryerns Medical Centre, Peterborough, Way, Basildon, SS14 3SS

Mid Essex Alliance

KEVELDON & FEERING HEALTH CENTRE	46 High Street, Kelvedon, Colchester, CO5 9AG
CHURCH LANE SURGERY	Braintree College , Church Lane, Braintree, CM7 5SN
FRESHFORD PRACTICE	Wethersfield Road, Finchingfield, CM7 4BQ
LONGFIELD MEDICAL CENTRE	Princes Road, Maldon, CM9 5DF
FERN HOUSE SURGERY	125-129 Newland Street, Witham, CM8 1BH
STOCK SURGERY	Common Road, Stock, CM4 9NF
WHITLEY HOUSE SURGERY	Crompton Building, Writtle Road, Chelmsford, CM1 3RW
THE ELIZABETH COURTAULD SURGERY	Factory Lane West, Halstead, CO9 1EX
RIVERMEAD GATE MEDICAL CENTRE	123 Rectory Lane , Chelmsford, CM1 1TR
THE TOLLESBURY PRACTICE	25 High Street, Tollesbury, CM9 8RG
BEAUCHAMP HOUSE	37 Baddow Road, Chelmsford, CM2 0DB

MOUNT CHAMBERS MEDICAL PRACTICE	92 Coggeshall Road, Braintree, CM7 9BY
THE WRITTLE SURGERY	16A Lordship Rd, Writtle, CM1 3EH
BLACKWATER MEDICAL CENTRE	Princes Road, Maldon, CM9 5GP
BEACON HEALTH GROUP-DANBURY MEDICAL CENTRE	52 Maldon Rd, Danbury, CM2 9LG
LITTLE WALTHAM & GT NOTLEY SURGERY	The Surgery, 30 Brook Hill, Lt Waltham, CM3 3LL
BADDOW VILLAGE SURGERY	Longmead Avenue, Chelmsford, CM2 7EZ
SUTHERLAND LODGE SURGERY	115 Baddow Road, Chelmsford, CM2 7PY
THE PUMP HOUSE SURGERY	Nonancourt Way, Earls Colne, Colchester, CO6 2SW
CHELMER MEDICAL PARTNERSHIP	Tennyson House Surgery, 20 Merlin Place, Chelmsford, CM1 4HW
BURNHAM SURGERY	Foundry Lane, Burnham on Crouch, CM0 8SJ
WILLIAM FISHER MEDICAL CENTRE	19 High Street, Southminster, CM0 7AY
BLANDFORD MEDICAL CENTRE	Mace Avenue, Braintree, CM7 2AE
THE LAURELS SURGERY	Sidney House, Strutt Close, Hatfield Peverel, CM3 2HB
KINGSWAY SURGERY	Crouch Vale Medical Centre, Burnham Road, South Woodham Ferrers, CM3 5QP
DOUGLAS GROVE SURGERY	Douglas Grove, Witham, CM8 1TE
THE DENGIE MEDICAL PARTNERSHIP	Tillingham Medical, 61 South Street, Tillingham, CM0 7TH
WITHAM HEALTH CENTRE	The Witham Health Centre, 4 Mayland Road, Witham, CM8 2UX
COLLINGWOOD ROAD SURGERY	40 Collingwood Road, Witham, CM8 2DZ
CHELMER VILLAGE SURGERY	Ashton Place, Chelmer Village, Chelmsford, CM2 6ST
GREENWOOD & WYNCROFT SURGERY	Crouch Vale Medical Centre, Burnham Road, South Woodham Ferrers, CM3 5QP
BLYTH'S MEADOW SURGERY	Trinovantian Way, Braintree, CM7 3JN
THE COGGESHALL SURGERY	Stoneham Street, Coggeshall, CO6 1UH
THE TRINITY MEDICAL PRACTICE	1 The Drive, Mayland, Chelmsford, CM3 6AB
HEDINGHAM MEDICAL CENTRE	10 Falcon Square, Castle Hedingham, CO9 3BY
NORTH CHELMSFORD NHS HCC	Sainsbury's, 2 White Hart Lane, Springfield, Chelmsford, CM2 5EF

SILVER END SURGERY	Broadway, Silver End, Witham, CM8 3RQ

South East Essex Alliance

DR KHAN & PARTNERS	91 Rushbottom Lane, Benfleet, SS7 4EA
DR F KHAN CARNAVON ROAD SURGERY	183-195 North Road , Westcliff On Sea, SS0 7AF
DR PUZEY FAMILY PRACTICE	Southwell House, Back Lane, Rochford, SS4 1AY
P A PATEL SURGERY	85 Hart Road, Thundersley, SS7 3PR
DR KRISHNAN & PTNR - KENT ELMS HEALTH CENTRE	1 Rayleigh Road, Leigh on Sea, SS9 5UU
THIRD AVENUE HEALTH CENTRE	Third Avenue, Canvey Island, SS8 9SU
CONNER & PARTNERS	175 Ferry Road, Hullbridge, SS5 6JH
WILLIAM HARVEY SURGERY	83 London Road, Rayleigh, SS6 9HR
THE GREENSWARD SURGERY	Greensward Lane, Hockley, SS5 5HQ
THE HOLLIES	41 Rectory Road, Hadleigh, SS7 2NA
THE QUEENSWAY SURGERY	75 Queensway, Southend, SS1 2AB
CENTRAL SURGERY - SOUTHCHURCH BLVD	27 Southchurch Boulevard, Southend, SS2 4UB
WAKERING MEDICAL CENTRE	274 High Street, Great Wakering, Southend-on Sea, SS3 0HX
DR SOORIAKUMARAN	3 Prince Avenue, Southend-on-Sea, SS2 6RL
OAKLANDS SURGERY	Central Canvey Primary Care Centre, Long Road, Canvey Island, SS8 0JA
THE VALKYRIE SURGERY	Valkyrie Road Primary Care Centre, 50 Valkyrie Road, Westcliff, SS0 8BU
ESSEX WAY SURGERY	34 Essex Way, Benfleet, SS7 1LT
HIGHLANDS SURGERY	1643 London Road, Leigh on Sea, SS9 2SQ
THE THORPE BAY SURGERY	99 Tyrone Road, Thorpe Bay, Shoeburyness, SS1 3HD
AUDLEY MILLS SURGERY	57 Eastwood Road, Rayleigh, SS6 7JF
CHURCH VIEW SURGERY	Burley House, 15-17 High St, Rayleigh, SS6 7DY
EASTWOOD GROUP PRACTICE	335 Eastwood Road North, Leigh on Sea, SS9 4LT
ST GEORGES MEDICAL PRACTICE	91 Rushbottom Lane, Benfleet, SS7 4EA

THE PALL MALL SURGERY	918 London Road, Leigh-on-Sea, SS9 3NG
DR NAVIN KUMAR	183-195 North Road, Westcliff, SS0 7AF
SOUTHEND MEDICAL CENTRE	50-52 London Road, Southend, SS1 1NX
WEST ROAD SURGERY	183-195 North Road , Westcliff, SS0 7AF
NORTH AVENUE SURGERY	332 North Avenue, Southend, SS2 4EQ
GHAURI PRACTICE	1a Hawkesbury Road, Canvey Island, SS8 0EX
DR BEKAS MEDICAL CENTRE	48 Argyll Road, Westcliff, SS0 7HN
DR MALIK - KENT ELMS HC	1 Rayleigh Road, Leigh on Sea, SS9 5UU
DR KUMAR & PTNR - SHOEBURY HEALTH CENTRE	Campfield Road, Shoeburyness, SS3 9BX
HIGH ROAD FAMILY DOCTORS	119 High Road, Benfleet, SS7 5LN
DRS. PALACIN	Campfield Road, Shoebury, SS3 9BX
WARRIOR SQUARE SURGERY	61 Warrior Square, Southend, SS1 2JJ
THE PRACTICE LEECON WAY	1 Leecon Way, Ashingdon Gardens, Rochford, SS4 1TU
ASHINGDON MEDICAL CENTRE	57 Lascelles Gardens, Ashington, SS4 3BW
THE LEIGH SURGERY	194 Elmsleigh Drive, Leigh on Sea, SS9 4JQ
CANVEY VILLAGE SURGERY	391 Long Road, Canvey Island, SS8 0JH
DOWNHALL PARK SURGERY	49 Rawreth Lane, Rayleigh, SS6 9QD
BENFLEET SURGERY	12 Constitution Hill, Benfleet, SS7 1ED
THE ISLAND SURGERY	Long Road, Canvey Island, SS8 0JA
THE COMMUNITY PRACTICE	Long Road, Canvey Island, SS8 0JA
SCOTT PARK SURGERY	205 Western Approaches, Southend, SS2 6XY
THE PRACTICE NORTHUMBERLAND AVENUE	32 Northumberland Avenue, Southend, SS1 2TH
ST LUKE'S HEALTH CENTRE	Pantile Avenue, Southend, SS2 4BD

Thurrock Alliance

AVELEY MEDICAL CENTRE	22 High Street, Aveley, RM15 4AD
THE RIGG-MILNER MEDICAL CENTRE	2 Bata Avenue, East Tilbury, RM18 8SD
SOUTHEND ROAD SURGERY	271A Southend Road, Stanford-le-Hope, SS17 8HD

TILBURY HEALTH CENTRE	London Road, Tilbury, RM18 8EB
CHAFFORD HUNDRED MEDICAL CENTRE	Drake Road, Chafford Hundred, RM16 6RS
PEARTREE SURGERY & WEST HORNDON SURGERY	Pear Tree Close, South Ockendon, RM15 6PR
ORSETT SURGERY	63 Rowley Road, Orsett, RM16 3ET
HASSENGATE MEDICAL CENTRE	Southend Road, Stanford-le-Hope, SS17 0PH
BALFOUR MEDICAL CENTRE	2 Balfour Road, Grays, RM17 5NS
NEERA MEDICAL CENTRE	2 Wharf Road, Stanford-le-Hope, SS17 0BY
STIFFORD CLAYS MEDICAL CENTRE	Crammavill Street, Stifford Clays, Grays, RM16 2AP
SANCTA MARIA MEDICAL CENTRE	Daiglen Drive, South Ockendon, RM15 5SZ
HORNDON-ON-THE-HILL SURGERY	High Rd, Horndon on the Hill, Stanford-le-Hope, SS17 8LB
COMMONWEALTH HEALTH CENTRE	Quebec Road, Tilbury, RM18 7RB
DR YADAVA PRACTICE	34 East Thurrock Road, Grays, RM17 6SP
DELL MEDICAL CENTRE	111 Orsett Road, Grays, RM17 5HB
KADIM PRIMECARE MEDICAL CENTRE	167 Bridge Road, Grays, RM17 6DB
DR YASIN SA PRACTICE	The Health Centre, Darenth Lane, South Ockendon, RM15 5LP
MILTON ROAD & THE GRAYS SURGERY	12 Milton Road, Grays, RM17 5EZ
MEDIC HOUSE	105A Ottawa Road, Tilbury, RM18 7RJ
DERRY COURT MEDICAL CENTRE	Derry Court, Derry Avenue, South Ockendon, RM15 5GN
DR DEVARAJA VC PRACTICE	The Sorrells Surgery, 7 The Sorrells, Stanford-le-Hope, SS17 7DZ
SAI MEDICAL CENTRE	105 Calcutta Road, Tilbury, RM18 7QA
PURFLEET CARE CENTRE	Tank Hill Road, Purfleet, RM19 1SX
ODDFELLOWS AND ST CLEMENTS	Odd Fellows Hall, Dell Road, Grays, RM17 5JY
THURROCK HEALTH CENTRE	55-57 High Street, Grays, RM17 6NB

7. Financial Management

7.1. Map of system groups and interrelationships [to follow, under development]

7.2. ICP Memorandum of Understanding [to follow, being refreshed]

7.3. System Compacts [to follow under development/being refreshed]

8. Summary Delegation Arrangements

8.1 Primary Care Medical Services, Dental Services, Ophthalmic Services and Pharmaceutical Services Delegation Agreement

8.2 Specialised Commissioning Services Delegation Agreement

Dated 2023

(1) **NHS ENGLAND**

- and -

(2) **NHS MID AND SOUTH ESSEX INTEGRATED CARE BOARD**

Delegation Agreement in Respect of

(i) Primary Medical Care Services
(ii) Primary Dental Services and Prescribed Dental Services
(iii) Primary Ophthalmic Services
(iv) Pharmaceutical Services and Local Pharmaceutical Services

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Clause heading and number — Page number

DELEGATION AGREEMENT FOR SPECIFIED FUNCTIONS

1. **PARTICULARS**

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

Integrated Care Board	Mid and South Essex
Area	Mid and South Essex
Date of Agreement	1 April 2023
ICB Representative	Anthony McKeever
ICB Email Address for Notices	ceooffice.mseics@nhs.net
NHS England Representative	[Insert details of name of the manager of this Agreement for NHS England]
NHS England Email Address for Notices	[Insert Address]

1.2 **The following Delegated Functions are included in this Agreement[1]:**

Delegated Functions	Schedule	Included	Effective Date of Delegation
Primary Medical Services Functions	Schedule 2A –	Yes	1st July 2022
Primary Dental Services and Prescribed Dental Services Functions	Schedule 2B –	Yes	1st April 2023
Primary Ophthalmic Services Functions	Schedule 2C –	Yes	1st April 2023
Pharmaceutical Services and Local Pharmaceutical Services Functions	Schedule 2D –	Yes	1st April 2023

1.3 This Agreement comprises:

1.3.1 the Particulars (clause 1);

1.3.2 the Terms and Conditions (clauses 2 to 31);

[1] This table must be completed to indicate which services are included in the Delegation.

1.3.3 the Schedules; and

1.3.4 the Mandated Guidance

Signed by **NHS England**

[Name]

[Title]

(for and on behalf of NHS England)

Signed by **Mid and South Essex Integrated Care Board**

Anthony McKeever

Chief Executive

for and on behalf of Mid and South Essex Integrated Care Board

TERMS AND CONDITIONS

2. **INTERPRETATION**

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

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

2.2.1 the Particulars and Terms and Conditions (clauses 1 to 31);

2.2.2 all Schedules excluding Local Terms;

2.2.3 Mandated Guidance; and

2.2.4 Local Terms.

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

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

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

3. **BACKGROUND**

3.1 By this Agreement NHS England delegates the Delegated Functions to the ICB under section 65Z5 of the NHS Act while retaining the Reserved Functions.

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

3.3 This Agreement sets out the terms that apply to the exercise of the Delegated Functions by the ICB and the Parties' associated responsibilities and measures required to ensure the effective and efficient exercise of the Delegated Functions and Reserved Functions.

4. **TERM**

4.1 This Agreement has effect from the Date of Agreement set out in the Particulars and will remain in force unless terminated in accordance with clause 26 *(Termination)* below.

5. **PRINCIPLES**

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

5.1.1 at all times have regard to the Triple Aim;

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

5.1.3 have regard to the intention that commissioning functions in respect of Primary Medical Services, Primary Dental Services and Primary Ophthalmic Services will in future be directly conferred on the ICB;

5.1.4 consider how it can meet its legal duties to involve patients and the public in shaping the provision of services, including by working with local

communities, under-represented groups and those with protected characteristics for the purposes of the Equality Act 2010;

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

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

5.1.7 act in a timely manner;

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

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

6. DELEGATION

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

6.2 The Delegated Functions are the functions described as being delegated to the ICB as have been identified as included in clause 1 (*Particulars*) and included as a Schedule to this Agreement.

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

6.4 NHS England may by Contractual Notice allocate Contracts to the ICB such that they are included as part of the Delegation. The Delegated Functions must be exercised both in respect of the relevant Contract and any related matters concerning any Provider that is a party to Contract or Arrangement.

6.5 Subsequent to the Effective Date of Delegation and for the duration of this Agreement, unless otherwise agreed any new Contract entered into in respect of the Delegated Functions shall be managed by the ICB in accordance with the provisions of this Agreement.

6.6 NHS England may by Contractual Notice add or remove Contracts to or from the list of those allocated to the ICB for the purposes of this Agreement. In particular, NHS England may add or remove Contracts where this is associated with an extension or reduction of the scope of the Delegated Functions.

6.7 Decisions of the ICB in respect of the Delegated Functions and made in accordance with the terms of this Agreement shall be binding on NHS England and the ICB.

6.8 Unless expressly provided for in this Agreement, the ICB is not authorised by this Agreement to take any step or make any decision in respect of Reserved Functions. Any such purported decision of the ICB is invalid and not binding on NHS England unless ratified in writing by NHS England in accordance with the NHS England Scheme of Delegation and Standing Financial Instructions. NHS England may, acting reasonably and solely to the extent that the decision relates to the Delegated Functions, substitute its own decision for any decision which the ICB purports to make where NHS England reasonably considers that the impact of the ICB decision could, in relation to the Delegated Functions, cause the ICB to be acting unlawfully, in breach of this Agreement including Mandated Guidance, or in breach of any Contract. The ICB must

provide any information, assistance and support as NHS England requires to enable it to determine whether to make any such decision.

6.9 The terms of clause 6.8 are without prejudice to the ability of NHS England to enforce the terms of this Agreement or otherwise take action in respect of any failure by the ICB to comply with this Agreement.

7. EXERCISE OF DELEGATED FUNCTIONS

7.1 The ICB agrees that it will exercise the Delegated Functions in accordance with:

7.1.1 the terms of this Agreement including Mandated Guidance;

7.1.2 any Contractual Notices;

7.1.3 all applicable Law and Guidance;

7.1.4 the ICB's constitution;

7.1.5 the requirements of any assurance arrangements made by NHS England, and;

7.1.6 Good Practice.

7.2 In exercising the Delegated Functions, the ICB must comply with the Mandated Guidance set out at Schedule 9 (*Mandated Guidance)* or otherwise referred to in the Schedules to this Agreement and such further Mandated Guidance as may be issued by NHS England from time to time, including on the Direct Commissioning Guidance Webpage.

7.3 NHS England may, at its discretion, issue Contractual Notices from time to time relating to the manner in which the Delegated Functions must be exercised by the ICB. Contractual Notices will have effect as variations to this Agreement.

7.4 The ICB must establish effective, safe, efficient and economic arrangements for the discharge of the Delegated Functions.

7.5 The ICB must give due consideration to whether any of the Delegated Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act.

7.6 The ICB must develop an operational scheme(s) of delegation defining those individuals or groups of individuals, including committees, who may discharge aspects of the Delegated Functions. For the purposes of this clause, the ICB may include the operational scheme(s) of delegation within its general organisational scheme of delegation.

7.7 Subject to clauses 7.1 to 7.6, the ICB may determine the arrangements for the exercise of the Delegated Functions.

7.8 The ICB must perform the Delegated Functions:

7.8.1 in such a manner as to ensure NHS England's compliance with NHS England's statutory duties in respect of the Delegated Functions and to enable NHS England to fulfil its Reserved Functions; and

7.8.2 having regard to NHS England's accountability to the Secretary of State and Parliament in respect of both the Delegated Functions and Reserved Functions.

8. PERFORMANCE OF THE RESERVED FUNCTIONS

8.1 NHS England will exercise the Reserved Functions, including but not limited to those set out in the relevant Schedules to this Agreement.

8.2 For the avoidance of doubt, the Parties acknowledge that the Delegation may be amended, and additional functions may be delegated to the ICB, in which event consequential changes to this Agreement shall be agreed with the ICB pursuant to clause 25 (*Variations*) of this Agreement.

8.3 Where appropriate NHS England will work collaboratively with the ICB when exercising the Reserved Functions.

8.4 If there is any conflict or inconsistency between functions that are named as Delegated Functions and functions that are named as Reserved Functions, then such functions shall be interpreted as Reserved Functions unless and until NHS England confirms otherwise. In the event that an ICB identifies such a conflict or inconsistency it will inform NHS England as soon as is reasonably practicable.

8.5 The Parties acknowledge that where the ICB shall provide administrative and management services to NHS England in relation to certain Reserved Functions these shall be as set out in clause 9.14. and Schedule 10 *(Administrative and Management Services*).

8.6 The Parties further acknowledge that NHS England may ask the ICB to provide certain administrative and management services to NHS England in relation to other Reserved Functions.

8.7 Notwithstanding any arrangement for or provision of administrative or management services in respect of certain Reserved Functions, NHS England shall retain and be accountable for the exercise of such Reserved Functions.

9. FINANCE

9.1 Without prejudice to any other provision in this Agreement, the ICB must comply with such financial processes as required by NHS England for the management, reporting and accounting of funds used for the purposes of the Delegated Functions.

9.2 The ICB acknowledges that it will receive funds from NHS England in respect of the Delegated Functions (the “Delegated Funds”) and that these are in addition to the funds allocated to it within its Annual Allocation.

9.3 Subject to clause 9.4 and any provisions in the Schedules or Mandated Guidance, the ICB may use:

9.3.1 its Annual Allocation and the Delegated Funds in the exercise of the Delegated Functions; and

9.3.2 the Delegated Funds and its Annual Allocation in the exercise of the ICB’s functions other than the Delegated Functions.

9.4 The ICB’s expenditure on the Delegated Functions must be no less than that necessary to:

9.4.1 ensure that NHS England is able to fulfil its functions, including without limitation the Reserved Functions, effectively and efficiently;

9.4.2 meet all liabilities arising under or in connection with all Contracts allocated to the ICB in accordance with clauses 6.4 to 6.6 in so far as they relate to the Delegated Functions;

9.4.3 meet national commitments from time to time on expenditure on specific Delegated Functions including, without limitation, the Community Pharmacy Contractual Framework.

9.5 NHS England may increase or reduce the Delegated Funds in any Financial Year, by sending a notice to the ICB of such increase or decrease:

9.5.1 in order to take into account any monthly adjustments or corrections to the Delegated Funds that NHS England considers appropriate, including without limitation adjustments following any changes to the Delegated Functions, changes in allocations, changes in Contracts, to implement Mandated Guidance under Clause 7.4 or otherwise;

9.5.2 in order to comply with a change in the amount allocated to NHS England by the Secretary of State pursuant to section 223B of the NHS Act;

9.5.3 to take into account any Losses of NHS England for which the ICB is required to indemnify NHS England under clause 15;

9.5.4 to take into account any adjustments that NHS England considers appropriate (including without limitation in order to make corrections or otherwise to reflect notional budgets) to reflect funds transferred (or that should have been transferred) to the ICB in respect of the Delegated Functions and/or funds transferred (or that should have been transferred) to the ICB and in respect of which the ICB has management or administrative responsibility under Schedule 10 of this Agreement; or

9.5.5 in order to ensure compliance by NHS England with its obligations under the NHS Act (including without limitation, Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State in respect of NHS England under the NHS Act.

9.6 NHS England acknowledges that the intention of paragraph 9.5 is to reflect genuine corrections and adjustments to the Delegated Funds and may not be used to change the allocation of the Delegated Funds unless there are significant or exceptional circumstances that would require such corrections or adjustments.

9.7 The ICB acknowledges that it must comply with its statutory financial duties, including those under Part 11 of the NHS Act to the extent that these sections apply in relation to the receipt of the Delegated Funds.

9.8 NHS England may in respect of the Delegated Funds:

9.8.1 notify the ICB regarding the required payment of sums by the ICB to NHS England in respect of charges referable to the valuation or disposal of assets and such conditions as to records, certificates or otherwise;

9.8.2 by notice, require the ICB to take such action or step in respect of the Delegated Funds, in order to ensure compliance by NHS England of its duties or functions under the NHS (including without limitation, Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State under the NHS Act.

9.9 The Schedules to this Agreement identify further financial provisions in respect of the exercise of the Delegated Functions including but not limited to Schedule 5 (*Financial Provisions and Decision Making Limits*).

9.10 NHS England may issue Mandated Guidance in respect of the financial arrangements in respect of the Delegated Functions.

Payment and Transfer

9.11 NHS England will pay the Delegated Funds to the ICB using the revenue transfer process as used for the Annual Allocation or using such other process as notified to the ICB from time to time.

9.12 Without prejudice to any other obligation upon the ICB, the ICB agrees that it must use its resources for the purposes of the Delegated Functions in accordance with:

9.12.1 the terms and conditions of this Agreement including any Mandated Guidance issued by NHS England from time to time in relation to the use of resources for the purposes of the Delegated Functions (including in relation to the form or contents of any accounts);

9.12.2 the business rules as set out in NHS England's planning guidance or such other documents issued by NHS England from time to time;

9.12.3 any Capital Investment Guidance; and

9.12.4 the HM Treasury guidance *Managing Public Money* (dated September 2022)

9.13 Without prejudice to any other obligation upon the ICB, the ICB agrees that it must provide:

9.13.1 all information, assistance and support to NHS England in relation to the audit and/or investigation (whether internal or external and whether under Law or otherwise) in relation to the use of or payment of resources for the purposes of the Delegated Functions and the discharge of those functions;

9.13.2 such reports in relation to the expenditure on the Delegated Functions as set out in Mandated Guidance, the Schedules to this Agreement or as otherwise required by NHS England.

Administrative and/or Management Services

9.14 The provisions of Schedule 10 (*Administrative and Management Services)* in relation to Administrative and/or Management Services shall apply.

Pooled Funds

9.15 Subject to the provisions of this Agreement, the ICB may, for the purposes of exercising the Delegated Functions under this Agreement, establish and maintain a pooled fund in respect of any part of the Delegated Funds with:

9.15.1 NHS England in accordance with sections 13V or 65Z6 of the NHS Act;

9.15.2 one or more ICBs in accordance with section 65Z6 of the NHS Act as part of a Further Arrangement; or

9.15.3 NHS England and one or more ICBs in accordance with section 13V of the NHS Act; and

9.15.4 NHS England and one or more ICBs in accordance with section 65Z6 of the NHS Act.

9.16 At the date of this Agreement, details of the pooled funds (including any terms as to the governance and payments out of such pooled fund) of NHS England and the ICB are set out in the Local Terms.

10. INFORMATION, PLANNING AND REPORTING

10.1 The ICB must provide to NHS England:

10.1.1 all information or explanations in relation to the exercise of the Delegated Functions (including in relation to this Agreement), (and in such form) as requested by NHS England from time to time; and

10.1.2 all such information (and in such form), that may be relevant to NHS England in relation to the exercise by NHS England of its other duties or functions including, without limitation, the Reserved Functions.

10.2 The provisions of this clause 10 are without prejudice to the ability of NHS England to exercise its other powers and duties in obtaining information from and assessing the performance of the ICB.

Forward Plan and Annual Report

10.3 Before the start of each Financial Year, the ICB must describe in its joint forward plan prepared in accordance with section 14Z52 of the NHS Act how it intends to exercise the Delegated Functions.

10.4 The ICB must report on its exercise of the Delegated Functions in its annual report prepared in accordance with section 14Z58 of the NHS Act.

Risk Register

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

11. FURTHER ARRANGEMENTS

11.1 The ICB must give due consideration to whether any of the Delegated Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act.

11.2 The ICB may only make arrangements with another person (a "Sub-Delegate") concerning the exercise of the Delegated Functions ("Further Arrangements"), including without limitation arrangements under section 65Z5 and section 75 of the NHS Act, with the prior written approval of NHS England.

11.3 The approval of any Further Arrangements may:

11.3.1 include approval of the terms of the proposed Further Arrangements; and

11.3.2 require conditions to be met by the ICB and the Sub-Delegate in respect of that arrangement.

11.4 All Further Arrangements must be made in writing.

11.5 The ICB must not:

11.5.1 terminate Further Arrangements; or

11.5.2 make any material changes to the terms of Further Arrangements,

11.5.3 without the prior written approval of NHS England.

11.6 If the ICB enters into a Further Arrangement it must ensure that the Sub-Delegate does not make onward arrangements for the exercise of any or all of the Delegated Functions without the prior written approval of NHS England.

11.7 The terms of this clause 11 do not prevent the ICB from making arrangements for assistance and support in the exercise of the Delegated Functions with any person, where such arrangements reserve the consideration and making of any decision in respect of a Delegated Function to the ICB.

11.8 NHS England requires the ICB to make arrangements for assistance and support in the exercise of the Delegated Functions with those persons described in the Schedules including, but not limited to Schedule 6 (*Mandated Assistance and Support*) and with such other persons as NHS England may require from time to time.

11.9 Where Further Arrangements are made, and unless NHS England has otherwise given prior written agreement, any positive obligation or duty on the part of the ICB under this Agreement that is relevant to those Further Arrangements shall also require the ICB to ensure that all Sub-Delegates comply with that positive obligation or duty and support the ICB in doing so. In the same way, any negative duty or obligation on the part of the ICB under this Agreement that is relevant to Further Arrangement shall also require the ICB to ensure that all Sub-Delegates comply with that negative obligation or duty and support the ICB in doing so.

12. STAFFING AND WORKFORCE

12.1 The Staffing Model in respect of each Delegated Function shall at the Effective Date of Delegation be as approved by the relevant National Moderation Panel.

12.2 Where the staffing arrangements include the deployment of NHS England Staff to the ICB for the purposes of carrying out the relevant Delegated Functions then the provisions of Schedule 8 (*Deployment of NHS England Staff to the* ICB) shall apply.

12.3 The ICB must comply with any Mandated Guidance issued by NHS England from time to time in relation to the NHS England Staff.

12.4 For the avoidance of doubt, any breach by the ICB of the terms of this clause 12 (Staffing), including any breach of any Mandated Guidance issued in accordance with clause 12.3 above, will be a breach of the terms and conditions of this Agreement for the purposes of clauses 9.5 and 15.2.

13. BREACH

13.1 If the ICB does not comply with the terms of this Agreement, then NHS England may:

13.1.1 exercise its rights under this Agreement; and/or

13.1.2 take such steps as it considers appropriate in the exercise of its other functions concerning the ICB.

13.2 Without prejudice to clause 13.1, if the ICB does not comply with the terms of this Agreement (including if the ICB exceeds its delegated authority under the Delegation), NHS England may (at its sole discretion):

13.2.1 waive its rights in relation to such non-compliance in accordance with clause 13.3;

13.2.2 ratify any decision in accordance with clause 6.8;

13.2.3 substitute a decision in accordance with clause 6.9;

13.2.4 revoke the whole or part of the Delegation and terminate this Agreement in accordance with clause 26 *(Termination)* below;

13.2.5 exercise the Escalation Rights in accordance with clause 14 *(Escalation Rights)*; and/or

13.2.6 exercise its rights under common law.

13.3 NHS England may waive any non-compliance by the ICB with the terms of this Agreement provided that the ICB provides a written report to NHS England as required by clause 13.4 and, after considering the ICB's written report, NHS England is satisfied that the waiver is justified.

13.4 If:

13.4.1 the ICB does not comply (or, based on the risk register maintained by the ICB in accordance with clause 10.5 or any other information available to it the ICB considers that it may not be able to comply) with this Agreement; or

13.4.2 NHS England notifies the ICB that it considers the ICB has not complied, or may not be able to comply with, this Agreement,

then the ICB must provide a written report to NHS England within ten (10) Operational Days of the non-compliance (or the date on which the ICB considers that it may not be able to comply with this Agreement) or such notification pursuant to clause 13.4.2 setting out:

13.4.3 details of and reasons for the non-compliance (or likely non-compliance) with the Agreement and/or the Delegation; and

13.4.4 a plan for how the ICB proposes to remedy the non-compliance.

14. ESCALATION RIGHTS

14.1 If the ICB does not comply with this Agreement, NHS England may exercise the following Escalation Rights:

14.1.1 NHS England may require a suitably senior representative of the ICB to attend a review meeting within ten (10) days of NHS England becoming aware of the non-compliance; and

14.1.2 NHS England may require the ICB to prepare an action plan and report within twenty (20) days of the review meeting (to include details of the non-compliance and a plan for how the ICB proposes to remedy the non-compliance).

14.2 Nothing in clause 14 *(Escalation Rights)* will affect NHS England's right to substitute a decision in accordance with clause 6.9, revoke the Delegation and/or terminate this Agreement in accordance with clause 26 *(Termination)* below.

15. LIABILITY AND INDEMNITY

15.1 NHS England is liable in respect of any Losses arising in respect of NHS England's negligence, fraud, recklessness or deliberate breach in respect of the Delegated Functions and occurring after the Effective Date of Delegation and, if the ICB suffers any Losses in respect of such actions by NHS England, NHS England shall make such adjustments to the Annual Allocation (or other amounts payable to the ICB) in order to reflect any Losses suffered by the ICB (except to the extent that the ICB is liable for such Losses pursuant to clause 15.3).

15.2 For the avoidance of doubt, NHS England remains liable for a Claim relating to facts, events or circumstances concerning the Delegated Functions before the Effective Date of Delegation.

15.3 The ICB is liable to (and shall pay) NHS England for any Losses suffered by NHS England that result from or arise out of the ICB's negligence, fraud, recklessness or breach of the Delegation (including any actions that are taken that exceed the authority

conferred by the Delegation) or this Agreement and, in respect of such Losses, NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB or make such adjustments to the Delegated Funds pursuant to clause 9.5. The ICB shall not be liable to the extent that the Losses arose prior to the Effective Date of Delegation.

15.4 Each Party acknowledges and agrees that any rights acquired, or liabilities (including liabilities in tort) incurred, in respect of the exercise by the ICB of any Delegated Function are enforceable by or against the ICB only, in accordance with section 65Z5(6) of the NHS Act.

15.5 The ICB indemnifies NHS England and shall keep it indemnified on a continuing basis from and against any and all Losses which NHS England may incur by reason of any claim by any NHS England Staff:

15.5.1 arising out of a breach of duty by the ICB (whether under common law, statute or otherwise) to the extent that such claim is not met by either the ICB's or NHS England's insurance or indemnity cover;

15.5.2 under the Equality Act 2010 or Part V of the Employment Rights Act 1996 arising out of acts or omissions by the ICB (or any of its employees, directors or officers);

15.5.3 arising from any acts or omissions by the ICB resulting in the termination of their employment, including any claim arising from any instruction by the ICB to NHS England to discipline or dismiss any person.

15.6 Each Party shall co-operate with the other in making all reasonable efforts to minimise any liabilities and Losses in connection with the employment of NHS England Staff in Delegated Functions.

15.7 Each Party will at all times take all reasonable steps to minimise and mitigate any Losses or other matters for which one Party is entitled to be indemnified by or to bring a claim against the other under this Agreement.

16. CLAIMS AND LITIGATION

16.1 Nothing in this clause 16 *(Claims and Litigation)* shall be interpreted as affecting the reservation to NHS England of the Reserved Functions.

16.2 Except in the circumstances set out in clause 16.5 and subject always to compliance with this clause 16 *(Claims and Litigation)*, the ICB shall be responsible for and shall retain the conduct of any Claim.

16.3 The ICB must:

16.3.1 comply with any policy issued by NHS England from time to time in relation to the conduct of or avoidance of Claims and/or the pro-active management of Claims;

16.3.2 if it receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim, immediately notify NHS England and send to NHS England all copies of such correspondence;

16.3.3 co-operate fully with NHS England in relation to such Claim and the conduct of such Claim;

16.3.4 provide, at its own cost, to NHS England all documentation and other correspondence that NHS England requires for the purposes of considering and/or resisting such Claim; and/or

16.3.5 at the request of NHS England, take such action or step or provide such assistance as may in NHS England's discretion be necessary or desirable having regard to the nature of the Claim and the existence of any time limit in relation to avoiding, disputing, defending, resisting, appealing, seeking a review or compromising such Claim or to comply with the requirements of the provider of an Indemnity Arrangement in relation to such Claim.

16.4 Subject to clauses 16.3 and 16.5 and Schedule 5 (*Financial Provisions and Decision Making Limits*) the ICB is entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit.

NHS England Stepping into Claims

16.5 NHS England may, at any time following discussion with the ICB, send a notice to the ICB stating that NHS England will take over the conduct of the Claim and the ICB must immediately take all steps necessary to transfer the conduct of such Claim to NHS England unless and until NHS England transfers conduct back to the ICB. In such cases:

16.5.1 NHS England shall be entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit, provided that if NHS England wishes to invoke clause 16.5.3 it agrees to seek the ICB's views on any proposal to pay or settle that Claim prior to finalising such payment or settlement; and

16.5.2 the Delegation shall be treated as being revoked to the extent that and for so long as NHS England has assumed responsibility for exercising those of the Delegated Functions that are necessary for the purposes of having conduct of the Claim; and

16.5.3 NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or make an adjustment to the Delegated Funds pursuant to clause 9.5.3 for the purposes of meeting any Claim Losses associated with that Claim.

Claim Losses

16.6 The ICB and NHS England shall notify each other within a reasonable time period of becoming aware of any Claim Losses.

16.7 The ICB acknowledges that NHS England will pay to the ICB the funds that are attributable to the Delegated Functions. Accordingly, the ICB acknowledges that it must pay any Claim Losses out of either the Delegated Funds or its Annual Allocation. NHS England may, in respect of any Claim Losses, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or pursuant to clause 9.5.3 make such adjustments to the Delegated Funds to take into account the amount of any Claim Losses (other than any Claim Losses in respect of which NHS England has retained any funds, provisions or other resources to discharge such Claim Losses). For the avoidance of doubt, in circumstances where NHS England suffers any Claim Losses, then NHS England shall be entitled to recoup such Claim Losses pursuant to clause 9.5.3. If and to the extent that NHS England has retained any funds, provisions or other resources to discharge such Claim Losses, then NHS England may either use such funds to discharge the Claim Loss or make an upward adjustment to the amounts paid to the ICB pursuant to clause 9.5.3.

17. DATA PROTECTION, FREEDOM OF INFORMATION AND TRANSPARENCY

17.1 The Parties must ensure that all Personal Data processed by or on behalf of them in the course of carrying out the Delegated Functions and Reserved Functions is processed in accordance with the relevant Party's obligations under Data Protection

Legislation and Data Guidance and the Parties must assist each other as necessary to enable each other to comply with these obligations.

17.2 The ICB must respond to any information governance breach in accordance with IG Guidance for Serious Incidents. If the ICB is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach then as soon as reasonably practical and in any event on or before the first such notification is made the ICB must fully inform NHS England of the information governance breach. This clause does not require the ICB to provide NHS England with information which identifies any individual affected by the information governance breach where doing so would breach Data Protection Legislation.

17.3 Whether or not a Party is a Data Controller or Data Processor will be determined in accordance with Data Protection Legislation and any Data Guidance from a Regulatory or Supervisory Body. The Parties acknowledge that a Party may act as both a Data Controller and a Data Processor.

17.4 Each Party acknowledges that the other is a public authority for the purposes of the Freedom of Information Act 2000 (**"FOIA"**) and the Environmental Information Regulations 2004 (**"EIR"**).

17.5 Each Party may be statutorily required to disclose further information about the Agreement and the Relevant Information in response to a specific request under FOIA or EIR, in which case:

17.5.1 each Party shall provide the other with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR;

17.5.2 each Party shall consult the other regarding the possible application of exemptions in relation to the information requested; and

17.5.3 subject only to clause 16 *(Claims and Litigation)*, each Party acknowledges that the final decision as to the form or content of the response to any request is a matter for the Party to whom the request is addressed.

17.6 NHS England may, from time to time, issue a FOIA or EIR protocol or update a protocol previously issued relating to the dealing with and responding to FOIA or EIR requests in relation to the Delegated Functions. The ICB shall comply with such FOIA or EIR protocols.

17.7 Schedule 4 (*Further Information Governance and Sharing* Provisions) makes further provision about information sharing and information governance.

18. IT INTER-OPERABILITY

18.1 NHS England and the ICB will work together to ensure that all relevant IT systems operated by NHS England and the ICB in respect of the Delegated Functions and the Reserved Functions are inter-operable and that data may be transferred between systems securely, easily and efficiently.

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

19. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

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

19.2 Without prejudice to the general obligations set out in clause 19.1, the ICB must maintain a register of interests in respect of all persons making decisions concerning the Delegated Functions. This register must be publicly available. For the purposes of this clause, the ICB may rely on an existing register of interests rather than creating a further register.

20. PROHIBITED ACTS AND COUNTER-FRAUD

20.1 The ICB must not commit any Prohibited Act.

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

20.2.1 to revoke the Delegation; and

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

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

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

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

20.5 The ICB must implement any reasonable modifications to its counter-fraud arrangements required by a person referred to in clause 20.4 in order to meet the appropriate standards within whatever time periods as that person may reasonably require.

20.6 The ICB must, on becoming aware of:

20.6.1 any suspected or actual bribery, corruption or fraud involving public funds; or

20.6.2 any suspected or actual security incident or security breach involving Staff or involving NHS resources;

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

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

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

20.7.2 all Staff who may have information to provide;

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

21. CONFIDENTIAL INFORMATION OF THE PARTIES

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

21.2 Subject to clauses 21.3 to 21.5, the receiving Party agrees:

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

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

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

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

21.3.1 in connection with any Dispute Resolution;

21.3.2 in connection with any litigation between the Parties;

21.3.3 to comply with the Law;

21.3.4 to any appropriate Regulatory or Supervisory Body;

21.3.5 to its Staff, who in respect of that Confidential Information will be under a duty no less onerous than the Receiving Party's duty under clause 21.2;

21.3.6 to NHS Bodies for the purposes of carrying out their functions;

21.3.7 as permitted under or as may be required to give effect to clause 20 (*NHS Counter-Fraud*); and

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

21.4 The obligations in clauses 21.1 and 21.2 will not apply to any Confidential Information which:

21.4.1 is in or comes into the public domain other than by breach of this Agreement;

21.4.2 the receiving Party can show by its records was in its possession before it received it from the disclosing Party; or

21.4.3 the receiving Party can prove it obtained or was able to obtain from a source other than the disclosing Party without breaching any obligation of confidence.

21.5 This clause 21 does not prevent NHS England from making use of or disclosing any Confidential Information disclosed by the ICB where necessary for the purposes of exercising its functions in relation to the ICB.

21.6 The Parties acknowledge that damages would not be an adequate remedy for any breach of this clause 21 by the receiving Party, and in addition to any right to damages, the disclosing Party will be entitled to the remedies of injunction, specific performance and other equitable relief for any threatened or actual breach of this clause 21.

21.7 This clause 21 will survive the termination of this Agreement for any reason for a period of 5 years.

21.8 This clause 21 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

22. **INTELLECTUAL PROPERTY**

22.1 The ICB grants to NHS England a fully paid-up, non-exclusive, perpetual licence to use the ICB Deliverables for the purposes of the exercise of its statutory and contractual functions.

22.2 NHS England grants the ICB a fully paid-up, non-exclusive licence to use the NHS England Deliverables for the purpose of performing this Agreement and the Delegated Functions.

22.3 The ICB must co-operate with NHS England to enable it to understand and adopt Best Practice (including the dissemination of Best Practice to other commissioners or providers of NHS services), and must supply such materials and information in relation to Best Practice as NHS England may reasonably request, and (to the extent that any IPR attaches to Best Practice), grants NHS England a fully paid-up, non-exclusive, perpetual licence for NHS England to use Best Practice IPR for the commissioning and provision of NHS services and to share any Best Practice IPR with other commissioners of NHS services (and other providers of NHS services) to enable those parties to adopt such Best Practice.

23. **NOTICES**

23.1 Any notices given under this Agreement must be sent by e-mail to the other Party's address set out in the Particulars.

23.2 Notices by e-mail will be effective when sent in legible form, but only if, following transmission, the sender does not receive a non-delivery message.

24. **DISPUTES**

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

24.2 If a Dispute arises out of or in connection with this Agreement then the Parties must follow the procedure set out in this clause:

24.2.1 either Party must give to the other written notice of the Dispute, setting out its nature and full particulars ("**Dispute Notice**"), together with relevant supporting documents. On service of the Dispute Notice, the Agreement Representatives must attempt in good faith to resolve the Dispute;

24.2.2 if the Agreement Representatives are, for any reason, unable to resolve the Dispute within twenty (20) days of service of the Dispute Notice, the Dispute must be referred to the Chief Executive Officer (or equivalent person) of the ICB and a director of or other person nominated by NHS England (and who has authority from NHS England to settle the Dispute) who must attempt in good faith to resolve it; and

24.2.3 if the people referred to in clause 24.2.2 are for any reason unable to resolve the Dispute within twenty (20) days of it being referred to them, the Parties may attempt to settle it by mediation in accordance with the CEDR model mediation procedure. Unless otherwise agreed between the Parties, the mediator must be nominated by CEDR Solve. To initiate the mediation, a Party must serve notice in writing ('Alternative Dispute Resolution' (**ADR**) **notice**) to the other Party to the Dispute, requesting a mediation. A copy of the ADR notice should be sent to CEDR Solve. The mediation will start not later than ten (10) days after the date of the ADR notice.

24.3 If the Dispute is not resolved within thirty (30) days after service of the ADR notice, or either Party fails to participate or to continue to participate in the mediation before the

expiration of the period of thirty (30) days, or the mediation terminates before the expiration of the period of thirty (30) days, the Dispute must be referred to the Secretary of State, who shall resolve the matter and whose decision shall be binding upon the Parties.

25. VARIATIONS

25.1 The Parties acknowledge that the scope of the Delegated Functions may be reviewed and amended from time to time including by revoking this Agreement and making alternative arrangements.

25.2 NHS England may notify the ICB of a Variation Proposal in respect of this Agreement.

25.3 The Variation Proposal will set out the variation proposed and the date on which NHS England requires the variation to take effect.

25.4 The ICB must respond to a Variation Proposal within thirty (30) Operational Days following the date that it is issued by serving notice on NHS England confirming either:

25.4.1 that it accepts the Variation Proposal; or

25.4.2 that it refuses to accept the Variation Proposal, and sets out reasonable grounds for that refusal.

25.5 If the ICB accepts the Variation Proposal, the ICB agrees (without delay) to take all necessary steps (including executing a variation agreement) in order to give effect to any variation by the date on which the proposed variation will take effect as set out in the Variation Proposal.

25.6 If the ICB refuses to accept the Variation Proposal or to take such steps as are required to give effect to the variation, NHS England may terminate this Agreement in respect of some or all of the Delegated Functions.

25.7 The provisions of this clause 25 are without prejudice to the ability of NHS England to issue Contractual Notices which have the effect of varying this Agreement.

26. TERMINATION

26.1 The ICB may:

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

26.1.2 terminate this Agreement;

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

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

26.1.4 the ICB meets with NHS England within ten (10) Operational Days of NHS England receiving the notice set out at clause 26.1.3 above to discuss arrangements for termination and transition of the Delegated Functions to a successor commissioner,

in which case NHS England shall revoke the Delegation and this Agreement shall terminate with effect from the end of 31 March in the next calendar year.

26.2 NHS England may revoke the Delegation in whole or in part with effect from 23.59 hours on 31 March in any year, provided that it gives notice to the ICB of its intention to

terminate the Delegation on or before 30 September in the year prior to the year in which the Delegation will terminate, and in which case clause 26.4 will apply.

26.3 The Delegation may be revoked in whole or in part, and this Agreement may be terminated by NHS England at any time, including in (but not limited to) the following circumstances:

26.3.1 the ICB acts outside of the scope of its delegated authority;

26.3.2 the ICB fails to perform any material obligation of the ICB owed to NHS England under this Agreement;

26.3.3 the ICB persistently commits non-material breaches of this Agreement;

26.3.4 NHS England is satisfied that its intervention powers under section 14Z61 of the NHS Act apply;

26.3.5 to give effect to legislative changes, including conferral of any of the Delegated or Reserved Functions on the ICB;

26.3.6 failure to agree to a variation in accordance with clause 25 *(Variations)*;

26.3.7 NHS England and the ICB agree in writing that the Delegation shall be revoked and this Agreement shall terminate on such date as is agreed; and/or

26.3.8 the ICB merges with another ICB or other body.

26.4 This Agreement will terminate upon revocation or termination of the full Delegation (including revocation and termination in accordance with this clause 26 *(Termination)*) except that the provisions referred to at clause 28 (*Provisions Surviving Termination*) will continue in full force and effect.

26.5 Without prejudice to clause 13.3 and to avoid doubt, NHS England may waive any right to terminate this Agreement under this clause 26.5 *(Termination)*. Any such waiver is only effective if given in writing and shall not be deemed a waiver of any subsequent right or remedy.

26.6 As an alternative to termination of the Agreement in respect of all the Delegated Functions, NHS England may alternatively terminate the Agreement in respect of specified Delegated Functions (or aspects of such Delegated Functions) only, in which case this Agreement shall otherwise remain in effect.

27. CONSEQUENCE OF TERMINATION

27.1 Termination of this Agreement, or termination of the ICB's exercise of any of the Delegated Functions, will not affect any rights or liabilities of the Parties that have accrued before the date of that termination or which later accrue.

27.2 Subject to clause 27.4, on or pending termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, NHS England, the ICB and if appropriate any successor delegate will:

27.2.1 agree a plan for the transition of the Delegated Functions from the ICB to the successor delegate, including details of the transition, the Parties' responsibilities in relation to the transition, the Parties' arrangements in respect of those staff engaged in the Delegated Functions and the date on which the successor delegate will take responsibility for the Delegated Functions;

27.2.2 implement and comply with their respective obligations under the plan for transition agreed in accordance with clause 27.2.1 above; and

27.2.3 act with a view to minimising any inconvenience or disruption to the commissioning of healthcare in the Area.

27.3 For a reasonable period before and after termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, the ICB must:

27.3.1 co-operate with NHS England and any successor delegate in order to ensure continuity and a smooth transfer of the Delegated Functions; and

27.3.2 at the reasonable request of NHS England:

(a) promptly provide all reasonable assistance and information to the extent necessary to effect an orderly assumption of the Delegated Functions by a successor delegate;

(b) deliver to NHS England all materials and documents used by the ICB in the exercise of any of the Delegated Functions; and

27.3.3 use all reasonable efforts to obtain the consent of third parties to the assignment, novation or termination of existing contracts between the ICB and any third party which relate to or are associated with the Delegated Functions.

27.4 Where any or all of the Delegated Functions or Reserved Functions are to be directly conferred on the ICB, the Parties will co-operate with a view to ensuring continuity and a smooth transfer to the ICB.

28. PROVISIONS SURVIVING TERMINATION

28.1 Any rights, duties or obligations of any of the Parties which are expressed to survive, including those referred to in clause 28.2, or which otherwise by necessary implication survive the termination for any reason of this Agreement, together with all indemnities, will continue after termination, subject to any limitations of time expressed in this Agreement.

28.2 The surviving provisions include the following clauses together with such other provisions as are required to interpret and give effect to them:

28.2.1 Clause 9 (*Finance*);

28.2.2 Clause 12 (*Staffing and Workforce*);

28.2.3 Clause 15 *(Liability and Indemnity*);

28.2.4 Clause 16 (*Claims and Litigation*);

28.2.5 Clause 17 (*Data Protection, Freedom of Information and Transparency*);

28.2.6 Clause 24 (*Disputes*);

28.2.7 Clause 26 (*Termination*);

28.2.8 Schedule 4 (*Further Information Governance and Sharing Provisions*).

29. COSTS

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

30. **SEVERABILITY**

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

31. **GENERAL**

31.1 Nothing in this Agreement will create a partnership or joint venture or relationship of principal and agent between NHS England and the ICB.

31.2 A delay or failure to exercise any right or remedy in whole or in part shall not waive that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy.

31.3 This Agreement does not give rise to any rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this Agreement.

SCHEDULE 1

Definitions and Interpretation

1. The headings in this Agreement will not affect its interpretation.

2. Reference to any statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance, includes a reference to that statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance as from time to time updated, amended, extended, supplemented, re-enacted or replaced in whole or in part.

3. Reference to a statutory provision includes any subordinate legislation made from time to time under that provision.

4. References to clauses and schedules are to the clauses and schedules of this Agreement, unless expressly stated otherwise.

5. References to any body, organisation or office include reference to its applicable successor from time to time.

6. Any references to this Agreement or any other documents or resources includes reference to this Agreement or those other documents or resources as varied, amended, supplemented, extended, restated and/or replaced from time to time and any reference to a website address for a resource includes reference to any replacement website address for that resource.

7. Use of the singular includes the plural and vice versa.

8. Use of the masculine includes the feminine and all other genders.

9. Use of the term “including” or “includes” will be interpreted as being without limitation.

10. The following words and phrases have the following meanings:

Additional Pharmaceutical Services	Services provided in accordance with a direction under section 127 of the NHS Act (also referred to as advanced services and enhanced services in the Pharmaceutical Regulations);
Agreement	means this agreement between NHS England and the ICB comprising the Particulars, the Terms and Conditions, the Schedules and the Mandated Guidance;
Agreement Representatives	means the ICB Representative and the NHS England Representative as set out in the Particulars;
Annual Allocation	means the funds allocated to the ICB annually under section 223G of the NHS Act
APMS Contract	means an agreement or contract for the provision of primary medical services made under section 83(2) of the NHS Act (including any arrangements which are made in reliance on a combination of that section and other powers to arrange for primary medical services);
Area	means the area described in the Particulars;

Assigned Staff	means those NHS England staff as agreed between NHS England and the ICB from time to time;
Best Practice	means any methodologies, pathway designs and processes relating to this Agreement or the Delegated Functions developed by the ICB or its Staff for the purposes of delivering the Delegated Functions and which are capable of wider use in the delivery of healthcare services for the purposes of the NHS, but not including inventions that are capable of patent protection and for which patent protection is being sought or has been obtained, registered designs, or copyright in software;
Caldicott Principles	means the patient confidentiality principles set out in the report of the Caldicott Committee (December 1997 as amended by the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*) and now included in the NHS Confidentiality Code of Practice, as may be amended from time to time;
Capital	shall have the meaning set out in the Capital Investment Guidance or such other replacement Mandated Guidance as issued by NHS England from time to time;
Capital Expenditure Functions	means those functions of NHS England in relation to the use and expenditure of Capital funds (but excluding the Premises Costs Directions Functions);
Capital Investment Guidance	means any Mandated Guidance issued by NHS England from time to time in relation to the development, assurance and approvals process for proposals in relation to: • the expenditure of Capital, or investment in property, infrastructure or information and technology; and • the revenue consequences for commissioners or third parties making such investment;
CEDR	means the Centre for Effective Dispute Resolution;
Claims	means, for or in relation to the Delegated Functions (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or the Secretary of State, any governmental, regulatory or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by, any governmental, regulatory or similar body or agency;
Claim Losses	means all Losses arising in relation to any Claim;
Combined Authority	means a body of that name established under the provisions of the Local Democracy, Economic Development and Construction Act 2009;
Community Dental Services	means specialised dental services commissioned for patients who are unable to access treatment from Primary Dental

	Services due to a disability or medical condition, being a form of Prescribed Dental Service;
Community Pharmacy Contractual Framework	means the Community Pharmacy Contractual Framework as published by the Department of Health and Social Care from time to time;
Complaints Regulations	means the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009/309;
Confidential Information	means any information or data in whatever form disclosed, which by its nature is confidential or which the disclosing Party acting reasonably states in writing to the receiving Party is to be regarded as confidential, or which the disclosing Party acting reasonably has marked 'confidential' (including, financial information, strategy documents, tenders, employee confidential information, development or workforce plans and information, and information relating to services) but which is not information which is disclosed in response to a FOIA request, or information which is published as a result of NHS England or government policy in relation to transparency;
Contracts	Means any Prescribed Dental Services Contract, Primary Care Contract or Arrangement or other contract or arrangement in respect of the commissioning of any other Delegated Services;
Contractual Notice	means a contractual notice issued by NHS England to the ICB, or some or all ICBs (as the case may be), from time to time and relating to the allocation of contracts for the purposes of the Delegated Functions and/or the manner in which the Delegated Functions should be exercised by the ICB;
CQC	means the Care Quality Commission;
Data Controller	shall have the same meaning as set out in the UK GDPR;
Data Guidance	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency and the Information Commissioner;
Data Processor	shall have the same meaning as set out in the UK GDPR;
Data Protection Legislation	means the UK GDPR, the Data Protection Act 2018 and all applicable Law concerning privacy, confidentiality or the processing of personal data including but not limited to the Human Rights Act 1998, the Health and Social Care (Safety

	and Quality) Act 2015, the common law duty of confidentiality and the Privacy and Electronic Communications (EC Directive) Regulations 2003;
Data Sharing Agreement	means a data sharing agreement which should be in substantially the same form as the Data Sharing Agreement template shared by NHS England in respect of this Agreement;
Data Subject	shall have the same meaning as set out in the UK GDPR;
Delegated Functions	means the statutory functions delegated by NHS England to the ICB under the Delegation and as set out in detail in this Agreement;
Delegated Funds	means the funds defined in Clause 9.2;
Delegated Services	Means the services commissioned in exercise of the Delegated Functions;
Delegation	means the delegation of the Delegated Functions from NHS England to the ICB as described at clause 6.1;
Dental Care Services	means: (i) Primary Dental Services; and (ii) the Prescribed Dental Services;
Dental Services Contract	means: (i) a GDS Contract; (ii) a PDS Agreement (except for any Community Dental Services PDS Agreement, which constitutes a Prescribed Dental Services Contract); and (iii) any other contract for the provision of health services made pursuant to NHS England's functions under Part 5 of the NHS Act; in each case as amended or replaced from time to time and including all ancillary or related agreements directly relating to the subject matter of such agreements, contracts or arrangements;
Dental Services Provider	means a natural or legal person who holds a Dental Services Contract;
Direct Commissioning Guidance Webpage	means the webpage maintained by NHS England at https://www.england.nhs.uk/commissioning/how-commissioning-is-changing/;
Dispute	a dispute, conflict or other disagreement between the Parties arising out of or in connection with this Agreement;
Effective Date of Delegation	means the Effective Date of Delegation as set out in the Particulars;

EIR	means the Environmental Information Regulations 2004
Enhanced Services	means the nationally defined enhanced services, as set out in such directions made by the Secretary of State pursuant to his powers contained in sections 98A, 114A, 125A and 168A of the NHS Act as are in force from time to time, or which may be prescribed by NHS England under its Reserved Functions, and any other enhanced services schemes locally developed by the ICB in the exercise of its Delegated Functions (and excluding, for the avoidance of doubt, any enhanced services arranged or provided pursuant to the Section 7A Functions);
Escalation Rights	means the escalation rights as defined in clause 14 *(Escalation Rights)*;
Financial Year	shall bear the same meaning as in section 275 of the NHS Act;
FOIA	the Freedom of Information Act 2000;
Further Arrangements	means arrangements for the exercise of Delegated Functions as defined at clause 11.2;
GDS Contract	means a General Dental Services contract made under section 100 of the NHS Act;
GMS Contract	means a General Medical Services contract made under section 84(1) of the NHS Act;
Good Practice	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;
Guidance	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the ICB has a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified to the ICB by any relevant Regulatory or Supervisory Body but excluding Mandated Guidance;
HSCA	means the Health and Social Care Act 2012;
ICB	means an Integrated Care Board established pursuant to section 14Z25 of the NHS Act and named in the Particulars;
ICB Deliverables	all documents, products and materials developed by the ICB or its Staff in relation to this Agreement and the Delegated Functions in any form and required to be submitted to NHS England under this Agreement, including data, reports, policies, plans and specifications;

IG Guidance for Serious Incidents	IG Guidance for Serious Incidents NHS Digital's Checklist Guidance for Information Governance Serious Incidents Requiring Investigation June 2013, available at: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-informationgovernance/data-security-and-protection-toolkit
Indemnity Arrangement	means either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);
Information Law	the UK GDPR, the Data Protection Act 2018, regulations and guidance made under section 13S and section 251 of the NHS Act; guidance made or given under sections 263 and 265 of the HSCA; the Freedom of Information Act 2000; the common law duty of confidentiality; the Human Rights Act 1998 and all other applicable laws and regulations relating to processing of Personal Data and privacy;
IPR	means inventions, copyright, patents, database right, trademarks, designs and confidential know-how and any similar rights anywhere in the world whether registered or not, including applications and the right to apply for any such rights;
Law	means any applicable law, statute, rule, bye-law, regulation, direction, order, regulatory policy, guidance or code, rule of court or directives or requirements of any regulatory body, delegated or subordinate legislation or notice of any regulatory body (including any Regulatory or Supervisory Body);
Local Authority	means a county council in England, a Combined Authority, a district council in England, a London borough council, the Common Council of the City of London or the Council of the Isles of Scilly;
Local Incentive Schemes	means an incentive scheme developed by the ICB in the exercise of its Delegated Functions to extend the range or quality of essential and additional services provided under a Primary Medical Services Contract and support national frameworks in order to meet differing local population needs;
Local Pharmaceutical Services Contract	means • a contract entered into pursuant to section 134 of the NHS Act; or • a contract entered into pursuant to Paragraph 1 of Schedule 12 to the NHS Act;
Local Terms	means the terms set out in Schedule 7 *(Local Terms)* and/or such other Schedule or part thereof as designated as Local Terms;
Losses	means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional

	services) proceedings, demands and charges whether arising under statute, contract or common law;
Managing Conflicts of Interest in the NHS	the NHS publication by that name available at: https://www.england.nhs.uk/about/board-meetings/committees/coi/
Mandated Guidance	means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of the Delegated Functions and issued by NHS England to the ICB as Mandated Guidance from time to time, in accordance with clause 7.2 which at the Effective Date of Delegation shall include the Mandated Guidance set out in the Schedules**;**
National Moderation Panel	Means the NHS England panel in respect of the relevant Delegated Function that will have the delegated authority to approve the ICB arrangements in respect of a Delegated Function;
Need to Know	has the meaning set out in paragraph 6.2 of Schedule 4 (*Further Information Governance and Sharing Provisions)*;
NHS Act	means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022 or other legislation from time to time);
NHS Business Services Authority	means the Special Health Authority established under the NHS Business Services Authority (Establishment and Constitution Order) 2005 SI 2005/2414;
NHS Counter Fraud Authority	means the Special Health Authority established by and in accordance with the NHS Counter Fraud Authority (Establishment, Constitution, and Staff and Other Transfer Provisions) Order 2017/958;
NHS England	means the body established by section 1H of the NHS Act;
NHS England Deliverables	means all documents, products and materials NHS England in which NHS England holds IPRs which are relevant to this Agreement, the Delegated Functions or the Reserved Functions in any form and made available by NHS England to the ICB under this Agreement, including data, reports, policies, plans and specifications;
NHS England Functions	means all functions of NHS England as set out in Legislation excluding any functions that have been expressly delegated;
Non-Personal Data	means data which is not Personal Data;
Out of Hours Contract	means a primary medical services contract for the provision of primary medical services solely during the out of hours period (6.30pm Monday to Thursday until 8am the next day, 6.30pm Friday to 8am Monday, Christmas Day, Good Friday and bank holidays);
Operational Days	a day other than a Saturday, Sunday, Christmas Day, Good Friday or a bank holiday in England;

Particulars	means the Particulars of this Agreement as set out in clause 1 *(Particulars)*;
Party/Parties	means a party or both parties to this Agreement;
PDS Agreement	means a Personal Dental Services Agreement made under section 107 of the NHS Act;
Performers Lists	The lists of healthcare professionals maintained by NHS England pursuant to the National Health Service (Performers Lists) (England) Regulations 2013;
Personal Data	shall have the same meaning as set out in the UK GDPR and shall include references to Special Category Personal Data where appropriate;
Pharmaceutical List	means a list of persons who undertake to provide pharmaceutical services pursuant to regulation 10 of the Pharmaceutical Regulations;
Pharmaceutical Regulations	means the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013/349;
Pharmaceutical Services	means:- (i) services provided pursuant to arrangements under section 126 of the NHS Act; and (ii) Additional Pharmaceutical Services
Pharmaceutical Services Arrangement	means an arrangement for the provision of Pharmaceutical Services, including inclusion in a Pharmaceutical List;
Pharmaceutical Services Provider	means a natural or legal person who is party to a Pharmaceutical Services Arrangement or Local Pharmaceutical Services Contract;
PMS Agreement	means an agreement made in accordance with section 92 of the NHS Act;
Population	means the individuals for whom the ICB is responsible for commissioning health services;
Premises Agreements	means tenancies, leases and other arrangements in relation to the occupation of land for the delivery of services under the Primary Medical Services Contracts;
Premises Costs Directions	means the National Health Service (General Medical Services Premises Costs) Directions 2013, as amended;
Premises Costs Directions Functions	means NHS England's functions in relation to the Premises Costs Directions;
Prescribed Dental Services	means the dental services prescribed by such regulations made pursuant to section 3B(1)(a) of the NHS Act as are in force from time to time (including, for the avoidance of doubt,

	services commonly known as secondary care dental services and Community Dental Services);
Prescribed Dental Services Contract	means any contract for the provision of Prescribed Dental Services;
Primary Care Contract or Arrangement (PCCA)	means: (i) a Primary Medical Services Contract; (ii) a Dental Services Contract; (iii) a Primary Ophthalmic Services Contract; (iv) a Local Pharmaceutical Services Contract; and (v) a Pharmaceutical Services Arrangement.
Primary Care Functions	means:- (i) the statutory functions conferred on NHS England under Parts 4, 5, 6 and 7 of the NHS Act and secondary legislation made under those Parts; and (ii) the other statutory functions conferred on NHS England by either primary legislation, secondary legislation or by arrangement with another person in so far as they are applicable to the discharge of those functions set out at (i) above;
Primary Care Provider	means a natural or legal person who holds a Primary Care Contract, or is a Pharmaceutical Services Provider;
Primary Care Provider Personnel	means all persons (whether clinical or non-clinical) employed or engaged by a Primary Care Provider or by any Sub-Contractor (including volunteers, agency, locums, casual or seconded personnel) in the provision of Services or any activity related to or connected with the provision of the Services;
Primary Care Services	means the services in respect of which NHS England has a duty or power to make arrangements pursuant to the Primary Care Functions;
Primary Dental Services	means primary dental care services provided under arrangements made pursuant to Part 5 of the NHS Act, and in accordance with a Dental Services Contract;
Primary Medical Services	means primary medical services provided under arrangements made pursuant to Part 4 of the NHS Act, and in accordance with a Primary Medical Services Contract;
Primary Medical Services Contract	means: (i) a PMS Agreement; (ii) a GMS Contract; (iii) an APMS Contract; and

(iv) any other contract for the provision of health services made pursuant to NHS England's functions under Part 4 of the NHS Act;

in each case as amended or replaced from time to time and including all ancillary or related agreements directly relating to the subject matter of such agreements, contracts or arrangements but excluding any Premises Agreements and excluding any Out of Hours Contracts[2];

Primary Medical Services Provider means a natural or legal person who holds a Primary Medical Services Contract;

Primary Ophthalmic Services Contract means:

(i) a General Ophthalmic Services Contract; and

(ii) any other contract for the provision of health services made pursuant to NHS England's functions under Part 6 of the NHS Act;

in each case as amended or replaced from time to time and including all ancillary or related agreements directly relating to the subject matter of such agreements, contracts or arrangements;

Primary Ophthalmic Services Provider means a natural or legal person who holds a Primary Ophthalmic Services Contract;

Principles of Best Practice means the Mandated Guidance in relation to property and investment which is to be published either before or after the date of this Agreement;

Prohibited Act the ICB:

(i) offering, giving, or agreeing to give NHS England (or any of their officers, employees or agents) any gift or consideration of any kind as an inducement or reward for doing or not doing or for having done or not having done any act in relation to the obtaining of performance of this Agreement, the Reserved Functions, the Delegation or any other arrangement with the ICB, or for showing or not showing favour or disfavour to any person in relation to this Agreement or any other arrangement with the ICB; and

(ii) in connection with this Agreement, paying or agreeing to pay any commission, other than a payment, particulars of which (including the terms and conditions of the agreement for its payment) have been disclosed in writing to NHS England; or

(iii) committing an offence under the Bribery Act 2010;

QOF means the quality and outcomes framework;

[2] Arrangements for Out of Hours Contracts are dealt with under separate Directions outside of this Agreement and do not form part of any Delegated Functions.

Regulatory or Supervisory Body	means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: (i) CQC; (ii) NHS England; (iii) the Department of Health and Social Care; (iv) the National Institute for Health and Care Excellence; (v) Healthwatch England and Local Healthwatch; (vi) the General Medical Council; (vii) the General Dental Council; (viii) the General Optical Council; (ix) the General Pharmaceutical Council; (x) the Healthcare Safety Investigation Branch; and (xi) the Information Commissioner;
Relevant Information	means the Personal Data and Non-Personal Data processed under the Delegation and this Agreement, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*);
Reserved Functions	means statutory functions of NHS England that it has not delegated to the ICB including but not limited to those set out in the Schedules to this Agreement;
Secretary of State	means the Secretary of State for Health and Social Care from time to time;
Section 7A Functions	means those functions of NHS England exercised pursuant to section 7A of the NHS Act and relating to Primary Care Services;
Section 7A Funds	shall have the meaning in Schedule 10 Part 2;
Special Category Personal Data	shall have the same meaning as in UK GDPR;
Specified Purpose	means the purpose for which the Relevant Information is shared and processed, being to facilitate the exercise of the ICB's Delegated Functions and NHS England's Reserved Functions as specified in paragraph 2.1 of Schedule 4 *(Further Information Governance and Sharing Provisions)* to this Agreement;

Staff or Staffing	means the Parties' employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of either Party (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel;
Staffing Model	means the employment model for the exercise of the Delegated Functions including those as defined in Appendix 2 of the NHS England and NHS Improvement operating models: HR Framework for developing Integrated Care as may be amended or replaced from time to time;
Statement of Financial Entitlements Directions	means the General Medical Services Statement of Financial Entitlements Directions 2021, as amended or updated from time to time;
Sub-Delegate	shall have the meaning in clause 11.2;
Transfer Regulations	means the Transfer of Undertakings (Protection of Employment) Regulations 2006, as amended;
Triple Aim	means the duty to have regard to the wider effects of decisions, which is placed on each of the Parties under section 13NA (as regards NHS England) and section 14Z43 (as regards the ICB) of the NHS Act;
UK GDPR	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018;
Variation Proposal	means a written proposal for a variation to the Agreement, which complies with the requirements of clause 25.3.

SCHEDULE 2

Delegated Functions

Schedule 2A: Primary Medical Services

Part 1: General Obligations

1. Introduction

1.1 This Part 1 of Schedule 2A *(Primary Medical Services)* sets out further provision regarding the carrying out of those Delegated Functions relating to Primary Medical Services, being in summary:

1.1.1 decisions in relation to the commissioning and management of Primary Medical Services;

1.1.2 planning Primary Medical Services in the Area, including carrying out needs assessments;

1.1.3 undertaking reviews of Primary Medical Services in respect of the Area;

1.1.4 management of the Delegated Funds in the Area;

1.1.5 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

1.1.6 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

2. General Obligations

2.1 The ICB is responsible for planning the commissioning of primary medical services.

2.2 The role of the ICB includes:

2.2.1 carrying out needs assessments, and regular reviews of such assessments, to determine the needs of the population in the Area; and

2.2.2 identifying and implementing changes to meet any unmet needs which may be met through the delivery of Primary Medical Services.

2.3 In respect of integrated working, the ICB must:

2.3.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Authorities, Healthwatch, acute and community providers, the Local Medical Committee, and other stakeholders;

2.3.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Primary Medical Services generally; and

2.3.3 work with NHS England to coordinate the exercise of their respective performance management functions.

2.4 In relation to the Delegated Functions, the ICB agrees to perform the following general obligations:

2.4.1 to manage the Primary Medical Services Contracts and perform all of NHS England's obligations under each of the Primary Medical Services Contracts

in accordance with the terms of the Primary Medical Services Contracts as if it were named in the contract in place of NHS England;

2.4.2 actively manage the performance of the Primary Medical Services Provider in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches, serve notices or provide discretionary support;

2.4.3 ensure that it obtains value for money on behalf of NHS England, and avoids making any double payments under any Primary Medical Services Contracts;

2.4.4 notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the ICB of its obligations to perform any of NHS England's obligations under the Primary Medical Services Contracts;

2.4.5 undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;

2.4.6 keep a record of all of the Primary Medical Services Contracts that the ICB manages setting out the following details in relation to each Primary Medical Services Contract:

2.4.6.1 name of the Primary Medical Services Provider;

2.4.6.2 the name by which the Primary Medical Services Provider is known (if different to the name recorded under paragraph 2.4.6.1);

2.4.6.3 location of provision of services; and

2.4.6.4 amounts payable under the Primary Medical Services Contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.5 Without prejudice to clause 9 (*Finance*) of the Agreement or paragraph 2.4 above, the ICB must actively manage each of the relevant Primary Medical Services Contracts including by:

2.5.1 reviewing the performance of the relevant Primary Medical Services Contract, including in respect of quality standards, incentives and the QOF, observance of service specifications, and monitoring of activity and finance;

2.5.2 assessing quality and outcomes (including clinical effectiveness, patient experience, patient safety and addressing inequalities);

2.5.3 managing variations to the relevant Primary Medical Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.5.4 agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);

2.5.5 agreeing local prices, managing agreements or proposals for local variations and local modifications;

2.5.6 conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes; and

2.5.7 complying with and implementing any relevant Mandated Guidance issued from time to time.

2.6 This paragraph is without prejudice to clause 10 (*Information, Planning and Reporting*) or any other provision in this Agreement. The ICB must provide NHS England with:

2.6.1 such information relating to individual Primary Medical Services Providers in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the commissioning or performance of Primary Medical Services Providers;

2.6.2 such data/data sets as required by NHS England to ensure population of any national dashboards;

2.6.3 any other data/data sets as required by NHS England; and

2.6.4 the ICB shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

2.7 It should be noted that while the ICB is also required to exercise functions in respect of dispensing doctors, arrangements in respect of these functions are described in Schedule 2D (Pharmaceutical Services).

Part 2: Specific Obligations

1. Introduction

This Part 2 of Schedule 2A (Delegated Functions – Primary Medical Services) sets out further provision regarding the carrying out of each of the Delegated Functions.

2. Primary Medical Services Contract Management

The ICB must comply with any future national Mandated Guidance on equitable funding as may apply from time to time.

3. Enhanced Services

3.1 The ICB must manage the design (where applicable) and commissioning of any Enhanced Services, including re-commissioning these services annually where appropriate.

3.2 The ICB may consider any local enhanced services entered into with Primary Medical Services Providers in its Area using NHS Standard Contracts. Where these would continue to be beneficial to the Area, the ICB may manage the ongoing design and commissioning (including re-commissioning) of these services via a Local Incentives Scheme.

3.3 The ICB must ensure that it complies with any Mandated Guidance in relation to the design and commissioning of Enhanced Services.

3.4 When commissioning newly designed Enhanced Services the ICB must:

3.4.1 consider the needs of the local population in the Area;

3.4.2 develop the necessary specifications and templates for the Enhanced Services, as required to meet the needs of the local population in the Area;

3.4.3 when developing the necessary specifications and templates for the Enhanced Services, ensure that value for money will be obtained;

3.4.4 consult with Local Medical Committees and other stakeholders and comply with the duty of public involvement and consultation under section 14Z45 of the NHS Act;

3.4.5 liaise with system providers and representative bodies to ensure that the system in relation to the Directed Enhanced Services, NHS England Enhanced Services and Local Enhanced Services will be functional and secure;

3.4.6 support Data Controllers in providing 'fair processing' information as required by the UK GDPR; and

3.4.7 support Primary Medical Services Providers in entering into data processing agreements with data processors in the terms required by the UK GDPR.

4. Design of Local Incentive Schemes

4.1 The ICB may design and offer Local Incentive Schemes for Primary Medical Services Providers, sensitive to the differing needs of their particular communities. This includes in addition to or as an alternative to the national contractual frameworks (including as an alternative to QOF or Enhanced Services), provided that such schemes are voluntary, and the ICB continues to offer the national schemes.

4.2 There is no formal approvals process that the ICB must follow to develop a Local Incentive Scheme, although when designing and implementing any proposed new Local Incentive Scheme the ICB must:

4.2.1 consider the needs of the local population in the Area;

4.2.2 develop the specifications and templates for the Local Incentive Scheme;

4.2.3 consult with Local Medical Committees and other stakeholders and comply with the duty of public involvement and consultation under section 14Z45 of the NHS Act;

4.2.4 liaise with system providers and representative bodies to ensure that the system in relation to the Local Incentive Schemes will be functional and secure;

4.2.5 support Data Controllers in providing privacy information as required by the UK GDPR; and

4.2.6 support Primary Medical Services Providers in entering into data processing agreements with data processors in terms required by the UK GDPR.

4.3 The ICB must be able to:

4.3.1 demonstrate improved outcomes, reduced inequalities and value for money;

4.3.2 support ongoing national reporting requirements (where applicable); and

4.3.3 must reflect the changes agreed as part of the national PMS reviews (https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/05/implement-pms-fund-changes.pdf).

4.4 The ongoing assurance of any new Local Incentive Schemes will form part of the ICB's assurance process under any applicable assurance framework.

4.5 Any new Local Incentive Scheme must be implemented without prejudice to the right of Primary Medical Services Providers operating under a GMS Contract to obtain their entitlements which are negotiated and set nationally.

4.6 NHS England will continue to set national standing rules, to be reviewed annually, and the ICB must comply with these rules which shall for the purposes of this Agreement be Mandated Guidance.

5. Making Decisions on Discretionary Payments or Support

5.1 The ICB must manage and make decisions in relation to any discretionary payments or discretionary support to be made to Primary Medical Services Providers in a consistent, open and transparent way.

5.2 The ICB must exercise its discretion to determine the level of payment or type of support to Primary Medical Services Providers, in accordance with any relevant Mandated Guidance.

6. Making Decisions about Commissioning Urgent Care for Out of Area Registered Patients

6.1 The ICB must manage the design and commissioning of urgent care services (including home visits as required) for its patients registered out of area (including re-commissioning these services annually where appropriate).

6.2 The ICB must ensure that it complies with any Mandated Guidance in relation to the design and commissioning of these services.

6.3 For the purposes of paragraph 6.1, urgent care means the provision of primary medical services on an urgent basis.

7. Transparency and freedom of information

7.1 The ICB must:

7.1.1 Respond to requests for information from members of the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

7.1.2 Provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

8. Planning the Provider Landscape

8.1 The ICB must plan the primary medical services provider landscape in the Area, including considering and taking decisions in relation to:

8.1.1 establishing new Primary Medical Services Providers in the Area;

8.1.2 managing Primary Medical Services Providers providing inadequate standards of patient care;

8.1.3 the procurement or award of new Primary Medical Services Contracts (in accordance with any procurement protocol or Guidance issued by NHS England from time to time);

8.1.4 closure of practices and branch surgeries;

8.1.5 dispersing the patient lists of Primary Medical Services Providers; and

8.1.6 agreeing variations to the boundaries of Primary Medical Services Providers.

8.2 In relation to any new Primary Medical Services Contract to be entered into, the ICB must, without prejudice to any obligation in paragraph 14 (*Procurement and New Contracts*) below, and paragraph 2.5 of Part 1 of this Schedule 2A:

8.2.1 consider and use the form of Primary Medical Services Contract that will ensure compliance with NHS England's obligations under Law taking into account the persons to whom such Primary Medical Services Contracts may be awarded;

8.2.2 provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law; and

8.2.3 for the avoidance of doubt, Schedule 5 (Financial Provisions and Decision Making Limits) deals with the sign off requirements for Primary Medical Services Contracts.

9. Primary Care Networks

9.1 In managing the design and commissioning of the Network Contract Directed Enhanced Services, including re-commissioning these services annually where appropriate, the ICB must plan and manage the Primary Care Networks in the Area, complying with published specifications and Mandated Guidance, including to:

9.1.1 maintain or establish identified Network Areas to support the local population in the Area;

9.1.2 review any waived PCN list size requirements wherever possible and appropriate to best support the local population in the Area;

9.1.3 ensure that each PCN has at all times an accountable Clinical Director;

9.1.4 align each PCN with an ICB that would best support delivery of services to the local population in the Area; and

9.1.5 collaborate and work with other ICBs as appropriate to agree which ICB will be the lead ICB for the PCN.

10. Approving Primary Medical Services Provider Mergers and Closures

10.1 The ICB is responsible for approving Primary Medical Services Provider mergers and Primary Medical Services Provider closures in the Area.

10.2 The ICB must undertake all necessary consultation when taking any decision in relation to Primary Medical Services Provider mergers or Primary Medical Services Provider closures in the Area, including those set out under section 14Z45 of the NHS Act (duty for public involvement and consultation). The consultation undertaken must be appropriate and proportionate in the circumstances and should include consulting with the Local Medical Committee.

10.3 Prior to making any decision in accordance with this paragraph 10 (*Approving Primary Medical Services Provider Mergers and Closures*), the ICB must be able to clearly demonstrate the grounds for such a decision and must have fully considered any impact on the Primary Medical Services Provider's registered population and that of surrounding practices. The ICB must be able to clearly demonstrate that it has considered other options and has entered into dialogue with the Primary Medical Services Provider as to how any closure or merger will be managed.

10.4 In making any decisions pursuant to this paragraph 10 (*Approving Primary Medical Services Provider Mergers and Closures*), the ICB shall act in accordance with relevant Mandated Guidance and also take account of its obligations as set out in paragraph 14 *(Procurement and New Contracts)*, below, where applicable.

11. Making Decisions in relation to Management of Poorly Performing Primary Medical Services Providers

11.1 The ICB must make decisions in relation to the management of poorly performing Primary Medical Services Provider including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the Performers List).

11.2 In accordance with paragraph 11.1 above, the ICB must:

11.2.1 ensure regular and effective collaboration with the CQC to ensure that information on general practice is shared and discussed in an appropriate and timely manner;

11.2.2 ensure that any risks identified are managed and escalated where necessary;

11.2.3 respond to CQC assessments of Primary Medical Services Providers where improvement is required;

11.2.4 where a Primary Medical Services Provider is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and

11.2.5 take appropriate contractual action, including (without limitation) in response to CQC findings.

12. Premises Costs Directions Functions

12.1 The ICB must comply with the Premises Costs Directions and will be responsible for making decisions in relation to the Premises Costs Directions Functions.

12.2 In particular, but without limiting paragraph 12.1, the ICB shall make decisions concerning:

12.2.1 applications for new payments under the Premises Costs Directions (whether such payments are to be made by way of grants or in respect of recurring premises costs); and

12.2.2 revisions to existing payments being made under the Premises Costs Directions.

12.3 The ICB must comply with any decision-making limits set out in Schedule 5 (*Financial Provisions and Decision Making Limits*) when taking decisions in relation to the Premises Costs Directions Functions.

12.4 The ICB will comply with any Guidance issued by the Secretary of State or NHS England in relation to the Premises Costs Directions, including the Principles of Best Practice, and any other Mandated Guidance in relation to the Premises Costs Directions.

12.5 The ICB must work to ensure that the premises estate is properly managed and maintained, including by ensuring strategic estates planning is in place, and work cooperatively with other ICBs as appropriate.

12.6 The ICB must ensure it maintains comprehensive records of the primary care estate and any changes to it.

12.7 The ICB must liaise where appropriate with NHS Property Services Limited and Community Health Partnerships Limited in relation to the Premises Costs Directions Functions.

12.8 The ICB must prioritise the following measures in respect of management of the primary care estate in the Area:

12.8.1 working collaboratively with landlords and tenants to maximise the use of existing estate;

12.8.2 effective asset management practices including (without limitation) regularisation of the occupation of the estate, lease events, rent reviews and up-to-date documentation management; and

12.8.3 seeking the resolution of premises disputes in a timely manner.

13. Maintaining the Performers List

On receiving a notice from a practitioner (who is party to a Primary Medical Services Contract) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the Performers List as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.

14. Procurement and New Contracts

14.1 Until any new arrangements for awarding Primary Medical Services Contracts comes into force, the ICB will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

14.2 In discharging its responsibilities set out in this Schedule 2A, the ICB must comply at all times with Law and any relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services).

14.3 On the coming into force of new arrangements for awarding Primary Medical Services Contracts, the ICB will make decisions on awarding new contracts relevant to the exercise of the Delegated Functions.

14.4 When the ICB makes decisions in connection with the awarding of Primary Medical Services Contracts it should ensure that it is able to demonstrate compliance with requirements for the award of Primary Medical Services Contracts, including that the decision was:

14.4.1 made in the best interest of patients, taxpayers and the population;

14.4.2 robust and defensible, with conflicts of interests appropriately managed;

14.4.3 made transparently; and

14.4.4 compliant with the rules of the regime as set out in NHS England guidance.

14.5 Where the ICB wishes to develop and offer a locally designed contract, it must ensure that it has consulted with the relevant Local Medical Committees in relation to the proposal and that it can demonstrate that the scheme will:

14.5.1 improve outcomes for patients;

14.5.2 reduce inequalities in the population; and

14.5.3 provide value for money.

15. Complaints

15.1 The ICB will handle complaints made in respect of Primary Medical Services in accordance with the Complaints Regulations.

16. Commissioning ancillary support services

16.1 The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

16.1.1 collection and disposal of clinical waste;

16.1.2 provision of translation and interpretation services;

16.1.3 occupational health services.

17. Finance

Further requirements in respect of finance will be specified in Mandated Guidance.

18. Workforce

18.1 The arrangements for the provision and maintenance of sufficient and appropriately qualified, trained and experienced Staff in order for the ICB to fulfil its responsibilities for each of the Delegated Functions ("the Staffing Model"), will be communicated formally to the ICB by NHS England following recommendations made by the National Moderation Panel.

18.2 The ICB is not permitted to vary the Staffing Model agreed with NHS England as part of its application for delegation of the said functions however a variation can be applied for by the ICB and considered by the National Moderation Panel at any time.

Schedule 2B: Dental Care Services

The provisions of this Schedule 2B form part of this Agreement only where indicated in the Particulars.

Part 1A: General Obligations – Primary Dental Services

1. Introduction

1.1 This Part 1A of Schedule 2B *(Dental Care Services)* sets out general provisions regarding the carrying out of those Delegated Functions relating to Primary Dental Services, being in summary:

1.1.1 decisions in relation to the commissioning and management of Primary Dental Services;

1.1.2 planning Primary Dental Services in the Area, including carrying out needs assessments;

1.1.3 undertaking reviews of Primary Dental Services in the Area;

1.1.4 management of the Delegated Funds in the Area;

1.1.5 co-ordinating a common approach to the commissioning and delivery of Primary Dental Services with other health and social care bodies in respect of the Area where appropriate; and

1.1.6 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

2. General Obligations

2.1 The ICB is responsible for planning the commissioning of Primary Dental Services.

2.2 When planning and commissioning Primary Dental Services, the ICB must comply with Mandated Guidance issued by NHS England.

2.3 In respect of integrated working, the ICB must:

2.3.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Dental Professional Networks, Local Authorities, Healthwatch, acute and community providers, the Local Dental Committee, and other stakeholders;

2.3.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Primary Dental Services generally; and

2.3.3 work with NHS England to coordinate the exercise of their respective performance management functions.

2.4 In relation to the Delegated Functions, the ICB agrees to perform the following general obligations with regard to Dental Services Contracts:

2.4.1 to manage the Dental Services Contracts and perform all of NHS England's obligations under each of the Dental Services Contracts in accordance with the terms of the Dental Services Contracts as if it were named in the contract in place of NHS England;

2.4.2 working with other organisations, including the NHS Business Services Authority and the NHS England specialised commissioning team as appropriate, actively manage the performance of the Dental Services Provider in order to secure the needs of people who use the services,

improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches, serve notices or provide discretionary support;

2.4.3 ensure that it obtains value for money on behalf of NHS England, including by avoiding making any double payments under any Dental Services Contracts and reducing the number of contracts which are under-delivering so that funds can be reallocated to meet local oral health needs;

2.4.4 notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the ICB of its obligations to perform any of NHS England's obligations under the Dental Services Contracts;

2.4.5 undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;

2.4.6 keep a record of all of the Dental Services Contracts that the ICB manages on behalf of NHS England setting out the following details in relation to each Dental Services Contract:

2.4.6.1 name of Dental Services Provider;

2.4.6.2 any practice or trading name by which the Dental Services Provider is known (if different to the name recorded under paragraph 2.4.6.1);

2.4.6.3 location of provision of services; and

2.4.6.4 amounts payable under the contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.5 Without prejudice to clause 9 *(Finance)* or paragraph 2.4 above, the ICB must actively manage each of the relevant Dental Services Contracts including by:

2.5.1 reviewing and monitoring spending on services provided pursuant to Dental Services Contracts in the Area;

2.5.2 reviewing and monitoring spending on Primary Dental Services commissioned in the Area;

2.5.3 creating purchase orders, coding invoices and making appropriate amendments within the Compass contractor payments system;

2.5.4 managing the relevant Dental Services Contract, including in respect of quality standards, incentives, observance of service specifications, and monitoring of activity and finance;

2.5.5 assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);

2.5.6 managing variations to the relevant Dental Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.5.7 agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);

2.5.8 undertaking annual contract activity negotiations, including agreeing local prices, managing agreements or proposals for local variations and local modifications;

2.5.9 conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes;

2.5.10 allocating sufficient resources for undertaking contract mediation; and

2.5.11 complying with and implementing any relevant Mandated Guidance issued from time to time.

2.6 This paragraph is without prejudice to clause 10 *(Information, Planning and Reporting)* or any other provision in this Agreement. The ICB must provide NHS England with:

2.6.1 such information relating to individual providers of Primary Dental Services in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the commissioning or performances of providers of Primary Dental Services;

2.6.2 such data/data sets as required by NHS England to ensure population of any national dashboards;

2.6.3 any other data/data sets as required by NHS England; and

2.6.4 the ICB shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

Part 1B: Specific Obligations – Primary Dental Services only

1. Introduction

1.1 This Part 1B of Schedule 2B *(Dental Care Services)* sets out further provision regarding the carrying out of each of the Delegated Functions in relation to Primary Dental Services.

2. Dental Services Contract Management

2.1 The ICB must:

2.1.1 comply with all current and future relevant national Mandated Guidance regarding contract reviews;

2.1.2 monitor contract performance and primary care dental spending, with a view in particular to achieving a reduction in the number of contract holders who are under-delivering, and the reallocation of unused resources to meet the oral health needs of the Area; and

2.1.3 in cooperation with the NHS Business Services Authority, monitor contract performance with a view in particular to addressing patient safety concerns and promoting patient safety.

2.2 The ICB must undertake the annual reconciliation of monies claimed by providers against the services provided under any contract for the provision of Dental Care Services made pursuant to NHS England's functions under Part 5 of the NHS Act procuring such ancillary support services as are required for the performance of this function.

3. Transparency and freedom of information

3.1 The ICB must:

3.1.1 respond to requests for information from members of the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

3.1.2 provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

4. Planning the Provider Landscape

4.1 The ICB must plan the provider landscape in the Area, including considering and taking decisions in relation to:

4.1.1 establishing new Dental Services Providers in the Area;

4.1.2 managing Dental Services Providers providing inadequate standards of patient care;

4.1.3 the procurement or award of new Dental Services Contracts (in accordance with any procurement protocol or Guidance issued by NHS England from time to time); and

4.1.4 closure of practices.

4.2 In relation to any new Dental Services Contract to be entered into, the ICB must, without prejudice to any obligation in paragraph 9 (*Procurement and New Contracts*), below:

4.2.1 consider and use the form of Dental Services Contract that will ensure compliance with NHS England's obligations under Law taking into account the persons to whom such Dental Services Contracts may be awarded;

4.2.2 provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law; and

4.2.3 for the avoidance of doubt, Schedule 5 (*Financial Provisions and Decision Making Limits*) deals with the sign off requirements for Dental Services Contracts.

5. Finance

5.1 Further requirements in respect of finance will be specified in Mandated Guidance.

6. Staffing and Workforce

6.1 Subject to the terms of this Agreement, the Delegated Functions will be carried out by NHS England Staff in accordance with decisions concerning the Delegated Functions made by the ICB unless the Staff carrying out the Delegated Functions have transferred to the ICB (and/or the ICB has engaged or employed Staff for that purpose).

6.2 The arrangements for the provision and maintenance of sufficient and appropriately qualified, trained and experienced Staff in order for the ICB to fulfil its responsibilities for each of the Delegated Functions ("the Staffing Model"), will be communicated formally to the ICB by NHS England following recommendations made by the National Moderation Panel. Further requirements in respect of workforce will be specified in Mandated Guidance.

6.3 The ICB is not permitted to vary the Staffing Model agreed with NHS England as part of its application for delegation of the said functions however a variation can be applied for by the ICB and considered by the National Moderation Panel at any time.

7. Integrating dentistry into communities at Primary Care Network level

7.1 The ICB must exercise the Delegated Functions with a view to achieving greater integration of dentists into the Integrated Care System at the Primary Care Network level.

8. Making Decisions in relation to Management of Poorly Performing Dental Services Providers

8.1 The ICB must make decisions in relation to the management of poorly performing Dental Services Provider including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the Performers List).

8.2 In accordance with paragraph 8.1 above, the ICB must:

8.2.1 ensure regular and effective collaboration with the CQC to ensure that information is shared and discussed in an appropriate and timely manner;

8.2.2 ensure that any risks identified are managed and escalated where necessary;

8.2.3 respond to CQC assessments of Dental Services Providers where improvement is required;

8.2.4 where a Dental Services Provider is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and

8.2.5 take appropriate contractual action including (without limitation) in response to CQC findings.

9. Maintaining the Performers List

On receiving a notice from a practitioner (who is party to a Dental Services Contract) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the Performers List as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.

10. Procurement and New Contracts

10.1 Until any new arrangements for awarding Dental Services Contracts come into force, the ICB will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

10.2 In discharging its responsibilities set out in this Schedule 2B, the ICB must comply at all times with Law and all relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services).

10.3 On the coming into force of new arrangements for awarding Dental Services Contracts, the ICB will make decisions on awarding new contracts relevant to the exercise of the Delegated Functions.

10.4 When the ICB makes decisions in connection with the awarding of Dental Services Contracts it should ensure that it is able to demonstrate compliance with requirements for the award of Dental Services Contracts, including that the decision was:

10.4.1 made in the best interest of patients, taxpayers and the population;

10.4.2 robust and defensible, with conflicts of interests appropriately managed;

10.4.3 made transparently, and

10.4.4 compliant with the rules of the regime as set out in NHS England guidance.

11. Complaints

11.1 The ICB will handle all complaints made in respect of Primary Dental Services in accordance with the Complaints Regulations.

12. Commissioning Ancillary Support Services

12.1 The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

12.1.1 provision of translation and interpretation services; and

12.1.2 occupational health services.

Part 2A: General Obligations – Prescribed Dental Services

1. Introduction

1.1 This Part 2A of Schedule 2B *(Dental Care Services)* sets out general provisions regarding the carrying out of those Delegated Functions relating to Prescribed Dental Services. Prescribed Dental Services constitute Community Dental Services and Secondary Care Dental Services. These include:

1.1.1 decisions in relation to the commissioning and management of Prescribed Dental Services;

1.1.2 planning Prescribed Dental Services in the Area, including carrying out needs assessments;

1.1.3 undertaking reviews of Prescribed Dental Services in the Area;

1.1.4 management of the Delegated Funds in respect of Prescribed Dental Services in the Area;

1.1.5 co-ordinating a common approach to the commissioning and delivery of Prescribed Dental Services with other health and social care bodies where appropriate; and

1.1.6 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

1.2 For the purposes of this Schedule 2B, "Secondary Care Dental Services" refers to Prescribed Dental Services which are not Community Dental Services.

2. General Obligations

2.1 The ICB is responsible for commissioning Prescribed Dental Services for its Population which for the purpose of this Part 2A of Schedule 2B *(Dental Care Services)*, shall refer to a group of people for whom the ICB has core responsibility, as established under the rules published by NHS England under section 14Z31 of the Act.

2.2 In respect of integrated working, the ICB must take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Dental Professional Networks, Local Authorities, Healthwatch, acute and community providers, the Local Dental Committee, managed clinical networks and other stakeholders.

2.3 When planning and commissioning Prescribed Dental Services, the ICB must comply with Mandated Guidance issued by NHS England.

2.4 The provisions of Paragraph 2.4, 2.5 and 2.6 of Part 1A of this Schedule 2B shall apply in respect of Prescribed Dental Services as if "Dental Services Contract" includes all contracts for Prescribed Dental Services and "Primary Dental Services" include Prescribed Dental Services.

2.5 In awarding any new contract for Prescribed Dental Services, the ICB must:

2.5.1 comply with Law and all relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services);

2.5.2 use the current NHS Standard Contract published by NHS England from time to time; or an appropriate contract for the provision of Dental Care Services made pursuant to NHS England's functions under Part 5 of the NHS Act; and

2.5.3 where the NHS Standard Contract is used, pay for the Services in accordance with the NHS Payment Scheme (as defined in the Health and Social Care Act 2012).

Part 2B: Specific Obligations – Prescribed Dental Services

1. Introduction

1.1 This Part 2B of Schedule 2B *(Prescribed Dental Care Services)* sets out further provision regarding the carrying out of each of the Delegated Functions in relation to Prescribed Dental Services.

2. Community Dental Services Commissioning Obligations

2.1 Community Dental Services may currently be contracted for by way of either an NHS Standard Contract or a PDS Agreement, as appropriate to the particular service. Accordingly:

2.1.1 where Community Dental Services are commissioned on PDS Agreement terms (or it is appropriate to commission a new agreement for Community Dental Services on a PDS Agreement or other agreement made pursuant to NHS England's functions under Part 5 of the NHS Act), those contracts must be managed in accordance with the relevant provisions of Part 1A and Part 1B of this Schedule 2B as if they were Primary Dental Services for the purposes of that Part. The provisions of this Part 2A of Schedule 2B also apply; and

2.1.2 where Community Dental Services are commissioned on NHS Standard Contract terms, the provisions of this Part 2A of Schedule 2B apply in full.

3. Secondary Care Dental Services Commissioning Obligations

3.1 For the first financial year following delegation of Secondary Care Dental Services to the ICB (the "Initial Year of Delegation"), the Secondary Care Dental Services shall be commissioned through wider NHS Standard Contracts made between NHS England and the relevant providers that a) cover the whole population of England; and b) typically also cover other services. Accordingly, unless otherwise stated within a Contractual Notice, for the Initial Year of Delegation ONLY the following shall apply:

3.1.1 The commissioning responsibility for the Secondary Care Dental Service elements of the relevant NHS Standard Contracts is delegated to the ICB to the extent that they relate to its Population;

3.1.2 NHS England is, and will remain, the "co-ordinating commissioner" (as defined in the NHS Standard Contract) for those contracts, meaning that NHS England retains core contract management responsibility;

3.1.3 Delegation of commissioning responsibility for the Secondary Care Dental service elements of the relevant NHS Standard Contracts is permitted by clause GC12 of those contracts. NHS England has confirmed these delegation arrangements by letter to each affected provider so that they are aware of the ICB's role as Secondary Care Dental Services commissioner.

3.1.4 whilst the ICB is commissioner of the Secondary Care Dental Service elements of the contract that relate to its Population, it does not have any direct contract management role and must work with NHS England as co-ordinating commissioner, raising any contractual issues with NHS England for consideration and any appropriate action;

3.1.5 The ICB shall ensure that contractual payments are made to providers for the provision of Secondary Care Dental Services in respect of the ICB's Population, as required by the terms of those contracts. This may represent only a proportion of the overall payment due to the provider for Secondary Care Dental Services delivered more widely under that contract.

3.2 For all subsequent financial years following the Initial Year of Delegation the ICB will be responsible for ensuring that appropriate contractual arrangements are in place to ensure continuity of Secondary Care Dental Services for its Population.

4. Prescribed Dental Services Contract Management

4.1 Subject to Paragraph 4.2 of this Part 2B of Schedule 2B, the ICB must:

4.1.1 comply with all current and future relevant national Mandated Guidance regarding contract reviews;

4.1.2 monitor contract performance and prescribed care dental spending, with a view in particular to ensuring the delivery of agreed contract activity, and the reallocation of unused resources to meet the oral health needs of the Area;

4.1.3 monitor contract performance with a view in particular to addressing patient safety concerns and promoting patient safety; and

4.1.4 ensure appropriate oversight of the Prescribed Dental Services, including, where appropriate, procuring such ancillary support services as are required for the performance of this function.

4.2 For the Initial Year of Delegation in respect of Secondary Care Dental Services the requirements set out in paragraph 4.1 of this Part 2B of Schedule 2B do not apply and the terms of the relevant Contractual Notice shall apply.

5. Transparency and freedom of information

5.1 The ICB must:

5.1.1 respond to requests for information from members of the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

5.1.2 provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

6. Planning the Provider Landscape

6.1 The ICB must plan the provider landscape in the Area, including considering and taking decisions in relation to:

6.1.1 establishing new providers of Prescribed Dental Services in the Area;

6.1.2 managing providers of Prescribed Dental Services providing inadequate standards of patient care; and

6.1.3 the procurement or award of new contracts for Prescribed Dental Services (in accordance with any procurement protocol or Guidance issued by NHS England from time to time).

6.2 In relation to any new contracts for Prescribed Dental Services to be entered into, the ICB must, without prejudice to any obligation in paragraph 11 (*Procurement and New Contracts*):

6.2.1 consider and use the form of contract that will ensure compliance with NHS England's obligations under Law taking into account the persons to whom such contracts may be awarded;

6.2.2 provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law.

7. **Staffing and Workforce**

7.1 The provisions of paragraph 6 of Part 1B of this Schedule 2B shall apply.

8. Finance

8.1 The ICB must ensure the financial delivery of the Prescribed Dental Services in accordance with any Mandated Guidance provided by NHS England.

9. Integrating dentistry into communities at Primary Care Network level

9.1 The ICB must exercise the Delegated Functions with a view to achieving greater integration of dentists into the Integrated Care System at the Primary Care Network level.

10. Making Decisions in relation to Management of Poorly Performing Dental Services Providers

10.1 The ICB must make decisions in relation to the management of poorly performing providers of Prescribed Dental Services and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards.

10.2 In accordance with paragraph 9.1 above, the ICB must:

10.2.1 ensure regular and effective collaboration with the CQC to ensure that information is shared and discussed in an appropriate and timely manner;

10.2.2 ensure that any risks identified are managed and escalated where necessary;

10.2.3 respond to CQC assessments of providers of Prescribed Dental Services where improvement is required;

10.2.4 where a providers of Prescribed Dental Services is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and

10.2.5 take appropriate contractual action in response to CQC findings.

11. Maintaining the Performers List

On receiving a notice from a practitioner (who is party to a contract for Prescribed Dental Services) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the Performers List as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.

12. Procurement and New Contracts

12.1 Until any new arrangements for awarding contracts for Prescribed Dental Services come into force, the ICB will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

12.2 In discharging its responsibilities set out in this Schedule 2B, the ICB must comply at all times with Law and all relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services).

12.3 On the coming into force of new arrangements for awarding contracts for Prescribed Dental Services, the ICB will make decisions on awarding new contracts relevant to the exercise of the Delegated Functions.

12.4 When the ICB makes decisions in connection with the awarding of contracts for Prescribed Dental Services it should ensure that it is able to demonstrate compliance with requirements for the award of contracts for Prescribed Dental Services, including that the decision was:

12.4.1 made in the best interest of patients, taxpayers and the population;

12.4.2 robust and defensible, with conflicts of interests appropriately managed;

12.4.3 made transparently, and

12.4.4 compliant with the rules of the regime as set out in NHS England guidance.

13. Commissioning Ancillary Support Services

13.1 The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

13.1.1 provision of translation and interpretation services; and

13.1.2 occupational health services.

14. Complaints

14.1 The ICB shall be responsible for handling complaints made in respect of Prescribed Dental Services.

Schedule 2C: Primary Ophthalmic Services

The provisions of this Schedule 2C form part of this Agreement only where indicated in the Particulars.

Part 1: General Obligations

1. Introduction

1.1 This Part 1 of Schedule 2C *(Primary Ophthalmic Services)* sets out general provisions regarding the carrying out of the Delegated Functions, being, in summary:

1.1.1 decisions in relation to the management of Primary Ophthalmic Services;

1.1.2 undertaking reviews of Primary Ophthalmic Services in the Area;

1.1.3 management of the Delegated Funds in the Area;

1.1.4 co-ordinating a common approach to the commissioning of Primary Ophthalmic Services with other commissioners in the Area where appropriate; and

1.1.5 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

2. General Obligations

2.1 The ICB is responsible for managing the provision of Primary Ophthalmic Services.

2.2 When carrying out Delegated Functions in respect of Primary Ophthalmic Services, the ICB must comply with all Mandated Guidance issued by NHS England.

2.3 The role of the ICB includes identifying and seeking to address any unmet needs which may be met through the delivery of Primary Ophthalmic Services.

2.4 In respect of integrated working, the ICB must:

2.4.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Eye Health Networks, Local Authorities, Healthwatch, acute and community providers, Local Optical Committees, and other stakeholders;

2.4.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Primary Ophthalmic Services generally; and

2.4.3 work with NHS England to coordinate the exercise of their respective performance management functions.

2.5 In relation to the Delegated Functions, the ICB agrees to perform the following general obligations:

2.5.1 to manage the Primary Ophthalmic Services Contracts on behalf of NHS England and perform all of NHS England's obligations under each of the Primary Ophthalmic Services Contracts in accordance with the terms of the Primary Care Contracts as if it were named in the contract in place of NHS England;

2.5.2 working with other organisations, including the NHS Business Services Authority and NHS England as appropriate, actively manage the performance of the Primary Ophthalmic Services Provider in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by taking

timely action to enforce contractual breaches, serve notices or provide discretionary support;

2.5.3 ensure that it obtains value for money on behalf of NHS England and avoids making any double payments under any Primary Ophthalmic Services Contracts;

2.5.4 notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the ICB of its obligations to perform any of NHS England's obligations under the Primary Ophthalmic Services Contracts;

2.5.5 undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;

2.5.6 keep a record of all of the Primary Ophthalmic Services Contracts that the ICB manages on behalf of NHS England setting out the following details in relation to each Primary Ophthalmic Services Contract:

2.5.6.1 name of the Primary Ophthalmic Services Provider;

2.5.6.2 any practice or trading name by which the Primary Ophthalmic Services Provider is known (if different to the name recorded under paragraph 2.5.6.1);

2.5.6.3 location of provision of services; and

2.5.6.4 amounts payable under the Primary Ophthalmic Services Contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.6 Without prejudice to clause 9 *(Finance)* or paragraph 2.5 above, the ICB must actively manage each of the relevant Primary Ophthalmic Services Contracts including by:

2.6.1 managing the relevant Primary Ophthalmic Services Contract, including in respect of quality standards, incentives, observance of service specifications, and monitoring of activity and finance;

2.6.2 assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);

2.6.3 managing variations to the relevant Primary Ophthalmic Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.6.4 agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);

2.6.5 conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes; and

2.6.6 complying with and implementing any relevant Mandated Guidance issued from time to time.

2.7 This paragraph is without prejudice to clause 10 (*Information, Planning and Reporting*) or any other provision in this Agreement. The ICB must provide NHS England with:

2.7.1 such information relating to individual providers of Primary Ophthalmic Services in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the

commissioning or performances of providers of Primary Ophthalmic Services;

2.7.2 such data/data sets as required by NHS England to ensure population of any national dashboards;

2.7.3 any other data/data sets as required by NHS England; and

2.7.4 the ICB shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

Part 2: Specific Obligations

1. Introduction

1.1 This Part 2 of Schedule 2C *(Primary Ophthalmic Services)* sets out further provision regarding the carrying out of each of the Delegated Functions.

2. Primary Ophthalmic Services Contract Management

2.1 The ICB must:

2.1.1 comply with all current and future relevant national Mandated Guidance regarding General Ophthalmic Contract reviews and any other contract reviews;

2.1.2 take on the responsibility for existing services provided pursuant to a Primary Ophthalmic Services Contract, and for commissioning new services;

2.1.3 assume the responsibility for the award of new Primary Ophthalmic Services Contracts; and

2.1.4 monitor contract performance with a view to achieving assurance and improvement in the delivery of services in the context of the ICB;

in each case acknowledging that the NHS Business Services Authority provides end-to-end support services in relation to these functions, as referred to in Schedule 6 (*Mandated Assistance and Support*). The ICB accordingly agrees to co-operate with the NHS Business Services Authority in the delivery of these functions.

3. Transparency and freedom of information

3.1 The ICB must:

3.1.1 Respond to requests for information from members and the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

3.1.2 Provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

4. Maintaining the Performers List

4.1 On receiving a notice from a practitioner (who is party to a Primary Ophthalmic Services Contract) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the performers list as soon as possible after receiving the notice using the Primary Care Support

services provided by NHS England, insofar as that amendment relates to a change in contractor details.

5. Finance

5.1 Further requirements in respect of finance will be specified in Mandated Guidance.

6. Workforce

6.1 The arrangements for the provision and maintenance of sufficient and appropriately qualified, trained and experienced Staff in order for the ICB to fulfil its responsibilities for each of the Delegated Functions ("the Staffing Model"), will be communicated formally to the ICB by NHS England following recommendations made by the National Moderation Panel. Further requirements in respect of workforce will be specified in Mandated Guidance.

6.2 The ICB is not permitted to vary the Staffing Model agreed with NHS England as part of its application for delegation of the said functions however a variation can be applied for by the ICB and considered by the National Moderation Panel at any time.

7. Integrating optometry into communities at Primary Care Network level

7.1 The ICB must exercise the Delegated Functions with a view to achieving greater integration of optometrists into the Integrated Care System at the Primary Care Network level.

8. Complaints

8.1 The ICB will handle complaints made in respect of primary ophthalmic services in accordance with the Complaints Regulations.

9. Commissioning ancillary support services

9.1 The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

9.1.1 provision of translation and interpretation services; and

9.1.2 occupational health services.

Schedule 2D: Delegated Functions – Pharmaceutical Services

The provisions of this Schedule 2D form part of this Agreement only where indicated in the Particulars.

1. In this Schedule, the following additional definitions shall apply:

Advanced Services	has the meaning given to that term by the Pharmaceutical Regulations;
Conditions of Inclusion	means those conditions set out at Part 9 of the Pharmaceutical Regulations;
Delegated Pharmaceutical Functions	the functions set out at paragraph 2 of this Schedule;
Designated Commissioner	has the meaning given to that term at paragraph 2.3 of this Schedule;
Dispensing Doctor	has the meaning given to that term by the Pharmaceutical Regulations;
Dispensing Doctor Decisions	means decisions made under Part 8 of the Pharmaceutical Regulations;
Dispensing Doctor Lists	has the meaning given to that term by the Pharmaceutical Regulations;
Drug Tariff	has the meaning given to that term by the Pharmaceutical Regulations;
Electronic Prescription Service	has the meaning given to that term by the Pharmaceutical Regulations;
Enhanced Services	has the meaning given to that term by the Pharmaceutical Regulations;
Essential Services	is to be construed in accordance with paragraph 3 of Schedule 4 to the Pharmaceutical Regulations;
Fitness to Practise Functions	has the meaning given to that term at paragraph 2.1.10 of this Schedule;
Locally Commissioned Services	means services which are not Essential Services, Advanced Services, Enhanced Services or services commissioned under an LPS Scheme;
LPS Chemist	has the meaning given to that term by the Pharmaceutical Regulations;
LPS Scheme	has the meaning given to that term by Paragraph 1(2) of Schedule 12 to the NHS Act;
NHS Chemist	has the meaning given to that term by the Pharmaceutical Regulations;
Pharmaceutical Lists	has the meaning given to that term at paragraph 2.1.1. of this Schedule and any reference to a Pharmaceutical List should be construed accordingly;

Pharmaceutical Regulations	means the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and reference to a Regulation refers to a provision of the Pharmaceutical Regulations, unless otherwise stated;
Rurality Decisions	means decisions made under Part 7 of the Pharmaceutical Regulations;
Terms of Service	means the terms upon which, by virtue of the Pharmaceutical Regulations, a person undertakes to provide Pharmaceutical Services;

Delegated Pharmaceutical Functions

2. Except in so far as they fall within the scope of the Reserved Functions, and subject to paragraphs 2.2, 2.3, 4 and 5, the ICB agrees to perform the following functions of NHS England in respect of the Area (the "Delegated Pharmaceutical Functions"), in all cases in accordance with relevant Law, Mandated Guidance and other Guidance:

2.1 preparing, maintaining and submitting for publication by NHS England lists of persons, other than medical practitioners or dental practitioners, who have undertaken to provide pharmaceutical services from premises situated within the Area[3], specifically:

2.1.1 lists of persons who have undertaken to provide pharmaceutical services in particular by way of the provision of drugs;

2.1.2 lists of persons who have undertaken to provide pharmaceutical services only by way of the provision of appliances; and

2.1.3 lists of persons participating in the Electronic Prescription Service[4]

collectively referred to in this Schedule as the "Pharmaceutical Lists". In doing so, it is sufficient for the lists referred to at paragraphs 2.1.1.1 and 2.1.1.2 to include a marker showing which persons are also participating in the Electronic Prescription Service, rather than preparing a separate list for the purposes of paragraph 2.1.1.3.

2.1.4 managing and determining applications by persons for inclusion in a Pharmaceutical List[5];

2.1.5 managing and determining applications by persons included in a Pharmaceutical List;

2.1.6 responsibilities for financial resources related to the Delegated Pharmaceutical Functions as described in Mandated Guidance issued by NHS England;

2.1.7 overseeing the compliance of those included in the Pharmaceutical Lists with:

2.1.7.1 their Terms of Service and identifying and investigating breaches, including possible breaches, of those terms;

[3] Including (without limitation) updates to those lists following any removal under regulation 115 of the Pharmaceutical Regulations
[4] Regulation 10 of the Pharmaceutical Regulations
[5] Schedule 2 of the Pharmaceutical Regulations

2.1.7.2 relevant Conditions of Inclusion; and

2.1.7.3 requirements of the Community Pharmacy Contractual Framework.

2.1.8 exercising powers in respect of Performance Related Sanctions and Market Exit[6];

2.1.9 exercising all other rights, and complying with all other obligations, of NHS England in respect of the Terms of Service and Conditions of Inclusion of those included in the Pharmaceutical Lists;

2.1.10 communicating to those included in the Pharmaceutical Lists any announcement made by NHS England modifying Terms of Service of any person included in the Pharmaceutical Lists as a consequence of a disease being, or in anticipation of a disease being imminently:

2.1.11 pandemic; and

2.1.12 a serious risk or potentially a serious risk to human health[7];

2.1.13 communicating to those included in the Pharmaceutical Lists any other matters which NHS England may require the ICB to communicate from time to time;

2.1.14 performing functions in respect of the disqualification of practitioners, and related measures concerning a practitioners inclusion in the Pharmaceutical Lists, set out in Chapter 6 of Part 7 to the NHS Act and the provisions of the Pharmaceutical Regulations made under that Chapter ("the Fitness to Practise Functions");

2.1.15 performing functions in respect of enforcement, reviews and appeals relating to the Fitness to Practise Functions[8];

2.1.16 making LPS Schemes[9], subject to the requirements of paragraph 5;

2.1.17 overseeing the compliance of those who are party to Local Pharmaceutical Services Contracts with the terms of those contracts and identifying and investigating breaches, including possible breaches, of the terms of those contracts;

2.1.18 exercising all rights, and complying with all obligations, of NHS England under Local Pharmaceutical Services Contracts;

2.1.19 determining LPS matters[10] in respect of LPS Schemes;

2.1.20 determining Rurality Decisions and other rurality matters[11];

2.1.21 determining Dispensing Doctor Decisions[12];

2.1.22 preparing and maintaining Dispensing Doctor Lists[13];

[6] Part 10 of the Pharmaceutical Regulations
[7] Regulation 11(3) of the Pharmaceutical Regulations
[8] Part 11 of the Pharmaceutical Regulations
[9] Section 134 NHS Act and Part 13 of the Pharmaceutical Regulations.
[10] Part 13 of the Pharmaceutical Regulations
[11] Part 7 of the Pharmaceutical Regulations
[12] Part 8 of the Pharmaceutical Regulations
[13] Regulation 46 of the Pharmaceutical Regulations

2.1.23 making arrangements for the provision of adequate pharmaceutical service delivery across the ICB area;

2.1.24 making arrangements for the delivery of Essential Services, Advanced Services and Enhanced Services;

2.1.25 supporting implementation and delivery of all elements of the Community Pharmacy Contractual Framework;

2.1.26 consulting with patients, the public and other stakeholders to the extent required by the duty of public involvement and consultation under section 14Z45 of the NHS Act;

2.1.27 responding to Appeals to the Secretary of State and First Tier Tribunal in respect of the Delegated Pharmaceutical Functions[14];

2.1.28 responding to Claims in respect of the Delegated Pharmaceutical Functions;

2.1.29 recovering overpayments from NHS Chemists, LPS Chemists, Dispensing Doctors and Primary Medical Services Providers[15];

2.1.30 bringing any legal proceedings in respect of the Delegated Pharmaceutical Functions;

2.1.31 making any notifications to, and consulting with, third parties in respect of the Delegated Pharmaceutical Functions;

2.1.32 recognising one or more Local Pharmaceutical Committees which it considers are representative of Pharmaceutical Services Providers in the ICB's Area and liaising with and consulting such Local Pharmaceutical Committees as required by the Pharmaceutical Regulations;

2.1.33 commissioning the provision of NHS Smartcards to Pharmaceutical Services Providers and their staff by registration authorities;

2.1.34 making any payments due to NHS Chemists suspended from a Pharmaceutical List in accordance with the determination made by the Secretary of State in respect of such payments; and

2.1.35 undertaking any investigations relating (among other things) to whistleblowing claims (relating to a superintendent pharmacist, a director or the operation of a pharmacy contractor), infection control and patient complaints.

2.2 Where the Area comprises the areas of two or more Health and Wellbeing Boards in their entirety:

2.2.1 the Delegated Pharmaceutical Functions shall be exercised so as to maintain separately in respect of each Health and Wellbeing Board area:

2.2.1.1 Pharmaceutical Lists in respect of premises in that Health and Wellbeing Board area;

2.2.1.2 a list of LPS Chemists providing local pharmaceutical services at or from premises in that Health and Wellbeing Board area[16]; and

[14] Schedule 3 of the Pharmaceutical Regulations
[15] Regulation 94 of the Pharmaceutical Regulations
[16] Regulation 114 of the Pharmaceutical Regulations

2.2.1.3 a Dispensing Doctor List (together the "Relevant Lists"); and

2.2.1.4 the ICB shall comply with such Contractual Notices as NHS England may issue from time to time concerning the arrangements for the exercise of the Delegated Pharmaceutical Functions across two or more Health and Wellbeing Board areas.

2.3 Where the Area comprises part of the area of a Health and Wellbeing Board (the "Relevant Health and Wellbeing Board"):

2.3.1 NHS England shall by Contractual Notice designate:

2.3.1.1 the ICB;

2.3.1.2 another ICB whose area comprises in part the area of the Relevant Health and Wellbeing Board; or

2.3.1.3 NHS England;

as the body responsible for maintaining the Relevant Lists (as defined in paragraph 2.2.1 of this Schedule 2D) in respect of the Relevant Health and Wellbeing Board ("the Designated Commissioner");

2.3.2 the ICB shall exercise the Delegated Pharmaceutical Functions in respect of that part of the Relevant Health and Wellbeing Board's area that falls within the Area but in doing so shall liaise with any Designated Commissioner for the purposes of maintaining the accuracy of the Relevant Lists (as defined in paragraph 2.2.1 of this Schedule 2D) in respect of the Relevant Health and Wellbeing Board; and

2.3.3 the ICB shall comply with all Contractual Notices issued by NHS England for the purposes of determining responsibilities in the circumstances described in this paragraph 2.3.

Prescribed Support

3. Notwithstanding the inclusion of the following within the Delegated Functions, the ICB shall discharge the functions set out at:

3.1 Paragraph 2.1.1 (maintaining Pharmaceutical Lists)

3.2 Paragraph 2.1.2 (managing applications for inclusion)

3.3 Paragraph 2.1.3 (managing applications from those included in a list)

3.4 Paragraph 2.1.5 (overseeing compliance with Terms of Service and Conditions of Inclusion)

3.5 Paragraph 2.1.10 (Fitness to Practise)

3.6 Paragraph 2.1.18 (maintaining and publishing Dispensing Doctors Lists)

3.7 Paragraph 2.1.25 (recovery of overpayments)

with the assistance and support of the NHS Business Services Authority, Primary Care Support England or such other person as NHS England shall designate by Contractual Notice for these purposes from time to time and in accordance with the allocation of operational responsibilities described by NHS England in Mandated Guidance.

LPS Schemes

4. The ICB shall not without the prior written consent of NHS England make any new LPS Schemes.

Barred Persons

5. The ICB must ensure that persons barred from involvement in specific elements of the Delegated Functions are excluded from such involvement in accordance with the Pharmaceutical Regulations.

Other Services

6. The provisions of this schedule are without prejudice to the ability of the ICB to make arrangements for the provision of Locally Commissioned Services for the purposes of the NHS in accordance with its own commissioning functions and using its own financial resources.

Payments

7. In exercising the Delegated Pharmaceutical Functions, the ICB must ensure that:

    7.1 all payments to which the Drug Tariff applies are made solely in accordance with the Drug Tariff; and

    7.2 any other payments for services (including without limitation those relating to LPS Schemes and Enhanced Services) are made in accordance with recognised contractual mechanisms intended to apply to those services.

Flu vaccinations

8. The Parties acknowledge and agree that:

    8.1 responsibility for arranging any national scheme for flu vaccinations remains with NHS England as part of its Section 7A Functions; and

    8.2 where any such national scheme is arranged by NHS England, the ICB is required to commission flu vaccines as Advanced Services. For the purposes of this Agreement, this forms part of the ICB's responsibilities under this Agreement.

Integration

9. In respect of integrated working, the ICB must:

    9.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Authorities, Healthwatch, acute and community providers, professional representative groups, contractor representative groups and other stakeholders;

    9.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Pharmaceutical Services generally; and

    9.3 work with NHS England to coordinate the exercise of their respective performance management functions.

Integrating pharmacy into communities at Primary Care Network level

10. The ICB must exercise the Delegated Functions with a view to achieving greater integration of community pharmacy into the Integrated Care System at the Primary Care Network level including participation in network governance arrangements.

Complaints

11. The ICB will handle complaints made in respect of Pharmaceutical Services and Local Pharmaceutical Services in accordance with the Complaints Regulations.

Commissioning ancillary support services

12. The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

12.1 collection and disposal of clinical waste; and

12.2 provision of translation and interpretation services; and

12.3 occupational health services.

Finance

13. Further requirements in respect of finance will be specified in Mandated Guidance.

Workforce

14. Further requirements in respect of workforce will be specified in Mandated Guidance.

SCHEDULE 3

Reserved Functions

1. Introduction

1.1 In accordance with clause 8.4 of this Agreement, all functions of NHS England other than those defined as Delegated Functions are Reserved Functions.

1.2 This Schedule 3 (*Reserved Functions*) sets out further provision regarding the carrying out of the Reserved Functions.

1.3 The ICB will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions.

2. Management of the national performers list

2.1 Subject to Paragraph 2.2, NHS England will continue to perform its functions under the National Health Service (Performers Lists) (England) Regulations 2013.

2.2 The ICB will carry out administrative tasks in respect of the Performers Lists as described at:

2.2.1 Paragraph 9 of Part 2, Schedule 2A;

2.2.2 Paragraph 9 of Part 2, Schedule 2B; and

2.2.3 Paragraph 6 of Part 2, Schedule 2C.

2.3 NHS England's functions in relation to the management of the national performers list include:

2.3.1 considering applications and decision-making in relation to inclusion on the national performers list, inclusion with conditions and refusals;

2.3.2 identifying, managing and supporting primary care performers where concerns arise; and

2.3.3 managing suspension, imposition of conditions and removal from the national performers list.

2.4 NHS England may hold local Performance Advisory Group ("PAG") meetings to consider all complaints or concerns that are reported to NHS England in relation to a named performer and NHS England will determine whether an initial investigation is to be carried out.

2.5 NHS England may notify the ICB of all relevant PAG meetings at least seven (7) days in advance of such meetings. NHS England may require a representative of the ICB to attend such meetings to discuss any performer concerns and/or quality issues that may impact on individual performer cases.

2.6 The ICB must develop a mechanism to ensure that all complaints regarding any named performer are escalated to the Local NHS England Team for review. The ICB will comply with any Mandated Guidance issued by NHS England in relation to the escalation of complaints about a named performer.

3. Management of the revalidation and appraisal process

3.1 NHS England will continue to perform its functions under the Medical Profession (Responsible Officers) Regulations 2010 (as amended by the Medical Profession (Responsible Officers) (Amendment) Regulations 2013).

3.2 All functions in relation to GP appraisal and revalidation will remain the responsibility of NHS England, including:

3.2.1 the funding of GP appraisers;

3.2.2 quality assurance of the GP appraisal process; and

3.2.3 the responsible officer network.

3.3 Funding to support the GP appraisal is incorporated within the global sum payment to Primary Medical Services Provider.

3.4 The ICB must not remove or restrict the payments made to Primary Medical Services Provider in respect of GP appraisal.

3.5 Appraisal arrangements in respect of all other primary care practitioner groups shall also be Reserved Functions.

4. Administration of payments and related performers list management activities

4.1 NHS England reserves its functions in relation to the administration of payments to individual performers and related performers list management activities under the National Health Service (Performers Lists) (England) Regulations 2013 and other relevant legislation.

4.2 NHS England may continue to pay practitioners who are suspended from the national performers list in accordance with relevant determinations made by the Secretary of State.

4.3 For the avoidance of doubt, the ICB is responsible for any ad hoc or discretionary payments to Primary Medical Services Providers (including those under section 96 of the NHS Act) in accordance with Schedule 2A (*Delegated Functions*) Part 2 paragraphs 5.1 and 5.1 of this Agreement, including where such payments may be considered a consequence of actions taken under the National Health Service (Performers Lists) (England) Regulations 2013.

5. Section 7A and Capital Expenditure Functions

5.1 NHS England retains the Section 7A Functions and will be responsible for taking decisions in relation to the Section 7A Functions.

5.2 In accordance with Schedule 10 Part 2, the ICB will provide certain management and/or administrative services to NHS England in relation to the Section 7A Functions.

5.3 NHS England retains the Capital Expenditure Functions and will be responsible for taking decisions in relation to the Capital Expenditure Functions.

5.4 In accordance with Schedule 10 Part 1, the ICB will provide certain management and/or administrative services to NHS England in relation to the Capital Expenditure Functions.

6. Such other ancillary activities that are necessary in order to exercise the Reserved Functions

6.1 NHS England will continue to comply with its obligations under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

6.2 The ICB must assist NHS England's controlled drug accountable officer ("CDAO") to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

6.3 The ICB must nominate a relevant senior individual within the ICB (the "ICB CD Lead") to liaise with and assist NHS England to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

6.4 The ICB CD Lead must, in relation to the Delegated Functions:

6.4.1 on request provide NHS England's CDAO with all reasonable assistance in any investigation involving the Delegated Functions;

6.4.2 report all complaints involving controlled drugs to NHS England's CDAO;

6.4.3 report all incidents or other concerns involving the safe use and management of controlled drugs to NHS England's CDAO;

6.4.4 analyse the controlled drug prescribing data available; and

6.4.5 on request supply (or ensure organisations from whom the ICB commissions services involving the regular use of controlled drugs supply) periodic self–declaration and/or self-assessments to NHS England's CDAO.

7. Reserved Functions – Primary Medical Services

7.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Medical Services Functions"):

7.1.1 determining the outcomes expected from Primary Medical Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes and the Department of Health and Social Care mandate;

7.1.2 designing and delivering national transformation programmes in support of national priorities;

7.1.3 the negotiation and agreement of matters concerning General Medical Services contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary medical services nationally;

7.1.4 the development of national standard Primary Medical Service contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Medical Services providers;

7.1.5 the provision of commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

7.1.6 the provision of nationally contracted services delivering digital, logistical and support services for Primary Medical Services in England (including but not limited to):

7.1.6.1 Payments;

7.1.6.2 Pensions;

7.1.6.3 Patient Registration;

7.1.6.4 Medical Records;

7.1.6.5 Performer List;

7.1.6.6 Supplies;

7.1.6.7 Call and Recall for Cervical screening (CSAS); and

7.1.6.8 Pharmacy Market Management.

7.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

8. Reserved Functions – Primary Dental Services

8.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Dental Services Functions"):

8.1.1 determining the outcomes expected from Primary Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

8.1.2 the negotiation and agreement of matters concerning Dental Services Contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

8.1.3 the development of national standard Dental Service Contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Dental Services providers;

8.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties; and

8.1.5 the provision of nationally contracted services delivering digital, logistical and support services for Primary Dental Services in England (including but not limited to):

8.1.5.1 Payments;

8.1.5.2 Pensions;

8.1.5.3 Performer List; and

8.1.5.4 Market Management.

8.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

9. Reserved Functions – Primary Ophthalmic Services

9.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Ophthalmic Functions"):

9.1.1 the Primary Ophthalmic Services Contracts policy and associated documentation;

9.1.2 the negotiation and agreement of matters concerning Primary Ophthalmic Services with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of Ophthalmic Services nationally; and

9.1.3 the provision of nationally contracted services delivering digital, logistical and support services for Primary Ophthalmic Services in England (including but not limited to):

9.1.3.1 Payments;

9.1.3.2 Performers List;

9.1.3.3 Market Management/Entry; and

9.1.3.4 Contract management, assurance and post-payment verification.

9.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

10. Reserved Functions – Pharmaceutical Services and Local Pharmaceutical Services

10.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Pharmaceutical Functions"):

10.1.1 publication of Pharmaceutical Lists;

10.1.2 functions of NHS England as a determining authority in relation to pharmaceutical remuneration under Part 12 of the Pharmaceutical Regulations;

10.1.3 functions in respect of lists of performers of pharmaceutical services and assistants, noting that as at the date of this Agreement regulations for the purposes of these functions have not been made[17];

10.1.4 the negotiation and agreement of matters concerning NHS pharmaceutical services with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of Pharmaceutical Services nationally;

10.1.5 the provision of commissioning and contracting policy and guidance to support ICBs to meet their delegated duties; and

10.1.6 administration of the pharmacist pre-registration training grant scheme.

11. Reserved Functions – Primary Dental Services

11.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Dental Services Functions"):

11.1.1 determining the outcomes expected from Primary Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

11.1.2 the negotiation and agreement of matters concerning Dental Services Contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

11.1.3 the development of national standard Dental Service Contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Dental Services providers;

11.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

[17] Part 7, Chapter 4A of the NHS Act (not currently in force)

11.1.5 the provision of nationally contracted services delivering digital, logistical and support services for Primary Dental Services in England (including but not limited to):

11.1.5.1 Payments

11.1.5.2 Pensions

11.1.5.3 Performer List

11.1.5.4 Market Management.

11.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

12. Reserved Functions - Prescribed Dental Services

12.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Prescribed Dental Services Functions"):

12.1.1 determining the outcomes expected from Prescribed Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

12.1.2 in respect of any Prescribed Dental Services contracted pursuant to NHS England's functions under Part 5 of the NHS Act the negotiation and agreement of matters concerning those contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

12.1.3 in respect of any Prescribed Dental Services contracted pursuant to NHS England's functions under Part 5 of the NHS Act, the development of standard contracts and national contract variations and guidance;

12.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

12.1.5 in respect of any Prescribed Dental Services contracted pursuant to NHS England's functions under Part 5 of the NHS Act, the provision of nationally contracted services delivering digital, logistical and support services in England (including but not limited to):

12.1.5.1 Payments

12.1.5.2 Pensions

12.1.5.3 Performer List

12.1.5.4 Market Management.

12.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

SCHEDULE 4

Further Information Governance and Sharing Provisions

1. Introduction

1.1 The purpose of this Schedule 4 *(Further Information Governance and Sharing Provisions* is to set out the scope for the secure and confidential sharing of information between the Parties on a **Need To Know** basis, in order to enable the Parties to exercise their functions in pursuance of this Agreement.

1.2 References in this Schedule 4 *(Further Information Governance and Sharing Provisions)* to the **Need to Know** basis or requirement (as the context requires) should be taken to mean that the Data Controllers' personnel will only have access to Personal Data or Special Category Personal Data if it is lawful for such personnel to have access to such data for the Specified Purpose in paragraph 2.1 and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Special Category Personal Data specified.

1.3 This Schedule and the Data Sharing Agreements entered into under this Schedule are designed to:

1.3.1 provide information about the reasons why Relevant Information may need to be shared and how this will be managed and controlled by the Parties;

1.3.2 describe the purposes for which the Parties have agreed to share Relevant Information;

1.3.3 set out the lawful basis for the sharing of information between the Parties, and the principles that underpin the exchange of Relevant Information;

1.3.4 describe roles and structures to support the exchange of Relevant Information between the Parties;

1.3.5 apply to the sharing of Relevant Information relating to Delegated Functions in respect of

1.3.5.1 Primary Care Providers and Primary Care Provider Personnel; and

1.3.5.2 Dental Services Providers and their personnel;

1.3.5.3 All other providers of Delegated Functions.

1.3.6 apply to the sharing of Relevant Information whatever the medium in which it is held and however it is transmitted;

1.3.7 ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and how this sharing will be managed;

1.3.8 apply to the activities of the Parties' personnel; and

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

2. Purpose

2.1 The Specified Purpose of the data sharing is to facilitate the exercise of the ICB's Delegated Functions and NHS England's Reserved Functions as described in this Agreement.

2.2 ICBs must ensure that they have in place appropriate Data Sharing Agreements to enable data to be received by it from NHS Digital (or the successor to the relevant statutory functions of NHS Digital) and any other third party organisations from which the ICB must obtain data for the purpose of exercising the Delegated Functions. Specific and detailed purposes must be set out the Data sharing Agreement that complies with all relevant Legislation and Guidance.

3. Benefits of information sharing

3.1 The benefits of sharing information are the achievement of the Specified Purpose set out above, with benefits for service users and other stakeholders in terms of the improved delivery of the NHS services to which this Agreement relates.

4. Lawful basis for Sharing

4.1 Each Party shall comply with all relevant Information Law requirements and good practice in relation to the processing of Relevant Information shared further to this Agreement.

4.2 The ICB shall ensure that there is a Data Protection Impact Assessment ("DPIA") that covers all Delegated Functions. The ICB shall identify the lawful basis for sharing Relevant Information for each purpose and data flow, and where appropriate, enter into a Data Sharing Agreement.

5. Relevant Information to be shared

5.1 The Relevant Information to be shared shall be set out in a Data Sharing Agreement.

6. Restrictions on use of the Shared Information

6.1 Each Party shall only process the Relevant Information as is necessary to achieve the Specified Purpose, and, in particular, shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.

6.2 Access to, and processing of, the Relevant Information provided by a Party must be the minimum necessary to achieve the Specified Purpose. Information and Special Category Personal Data will be handled at all times on a restricted basis, in compliance with Information Law requirements, and the parties' personnel should only have access to Personal Data on a justifiable **Need to Know** basis.

6.3 Neither the provisions of this Schedule 4 *(Further Information Governance and Sharing Provisions)* nor any Data Sharing Agreements entered into in accordance with this Schedule should be taken to permit unrestricted access to data held by any Party. It lays the parameters for the safe and secure sharing and processing of information on a justifiable **Need to Know** basis.

6.4 Neither Party shall subcontract any processing of the Relevant Information without the prior written consent of the other Party. Where a Party subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor which imposes the same obligations as are imposed on the Data Controllers under this Agreement.

6.5 Neither Party shall cause or allow Data to be transferred to any territory outside the United Kingdom without the prior written permission of the responsible Data Controller.

6.6 Any particular restrictions on use of certain Relevant Information are included in the Personal Data Agreement annexed to this Schedule.

7. Ensuring fairness to the Data Subject

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

7.1.1 amendment of internal guidance to improve awareness and understanding among personnel;

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

7.1.3 ensuring that information and communications relating to the processing of data is easily accessible and easy to understand, and that clear and plain language be used; and

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

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

7.3 Each Party shall reasonably cooperate with the other in undertaking any Data Protection Impact Assessment associated with the processing of data further to this Agreement, and in doing so engage with their respective Data Protection Officers in the performance by them of their duties pursuant to Article 39 UK GDPR.

7.4 Further provision in relation to specific data flows should be included in Data Protection Agreements.

8. Governance: personnel

8.1 Each Party must take reasonable steps to ensure the suitability, reliability, training and competence, of any personnel who have access to the Personal Data (and Special Category Personal Data) including reasonable background checks and evidence of completeness should be available on request by each Party.

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

8.3 Each Party shall ensure that all personnel required to access the Personal Data (including Special Category Personal Data) are informed of the confidential nature of the Personal Data and each Party shall include appropriate confidentiality clauses in employment/service contracts of all personnel that have any access whatsoever to the Relevant Information, including details of sanctions for acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure provisions of Information Law requirements, or causes damage to or loss of the Relevant Information.

8.4 Each Party shall provide evidence (further to any reasonable request) that all personnel that have any access to the Relevant Information whatsoever are adequately and appropriately trained to comply with their responsibilities under Information Law and this Agreement.

8.5 Each Party shall ensure that:

8.5.1 only those personnel involved in delivery of the Agreement use or have access to the Relevant Information; and

8.5.2 that such access is granted on a strict **Need to Know** basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited. Evidence of audit should be made freely available on request by the originating Data Controller.; and

8.5.3 specific limitations on the personnel who may have access to the Information are set out in the relevant Data Sharing Agreement

9. Governance: Protection of Personal Data

9.1 At all times, the Parties shall have regard to the requirements of Information Law and the rights of Data Subjects.

9.2 Wherever possible (in descending order of preference), only anonymised information, or strongly or weakly pseudonymised information will be shared and processed by Parties, without the need to share easily identifiable Personal Data. The Parties shall cooperate in exploring alternative strategies to avoid the use of Personal Data in order to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data/Special Category Personal Data.

9.3 Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a **Need to Know** basis. If either Party:

9.3.1 becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or

9.3.2 becomes aware of any security vulnerability or breach,

in respect of the Relevant Information it shall promptly (and within 48 hours) notify the other Party. The Parties shall fully cooperate with one another to remedy the issue as soon as reasonably practicable, and in making information about the incident available to the Information Commissioner and Data Subjects where required by Information Law.

9.4 In processing any Relevant Information further to this Agreement, each Party shall:

9.4.1 process the Personal Data (including Special Category Personal Data) only in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only in accordance with written instructions from the originating Data Controller in respect of its Relevant Information;

9.4.2 process the Personal Data (including Special Category Personal Data) only to the extent as is necessary for the provision of the Specified Purpose or as is required by law or any regulatory body;

9.4.3 process the Personal Data (including Special Category Personal Data) only in accordance with Information Law requirements and shall not perform its obligations under this Agreement in such a way as to cause any other Data

Controller to breach any of their applicable obligations under Information Law; and

9.4.4 process the Personal Data in accordance with the requirements of Information Law and in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) UK GDPR.

9.5 Each Party shall act generally in accordance with Information Law requirements, and in particular shall implement, maintain and keep under review appropriate technical and organisational measures to ensure and to be able to demonstrate that the processing of Personal Data is undertaken in accordance with Information Law, and in particular to protect the Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:

9.5.1 Take account of the nature, scope, context and purposes of processing as well as the risks of varying likelihood and severity for the rights and freedoms of Data Subjects; and

9.5.2 Be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data (and Special Category Personal Data) and having regard to the nature of the Personal Data (and Special Category Personal Data) which is to be protected.

9.6 In particular, each Party shall:

9.6.1 ensure that only personnel authorised under this Agreement have access to the Personal Data (and Special Category Personal Data);

9.6.2 ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display or distribution, of the Relevant Information;

9.6.3 obtain prior written consent from the originating Party in order to transfer the Relevant Information to any third party;

9.6.4 permit the other Party or their representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors or assigns) and comply with all reasonable requests or directions to enable each Party to verify and/or procure that the other is in full compliance with its obligations under this Agreement; and

9.6.5 if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.

9.7 Each Party shall adhere to the specific requirements as to information security set out in the Data Sharing Agreements.

9.8 Each Party shall use best endeavours to achieve and adhere to the requirements of the NHS Digital Data Security and Protection Toolkit.

9.9 The Parties' Single Points of Contact set out in paragraph 14 *(Governance: Single Points of Contact)* below will be the persons who, in the first instance, will have oversight of third party security measures.

10. Governance: Transmission of Information between the Parties

10.1 This paragraph supplements paragraph 9 *(Governance: Protection of Personal Data)* of this Schedule.

10.2 Transfer of Personal Data between the Parties shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net / gcsx) email.

10.3 Wherever possible, Personal Data should be transmitted (and held) in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, so as to ensure that the correct patient record/data is identified.

10.4 Any other special measures relating to security of transfer should be included in a Data Sharing Agreement.

10.5 Each Party shall keep an audit log of Relevant Information transmitted and received in the course of this Agreement.

10.6 The Parties' Single Point of Contact notified pursuant to paragraph 14 *(Governance: Single Points of Contact)* will be the persons who, in the first instance, will have oversight of the transmission of information between the Parties.

11. Governance: Quality of Information

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

11.2 Special measures relating to ensuring quality are set out in the Personal Data Agreement annexed to this Schedule.

12. Governance: Retention and Disposal of Shared Information

12.1 The non-originating Party shall securely destroy or return the Relevant Information once the need to use it has passed or, if later, upon the termination of this Agreement, howsoever determined. Where Relevant Information is held electronically the Relevant Information will be deleted and formal notice of the deletion sent to the Party that shared the Relevant Information. Once paper information is no longer required, paper records will be securely destroyed or securely returned to the Party they came from.

12.2 Each Party shall provide an explanation of the processes used to securely destroy or return the information, or verify such destruction or return, if requested by the other Party and shall comply with any request of the Data Controllers to dispose of data in accordance with specified standards or criteria.

12.3 If either Party is required by any law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy under this paragraph 12 *(Governance: Retention and Disposal of Shared Information)*, it shall notify the other Party in writing of that retention, giving details of the documents or materials that it must retain.

12.4 Retention of any data shall comply with the requirements of Article 5(1)(e) GDPR and with all good practice including the Records Management NHS Code of Practice, as updated or amended from time to time.

12.5 Any special retention periods should be set out in the Data Sharing Agreements.

12.6 Each Party shall ensure that Relevant Information held in paper form is held in secure files, and, when it is no-longer needed, destroyed using a cross cut shredder or

subcontracted to a confidential waste company that complies with European Standard EN15713.

12.7 Each Party shall ensure that, when no longer required, electronic storage media used to hold or process Personal Data are destroyed or overwritten to current policy requirements.

12.8 Electronic records will be considered for deletion once the relevant retention period has ended.

12.9 In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Party shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

13. Governance: Complaints and Access to Personal Data

13.1 Each Party shall assist the other in responding to any request made under Information Law made by persons who wish to access copies of information held about them ("**Subject Access Requests**"), as well as any other purported exercise of a Data Subject's rights under Information Law or complaint to or investigation undertaken by the Information Commissioner.

13.2 Complaints about information sharing shall be routed through each Party's own complaints procedure but reported to the Single Points of Contact set out in paragraph 14 *(Governance: Single Points of Contact)* below.

13.3 The Parties shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Agreement or any data processing carried out further to it.

13.4 Basic details of the Agreement shall be included in the appropriate log under each Party's Publication Scheme.

14. Governance: Single Points of Contact

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

15. Monitoring and review

1. The Parties shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Information Law and best practice. Specific monitoring requirements must be set out in the relevant Data Sharing Agreement.

SCHEDULE 5

Financial Provisions and Decision Making Limits

Part 1 - Financial Limits and Approvals for Primary Care

1. The ICB shall ensure that any decisions in respect of the Delegated Functions and which exceed the financial limits set out below are only taken:

    1.1 by the following persons and/or individuals set out in column 2 of Table 1 below; and

    1.2 following the approval of NHS England (if any) as set out in column 3 of the Table 1 below.

2. NHS England may, from time to time, update Table 1 by sending a notice to the ICB of amendments to Table 1.

Table 1 – Financial Limits		
Decision	**Person/Individual**	**NHS England Approval**
General		
Taking any step or action in relation to the settlement of a Claim, where the value of the settlement exceeds £100,000	ICB Chief Executive Officer or Chief Finance Officer or Chair	NHS England Head of Legal Services and Local NHS England Team Director or Director of Finance
Any matter in relation to the Delegated Functions which is novel, contentious or repercussive	ICB Chief Executive Officer or Chief Finance Officer or Chair	Local NHS England Team Director or Director of Finance or NHS England Region Director or Director of Finance or NHS England Chief Executive or Chief Financial Officer
Revenue Contracts		
The entering into of any Primary Care Contract or Arrangement which has or is capable of having a term which exceeds five (5) years	ICB Chief Executive Officer or Chief Finance Officer or Chair	Local NHS England Team Director or Director of Finance
Capital Note: As at the date of this Agreement, the ICB will not have delegated or directed responsibility for decisions in relation to Capital expenditure (and these decisions are retained by NHS England) but the ICB may be required to carry out certain administrative services in relation to Capital expenditure under paragraph 13 *(Financial Provisions and Liability)*.		

SCHEDULE 6

Mandated Assistance and Support

1. Primary Dental Services

1.1 NHS Business Services Authority has existing agreements with NHS England to support its delivery of the following services:

1.1.1 Contract management – end-to-end administration of contract variations and other regional team/ICB support activities;

1.1.2 Performance management - provide mid and end of year administration process to support regional teams and ICBs and undertake risk based assurance reviews - PPV can also be instigated by the ICS or Counter Fraud;

1.1.3 Clinical assurance reviews – provide clinical assurance of quality of dental services delivered, working in collaboration with regional teams/ICBs to identify and seek to address any concerns;

1.1.4 Provide data reports to teams defining quantity and service delivery at a contractor level.

2. Primary Ophthalmic Services

2.1 NHS Business Services Authority have existing agreements with NHS England to support its delivery of the following services:

2.1.1 Contract management. End-to-end administration of new contract applications, contract variations and contract terminations.

2.1.2 Contract assurance. Administration of the annual contractor assurance declaration and additional in-depth assurance declaration where appropriate. Provision of assurance reports at ICS and contractor level, supporting further assurance decisions.

2.1.3 GOS complaints. Administration of the annual GOS complaints survey.

2.1.4 Post-Payment Verification (PPV). End-to-end process for identifying and verifying GOS claims as part of the national PPV framework. This includes obtaining and reviewing claims and carrying out a financial recovery where appropriate. PPV can also be instigated by the ICS or Counter Fraud.

2.1.5 GOS 4 pre-authorisation of repair or replacement glasses.

3. Pharmaceutical Services and Local Pharmaceutical Services

3.1 NHS Business Services Authority has existing agreements with NHS England to support ICBs to discharge their assurance responsibilities by the delivery of the following services to ICBs:

3.1.1 Performance management – direct support to commissioners and community pharmacy contractors to implement corrective and preventative intervention;

3.1.2 Contract assurance – administration of the annual contractor assurance declaration and additional in-depth assurance declaration where

appropriate, provision of assurance reports at ICS and contractor level supporting further assurance decisions by the ICB;

3.1.3 Post-Payment Verification (PPV) – end-to-end process for identifying and verifying claims as part of the national PPV framework to support ICBs to play their part in ensuring compliance with contractual requirements and delivery of quality and value for money. This includes obtaining and reviewing claims, investigation of outliers and other potential inappropriate claims, along with referrals and investigatory reports to the ICB to consider and decide overpayment recoveries, and carrying out the financial recovery where appropriate. PPV can also be instigated by the ICS or Counter Fraud.

4. Support Services directed by DHSC

4.1 NHS Business Services Authority is directed by DHSC to undertake specific activities as well as having existing agreements with NHS England to support its delivery of primary care services. These include (without limitation):

4.1.1 The administration of national payment platforms for primary care services to dentists, pharmacy contractors, appliance contractors, oxygen contractors and special school eye care providers;

4.1.2 The calculation of payment for covid-19 and flu vaccinations to PCNs and GP practices as well as payments to Dispensing Doctors and prescribing only doctors for personal administration claims and sharing this information accurately and in a timely manner;

4.1.3 Clinical advisory support;

4.1.4 Administration functions;

4.1.5 Assurance services - performance and contract management of primary care providers;

4.1.6 The provision of information to primary care organisations for all contractor groups via standardised reporting (eg. ePACT2, eDEN and eOPS);

4.1.7 Working with NHS England and ICB Counter Fraud Teams to reduce loss across the system.

SCHEDULE 7

Local Terms

Primary Care staffing (incl. Finance)	The employment of the Primary Medical Care, Dental and Finance staff delivering contracting and commissioning functions will be transferred to Mid and South Essex ICB with effect from 1st April 2023. The employment of the Pharmacy and Optometry team will transfer to Hertfordshire and West Essex ICB only, to support the hosting arrangement agreed between the six East of England ICBs.
Professional Networks (Dental, Eye, Pharmaceutical)	The professional networks will be retained by NHSE for a transitional year 2023/24, reporting to the Medical Directorate and direct links into the ICBs. During 2023/24 there will be a review of the structure and reporting lines of the professional networks.
Complaints	On 1st April 2023, the Complaints Team will align to ICBs to support the delegated responsibility for Primary Care complaints. Employment of the team is planned to transfer to ICBs on 1st July 2023.

SCHEDULE 8

Deployment of NHS England Staff to the ICB

Note: This schedule relates to the Deployment of Staff who are employed by NHS England only.

Deployment of NHS England Staff

1. NHS England may deploy Staff to the ICB for the purposes of carrying out the Delegated Functions.

2. The Parties have agreed that arrangements for the provision of NHS England Staff and the associated employment model envisaged by section 5.9 of the HR Framework **https://www.england.nhs.uk/wp-content/uploads/2021/06/B1427-Human-resources-framework-for-developing-integrated-care-boards-version-2-March-2022.pdf**) will be determined by the National Moderation Panel convened for this purpose and endorsed by NHS England's Executive Group.

3. The Parties agree and acknowledge that the Staffing Models will be developed in conjunction with the ICB and are subject to the decision of the National Moderation Panel and cannot be varied without the express agreement of NHS England.

4. A proposal for a variation to any Staffing Model must be made by means of a formal submission to the National Moderation Panel which will determine the proposal, following which the proposal if approved, will be endorsed by NHS England's Executive Group.

5. Subject to any variation made in accordance with paragraphs 3 and 4 above, a Staffing Model determined in accordance with paragraph 2 will apply for the duration of this Agreement.

Availability of NHS England Staff

6. In addition to any Staff deployed in any communicated Staffing Model arrangement, NHS England may deploy additional Staff to the ICB to perform administrative and management support services together with such other services specified in SCHEDULE 7 (Local Terms) (the "Services") so as to facilitate the ICB in undertaking the Delegated Functions pursuant to the terms of this Agreement.

7. NHS England will take all reasonable steps to ensure that the NHS England Staff deployed for the purposes of carrying out the Delegated Functions shall:

    a. faithfully and diligently perform duties and exercise such powers as may from time to time be reasonably assigned to or vested in them; and

    b. perform all duties assigned to them pursuant to this Schedule 8.

8. The ICB shall notify NHS England if the ICB becomes aware of any act or omission by any NHS England Staff which may have a material adverse impact on the provision of the Services or constitute a material breach of the terms and conditions of employment of the NHS England Staff.

9. NHS England shall use all reasonable efforts to make its Staff available for the purposes of this Schedule 8 whilst the NHS England Staff are absent:

    a. by reason of industrial action;

    b. as a result of the suspension or exclusion of employment or secondment of any Staff by NHS England;

c. in accordance with the NHS England Staff's respective terms and conditions of employment and policies, including, but not limited to, by reason of training, holidays, sickness, injury, trade union duties, paternity leave or maternity or where absence is permitted or required by Law;

d. if making the NHS England Staff available would breach or contravene any Law;

e. as a result of the cessation of employment of any individual NHS England Staff; and/or

f. at such other times as may be agreed between NHS England and the ICB.

Employment of the NHS England Deployed Staff

10. NHS England shall employ their Staff and shall be responsible for the employment of their Staff at all times on whatever terms and conditions as NHS England and their Staff may agree from time to time.

11. NHS England shall pay their Staff their salaries and benefits and make any deductions for income tax liability and national insurance or similar contributions it is required to make from the Staff's salaries and other payments.

12. NHS England shall not, and shall procure that the NHS England Staff shall not, hold themselves out as employees of the ICB.

Management of NHS England staff

13. NHS England where appropriate, shall in consultation with the ICB, make arrangements to ensure the day-to-day control of the activities of their Staff is shared with the ICB and deal with any relevant management issues concerning their Staff including, without limitation, performance appraisal, discipline and leave requests.

14. The ICB agrees to provide all such assistance and co-operation that NHS England may reasonably request from time to time to resolve grievances raised by NHS England Staff and to deal with any disciplinary allegations made against NHS England Staff arising out of or in connection with the provision of the Services which shall include, without limitation, supplying NHS England with all information and the provision of access to all documentation and NHS England Staff as NHS England requires for the purposes of considering and dealing with such issues and participating promptly in any action which may be necessary.

Conduct of Claims

15. If the ICB becomes aware of any matter that may give rise to a claim by or against a member of NHS England Staff, notice of that fact shall be given as soon as possible to NHS England. NHS England and the ICB shall co-operate in relation to the investigation and resolution of any such claims or potential claims.

16. No admission of liability shall be made by or on behalf of the ICB and any such claim shall not be compromised, disposed of or settled without the consent of NHS England.

Confidential Information and Property

17. For the avoidance of doubt, this paragraph 17 (Confidential Information and Property) is without prejudice to any other provision of this Agreement in relation to confidential information.

18. It is acknowledged that to enable the NHS England Staff to provide the Services, the Parties may share Confidential Information.

19. The Parties agree to adopt all such procedures as the other party may reasonably require and to keep confidential all Confidential Information.

Intellectual Property

20. All IPR made, written, designed, discovered or originated by Staff (People Resources) deployed by NHS England, shall be the property of NHS England to the fullest extent permitted by Law and NHS England shall be the absolute beneficial owner of the copyright in any such IPR.

SCHEDULE 9

Mandated Guidance

Primary Medical Care

- Primary Medical Care Policy and Guidance Manual.
- The 'Principles of Best Practice' and any other guidance relating to *the Premises Cost Directions 2013.*
- Guidance relating to the Minimum Practice Income Guarantee.
- Guidance relating to Primary Medical Care discretionary payments.
- Guidance for Commissioners: Interpreting and Translation Services in Primary Care.
- Framework for Patient and Public Participation in Primary Care Commissioning.
- NHS England National Primary Care Occupational Health Service Specification.
- Guidance relating to list cleansing in relation to Primary Medical Care providers.
- Guidance relating to mergers and closures of GP practices and/or Primary Medical Care providers.
- Guidance relating to Primary Medical Care and POD contract reviews.
- Guidance relating to the escalation of complaints from a named 'performer'.
    - Including: *Framework for Managing Performer Concerns.*

Pharmaceutical Services and Local Pharmaceutical Services

- Pharmacy Manual.
- NHS England National Primary Care Occupational Health Service Specification.
- The NHS Pharmacy Regulations Guidance 2020[1].
- Guidance for ICSs and STPs on transformation and improvement opportunities to benefit patients through integrated pharmacy and medicines optimisation.

Primary Ophthalmic Services

- Policy Book for Eye Health.
- NHS England National Primary Care Occupational Health Service Specification.

Primary and Prescribed Dental Services

- Policy Book for Primary Dental Services.
- Securing Excellence in Commissioning NHS Dental Services.
- Securing Excellence in Commissioning NHS Dental Services: Key facts.
- Securing Excellence in Commissioning NHS Dental Services: FAQs.
- Quick Guide: Best use of unscheduled dental care services.
- How to update NHS Choices for Dental Practices.
- Flowchart for managing patients with a dental problem/pain.
- Guidance on NHS 111 Directory of Services for dental providers.
- Definitions – Unscheduled Dental Care.
- Introductory Guide for Commissioning Dental Specialties.
- Guide for Commissioning Dental Specialties: Orthodontics.
- Guide for Commissioning Dental Specialties: Oral Surgery and Oral Medicine.
- Guide for Commissioning Dental Specialties: Special Care Dentistry.
- Guide for Commissioning Service Standards: Conscious Sedation in a Primary Care Setting.
- Commissioning Standard for Dental Specialties: Paediatric Dentistry.
- Commissioning Standard for Urgent Dental Care.
- Commissioning Standard for Restorative Dentistry.

[1] https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-manual/nhs-pharmacy-regulations-guidance-2020/

- Commissioning Standard for Dental Care for People with Diabetes.
- Accreditation of Performers and Providers of Level 2 Complexity Care.
- NHS England National Primary Care Occupational Health Service Specification.
- Dental Access Controls.

Finance

- Guidance on NHS System Capital Envelopes.
- Finance and Payments Guidance for Community Pharmacy, Dental and Primary Care Ophthalmology Services Delegated to ICBs from 2022.
- Managing Public Money (HM Treasury).
- Guidance relating to Personal Service Medical Reviews.
    - Including: *Implementing Personal Medical Services Reviews.*
- Dental Commissioning and Financial Management Guidance.

Workforce

- Guidance on the Employment Commitment.

Other Guidance

- National Guidance on System Quality Groups.
- Managing Conflicts of Interest in the NHS.
- Arrangements for Delegation and Joint Exercise of Statutory Functions.
- Guidance relating to procurement and provider selection.
- IG Guidance relating to serious incidents.
- All other applicable IG and Data Protection Guidance.
- Any applicable Freedom of Information protocols.
- Any applicable guidance on Counter Fraud, including from The NHS Counter Fraud Authority.
- Any applicable guidance relating to the use of data and data sets for reporting.
- Any applicable guidance relating to the commissioning and management of clinical waste in primary care e.g.
    - Including: Management and disposal of healthcare waste.

SCHEDULE 10

Administrative and Management Services

1. The ICB shall provide the following administrative and management services to NHS England:

   1.1 the administrative and management services in relation to the Capital Expenditure Functions and the Capital Expenditure Funds as more particularly set out in this Part 1 of this Schedule 10 (*Administrative and Management Services*); and

   1.2 the administrative and management services in relation to the Section 7A Functions and Section 7A Funds as more particularly set out in Part 2 of this Schedule 10.

   1.3 the administrative and management services in relation to other Reserved Functions as more particularly set out in Part 3 of this Schedule 10 (*Administrative and Management Services*).

Part 1: Administrative and/or Management Services and Funds in relation to the Capital Expenditure Functions

1. The Parties acknowledge that the Capital Expenditure Functions are a Reserved Function.

2. The Parties further acknowledge that:

   2.1 accordingly, the Delegated Funds do not include any funds in respect of amounts payable in relation to the Capital Expenditure Functions (**"Capital Expenditure Funds"**); and

   2.2 NHS England remains responsible and accountable for the discharge of the Capital Expenditure Functions and nothing in Part 1 of this Schedule 10 (*Administrative and Management Services*) shall be construed as a divestment or delegation of NHS England's Capital Expenditure Functions.

3. Without prejudice to paragraph 3 above, the ICB will comply with any Mandated Guidance issued in relation to the Capital Expenditure Functions and shall (on request from NHS England) provide the following administrative services to NHS England in respect of the Capital Expenditure Funds:

   3.1 the administration and payment of sums that NHS England has approved as payable in relation to the Capital Expenditure Functions;

   3.2 if requested by NHS England and taking into account (i) any other support or services provided to NHS England by NHS Property Services Limited or otherwise and (ii) any Mandated Guidance issued in respect of the Capital Expenditure Functions, the provision of advice and/or recommendations to NHS England in respect of expenditure to be made under the Capital Expenditure Functions; and

   3.3 such other support or administrative assistance to NHS England that NHS England may reasonably request in order to facilitate the discharge by NHS England of its responsibilities under or in respect of the Capital Expenditure Functions.

4. NHS England may, at the same time as it allocates the Delegated Funds to the ICB under Clause 9.11, transfer to the ICB such amounts as are necessary to enable the discharge of the ICB's obligations under this Part 1 of Schedule 10 (*Administrative and Management Services*) in respect of the Capital Expenditure Functions.

Part 2 - Administrative and/or Management Services and Funds in relation to Section 7A Functions

1. The Parties acknowledge that the Section 7A Functions are part of the Reserved Functions.

2. The Parties further acknowledge that:

   2.1 accordingly, the Delegated Funds do not include any funds in respect of amounts payable in relation to the Section 7A Functions (whether such arrangements are included in or under Primary Care Contracts or Arrangements or not) (**"Section 7A Funds"**); and

   2.2 NHS England remains responsible and accountable for the discharge of the Section 7A Functions and nothing in this Schedule 10 Part 2 shall be construed as a divestment or delegation of the Section 7A Functions.

3. The ICB will provide the following services to NHS England in respect of the Section 7A Funds:

4. the administration and payment of sums that NHS England has approved as payable under or in respect of arrangements for the Section 7A Functions; and

5. such other support or administrative assistance to NHS England that NHS England may reasonably request in order to facilitate the discharge by NHS England of its responsibilities under or in respect of the Section 7A Funds.

6. NHS England shall, at the same time as it allocates the Delegated Funds to the ICB under Clause 9.11, allocate to the ICB such amounts as are necessary to enable the discharge of the ICB's obligations under this Schedule 10 Part 2 in respect of the Section 7A Funds.

Part 3: Administrative and/or Management Services and Funds in relation to other Reserved Functions

1. NHS England may ask the ICB to provide certain management and/or administrative services to NHS England (from a date to be notified by NHS England to the ICB) in relation to the carrying out of any of the Reserved Functions.

2. If NHS England makes such a request to the ICB, then the ICB will, but only if the ICB agrees to provide such services, from the date requested by NHS England, comply with:

3. provisions equivalent to those set out above in relation to the Capital Expenditure Functions (Part 1 of this Schedule 10) and the Section 7A Functions (Part 2 of this Schedule 10) including in relation to the administration of any funds for such functions but only to the extent that such provisions are relevant to the management or administrative services to be provided; and

4. such other provisions in respect of the carrying out of such management and administrative services as agreed between NHS England and the ICB.

Dated 2024

(1) **NHS ENGLAND**

- and -

(2) **NHS MID AND SOUTH ESSEX INTEGRATED CARE BOARD**

Delegation Agreement between NHS England and Mid and South Essex ICB in relation to Specialised Commissioning Functions

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DELEGATION AGREEMENT FOR SPECIFIED FUNCTIONS

1. **PARTICULARS**

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

Integrated Care Board	NHS MID AND SOUTH ESSEX ICB
Area	All of the Borough of Bedford, District of Central Bedfordshire, Borough of Luton and the Borough of Milton Keynes. The following Lower Layer Super Output Areas of the County of Buckinghamshire: E01017695, E01017696, E01017669, E01017670."
Date of Agreement	[Date]
ICB Representative	Dr Matthew Sweeting Executive Medical Director
ICB Email Address for Notices	matthew.sweeting@nhs.net emilyj.hughes@nhs.net
NHS England Representative	Ruth Derrett, Regional Director of Specialised Commissioning
NHS England Email Address for Notices	ruth.derrett@nhs.net alex.ridgeon@nhs.net

1.2 This Agreement comprises:

1.2.1 the Particulars (Clause 1),

1.2.2 the Terms and Conditions (Clauses 2 to 32),

1.2.3 the Schedules, and

1.2.4 the Mandated Guidance

Signed by **NHS England**

Clare Panniker

Regional Director - NHS England – East of England

(for and on behalf of NHS England)

Signed by **NHS Mid and South Essex Integrated Care Board**

Tracy Dowling

Chief Executive Officer

for and on behalf of NHS Mid and South Essex Integrated Care Board

TERMS AND CONDITIONS

2. INTERPRETATION

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

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

2.2.1 the Developmental Arrangements,

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

2.2.3 Mandated Guidance,

2.2.4 all Schedules excluding Developmental Arrangements and Local Terms, and

2.2.5 Local Terms.

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

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

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

3. BACKGROUND

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

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

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

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

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

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

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

4. TERM

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

5. PRINCIPLES

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

5.1.1 at all times have regard to the Triple Aim,

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

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

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

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

5.1.6 act in a timely manner,

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

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

6. DELEGATION

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

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

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

6.4 Decisions of the ICB in respect of the Delegated Functions and made in accordance with the terms of this Agreement shall be binding on NHS England and the ICB.

6.5 Unless expressly provided for in this Agreement, the ICB is not authorised by this Agreement to take any step or make any decision in respect of Reserved Functions. Any such purported decision of the ICB is invalid and not binding on NHS England

unless ratified in writing by NHS England in accordance with the NHS England Scheme of Delegation and Standing Financial Instructions.

6.6 NHS England may, acting reasonably and solely to the extent that the decision relates to the Delegated Functions, substitute its own decision for any decision which the ICB purports to make where NHS England reasonably considers that the impact of the ICB decision could, in relation to the Delegated Functions, cause the ICB to be acting unlawfully, in breach of this Agreement including Mandated Guidance, or in breach of any Contract. The ICB must provide any information, assistance and support as NHS England requires to enable it to determine whether to make any such decision.

6.7 The terms of Clauses 6.5 and 6.6 are without prejudice to the ability of NHS England to enforce the terms of this Agreement or otherwise take action in respect of any failure by the ICB to comply with this Agreement.

7. EXERCISE OF DELEGATED FUNCTIONS

7.1 The ICB must establish effective, safe, efficient and economic arrangements for the discharge of the Delegated Functions.

7.2 The ICB agrees that it will exercise the Delegated Functions in accordance with:

7.2.1 the terms of this Agreement,

7.2.2 Mandated Guidance,

7.2.3 any Contractual Notices,

7.2.4 the Local Terms,

7.2.5 any Developmental Arrangements,

7.2.6 all applicable Law and Guidance,

7.2.7 the ICB's constitution,

7.2.8 the requirements of any assurance arrangements made by NHS England, and

7.2.9 Good Practice.

7.3 The ICB must perform the Delegated Functions in such a manner:

7.3.1 so as to ensure NHS England's compliance with NHS England's statutory duties in respect of the Reserved Functions and to enable NHS England to fulfil its Reserved Functions, and

7.3.2 having regard to NHS England's accountability to the Secretary of State and Parliament in respect of both the Delegated Functions and Reserved Functions, and

7.3.3 so as to ensure that the ICB complies with its statutory duties and requirements including those duties set out in Section 14Z32 to Section 14Z44 and the NICE Regulations.

7.4 In exercising the Delegated Functions, the ICB must comply with all Mandated Guidance as set out in this Agreement or as otherwise may be issued by NHS England from time to time including, but not limited to, ensuring compliance with National Standards and following National Specifications.

7.5 Where Developmental Arrangements conflict with any other term of this Agreement, the Developmental Arrangements shall take precedence until such time as NHS England agrees to the removal or amendment of the relevant Developmental Arrangements in accordance with Clause 26 (Variations).

7.6 The ICB must develop an operational scheme(s) of delegation defining those individuals or groups of individuals, including committees, who may discharge aspects of the Delegated Functions. For the purposes of this clause, the ICB may include the operational scheme(s) of delegation within its general organisational scheme of delegation.

7.7 NHS England may by Contractual Notice allocate Contracts to the ICB such that they are included as part of the Delegation. The Delegated Functions must be exercised both in respect of the relevant Contract and any related matters concerning any Specialised Service Provider that is a party to a Contract. NHS England may add or remove Contracts where this is associated with an extension or reduction of the scope of the Delegated Functions.

7.8 Subsequent to the Effective Date of Delegation and for the duration of this Agreement, unless otherwise agreed any new Contract entered into in respect of the Delegated Functions shall be managed by the ICB in accordance with the provisions of this Agreement.

7.9 Subject to the provisions of this Agreement, the ICB may determine the arrangements for the exercise of the Delegated Functions.

8. REQUIREMENT FOR ICB COLLABORATION ARRANGEMENT

8.1 Subject to the provisions of Clause 12 (Further Arrangements), the ICB must establish appropriate ICB Collaboration Arrangements with other ICBs in order to ensure that the commissioning of the Delegated Services can take place across an appropriate geographical footprint for the nature of each particular Delegated Service with consideration of population size, provider landscape and patient flow. Such ICB arrangements in respect of the Delegated Functions must be approved in advance by NHS England.

8.2 The ICB must establish, as part of or separate to the arrangements set out in Clause 8.1, an agreement that sets out the arrangements in respect of the Commissioning Team as required by Clause 13.

8.3 The ICB must participate in discussions, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view with the other ICBs within the ICB Collaboration Arrangement. The members of the ICB Collaboration Arrangement shall have a collective responsibility for the operation of the ICB Collaboration Arrangement.

8.4 The ICB shall ensure that any ICB Collaboration Arrangement is documented and such documentation must include (but is not limited to) the following:

8.4.1 membership which is limited solely to ICBs unless otherwise approved by NHS England,

8.4.2 clear governance arrangements including reporting lines to the ICBs' Boards,

8.4.3 provisions for independent scrutiny of decision making,

8.4.4 the Delegated Functions or elements thereof which are the subject of the arrangements,

8.4.5 the Delegated Services which are subject to the arrangements,

8.4.6 financial arrangements and any pooled fund arrangements,

8.4.7 data sharing arrangements including evidence of a Data Protection Impact Assessment,

8.4.8 terms of reference for decision making, and

8.4.9 limits on onward delegation.

8.5 The ICB must not terminate an ICB Collaboration Arrangement in respect of the Delegated Functions without the prior written approval of NHS England.

9. PERFORMANCE OF THE RESERVED FUNCTIONS AND COMMISSIONING SUPPORT ARRANGEMENTS

9.1 NHS England will remain responsible for the performance of the Reserved Functions.

9.2 For the avoidance of doubt, the Parties acknowledge that the Delegation may be amended, and additional functions may be delegated to the ICB, in which event consequential changes to this Agreement shall be agreed with the ICB pursuant to Clause 26 (Variations) of this Agreement.

9.3 Where it considers appropriate NHS England will work collaboratively with the ICB when exercising the Reserved Functions.

9.4 If there is any conflict or inconsistency between functions that are named as Delegated Functions and functions that are named as Reserved Functions, then such functions shall be interpreted as Reserved Functions unless and until NHS England confirms otherwise. If an ICB identifies such a conflict or inconsistency, it will inform NHS England as soon as is reasonably practicable.

9.5 The Parties acknowledge that they may agree for the ICB to provide Administrative and Management Services to NHS England in relation to certain Reserved Functions and Retained Services in order to assist in the efficient and effective exercise of such functions. Any such Commissioning Team Arrangements shall be set out in writing.

9.6 Notwithstanding any arrangement for or provision of Administrative and Management Services in respect of the Retained Services and Reserved Functions, NHS England shall retain statutory responsibility for, and be accountable for, the commissioning of the Retained Services.

9.7 The Parties acknowledge that they may agree for NHS England to provide Administrative and Management Services to ICBs in relation to certain Delegated Functions and Delegated Services in order to assist in the efficient and effective exercise of such Delegated Functions. Any such Administrative and Management Services shall be set out in writing.

9.8 Notwithstanding any arrangement for or provision of Administrative and Management Services in respect of the Delegated Services, the ICB shall retain delegated responsibility for the commissioning of the Delegated Services.

10. FINANCE

10.1 Without prejudice to any other provision in this Agreement, the ICB must comply with the Finance Guidance and any such financial processes as required by NHS England for the management, reporting and accounting of funds used for the purposes of the Delegated Functions.

10.2 The ICB acknowledges that it will receive funds from NHS England in respect of the Delegated Functions (the "Delegated Funds") and that these are in addition to the funds allocated to it within its Annual Allocation.

10.3 Subject to Clause 10.4 and any provisions in the Schedules or Mandated Guidance, the ICB may use:

10.3.1 its Annual Allocation and the Delegated Funds in the exercise of the Delegated Functions, and

10.3.2 the Delegated Funds and its Annual Allocation in the exercise of the ICB's Functions other than the Delegated Functions.

10.4 The ICB's expenditure on the Delegated Functions must be sufficient to:

10.4.1 ensure that NHS England is able to fulfil its functions, including without limitation the Reserved Functions, effectively and efficiently,

10.4.2 meet all liabilities arising under or in connection with all Contracts in so far as they relate to the exercise of the Delegated Functions,

10.4.3 appropriately commission the Delegated Services in accordance with Mandatory Guidance, National Specifications, National Standards and Guidance, and

10.4.4 meet national commitments from time to time on expenditure on specific Delegated Functions.

10.5 NHS England may increase or reduce the Delegated Funds in any Financial Year, by sending a notice to the ICB of such increase or decrease:

10.5.1 in order to take into account any monthly adjustments or corrections to the Delegated Funds that NHS England considers appropriate, including without limitation, adjustments following any changes to the Delegated Functions, changes in allocations, changes in Contracts, to implement Mandated Guidance or otherwise,

10.5.2 in order to comply with a change in the amount allocated to NHS England by the Secretary of State pursuant to section 223B of the NHS Act,

10.5.3 to take into account any Losses of NHS England for which the ICB is required to indemnify NHS England under Clause 17 (Claims and Litigation),

10.5.4 to take into account any adjustments that NHS England considers appropriate (including without limitation in order to make corrections or otherwise to reflect notional budgets) to reflect funds transferred (or that should have been transferred) to the ICB in respect of the Delegated Functions or funds transferred (or that should have been transferred) to the ICB in respect of Administrative and Management Services, and

10.5.5 in order to ensure compliance by NHS England with its obligations under the NHS Act (including, Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State in respect of NHS England under the NHS Act.

10.6 NHS England acknowledges that the intention of Clause 10.5 is to reflect genuine corrections and adjustments to the Delegated Funds and may not be used to change the allocation of the Delegated Funds unless there are significant or exceptional circumstances that would require such corrections or adjustments.

10.7 The ICB acknowledges that it must comply with its statutory financial duties, including those under Part 11 of the NHS Act to the extent that these sections apply in relation to the receipt of the Delegated Funds.

10.8 NHS England may in respect of the Delegated Funds:

10.8.1 notify the ICB regarding the required payment of sums by the ICB to NHS England in respect of charges referable to the valuation or disposal of assets and such conditions as to records, certificates or otherwise,

10.8.2 by notice, require the ICB to take such action or step in respect of the Delegated Funds, in order to ensure compliance by NHS England of its duties or functions under the NHS (including Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State under the NHS Act.

10.9 The Schedules to this Agreement may identify further financial provisions in respect of the exercise of the Delegated Functions.

10.10 NHS England may issue Mandated Guidance in respect of the financial arrangements in respect of the Delegated Functions.

10.11 NHS England will pay the Delegated Funds to the ICB using the revenue transfer process as used for the Annual Allocation or such other process as notified to the ICB from time to time.

10.12 Without prejudice to any other obligation upon the ICB, for the purposes of the Delegated Functions the ICB agrees that it must use its resources in accordance with:

10.12.1 the terms and conditions of this Agreement including any Mandated Guidance issued by NHS England from time to time in relation to the use of resources for the purposes of the Delegated Functions (including in relation to the form or contents of any accounts),

10.12.2 any NHS payment scheme published by NHS England,

10.12.3 the business rules as set out in NHS England's planning guidance or such other documents issued by NHS England from time to time,

10.12.4 any Capital Investment Guidance,

10.12.5 the HM Treasury Guidance *Managing Public Money* (dated September 2022) as replaced or updated from time to time, and

10.12.6 any other Guidance published by NHS England with respect to the financial management of Delegated Functions.

10.13 Without prejudice to any other obligation upon the ICB, the ICB agrees that it must provide:

10.13.1 all information, assistance and support to NHS England in relation to the audit and/or investigation (whether internal or external and whether under Law or otherwise) in relation to the use of or payment of resources for the purposes of the Delegated Functions and the discharge of those functions,

10.13.2 such reports in relation to the expenditure on the Delegated Functions as set out in Mandated Guidance, the Schedules to this Agreement or as otherwise required by NHS England.

Pooled Funds

10.14 Subject to the provisions of this Agreement, the ICB may, for the purposes of exercising the Delegated Functions under this Agreement, establish and maintain a pooled fund(s) in respect of any part of the Delegated Funds with:

10.14.1 NHS England in accordance with sections 13V or 65Z6 of the NHS Act,

10.14.2 one or more ICBs in accordance with section 65Z6 of the NHS Act as part of a Further Arrangement, or

10.14.3 NHS England and one or more ICBs in accordance with section 13V of the NHS Act, and

10.15 NHS England and one or more ICBs in accordance with section 65Z6 of the NHS Act. Where the ICB has decided to enter into arrangements under Clause 10.14 the agreement must be in writing and must specify:

10.15.1 the agreed aims and outcomes of the arrangements,

10.15.2 the payments to be made by each partner and how those payments may be varied,

10.15.3 the specific Delegated Functions which are the subject of the arrangements,

10.15.4 the Delegated Services which are subject to the arrangements,

10.15.5 the duration of the arrangements and provision for the review or variation or termination of the arrangements,

10.15.6 the arrangements in place for governance of the pooled fund, and

10.15.7 the arrangements in place for assuring, oversight and monitoring of the ICB's exercise of the functions referred to in 10.15.3.

10.16 At the date of this Agreement, details of the pooled funds (including any terms as to the governance and payments out of such pooled fund) of NHS England and the ICB are set out in the Local Terms.

11. INFORMATION, PLANNING AND REPORTING

11.1 The ICB must provide to NHS England:

11.1.1 such information or explanations in relation to the exercise of the Delegated Functions, as required by NHS England from time to time, and

11.1.2 all such information (and in such form), that may be relevant to NHS England in relation to the exercise by NHS England of its other duties or functions including, without limitation, the Reserved Functions.

11.2 The provisions of this Clause 11 are without prejudice to the ability of NHS England to exercise its other powers and duties in obtaining information from and assessing the performance of the ICB.

Forward Plan and Annual Report

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

11.4 The ICB must report on its exercise of the Delegated Functions in its annual report prepared in accordance with section 14Z58 of the NHS Act.

Risk Register

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

12. FURTHER ARRANGEMENTS

12.1 In addition to any ICB Collaboration Arrangement agreed in accordance with Clause 8 (ICB Collaboration Arrangements) the ICB must give due consideration to whether any of the Delegated Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act ("Further Arrangements").

12.2 The ICB may only make Further Arrangements with another person (a "Sub-Delegate") with the prior written approval of NHS England.

12.3 The approval of any Further Arrangements may:

12.3.1 include approval of the terms of the proposed Further Arrangements, and

12.3.2 require conditions to be met by the ICB and the Sub-Delegate in respect of that arrangement.

12.4 All Further Arrangements must be made in writing.

The ICB must not terminate Further Arrangements without the prior written approval of NHS England.

12.5 If the ICB enters into a Further Arrangement it must ensure that the Sub-Delegate does not make onward arrangements for the exercise of any or all of the Delegated Functions without the prior written approval of NHS England.

12.6 The terms of this Clause 12 do not prevent the ICB from making arrangements for assistance and support in the exercise of the Delegated Functions with any person, where such arrangements reserve the consideration and making of any decision in respect of a Delegated Function to the ICB.

12.7 Where Further Arrangements are made, and unless NHS England has otherwise given specific prior written agreement, any obligations or duties on the part of the ICB under this Agreement that are relevant to those Further Arrangements shall also require the ICB to ensure that all Sub-Delegates comply with such obligations or duties and support the ICB in doing so.

13. STAFFING, WORKFORCE AND COMMISSIONING TEAMS

13.1 Where there is an arrangement for NHS England to provide Administrative and Management Services to the ICB, the ICB shall provide full co-operation with NHS England and enter into any necessary arrangements with NHS England and, where appropriate, other ICBs in respect of the Specialised Services Staff.

13.2 The ICB shall, if and where required by NHS England, enter into appropriate arrangements with NHS England in respect of the transfer of Specialised Services Staff.

13.3 The ICB shall, where appropriate, enter into an agreement with other ICBs, in order to establish arrangements in respect of the Commissioning Team Where appropriate, this agreement may be included as part of the ICB Collaboration Arrangement entered into in accordance with Clause 8.

14. BREACH

14.1 If the ICB does not comply with the terms of this Agreement, then NHS England may:

14.1.1 exercise its rights under this Agreement, and

14.1.2 take such steps as it considers appropriate in the exercise of its other functions concerning the ICB.

14.2 Without prejudice to Clause 14.1, if the ICB does not comply with the terms of this Agreement (including if the ICB exceeds its delegated authority under the Delegation), NHS England may (at its sole discretion):

14.2.1 waive its rights in relation to such non-compliance in accordance with Clause 14.3,

14.2.2 ratify any decision in accordance with Clause 6.5,

14.2.3 substitute a decision in accordance with Clause 6.6,

14.2.4 amend Developmental Arrangements or impose new Developmental Arrangements,

14.2.5 revoke the whole or part of the Delegation and terminate this Agreement in accordance with Clause 27 (Termination) below,

14.2.6 exercise the Escalation Rights in accordance with Clause 15 (Escalation Rights), and/or

14.2.7 exercise its rights under common law.

14.3 NHS England may waive any non-compliance by the ICB with the terms of this Agreement provided that the ICB provides a written report to NHS England as required by Clause 14.4 and, after considering the ICB's written report, NHS England is satisfied that the waiver is justified.

14.4 If:

14.4.1 the ICB does not comply with this Agreement,

14.4.2 the ICB considers that it may not be able to comply with this Agreement,

14.4.3 NHS England notifies the ICB that it considers the ICB has not complied with this Agreement, or

14.4.4 NHS England notifies the ICB that it considers that the ICB may not be able to comply with this Agreement,

then the ICB must provide a written report to NHS England within ten (10) Operational Days of the non-compliance (or the date on which the ICB identifies that it may not be able to comply with this Agreement) setting out:

14.4.5 details of and reasons for the non-compliance (or likely non-compliance) with the Agreement and/or the Delegation, and

14.4.6 a plan for how the ICB proposes to remedy the non-compliance.

15. ESCALATION RIGHTS

15.1 If the ICB does not comply with this Agreement, NHS England may exercise the following Escalation Rights:

15.1.1 NHS England may require a suitably senior representative of the ICB to attend a review meeting within ten (10) Operational Days of NHS England becoming aware of the non-compliance, and

15.1.2 NHS England may require the ICB to prepare an action plan and report within twenty (20) Operational Days of the review meeting (to include details of the non-compliance and a plan for how the ICB proposes to remedy the non-compliance).

15.2 If NHS England does not comply with this Agreement, the ICB may require a suitably senior representative of NHS England to attend a review meeting within ten (10) Operational Days of the ICB making NHS England aware of the non-compliance.

15.3 Nothing in Clause 15 (Escalation Rights) will affect NHS England's right to substitute a decision in accordance with Clause 6.76, revoke the Delegation or terminate this Agreement in accordance with Clause 27 (Termination) below.

16. LIABILITY AND INDEMNITY

16.1 NHS England is liable in respect of any Losses arising in respect of NHS England's negligence, fraud, recklessness or deliberate breach in respect of the Delegated Functions and occurring after the Effective Date of Delegation and, if the ICB suffers any Losses in respect of such actions by NHS England, NHS England shall make such adjustments to the Annual Allocation (or other amounts payable to the ICB) in order to reflect any Losses suffered by the ICB (except to the extent that the ICB is liable for such Losses pursuant to Clause 16.3).

16.2 For the avoidance of doubt, NHS England remains liable for a Claim relating to facts, events or circumstances concerning the Delegated Functions before the Effective Date of Delegation.

16.3 The ICB is liable to (and shall pay) NHS England for any Losses suffered by NHS England that result from or arise out of the ICB's negligence, fraud, recklessness or breach of the Delegation (including any actions that are taken that exceed the authority conferred by the Delegation) or this Agreement. In respect of such Losses, NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB or make such adjustments to the Delegated Funds pursuant to Clause 10.5. The ICB shall not be liable to the extent that the Losses arose prior to the Effective Date of Delegation.

16.4 Each Party acknowledges and agrees that any rights acquired, or liabilities (including liabilities in tort) incurred, in respect of the exercise by the ICB of any Delegated Function are enforceable by or against the ICB only, in accordance with section 65Z5(6) of the NHS Act.

16.5 Each Party will at all times take all reasonable steps to minimise and mitigate any Losses or other matters for which one Party is entitled to be indemnified by or to bring a claim against the other under this Agreement.

17. CLAIMS AND LITIGATION

17.1 Nothing in this Clause 17 (Claims and Litigation) shall be interpreted as affecting the reservation to NHS England of the Reserved Functions.

17.2 Except in the circumstances set out in Clause 17.5 and subject always to compliance with this Clause 17 (Claims and Litigation), the ICB shall be responsible for and shall retain the conduct of any Claim.

17.3 The ICB must:

17.3.1 comply with any policy issued by NHS England from time to time in relation to the conduct of or avoidance of Claims and the pro-active management of Claims,

17.3.2 if it receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim, immediately notify NHS England and send to NHS England all copies of such correspondence,

17.3.3 co-operate fully with NHS England in relation to such Claim and the conduct of such Claim,

17.3.4 provide, at its own cost, to NHS England all documentation and other correspondence that NHS England requires for the purposes of considering and/or resisting such Claim, and

17.3.5 at the request of NHS England, take such actions or step or provide such assistance as may in NHS England's discretion be necessary or desirable having regard to the nature of the Claim and the existence of any time limit in relation to avoiding, disputing, defending, resisting, appealing, seeking a review or compromising such Claim or to comply with the requirements of the provider of an Indemnity Arrangement in relation to such Claim.

17.4 Subject to Clauses 17.3 and 17.5 the ICB is entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit.

NHS England Stepping into Claims

17.5 NHS England may, at any time following discussion with the ICB, send a notice to the ICB stating that NHS England will take over the conduct of the Claim and the ICB must immediately take all steps necessary to transfer the conduct of such Claim to NHS England unless and until NHS England transfers conduct back to the ICB. In such cases:

17.5.1 NHS England shall be entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit, provided that if NHS England wishes to invoke Clause 17.5.3 it agrees to seek the ICB's views on any proposal to pay or settle that Claim prior to finalising such payment or settlement, and

17.5.2 the Delegation shall be treated as being revoked to the extent that and for so long as NHS England has assumed responsibility for exercising those of the Delegated Functions that are necessary for the purposes of having conduct of the Claim, and

17.5.3 NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or make an adjustment to the Delegated Funds pursuant to Clause 10.5.3 for the purposes of meeting any Claim Losses associated with that Claim.

Claim Losses

17.6 The ICB and NHS England shall notify each other as soon as reasonably practicable of becoming aware of any Claim Losses.

17.7 The ICB acknowledges that NHS England will pay to the ICB the funds that are attributable to the Delegated Functions. Accordingly, the ICB acknowledges that it must pay any Claim Losses out of either the Delegated Funds or its Annual Allocation. NHS England may, in respect of any Claim Losses, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or pursuant

to Clause 10.5.3 make such adjustments to the Delegated Funds to take into account the amount of any Claim Losses (other than any Claim Losses in respect of which NHS England has retained any funds, provisions or other resources to discharge such Claim Losses). For the avoidance of doubt, in circumstances where NHS England suffers any Claim Losses, then NHS England shall be entitled to recoup such Claim Losses pursuant to Clause 10.5.3. If and to the extent that NHS England has retained any funds, provisions or other resources to discharge such Claim Losses, then NHS England may either use such funds to discharge the Claim Loss or make an upward adjustment to the amounts paid to the ICB pursuant to Clause 10.5.3.

18. DATA PROTECTION, FREEDOM OF INFORMATION AND TRANSPARENCY

18.1 The Parties must ensure that all Personal Data processed by or on behalf of them while carrying out the Delegated Functions and Reserved Functions is processed in accordance with the relevant Party's obligations under Data Protection Legislation and Data Guidance and the Parties must assist each other as necessary to enable each other to comply with these obligations.

18.2 The ICB must respond to any information governance breach in accordance with Information Governance Guidance for Serious Incidents. If the ICB is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach then as soon as reasonably practical and in any event on or before the first such notification is made the ICB must fully inform NHS England of the information governance breach. This clause does not require the ICB to provide NHS England with information which identifies any individual affected by the information governance breach where doing so would breach Data Protection Legislation.

18.3 Whether or not a Party is a Data Controller or Data Processor will be determined in accordance with Data Protection Legislation and any Data Guidance from a Regulatory or Supervisory Body. The Parties acknowledge that a Party may act as both a Data Controller and a Data Processor.

18.4 NHS England may, from time to time, issue a data sharing protocol or update a protocol previously issued relating to the data sharing in relation to the Delegated Functions and/or Reserved Functions. The ICB shall comply with such data sharing protocols.

18.5 Each Party acknowledges that the other is a public authority for the purposes of the Freedom of Information Act 2000 ("FOIA") and the Environmental Information Regulations 2004 ("EIR").

18.6 Each Party may be required by statute to disclose further information about the Agreement and the Relevant Information in response to a specific request under FOIA or EIR, in which case:

18.6.1 each Party shall provide the other with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR,

18.6.2 each Party shall consult the other regarding the possible application of exemptions in relation to the information requested, and

18.6.3 subject only to Clause 17 (Claims and Litigation), each Party acknowledges that the final decision as to the form or content of the response to any request is a matter for the Party to whom the request is addressed.

18.7 NHS England may, from time to time, issue a FOIA or EIR protocol or update a protocol previously issued relating to the handling and responding to of FOIA or EIR requests in relation to the Delegated Functions. The ICB shall comply with such FOIA or EIR protocols.

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

19. IT INTER-OPERABILITY

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

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

20. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

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

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

21. PROHIBITED ACTS AND COUNTER-FRAUD

21.1 The ICB must not commit any Prohibited Act.

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

21.2.1 to revoke the Delegation,

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

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

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

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

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

21.6 The ICB must, on becoming aware of:

21.6.1 any suspected or actual bribery, corruption or fraud involving public funds, or

21.6.2 any suspected or actual security incident or security breach involving Staff or involving NHS resources,

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

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

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

21.7.2 all Staff who may have information to provide.

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

22. CONFIDENTIAL INFORMATION OF THE PARTIES

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

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

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

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

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

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

22.3.1 in connection with any dispute resolution procedure under Clause 25,

22.3.2 in connection with any litigation between the Parties,

22.3.3 to comply with the Law,

22.3.4 to any appropriate Regulatory or Supervisory Body,

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

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

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

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

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

22.4.1 is in, or comes into, the public domain other than by breach of this Agreement,

22.4.2 the receiving Party can show by its records was in its possession before it received it from the disclosing Party, or

22.4.3 the receiving Party can prove it obtained or was able to obtain from a source other than the disclosing Party without breaching any obligation of confidence.

22.5 This Clause 22 does not prevent NHS England making use of or disclosing any Confidential Information disclosed by the ICB where necessary for the purposes of exercising its functions in relation to the ICB.

22.6 The Parties acknowledge that damages would not be an adequate remedy for any breach of this Clause 22 by the receiving Party, and in addition to any right to damages the disclosing Party will be entitled to the remedies of injunction, specific performance and other equitable relief for any threatened or actual breach of this Clause 22.

22.7 This Clause 22 will survive the termination of this Agreement for any reason for a period of five (5) years.

22.8 This Clause 22 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

23. INTELLECTUAL PROPERTY

23.1 The ICB grants to NHS England a fully paid-up, non-exclusive, perpetual licence to use the ICB Deliverables for the purposes of the exercise of its statutory and contractual functions.

23.2 NHS England grants the ICB a fully paid-up, non-exclusive licence to use the NHS England Deliverables for the purpose of performing this Agreement and the Delegated Functions.

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

24. NOTICES

24.1 Any notices given under this Agreement must be sent by e-mail to the other Party's address set out in the Particulars or as otherwise notified by one Party to another as the appropriate address for this Clause 24.1.

24.2 Notices by e-mail will be effective when sent in legible form, but only if, following transmission, the sender does not receive a non-delivery message.

25. DISPUTES

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

25.2 If a Dispute arises out of, or in connection with, this Agreement then the Parties must follow the procedure set out in this clause:

25.2.1 either Party must give to the other written notice of the Dispute, setting out its nature and full particulars ("Dispute Notice"), together with relevant supporting documents. On service of the Dispute Notice, the Agreement Representatives must attempt in good faith to resolve the Dispute,

25.2.2 if the Agreement Representatives are, for any reason, unable to resolve the Dispute within twenty (20) Operational Days of service of the Dispute Notice, the Dispute must be referred to the Chief Executive Officer (or equivalent person) of the ICB and a director of or other person nominated by NHS England (and who has authority from NHS England to settle the Dispute) who must attempt in good faith to resolve it, and

25.2.3 if the people referred to in Clause 25.2.2 are for any reason unable to resolve the Dispute within twenty (20) Operational Days of it being referred to them, the Parties may attempt to settle it by mediation in accordance with the CEDR model mediation procedure. Unless otherwise agreed between the Parties, the mediator must be nominated by CEDR. To initiate the mediation, a Party must serve notice in writing ('Alternative Dispute Resolution' ("ADR) notice") to the other Party to the Dispute, requesting a mediation. A copy of the ADR notice should be sent to CEDR. The mediation will start no later than ten (10) Operational Days after the date of the ADR notice.

25.3 If the Dispute is not resolved within thirty (30) Operational Days after service of the ADR notice, or either Party fails to participate or to continue to participate in the mediation before the expiration of the period of thirty (30) Operational Dys, or the mediation terminates before the expiration of the period of thirty (30) Operational Days, the Dispute must be referred to the NHS England Board, who shall resolve the matter and whose decision shall be binding upon the Parties.

26. VARIATIONS

26.1 The Parties acknowledge that the scope of the Delegated Functions may be reviewed and amended from time to time including by revoking this Agreement and making alternative arrangements.

26.2 NHS England may vary this Agreement without the ICB's consent where:

26.2.1 it is reasonably satisfied that the variation is necessary in order to comply with Legislation, NHS England's statutory duties, or any requirements or direction given by the Secretary of State,

26.2.2 where variation is as a result of amendment to or additional Mandated Guidance,

26.2.3 it is satisfied that any Developmental Arrangements are no longer required,

26.2.4 it reasonably considers that Developmental Arrangements are required under Clause 14 (Breach), or

26.2.5 it is satisfied that such amendment or Developmental Arrangement is required in order to ensure the effective commissioning of the Delegated Services or other Specialised Services.

26.3 Where NHS England wishes to vary the Agreement in accordance with Clause 26.2 it must notice in writing to the ICB of the wording of the proposed variation and the date on which that variation is to take effect which must, unless it is not reasonably practicable, be a date which falls at least thirty (30) Operational Days after the date on which the notice under that clause is given to the ICB.

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

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

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

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

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

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

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

26.7.1 that it accepts the Variation Proposal, or

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

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

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

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

27. TERMINATION

27.1 The ICB may:

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

27.1.2 terminate this Agreement,

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

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

27.1.4 the ICB meets with NHS England within ten (10) Operational Days of NHS England receiving the notice set out at Clause 27.1.3 above to discuss arrangements for termination and transition of the Delegated Functions to a successor commissioner in accordance with Clause 28.2, and

27.1.5 the ICB confirms satisfactory arrangements for terminating any ICB Collaboration Arrangements or Further Agreements in whole or part as required including agreed succession arrangements for Commissioning Teams,

in which case NHS England shall revoke the Delegation and this Agreement shall terminate with effect from the end of 31 March in the next calendar year.

27.2 NHS England may revoke the Delegation in whole or in part with effect from 23.59 hours on 31 March in any year, provided that it gives notice to the ICB of its intention to terminate the Delegation on or before 30 September in the year prior to the year in which the Delegation will terminate, and in which case Clause 27.4 will apply.

27.3 The Delegation may be revoked in whole or in part, and this Agreement may be terminated by NHS England at any time, including in (but not limited to) the following circumstances:

27.3.1 the ICB acts outside of the scope of its delegated authority,

27.3.2 the ICB fails to perform any material obligation of the ICB owed to NHS England under this Agreement,

27.3.3 the ICB persistently commits non-material breaches of this Agreement,

27.3.4 NHS England is satisfied that its intervention powers under section 14Z61 of the NHS Act apply,

27.3.5 to give effect to legislative changes, including conferral of any of the Delegated or Reserved Functions on the ICB,

27.3.6 failure to agree to a variation in accordance with Clause 26 (Variations),

27.3.7 NHS England and the ICB agree in writing that the Delegation shall be revoked and this Agreement shall terminate on such date as is agreed, and/or

27.3.8 the ICB merges with another ICB or other body.

27.4 This Agreement will terminate upon revocation or termination of the full Delegation (including revocation and termination in accordance with this Clause 27 (Termination)) except that the provisions referred to in Clause 29 (Provisions Surviving Termination) will continue in full force and effect.

27.5 Without prejudice to Clause 14.3 and to avoid doubt, NHS England may waive any right to terminate this Agreement under this Clause 27 (Termination). Any such waiver is only effective if given in writing and shall not be deemed a waiver of any subsequent right or remedy.

27.6 As an alternative to termination of the Agreement in respect of all the Delegated Functions, NHS England may terminate the Agreement in respect of specified Delegated Functions (or aspects of such Delegated Functions) only, in which case this Agreement shall otherwise remain in effect.

28. CONSEQUENCE OF TERMINATION

28.1 Termination of this Agreement, or termination of the ICB's exercise of any of the Delegated Functions, will not affect any rights or liabilities of the Parties that have accrued before the date of that termination or which later accrue in respect of the term of this Agreement. For the avoidance of doubt, the ICB shall be responsible for any Claims or other costs or liabilities incurred in the exercise of the Delegated Functions

during the period of this Agreement unless expressly agreed otherwise by NHS England.

28.2 Subject to Clause 28.4, on or pending termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, NHS England, the ICB and, if appropriate, any successor delegate will:

28.2.1 agree a plan for the transition of the Delegated Functions from the ICB to the successor delegate, including details of the transition, the Parties' responsibilities in relation to the transition, the Parties' arrangements in respect of the Staff engaged in the Delegated Functions and the date on which the successor delegate will take responsibility for the Delegated Functions,

28.2.2 implement and comply with their respective obligations under the plan for transition agreed in accordance with Clause 28.2.1, and

28.2.3 act with a view to minimising any inconvenience or disruption to the commissioning of healthcare in the Area.

28.3 For a reasonable period before and after termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, the ICB must:

28.3.1 co-operate with NHS England and any successor delegate to ensure continuity and a smooth transfer of the Delegated Functions, and

28.3.2 at the reasonable request of NHS England:

28.3.2.1 promptly provide all reasonable assistance and information to the extent necessary for an efficient assumption of the Delegated Functions by a successor delegate,

28.3.2.2 deliver to NHS England all materials and documents used by the ICB in the exercise of any of the Delegated Functions, and

28.3.2.3 use all reasonable efforts to obtain the consent of third parties to the assignment, novation or termination of existing contracts between the ICB and any third party which relate to or are associated with the Delegated Functions.

28.4 Where any or all of the Delegated Functions or Reserved Functions are to be directly conferred on the ICB, the Parties will co-operate with a view to ensuring continuity and a smooth transfer to the ICB.

29. PROVISIONS SURVIVING TERMINATION

29.1 Any rights, duties or obligations of any of the Parties which are expressed to survive, including those referred to in Clause 29.2, or which otherwise by necessary implication survive the termination for any reason of this Agreement, together with all indemnities, will continue after termination, subject to any limitations of time expressed in this Agreement.

29.2 The surviving provisions include the following clauses together with such other provisions as are required to interpret and give effect to them:

29.2.1 Clause 10 (Finance),

29.2.2 Clause 13 (Staffing, Workforce and Commissioning Teams),

29.2.3 Clause 16 (Liability and Indemnity),

29.2.4 Clause 17 (Claims and Litigation),

29.2.5 Clause 18 (Data Protection, Freedom of Information and Transparency),

29.2.6 Clause 25 (Disputes),

29.2.7 Clause 27 (Termination),

29.2.8 Schedule 6 (Further Information Governance and Sharing Provisions).

30. COSTS

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

31. SEVERABILITY

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

32. GENERAL

32.1 Nothing in this Agreement will create a partnership or joint venture or relationship of principal and agent between NHS England and the ICB.

32.2 A delay or failure to exercise any right or remedy in whole or in part shall not waive that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy.

32.3 This Agreement does not give rise to any rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this Agreement.

SCHEDULE 1 DEFINITIONS AND INTERPRETATION

1. The headings in this Agreement will not affect its interpretation.

2. Reference to any statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance, includes a reference to that statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance as from time to time updated, amended, extended, supplemented, re-enacted or replaced in whole or in part.

3. Reference to a statutory provision includes any subordinate legislation made from time to time under that provision.

4. References to clauses and schedules are to the clauses and schedules of this Agreement, unless expressly stated otherwise.

5. References to any body, organisation or office include reference to its applicable successor from time to time.

6. Any references to this Agreement or any other documents or resources includes reference to this Agreement or those other documents or resources as varied, amended, supplemented, extended, restated and/or replaced from time to time and any reference to a website address for a resource includes reference to any replacement website address for that resource.

7. Use of the singular includes the plural and vice versa.

8. Use of the masculine includes the feminine and all other genders.

9. Use of the term “including” or “includes” will be interpreted as being without limitation.

10. The following words and phrases have the following meanings:

Administrative and Management Services	means administrative and management support provided in accordance with Clause 9.5 or 9.7,
Agreement	means this agreement between NHS England and the ICB comprising the Particulars, the Terms and Conditions, the Schedules and the Mandated Guidance,
Agreement Representatives	means the ICB Representative and the NHS England Representative as set out in the Particulars or such person identified to the other Party from time to time as the relevant representative,
Annual Allocation	means the funds allocated to the ICB annually under section 223G of the NHS Act,
Area	means the geographical area covered by the ICB,
Assurance Processes	has the definition given in paragraph 3.1 of Schedule 3,
Best Practice	means any methodologies, pathway designs and processes relating to this Agreement or the Delegated Functions developed by the ICB or its Staff for the purposes of delivering the Delegated Functions and which are capable of wider use in the delivery of healthcare services for the purposes of the NHS, but not including inventions that are capable of patent protection and for which patent protection is being sought or has been obtained, registered designs, or copyright in software,

Capital Investment Guidance	means any Mandated Guidance issued by NHS England from time to time in relation to the development, assurance and approvals process for proposals in relation to: - the expenditure of Capital, or investment in property, infrastructure or information and technology, and - the revenue consequences for commissioners or third parties making such investment,
CEDR	means the Centre for Effective Dispute Resolution,
Claims	means, for or in relation to the Delegated Functions (i) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or the Secretary of State, any governmental, regulatory or similar body, or any department, board or agency or (ii) any dispute with, or any investigation, inquiry or enforcement proceedings by, any governmental, regulatory or similar body or agency,
Claim Losses	means all Losses arising in relation to any Claim,
Clinical Commissioning Policies	means a nationally determined clinical policy setting out the commissioning position on a particular clinical treatment issue and defines accessibility (including a not for routine commissioning position) of a medicine, medical device, diagnostic technique, surgical procedure or intervention for patients with a condition requiring a specialised service,
Clinical Reference Groups	means a group consisting of clinicians, commissioners, public health experts, patient and public voice representatives and professional associations, which offers specific knowledge and expertise on the best ways that Specialised Services should be provided,
Collaborative Agreement	Means the 'Collaboration Agreement for the Commissioning of Delegated Specialised Services in the East of England' agreed between all ICBs in the East of England and NHS England, East of England Regional Team,
Collaborative Commissioning Agreement	means an agreement under which NHS Commissioners set out collaboration arrangements in respect of commissioning Specialised Services Contracts,
Commissioning Functions	means the respective statutory functions of the Parties in arranging for the provision of services as part of the health service,
Commissioning Team	means those Specialised Services Staff that support the commissioning of Delegated Services immediately prior to this Agreement and, at the point that Staff transfer from NHS England to an identified ICB, it shall mean those NHS England

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

	Human Rights Act 1998, the Health and Social Care (Safety and Quality) Act 2015, the common law duty of confidentiality and the Privacy and Electronic Communications (EC Directive) Regulations 2003,
Data Sharing Agreement	means a data sharing agreement which should be in substantially the same form as a Data Sharing Agreement template approved by NHS England,
Data Subject	shall have the same meaning as set out in the UK GDPR,
Delegated Commissioning Group (DCG)	means the advisory forum in respect of Delegated Services set up by NHS England currently known as the Delegated Commissioning Group for Specialised Services,
Delegated Functions	means the statutory functions delegated by NHS England to the ICB under the Delegation and as set out in detail in this Agreement,
Delegated Funds	means the funds defined in Clause 10.2,
Delegated Services	means the services set out in Schedule 2 of this Agreement and which may be updated from time to time by NHS England,
Delegation	means the delegation of the Delegated Functions from NHS England to the ICB as described at Clause 6.1,
Developmental Arrangements	means the arrangements set out in Schedule 9 as amended or replaced,
Dispute	a dispute, conflict or other disagreement between the Parties arising out of or in connection with this Agreement,
Effective Date of Delegation	means for the Specialised Services set out in Schedule 2, the date set out in Schedule 2 as the date delegation will take effect in respect of that particular Specialised Service and for any future delegations means the date agreed by the parties as the date that the delegation will take effect,
EIR	means the Environmental Information Regulations 2004,
Escalation Rights	means the escalation rights as defined in Clause 15 (Escalation Rights),
Finance Guidance	means the guidance, rules and operating procedures produced by NHS England that relate to these delegated arrangements, including but not limited to the following: - Commissioning Change Management Business Rules, - Contracting Standard Operating Procedure, - Cashflow Standard Operating Procedure, - Finance and Accounting Standard Operating Procedure,

	- Service Level Framework Guidance,
Financial Year	shall bear the same meaning as in section 275 of the NHS Act,
FOIA	means the Freedom of Information Act 2000,
Further Arrangements	means arrangements for the exercise of Delegated Functions as defined at Clause 12,
Good Practice	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner,
Guidance	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the ICB has a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified to the ICB by any relevant Regulatory or Supervisory Body but excluding Mandated Guidance,
High Cost Drugs	means medicines not reimbursed though national prices and identified on the NHS England high cost drugs list,
Host ICB	Means the designated host ICB that will employ the Commissioning Team as part of the Commissioning Team Arrangements after 2024/25. During 2024/25 they will take the lead ICB role for managing the work of the Commissioning Team employed within NHS England on behalf of the ICBs.
ICB	means an Integrated Care Board established pursuant to section 14Z25 of the NHS Act and named in the Particulars,
ICB Collaboration Arrangement	means an arrangement entered into by the ICB and at least one other ICB under which the parties agree joint working arrangements in respect of the exercise of the Delegated Functions,
Deliverables	all documents, products and materials developed by the ICB or its Staff in relation to this Agreement and the Delegated Functions in any form and required to be submitted to NHS England under this Agreement, including data, reports, policies, plans and specifications,
ICB Functions	the Commissioning Functions of the ICB,
Information Governance Guidance for Serious Incidents	means the checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation' (2015) as may be amended or replaced,

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

NICE Regulations	means the National Institute for Health and Care Excellence (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013 as amended or replaced,
NHS Act	means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022 and other legislation from time to time),
NHS Counter Fraud Authority	means the Special Health Authority established by and in accordance with the NHS Counter Fraud Authority (Establishment, Constitution, and Staff and Other Transfer Provisions) Order 2017/958,
NHS Digital Data Security and Protection Toolkit	means the toolkit published by NHS Digital and available on the NHS Digital website at: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/data-security-and-protection-toolkit ,
NHS England	means the body established by section 1H of the NHS Act,
NHS England Deliverables	means all documents, products and materials NHS England in which NHS England holds IPRs which are relevant to this Agreement, the Delegated Functions or the Reserved Functions in any form and made available by NHS England to the ICB under this Agreement, including data, reports, policies, plans and specifications,
NHS England Functions	means all functions of NHS England as set out in legislation excluding any functions that have been expressly delegated,
Non-Personal Data	means data which is not Personal Data,
Operational Days	a day other than a Saturday, Sunday, Christmas Day, Good Friday or a bank holiday in England,
Oversight Framework	means the NHS Oversight Framework, as may be amended or replaced from time to time, and any relevant associated Guidance published by NHS England,
Party/Parties	means a party or both parties to this Agreement,
Patient Safety Incident Response Framework	means the framework published by NHS England and made available on the NHS England website at: https://www.england.nhs.uk/patient-safety/incident-response-framework/ ,
Personal Data	shall have the same meaning as set out in the UK GDPR and shall include references to Special Category Personal Data where appropriate,
Population	means the individuals for whom the ICB has responsibility in respect of commissioning the Delegated Services,

Prescribed Specialised Services Manual	means the document which may be amended or replaced from time to time which is currently known as the prescribed specialised services manual which describes how NHS England and ICBs commission specialised services and sets out the identification rules which describe how NHS England and ICBs identify Specialised Services activity within data flows,
Provider Collaborative	means a group of Specialised Service Providers who have agreed to work together to improve the care pathway for one or more Specialised Services,
Provider Collaborative Guidance	means the guidance published by NHS England in respect of Provider Collaboratives,
Prohibited Act	means the ICB: (i) offering, giving, or agreeing to give NHS England (or an of their officers, employees or agents) any gift or consideration of any kind as an inducement or reward for doing or not doing or for having done or not having done any act in relation to the obtaining of performance of this Agreement, the Reserved Functions, the Delegation or any other arrangement with the ICB, or for showing or not showing favour or disfavour to any person in relation to this Agreement or any other arrangement with the ICB, and (ii) in connection with this Agreement, paying or agreeing to pay any commission, other than a payment, particulars of which (including the terms and conditions of the agreement for its payment) have been disclosed in writing to NHS England, or (iii) committing an offence under the Bribery Act 2010,
Regional Quality Group	means a group set up to act as a strategic forum at which regional partners from across health and social care can share, identify and mitigate wider regional quality risks and concerns as well as share learning so that quality improvement and best practice can be replicated,
Regulatory or Supervisory Body	means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: (i) CQC, (ii) NHS England, (iii) the Department of Health and Social Care, (iv) the National Institute for Health and Care Excellence, (v) Healthwatch England and Local Healthwatch, (vi) the General Medical Council,

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

Specialised Services Contract	means a contract for the provision of Specialised Services entered into in the exercise of the Specialised Commissioning Functions,
Specialised Services Provider	means a provider party to a Specialised Services Contract,
Specialised Services Staff	means the Staff of roles identified as carrying out the Delegated Services Functions immediately prior to the date of this Agreement,
Specified Purpose	means the purpose for which the Relevant Information is shared and processed, being to facilitate the exercise of the ICB's Delegated Functions and NHS England's Reserved Functions as specified in paragraph 2.1. of Schedule 6 (Further Information Governance and Sharing Provisions) to this Agreement,
Staff or Staffing	means the Parties' employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of either Party (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel,
Sub-Delegate	shall have the meaning in Clause 12.2,
System Quality Group	means a group set up to identify and manage concerns across the local system. The system quality group shall act as a strategic forum at which partners from across the local health and social care footprint can share issues and risk information to inform response and management, identify and mitigate quality risks and concerns as well as share learning and best practice,
Triple Aim	means the duty to have regard to wider effect of decisions, which is placed on each of the Parties under section 13NA (as regards NHS England) and section 14Z43 (as regards the ICB) of the NHS Act,
UK GDPR	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018,
Variation Proposal	means a written proposal for a variation to the Agreement, which complies with the requirements of Clause 26.5.

SCHEDULE 2 DELEGATED SERVICES

Delegated Services

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

The following Specialised Services were delegated to the ICB on 1 April 2024.

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
2	Adult congenital heart disease services	13X	Adult congenital heart disease services (non-surgical)
		13Y	Adult congenital heart disease services (surgical)
3	Adult specialist pain management services	31Z	Adult specialist pain management services
4	Adult specialist respiratory services	29M	Interstitial lung disease (adults)
		29S	Severe asthma (adults)
		29L	Lung volume reduction (adults)
5	Adult specialist rheumatology services	26Z	Adult specialist rheumatology services
7	Adult Specialist Cardiac Services	13A	Complex device therapy
		13B	Cardiac electrophysiology & ablation
		13C	Inherited cardiac conditions
		13E	Cardiac surgery (inpatient)
		13F	PPCI for ST- elevation myocardial infarction
		13H	Cardiac magnetic resonance imaging
		13T	Complex interventional cardiology (adults)
		13Z	Cardiac surgery (outpatient)
9	Adult specialist endocrinology services	27E	Adrenal Cancer (adults)
		27Z	Adult specialist endocrinology services
11	Adult specialist neurosciences services	08O	Neurology (adults)
		08P	Neurophysiology (adults)
		08R	Neuroradiology (adults)
		08S	Neurosurgery (adults)
		08T	Mechanical Thrombectomy
		58A	Neurosurgery LVHC national: surgical removal of clival chordoma and chondrosarcoma
		58B	Neurosurgery LVHC national: EC-IC bypass (complex/high flow)
		58C	Neurosurgery LVHC national: transoral excision of dens
		58D	Neurosurgery LVHC regional: anterior skull based tumours
		58E	Neurosurgery LVHC regional: lateral skull based tumours
		58F	Neurosurgery LVHC regional: surgical removal of brainstem lesions
		58G	Neurosurgery LVHC regional: deep brain stimulation
		58H	Neurosurgery LVHC regional: pineal tumour surgeries - resection
		58I	Neurosurgery LVHC regional: removal of arteriovenous malformations of the nervous system
		58J	Neurosurgery LVHC regional: epilepsy
		58K	Neurosurgery LVHC regional: insula glioma's/ complex low grade glioma's
		58L	Neurosurgery LVHC local: anterior lumbar fusion
	Adult specialist neurosciences services (continued)	58M	Neurosurgery LVHC local: removal of intramedullary spinal tumours
		58N	Neurosurgery LVHC local: intraventricular tumours resection
		58O	Neurosurgery LVHC local: surgical repair of aneurysms (surgical clipping)

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
		58P	Neurosurgery LVHC local: thoracic discectomy
		58Q	Neurosurgery LVHC local: microvascular decompression for trigeminal neuralgia
		58R	Neurosurgery LVHC local: awake surgery for removal of brain tumours
		58S	Neurosurgery LVHC local: removal of pituitary tumours including for Cushing's and acromegaly
12	Adult specialist ophthalmology services	37C	Artificial Eye Service
		37Z	Adult specialist ophthalmology services
13	Adult specialist orthopaedic services	34A	Orthopaedic surgery (adults)
		34R	Orthopaedic revision (adults)
15	Adult specialist renal services	11B	Renal dialysis
		11C	Access for renal dialysis
16	Adult specialist services for people living with HIV	14A	Adult specialised services for people living with HIV
17	Adult specialist vascular services	30Z	Adult specialist vascular services
18	Adult thoracic surgery services	29B	Complex thoracic surgery (adults)
		29Z	Adult thoracic surgery services: outpatients
30	Bone conduction hearing implant services (adults and children)	32B	Bone anchored hearing aids service
		32D	Middle ear implantable hearing aids service
35	Cleft lip and palate services (adults and children)	15Z	Cleft lip and palate services (adults and children)
36	Cochlear implantation services (adults and children)	32A	Cochlear implantation services (adults and children)
40	Complex spinal surgery services (adults and children)	06Z	Complex spinal surgery services (adults and children)
		08Z	Complex neuro-spinal surgery services (adults and children)
54	Fetal medicine services (adults and adolescents)	04C	Fetal medicine services (adults and adolescents)
58	Specialist adult gynaecological surgery and urinary surgery services for females	04A	Severe Endometriosis
		04D	Complex urinary incontinence and genital prolapse
58A	Specialist adult urological surgery services for men	41P	Penile implants
		41S	Surgical sperm removal
		41U	Urethral reconstruction
59	Specialist allergy services (adults and children)	17Z	Specialist allergy services (adults and children)
61	Specialist dermatology services (adults and children)	24Z	Specialist dermatology services (adults and children)
62	Specialist metabolic disorder services (adults and children)	36Z	Specialist metabolic disorder services (adults and children)
63	Specialist pain management services for children	23Y	Specialist pain management services for children
64	Specialist palliative care services for children and young adults	E23	Specialist palliative care services for children and young adults
65	Specialist services for adults with infectious diseases	18A	Specialist services for adults with infectious diseases
		18E	Specialist Bone and Joint Infection (adults)

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
72	Major trauma services (adults and children)	34T	Major trauma services (adults and children)
78	Neuropsychiatry services (adults and children)	08Y	Neuropsychiatry services (adults and children)
83	Paediatric cardiac services	23B	Paediatric cardiac services
94	Radiotherapy services (adults and children)	01R	Radiotherapy services (Adults)
		51R	Radiotherapy services (Children)
		01S	Stereotactic Radiosurgery / radiotherapy
105	Specialist cancer services (adults)	01C	Chemotherapy
		01J	Anal cancer (adults)
		01K	Malignant mesothelioma (adults)
		01M	Head and neck cancer (adults)
		01N	Kidney, bladder and prostate cancer (adults)
		01Q	Rare brain and CNS cancer (adults)
		01U	Oesophageal and gastric cancer (adults)
		01V	Biliary tract cancer (adults)
		01W	Liver cancer (adults)
		01Y	Cancer Outpatients (adults)
		01Z	Testicular cancer (adults)
		04F	Gynaecological cancer (adults)
		19V	Pancreatic cancer (adults)
		24Y	Skin cancer (adults)
		19C	Biliary tract cancer surgery (adults)
		19M	Liver cancer surgery (adults)
		19Q	Pancreatic cancer surgery (adults)
		51A	Interventional oncology (adults)
		51B	Brachytherapy (adults)
		51C	Molecular oncology (adults)
		61M	Head and neck cancer surgery (adults)
		61Q	Ophthalmic cancer surgery (adults)
		61U	Oesophageal and gastric cancer surgery (adults)
		61Z	Testicular cancer surgery (adults)
		33C	Transanal endoscopic microsurgery (adults)
		33D	Distal sacrectomy for advanced and recurrent rectal cancer (adults)
106	Specialist cancer services for children and young adults	01T	Teenage and young adult cancer
		23A	Children's cancer
106A	Specialist colorectal surgery services (adults)	33A	Complex surgery for faecal incontinence (adults)
		33B	Complex inflammatory bowel disease (adults)
107	Specialist dentistry services for children	23P	Specialist dentistry services for children
108	Specialist ear, nose and throat services for children	23D	Specialist ear, nose and throat services for children
109	Specialist endocrinology services for children	23E	Specialist endocrinology and diabetes services for children
110	Specialist gastroenterology, hepatology and nutritional support services for children	23F	Specialist gastroenterology, hepatology and nutritional support services for children
112	Specialist gynaecology services for children	73X	Specialist paediatric surgery services - gynaecology
113	Specialist haematology services for children	23H	Specialist haematology services for children

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
115B	Specialist maternity care for adults diagnosed with abnormally invasive placenta	04G	Specialist maternity care for women diagnosed with abnormally invasive placenta
118	Neonatal critical care services	NIC	Specialist neonatal care services
119	Specialist neuroscience services for children	23M	Specialist neuroscience services for children
		07Y	Paediatric neurorehabilitation
		08J	Selective dorsal rhizotomy
120	Specialist ophthalmology services for children	23N	Specialist ophthalmology services for children
121	Specialist orthopaedic services for children	23Q	Specialist orthopaedic services for children
122	Paediatric critical care services	PIC	Specialist paediatric intensive care services
125	Specialist plastic surgery services for children	23R	Specialist plastic surgery services for children
126	Specialist rehabilitation services for patients with highly complex needs (adults and children)	07Z	Specialist rehabilitation services for patients with highly complex needs (adults and children)
127	Specialist renal services for children	23S	Specialist renal services for children
128	Specialist respiratory services for children	23T	Specialist respiratory services for children
129	Specialist rheumatology services for children	23W	Specialist rheumatology services for children
130	Specialist services for children with infectious diseases	18C	Specialist services for children with infectious diseases
131	Specialist services for complex liver, biliary and pancreatic diseases in adults	19L	Specialist services for complex liver diseases in adults
		19P	Specialist services for complex pancreatic diseases in adults
		19Z	Specialist services for complex liver, biliary and pancreatic diseases in adults
		19B	Specialist services for complex biliary diseases in adults
132	Specialist services for haemophilia and other related bleeding disorders (adults and children)	03X	Specialist services for haemophilia and other related bleeding disorders (Adults)
		03Y	Specialist services for haemophilia and other related bleeding disorders (Children)
134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	05P	Prosthetics (adults and children)
135	Specialist paediatric surgery services	23X	Specialist paediatric surgery services - general surgery
136	Specialist paediatric urology services	23Z	Specialist paediatric urology services
139A	Specialist morbid obesity services for children	35Z	Specialist morbid obesity services for children
139AA	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital	04P	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital
ACC	Adult Critical Care	ACC	Adult critical care

SCHEDULE 3 DELEGATED FUNCTIONS

1 Introduction

1.1 Subject to the reservations set out in Schedule 4 (Reserved Functions) and the provisions of any Developmental Arrangements, NHS England delegates to the ICB the statutory function for commissioning the Delegated Services. This Schedule 3 sets out the key powers and duties that the ICB will be required to carry out in exercise of the Delegated Functions being, in summary:

1.1.1 decisions in relation to the commissioning and management of Delegated Services,

1.1.2 planning Delegated Services for the Population, including carrying out needs assessments,

1.1.3 undertaking reviews of Delegated Services in respect of the Population,

1.1.4 supporting the management of the Specialised Commissioning Budget,

1.1.5 co-ordinating a common approach to the commissioning and delivery of Delegated Services with other health and social care bodies in respect of the Population where appropriate, and

1.1.6 such other ancillary activities that are necessary to exercise the Specialised Commissioning Functions.

1.2 When exercising the Delegated Functions, ICBs are not acting on behalf of NHS England but acquire rights and incur any liabilities in exercising the functions.

2 General Obligations

2.1 The ICB is responsible for planning the commissioning of the Delegated Services in accordance with this Agreement. This includes ensuring at all times that the Delegated Services are commissioned in accordance with the National Standards.

2.2 The ICB shall put in place arrangements for collaborative working with other ICBs in accordance with Clause 8 (Requirement for ICB Collaboration Arrangement).

2.3 The Developmental Arrangements set out in Schedule 9 shall apply.

Specific Obligations

3 Assurance and Oversight

3.1 The ICB must at all times operate in accordance with:

3.1.1 the Oversight Framework published by NHS England,

3.1.2 any national oversight and/or assurance guidance in respect of Specialised Services and/or joint working arrangements, and

3.1.3 any other relevant NHS oversight and assurance guidance,

collectively known as the “Assurance Processes”.

3.2 The ICB must:

3.2.1 develop and operate in accordance with mutually agreed ways of working in line with the Assurance Processes,

3.2.2 oversee the provision of Delegated Services and the outcomes being delivered for its Population in accordance with the Assurance Processes,

3.2.3 assure that Specialised Service Providers are meeting, or have an improvement plan in place to meet, National Standards,

3.2.4 provide any information and comply with specific actions in relation to the Delegated Services, as required by NHS England, including metrics and detailed reporting.

4 Attendance at governance meetings

4.1 The ICB must ensure that there is appropriate representation at forums established through the ICB Collaboration Arrangement.

4.2 The ICB must ensure that an individual(s) has been nominated to represent the ICB at the Delegated Commissioning Group (DCG) and regularly attends that group. This could be a single representative on behalf of the members of an ICB Collaboration Arrangement. Where that representative is not an employee of the ICB, the ICB must have in place appropriate arrangements to enable the representative to feedback to the ICB.

4.3 The ICB should also ensure that they have a nominated representative with appropriate subject matter expertise to attend National Standards development forums as requested by NHS England. This could be a single representative on behalf of the members of an ICB Collaboration Arrangement. Where that representative is not an employee of the ICB, the ICB must have in place appropriate arrangements to enable the representative to feedback to the ICB.

5 Clinical Leadership and Clinical Reference Groups

5.1 The ICB shall support the development of clinical leadership and expertise at a local level in respect of Specialised Services.

5.2 The ICB shall support local and national groups including Relevant Clinical Networks and Clinical Reference Groups that are involved in developing Clinical Commissioning Policies, National Specifications, National Standards and knowledge around Specialised Services.

6 Clinical Networks

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

6.2 The ICB will be involved in the development and agreement of a single annual plan for the Relevant Clinical Network.

6.3 The ICB shall monitor the implementation of the annual plan and receive an annual report from the Relevant Clinical Network that considers delivery against the annual plan.

6.4 The ICB shall actively support and participate in dialogue with Relevant Clinical Networks and shall ensure that there is a clear and effective mechanism in place for giving and receiving information with the Relevant Clinical Networks including network reports.

6.5 The ICB shall support NHS England in the management of Relevant Clinical Networks.

6.6 The ICB shall actively engage and promote Specialised Service Provider engagement in appropriate Relevant Clinical Networks.

6.7 Where a Relevant Clinical Network identifies any concern, the ICB shall seek to consider and review that concern as soon as is reasonably practicable and take such action, if any, as it deems appropriate.

6.8 The ICB shall ensure that network reports are considered where relevant as part of exercising the Delegated Functions.

7 Complaints

7.1 The ICB shall provide full co-operation with NHS England in relation to any complaints received in respect of the Delegated Services which shall retain the function of complaints management in respect of the Delegated Services.

7.2 The ICB shall provide the relevant individuals at NHS England with appropriate access to data held by the ICB necessary to carry out the complaints function.

7.3 At such time as agreed between the ICB and NHS England, the management of complaints function in respect of the Delegated Services shall be delegated to the ICB and the following provisions shall apply:

7.3.1 NHS England shall provide the relevant individuals at the ICB with appropriate access to complaints data held by NHS England necessary to carry out the complaints function as set out in the Complaints Sharing Protocol.

7.3.2 The ICB shall provide information relating to key performance indicators ("KPIs") as requested by NHS England. These KPIs shall include information reporting on the following:

7.3.2.1 acknowledgements provided within three (3) Operational Days,

7.3.2.2 responses provided within forty (40) Operational Days,

7.3.2.3 response not provided within six (6) months

7.3.2.4 open cases with the Parliamentary and Health Services Ombudsman and providing information on any fully or partly upheld complaints, and

7.3.2.5 overall activity by volume (not as a KPI).

7.3.3 The ICB shall co-operate with NHS England in respect of the review of complaints related to the Delegated Services and shall, on request, share any learning identified in carrying out the complaints function.

7.3.4 The ICB shall take part in any peer review process put in place in respect of the complaints function.

7.4 Where NHS England has provided the ICB with a protocol for sharing complaints in respect of any or all Specialised Services then those provisions shall apply and are deemed to be part of this Agreement.

8 Commissioning and optimisation of High Cost Drugs

8.1 The ICB must ensure the effective and efficient commissioning of High Cost Drugs for Delegated Services.

8.2 Where necessary the ICB must collaborate with NHS England in respect of the payment arrangements for High Cost Drugs.

8.3 The ICB must develop and implement Shared Care Arrangements across the Area of the ICB.

8.4 The ICB must provide clinical and commissioning leadership in the commissioning and management of High Cost Drugs. This includes supporting the Specialised Service

Provider pharmacy services and each Party in the development access to medicine strategies, and minimising barriers that may exacerbate health inequalities.

8.5 The ICB must ensure:

8.5.1 safe and effective use of High Cost Drugs in line with national Clinical Commissioning Policies,

8.5.2 effective introduction of new medicines,

8.5.3 compliance with all NHS England commercial processes and frameworks for High Cost Drugs,

8.5.4 Specialised Services Providers adhere to all NHS England commercial processes and frameworks for High Cost Drugs,

8.5.5 appropriate use of Shared Care Arrangements, ensuring that they are safe and well monitored, and

8.5.6 consistency of prescribing and unwarranted prescribing variation are addressed.

8.6 The ICB must have in place appropriate monitoring mechanisms, including prescribing analysis, to support the financial management of High Cost Drugs.

8.7 The ICB must engage in the development, implementation and monitoring of initiatives that enable use of better value medicines. Such schemes include those at a local, regional or national level.

8.8 The ICB must provide support to prescribing networks and forums, including but not limited to, Immunoglobulin Assessment panels, prescribing networks and medicines optimisation networks.

9 Contracting

9.1 The ICB shall be responsible for ensuring appropriate arrangements are in place for the commissioning of the Delegated Services which for the avoidance of doubt includes:

9.1.1 co-ordinating or collaborating in the award of appropriate Specialised Service Contracts,

9.1.2 drafting of the contract schedules so that it reflects Mandatory Guidance, National Specifications and any specific instructions from NHS England, and

9.1.3 management of Specialised Services Contracts.

9.2 In relation to the contracting for NHS England Retained Services where the ICB has agreed to act as the co-ordinating commissioner, to implement NHS England's instructions in relation to those Retained Services and, where appropriate, put in place a Collaborative Commissioning Agreement with NHS England as a party.

10 Data Management and Analytics

10.1 The ICB shall:

10.1.1 lead on standardised collection, processing, and sharing of data for Delegated Services in line with broader NHS England, Department of Health and Social Care and government data strategies,

10.1.2 lead on the provision of data and analytical services to support commissioning of Delegated Services,

10.1.3 ensure collaborative working across partners on agreed programmes of work focusing on provision of pathway analytics,

10.1.4 share expertise and existing reporting tools with partner ICBs in the ICB Collaboration Arrangement,

10.1.5 ensure interpretation of data is made available to NHS England and other ICBs within the ICB Collaboration Arrangement,

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

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

11 Finance

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

12 Freedom of Information and Parliamentary Requests

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

13 Incident Response and Management

13.1 The ICB shall:

13.1.1 lead on local incident management for Delegated Services as appropriate to the stated incident level,

13.1.2 support national and regional incident management relating to Specialised Services, and

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

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

14 Individual Funding Requests

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

15 Innovation and New Treatments

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

16 Mental Health, Learning Disability and Autism NHS-led Provider Collaboratives

16.1 The ICB shall co-operate fully with NHS England in the development, management and operation of mental health, learning disability and autism NHS-led Provider Collaboratives including, where requested by NHS England, to consider the Provider Collaborative arrangements as part of the wider pathway delivery.

17 Provider Selection and Procurement

17.1 The ICB shall:

17.1.1 run appropriate local provider selection and procurement processes for Delegated Services,

17.1.2 align all procurement processes with any changes to national procurement policy (for example new legislation) for Delegated Services,

17.1.3 support NHS England with national procurements where required with subject matter expertise on provider engagement and provider landscape, and

17.1.4 monitor and provide advice, guidance and expertise to NHS England on the overall provider market and provider landscape.

17.2 In discharging these responsibilities, the ICB must comply at all times with Law and any relevant Guidance including but not limited to Mandated Guidance, any applicable procurement law and Guidance on the selection of, and award of contracts to, providers of healthcare services.

17.3 When the ICB makes decisions in connection with the awarding of Specialised Services Contracts, it should ensure that it can demonstrate compliance with requirements for the award of such Contracts, including that the decision was:

17.3.1 made in the best interest of patients, taxpayers and the Population,

17.3.2 robust and defensible, with conflicts of interests appropriately managed,

17.3.3 made transparently, and

17.3.4 compliant with relevant Guidance and legislation.

18 Quality

18.1 The ICB must ensure that appropriate arrangements for quality oversight are in place. This must include:

18.1.1 clearly defined roles and responsibilities for ensuring governance and oversight of Delegated Services,

18.1.2 defined roles and responsibilities for ensuring robust communication and appropriate feedback, particularly where Delegated Services are commissioned through an arrangement with one or more other ICBs,

18.1.3 working with providers and partner organisations to address any issues relating to Delegated Services and escalate appropriately if such issues cannot be resolved,

18.1.4 developing and standardising processes that align with regional systems to ensure oversight of the quality of Delegated Services, and participating in local System Quality Groups and Regional Quality Groups, or their equivalent,

18.1.5 ensuring processes are robust and concerns are identified, mitigated and escalated as necessary,

18.1.6 ensuring providers are held to account for delivery of safe, patient-focused and quality care for Delegated Services, including mechanisms for monitoring patient complaints, concerns and feedback, and

18.1.7 the implementation of the Patient Safety Incident Response Framework for the management of incidents and serious events, appropriate reporting of any incidents, undertaking any appropriate patient safety incident investigation and obtaining support as required.

18.2 The ICB must establish a plan to ensure that the quality of the Delegated Services is measured consistently, using nationally and locally agreed metrics triangulated with professional insight and soft intelligence.

18.3 The ICB must ensure that the oversight of the quality of the Delegated Services is integrated with wider quality governance in the local system and aligns with the NHS England National Quality Board's recommended quality escalation processes.

18.4 The ICB must ensure that there is a System Quality Group (or equivalent) to identify and manage concerns across the local system.

18.5 The ICB must ensure that there is appropriate representation at any Regional Quality Groups or their equivalent.

18.6 The ICB must have in place all appropriate arrangements in respect of child and adult safeguarding and comply with all relevant Guidance.

19 Service Planning and Strategic Priorities

19.1 The ICB is responsible for setting local commissioning strategy, policy and priorities and planning for and carrying out needs assessments for the Delegated Services.

19.2 In planning, commissioning and managing the Delegated Services, the ICB must have processes in place to assess and monitor equitable patient access, in accordance with the access criteria set out in Clinical Commissioning Policies and National Specifications, taking action to address any apparent anomalies.

19.3 The ICB must ensure that it works with Specialised Service Providers and Provider Collaboratives to translate local strategic priorities into operational outputs for Delegated Services.

19.4 The ICB shall provide input into any consideration by NHS England as to whether the commissioning responsibility in respect of any of the Retained Services should be delegated.

20 National Standards, National Specifications and Clinical Commissioning Policies

20.1 The ICB shall provide input into national decisions on National Standards and national transformation regarding Delegated Services through attendance at governance meetings.

20.2 The ICB shall facilitate engagement with local communities on National Specification development.

20.3 The ICB must comply with the National Specifications and relevant Clinical Commissioning Policies and ensure that all clinical Specialised Services Contracts accurately reflect Clinical Commissioning Policies and include the relevant National Specification, where one exists in relation to the relevant Delegated Service.

20.4 The ICB must co-operate with any NHS England activities relating to the assessment of compliance against National Standards, including through the Assurance Processes.

20.5 The ICB must have appropriate mechanisms in place to ensure National Standards and National Specifications are being adhered to.

20.6 Where the ICB has identified that a Specialised Services Provider may not be complying with the National Standards set out in the relevant National Specification, the ICB shall consider the action to take to address this in line with the Assurance Processes.

21 Transformation

21.1 The ICB shall:

21.1.1 prioritise pathways and services for transformation according to the needs of its Population and opportunities for improvement in ICB commissioned services and for Delegated Services,

21.1.2 lead ICB and ICB Collaboration Arrangement driven transformation programmes across pathways for Delegated Services,

21.1.3 lead the delivery locally of transformation in areas of national priority (such as Cancer, Mental Health and Learning Disability and Autism), including supporting delivery of commitments in the NHS Long Term Plan,

21.1.4 support NHS England with agreed transformational programmes for Retained Services,

21.1.5 support NHS England with agreed transformational programmes and identify future transformation programmes for consideration and prioritisation for Delegated Services where national co-ordination and enablement may support transformation,

21.1.6 work collaboratively with NHS England on the co-production and co-design of transformation and improvement interventions and solutions in those areas prioritised, and

21.1.7 ensure Relevant Clinical Networks and other clinical networks use levers to facilitate and embed transformation at a local level for Delegated Services.

SCHEDULE 4 RESERVED FUNCTIONS

Introduction

1 Reserved Functions in Relation to the Delegated Services

1.1 In accordance with Clause 6.2 of this Agreement, all functions of NHS England other than those defined as Delegated Functions, are Reserved Functions.

1.2 This Schedule sets out further provision regarding the carrying out of the Reserved Functions as they relate to the Delegated Functions.

1.3 The ICB will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions.

1.4 The following functions and related activities shall continue to be exercised by NHS England.

2 Retained Services

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

3 Reserved Specialised Service Functions

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

Reserved Functions

4 Assurance and Oversight

4.1 NHS England shall:

4.1.1 have oversight of what ICBs are delivering (inclusive of Delegated Services) for their Populations and all patients,

4.1.2 design and implement appropriate assurance of ICBs' exercise of Delegated Functions including the Assurance Processes,

4.1.3 help the ICB to coordinate and escalate improvement and resolution interventions where challenges are identified (as appropriate),

4.1.4 ensure that the NHS England Board is assured that Delegated Functions are being discharged appropriately,

4.1.5 ensure specialised commissioning considerations are appropriately included in NHS England frameworks that guide oversight and assurance of service delivery, and

4.1.6 host a Delegated Commissioning Group ("DCG") that will undertake an assurance role in line with the Assurance Processes. This assurance role shall include assessing and monitoring the overall coherence, stability and sustainability of the commissioning model of Specialised Services at a national level, including identification, review and management of appropriate cross-ICB risks.

5 Attendance at governance meetings

5.1 NHS England shall ensure that there is appropriate representation in respect of Reserved Functions and Retained Services at local governance forums (for example, the Regional Leadership Team) and at NCG.

5.2 NHS England shall:

5.2.1 ensure that there is appropriate representation by NHS England subject matter expert(s) at National Standards development forums,

5.2.2 ensure there is appropriate attendance by NHS England representatives at nationally led clinical governance meetings, and

5.2.3 co-ordinate, and support key national governance groups.

6 Clinical Leadership and Clinical Reference Groups

6.1 NHS England shall be responsible for the following:

6.1.1 developing local leadership and support for the ICB relating to Specialised Services,

6.1.2 providing clinical leadership, advice and guidance to the ICB in relation to the Delegated Services,

6.1.3 providing point-of-contact and ongoing engagement with key external bodies, such as interest groups, charities, NICE, DHSC, and Royal Colleges, and enabling access to clinical trials for new treatments and medicines.

6.2 NHS England will host Clinical Reference Groups, which will lead on the development and publication of the following for Specialised Services:

6.2.1 Clinical Commissioning Policies,

6.2.2 National Specifications, including National Standards for each of the Specialised Services.

7 Clinical Networks

7.1 Unless otherwise agreed between the Parties, NHS England shall put in place contractual arrangements and funding mechanisms for the commissioning of the Relevant Clinical Networks.

7.2 NHS England shall ensure development of multi-ICB, and multi-region (where necessary) governance and oversight arrangements for Relevant Clinical Networks that give line of sight between all clinical networks and all ICBs whose Population they serve.

7.3 NHS England shall be responsible for:

7.3.1 developing national policy for the Relevant Clinical Networks,

7.3.2 developing and approving the specifications for the Relevant Clinical Networks,

7.3.3 maintaining links with other NHS England national leads for clinical networks not focused on Specialised Services,

7.3.4 convening or supporting national networks of the Relevant Clinical Networks,

7.3.5 agreeing the annual plan for each Relevant Clinical Network with the involvement of the ICB and Relevant Clinical Network, ensuring these reflect national and regional priorities,

7.3.6 managing Relevant Clinical Networks jointly with the ICB, and

7.3.7 agreeing and commissioning the hosting arrangements of the Relevant Clinical Networks.

8 Complaints

8.1 NHS England shall manage all complaints in respect of the Delegated Services at the date of this Agreement and until such time as it agrees the delegation of complaints to the ICB.

8.2 NHS England shall manage all complaints in respect of the Reserved Services.

9 Commissioning and optimisation of High Cost Drugs

9.1 In respect of pharmacy and optimisation of High Cost Drugs, NHS England shall:

9.1.1 comply as appropriate with the centralised process for the reimbursement of Specialised Services High Cost Drugs and, where appropriate, ensuring that only validated drugs spend is reimbursed, there is timely drugs data and drugs data quality meets the standards set nationally,

9.1.2 support the ICB on strategy for access to medicines used within Delegated Services, minimising barriers to health inequalities,

9.1.3 provide support, as reasonably required, to the ICB to assist it in the commissioning of High Cost Drugs for Delegated Services including shared care agreements,

9.1.4 seek to address consistency of prescribing in line with national commissioning policies, introduction of new medicines, and addressing unwarranted prescribing variation,

9.1.5 provide input into national procurement, homecare and commercial processes,

9.1.6 provide expert medicines advice and input into immunoglobin assessment panels and support to the national Programmes of Care and Clinical Reference Groups,

9.1.7 provide expert medicines advice and input into the Individual Funding Request process for Delegated Services, and

9.1.8 collaborate with commissioners of health and justice services to ensure detained people can access High Cost Drugs using the NHS England or ICB commissioning policies in line with community patient access, including who prescribes and supplies the medicine.

10 Contracting

10.1 NHS England shall retain the following obligations in relation to contracting for Delegated Services:

10.1.1 ensure Specialised Services are included in national NHS England contracting and payment strategy (for example, Aligned Payment Incentives),

10.1.2 provide advice for ICBs on schedules to support the Delegated Services,

10.1.3 set, publish or make otherwise available the Contracting Standard Operating Procedure and Mandated Guidance detailing contracting strategy and policy for Specialised Services, and

10.1.4 provide and distribute contracting support tools and templates to the ICB.

10.2 In respect of the Retained Services, NHS England shall:

10.2.1 where appropriate, ensure a Collaborative Commissioning Agreement is in place between NHS England and the ICB(s), and

10.2.2 where appropriate, construct model template schedules for Retained Services and issue to ICBs.

11 Data Management and Analytics

11.1 NHS England shall:

11.1.1 support the ICB by collaborating with the wider data and analytics network (nationally) to support development and local deployment or utilisation of support tools,

11.1.2 support the ICB to address data quality and coverage needs, accuracy of reporting Specialised Services activity and spend on a Population basis to support commissioning of Specialised Services,

11.1.3 ensure inclusion of Specialised Services data strategy in broader NHS England, DHSC and government data strategies,

11.1.4 lead on defining relevant contractual content of the information schedule (Schedule 6) of the NHS Standard Contract for Clinical Services,

11.1.5 work collaboratively with the ICB to drive continual improvement of the quality and coverage of data used to support commissioning of Specialised Services,

11.1.6 provide a national analytical service to support oversight and assurance of Specialised Services, and support (where required) the national Specialised Commissioning team, Programmes of Care and Clinical Reference Groups, and

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

12 Finance

12.1 The provisions of Clause 10 shall apply in respect of the financial arrangements in respect of the Delegated Functions.

13 Freedom of Information and Parliamentary Requests

13.1 NHS England shall:

13.1.1 lead on handling, managing and responding to all national FOIA and parliamentary correspondence relating to Retained Services, and

13.1.2 co-ordinate a response when a single national response is required in respect of Delegated Services.

14 Incident Response and Management

14.1 NHS England shall:

14.1.1 provide guidance and support to the ICB in the event of a complex incident,

14.1.2 lead on national incident management for Specialised Services as appropriate to stated incident level and where nationally commissioned services are impacted,

14.1.3 lead on monitoring, planning and support for service and operational resilience at a national level and provide support to the ICB, and

14.1.4 respond to specific service interruptions where appropriate, for example, supplier and workforce challenges and provide support to the ICB in any response to interruptions.

15 Individual Funding Requests

15.1 NHS England shall be responsible for:

15.1.1 leading on Individual Funding Requests (IFR) policy, IFR governance and managing the IFR process for Delegated Services and Retained Services,

15.1.2 taking decisions in respect of IFRs at IFR Panels for both Delegated Services and Retained Services, and

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

16 Innovation and New Treatments

16.1 NHS England shall support the local implementation of innovative treatments for Delegated Services.

16.2 NHS England shall ensure services are in place for innovative treatments such as advanced medicinal therapy products recommended by NICE technology appraisals within statutory requirements.

16.3 NHS England shall provide national leadership for innovative treatments with significant service impacts including liaison with NICE.

17 Mental Health, Learning Disability and Autism NHS-led Provider Collaboratives

17.1 NHS England shall commission and design NHS-led Provider Collaborative arrangements for mental health, learning disability and autism services. Where it considers appropriate, NHS England shall seek the input of the ICB in relation to relevant Provider Collaborative arrangements.

18 Provider Selection and Procurement

18.1 In relation to procurement, NHS England shall be responsible for:

18.1.1 setting standards and agreeing frameworks and processes for provider selections and procurements for Specialised Services,

18.1.2 monitoring and providing advice, guidance and expertise on the overall provider market in relation to Specialised Services, and

18.1.3 where appropriate, running provider selection and procurement processes for Specialised Services.

19 Quality

19.1 In respect of quality, NHS England shall:

19.1.1 work with the ICB to ensure oversight of Specialised Services through quality surveillance and risk management and escalate as required,

19.1.2 work with the ICB to seek to ensure that quality and safety issues and risks are managed effectively and escalated to the National Specialised Commissioning Quality and Governance Group (QGG), or other appropriate forums, as necessary,

19.1.3 work with the ICB to seek to ensure that the quality governance and processes for Delegated Services are aligned and integrated with broader clinical quality governance and processes in accordance with National Quality Board Guidance,

19.1.4 facilitate improvement when quality issues impact nationally and regionally, through programme support, and mobilising intensive support when required on specific quality issues,

19.1.5 provide guidance on quality and clinical governance matters and benchmark available data,

19.1.6 support the ICB to identify key themes and trends and utilise data and intelligence to respond and monitor as necessary,

19.1.7 report on quality to both NCG and DCG as well as QGG and Executive Quality Group as required,

19.1.8 facilitate and support the national quality governance infrastructure (for example, the QGG), and

19.1.9 identify and act upon issues and concerns that cross multiple ICBs, coordinating response and management as necessary.

20 National Standards, National Specifications and Clinical Commissioning Policies

20.1 NHS England shall carry out:

20.1.1 development, engagement and approval of National Standards for Specialised Services (including National Specifications, Clinical Commissioning Policies, quality and data standards),

20.1.2 production of national commissioning products and tools to support commissioning of Specialised Services,

20.1.3 maintenance and publication of the Prescribed Specialised Services Manual and engagement with the DHSC on policy matters, and

20.1.4 determination of content for national clinical registries.

21 Transformation

21.1 NHS England shall be responsible for:

21.1.1 co-ordinating and enabling ICB-led specialised service transformation programmes for Delegated Services where necessary,

21.1.2 supporting the ICB to implement national policy and guidance across its Populations for Retained Services,

21.1.3 supporting the ICB with agreed transformational programmes where national transformation support has been agreed for Delegated Services,

21.1.4 providing leadership for transformation programmes and projects that have been identified as priorities for national coordination and support, or are national priorities for the NHS, including supporting delivery of commitments in the NHS Long Term Plan,

21.1.5 co-production and co-design of transformation programmes with the ICB and wider stakeholders, and

21.1.6 providing access to subject matter expertise including Clinical Reference Groups, national clinical directors, Programme of Care leads for the ICB where it needs support, including in relation to local priority transformation.

SCHEDULE 5 RETAINED SERVICES

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

SCHEDULE 6 FURTHER INFORMATION GOVERNANCE AND SHARING PROVISIONS

PART 1

1 Introduction

1.1 This Schedule sets out the scope for the secure and confidential sharing of information between the Parties on a Need To Know basis, in order to enable the Parties to exercise their functions in pursuance of this Agreement.

1.2 References in this Schedule (Further Information Governance and Sharing Provisions) to the Need to Know basis or requirement (as the context requires) should be taken to mean that the Data Controllers' Staff will only have access to Personal Data or Special Category Personal Data if it is lawful for such Staff to have access to such data for the Specified Purpose in paragraph 2.1 and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Special Category Personal Data specified.

1.3 This Schedule and the Data Sharing Agreements entered under this Schedule are designed to:

1.3.1 provide information about the reasons why Relevant Information may need to be shared and how this will be managed and controlled by the Parties,

1.3.2 describe the purposes for which the Parties have agreed to share Relevant Information,

1.3.3 set out the lawful basis for the sharing of information between the Parties, and the principles that underpin the exchange of Relevant Information,

1.3.4 describe roles and structures to support the exchange of Relevant Information between the Parties,

1.3.5 apply to the sharing of Relevant Information relating to Specialised Services Providers and their Staff,

1.3.6 apply to the sharing of Relevant Information whatever the medium in which it is held and however it is transmitted,

1.3.7 ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and how this sharing will be managed,

1.3.8 apply to the activities of the Parties' Staff, and

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

2 Purpose

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

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

3 Benefits of information sharing

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

4 Lawful basis for sharing

4.1 The Parties shall comply with all relevant Data Protection Legislation requirements and Good Practice in relation to the processing of Relevant Information shared further to this Agreement.

4.2 The Parties shall ensure that there is a Data Protection Impact Assessment ("DPIA") that covers processing undertaken in pursuance of the Specified Purpose. The DPIA shall identify the lawful basis for sharing Relevant Information for each purpose and data flow.

4.3 Where appropriate, the Relevant Information to be shared shall be set out in a Data Sharing Agreement.

5 Restrictions on use of the Shared Information

5.1 Each Party shall only process the Relevant Information as is necessary to achieve the Specified Purpose and, in particular, shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.

5.2 Access to, and processing of, the Relevant Information provided by a Party must be the minimum necessary to achieve the Specified Purpose. Information and Special Category Personal Data will be handled at all times on a restricted basis, in compliance with Data Protection Legislation requirements, and the Parties' Staff should only have access to Personal Data on a justifiable Need to Know basis.

5.3 Neither the provisions of this Schedule nor any associated Data Sharing Agreements should be taken to permit unrestricted access to data held by any of the Parties.

5.4 Neither Party shall subcontract any processing of the Relevant Information without the prior consent of the other Party. Where a Party subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor which imposes the same obligations as are imposed on the Data Controllers under this Agreement.

5.5 The Parties shall not cause or allow Data to be transferred to any territory outside the United Kingdom without the prior written permission of the responsible Data Controller.

5.6 Any particular restrictions on use of certain Relevant Information should be included in a Personal Data Agreement.

6 Ensuring fairness to the Data Subject

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

6.1.1 amendment of internal guidance to improve awareness and understanding among Staff,

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

6.1.3 ensuring that information and communications relating to the processing of data is clear and easily accessible, and

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

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

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

6.4 Further provision in relation to specific data flows may be included in a Personal Data Agreement between the Parties.

7 Governance: Staff

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

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

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

7.4 Each Party shall provide evidence (further to any reasonable request) that all Staff that have any access to the Relevant Information whatsoever are adequately and appropriately trained to comply with their responsibilities under Data Protection Legislation and this Agreement.

7.5 The Parties shall ensure that:

7.5.1 only those Staff involved in delivery of the Agreement use or have access to the Relevant Information,

7.5.2 that such access is granted on a strict Need to Know basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited. Evidence of audit should be made freely available on request by the originating Data Controller, and

7.5.3 specific limitations on the Staff who may have access to the Relevant Information are set out in any Data Sharing Agreement entered into in accordance with this Schedule.

8 Governance: Protection of Personal Data

8.1 At all times, the Parties shall have regard to the requirements of Data Protection Legislation and the rights of Data Subjects.

8.2 Wherever possible (in descending order of preference), only anonymised information, or, strongly or weakly pseudonymised information will be shared and processed by the Parties. The Parties shall co-operate in exploring alternative strategies to avoid the use of Personal Data in order to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data or Special Category Personal Data.

8.3 Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need to Know basis.

8.4 If any Party becomes aware of:

8.4.1 any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable, or

8.4.2 any security vulnerability or breach in respect of the Relevant Information,

it shall promptly, within 48 hours, notify the other Parties. The Parties shall fully co-operate with one another to remedy the issue as soon as reasonably practicable, and in making information about the incident available to the Information Commissioner and Data Subjects where required by Data Protection Legislation.

8.5 In processing any Relevant Information further to this Agreement, the Parties shall process the Personal Data and Special Category Personal Data only:

8.5.1 in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only in accordance with written instructions from the originating Data Controller in respect of its Relevant Information,

8.5.2 to the extent as is necessary for the provision of the Specified Purpose or as is required by law or any regulatory body, and

8.5.3 in accordance with Data Protection Legislation requirements, in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) UK GDPR, and not in such a way as to cause any other Data Controller to breach any of their applicable obligations under Data Protection Legislation.

8.6 The Parties shall act generally in accordance with Data Protection Legislation requirements. This includes implementing, maintaining and keeping under review appropriate technical and organisational measures to ensure and demonstrate that the processing of Personal Data is undertaken in accordance with Data Protection Legislation, and in particular to protect Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing, and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:

8.6.1 take account of the nature, scope, context and purposes of processing as well as the risks, of varying likelihood and severity for the rights and freedoms of Data Subjects, and

8.6.2 be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data and Special Category Personal Data, and having the nature of the Personal Data and Special Category Personal Data which is to be protected.

8.7 In particular, each Party shall:

8.7.1 ensure that only Staff as provided under this Schedule have access to the Personal Data and Special Category Personal Data,

8.7.2 ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and

proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display or distribution, of the Relevant Information,

8.7.3 obtain prior written consent from the originating Party in order to transfer the Relevant Information to any third party,

8.7.4 permit any other party or their representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors or assigns) and comply with all reasonable requests or directions to enable each Party to verify and/or procure that the other is in full compliance with its obligations under this Agreement, and

8.7.5 if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.

8.8 The Parties shall adhere to the specific requirements as to information security set out in any Data Sharing Agreement entered into in accordance with this Schedule.

8.9 The Parties shall use best endeavours to achieve and adhere to the requirements of the NHS Digital Data Security and Protection Toolkit.

8.10 The Parties' Single Points of Contact set out in paragraph 13 will be the persons who, in the first instance, will have oversight of third party security measures.

9 Governance: Transmission of Information between the Parties

9.1 This paragraph supplements paragraph 8 of this Schedule.

9.2 Transfer of Personal Data between the Parties shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net or gcsx) e-mail.

9.3 Wherever possible, Personal Data should be transmitted and held in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, so as to ensure that the correct patient record and/or data is identified.

9.4 Any other special measures relating to security of transfer should be specified in a Data Sharing Agreement entered into in accordance with this Schedule.

9.5 Each Party shall keep an audit log of Relevant Information transmitted and received in the course of this Agreement.

9.6 The Parties' Single Point of Contact notified pursuant to paragraph 13 will be the persons who, in the first instance, will have oversight of the transmission of information between the Parties.

10 Governance: Quality of Information

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

11 Governance: Retention and Disposal of Shared Information

11.1 A non-originating Party shall securely destroy or return the Relevant Information once the need to use it has passed or, if later, upon the termination of this Agreement, howsoever determined. Where Relevant Information is held electronically, the Relevant Information will be deleted and formal notice of the deletion sent to the Party that shared the Relevant Information. Once paper information is no longer required, paper records will be securely destroyed or securely returned to the Party they came from.

11.2 Each Party shall provide an explanation of the processes used to securely destroy or return the information, or verify such destruction or return, upon request and shall comply with any request of the Data Controllers to dispose of data in accordance with specified standards or criteria.

11.3 If a Party is required by any law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy in accordance with this Schedule, it shall notify the other Parties in writing of that retention, giving details of the documents or materials that it must retain.

11.4 Retention of any data shall comply with the requirements of Article 5(1)(e) GDPR and with all Good Practice including the Records Management NHS Code of Practice, as updated or amended from time to time.

11.5 The Parties shall set out any special retention periods in a Data Sharing Agreement where appropriate.

11.6 The Parties shall ensure that Relevant Information held in paper form is held in secure files, and, when it is no-longer needed, destroyed using a cross cut shredder or subcontracted to a confidential waste company that complies with European Standard EN15713.

11.7 Each Party shall ensure that, when no longer required, electronic storage media used to hold or process Personal Data are destroyed or overwritten to current policy requirements.

11.8 Electronic records will be considered for deletion once the relevant retention period has ended.

11.9 In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Party shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

12 Governance: Complaints and Access to Personal Data

12.1 The Parties shall assist each other in responding to any requests made under Data Protection Legislation made by persons who wish to access copies of information held about them ("Subject Access Requests"), as well as any other exercise of a Data Subject's rights under Data Protection Legislation or complaint to or investigation undertaken by the Information Commissioner.

12.2 Complaints about information sharing shall be reported to the Single Points of Contact and the ICB. Complaints about information sharing shall be routed through each Parties' own complaints procedure unless otherwise provided for in the Agreement or determined by the ICB.

12.3 The Parties shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Schedule or any data processing carried out further to it.

12.4 Basic details of the Agreement shall be included in the appropriate log under each Party's publication scheme.

13 Governance: Single Points of Contact

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

14 Monitoring and review

14.1 The Parties shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Data Protection Legislation and best practice.

Specific monitoring requirements must be set out in the relevant Data Sharing Agreement.

SCHEDULE 7 MANDATED GUIDANCE

Generally applicable Mandated Guidance

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

Workforce

- Guidance on the Employment Commitment.

Finance

- Guidance on NHS System Capital Envelopes.
- Managing Public Money (HM Treasury).

Specialised Services Mandated Guidance

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

SCHEDULE 8 LOCAL TERMS

The ICB, along with the other five ICBs in the East of England region and NHS England, has signed a Collaboration Agreement that sets out the detail needed to ensure that delegated specialised commissioned services are delivered safely and effectively.

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

General

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

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

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

Part 1 – the service Name and/or job title of designated substitute from the ICB s to be planned or commissioned at an ICB level

In the first instance, all delegated services will be commissioned collectively by all six ICBs. Any changes to this arrangement will be reflected in the Collaboration Agreement, Schedule 3 (Individual Schemes).

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

In the first instance, all delegated services will be commissioned collectively by all six ICBs. Any changes to this arrangement will be reflected in the Collaboration Agreement, Schedule 3 (Individual Schemes).

Part 3 – Funding arrangements

Funding arrangements are set out in the Collaboration Agreement, Schedule 4 (Financial Arrangements).

Part 3 – Workforce and Commissioning Team Arrangements

Workforce and commissioning team arrangements are set out in the Collaboration Agreement, Schedule 5 (Commissioning Team Arrangements).

Part 4 – ICB Collaboration Arrangements

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

Part 5 – Pooled Funds and Non-Pooled Funds

The ICBs have determined that they will not seek to create Pooled or Non-Pooled Funds. Financial arrangements are set out in the Collaboration Agreement, Schedule 4 (Financial Arrangements).

Part 6 – Provider Collaboratives

There are currently no arrangements to delegate functions to provider collaboratives.

Part 7 – Further Governance Arrangements

The Partners have established a Joint Commissioning Consortium to oversee and take decisions in relation to the Delegated Services. The Joint Commissioning Consortium will also oversee and advise NHS England on its retained commissioning activity. Terms of reference for the Consortium have been agreed as a separate document.

The Joint Commissioning Consortium is not a formal committee of the Board and its members will be Authorised Officers from each of the ICBs and NHS England. The ICB shall ensure that their Authorised Officer and any substitutes have appropriate delegated authority, in accordance with the ICB's Scheme of Reservation and Delegation, to represent the interests of the ICB on the Consortium and any other sub-groups established by the Consortium.

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

SCHEDULE 9 DEVELOPMENTAL ARRANGEMENTS

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

The Developmental Arrangements

There are no developmental arrangements in place for the ICB for this agreement.

SCHEDULE 10 ADMINISTRATIVE AND MANAGEMENT SERVICES

Administrative and management services are set out in the Collaboration Agreement, Schedule 6 (Commissioning Team Arrangements).

9. Duty to Engage

9.1. Communications and Engagement Strategy –

MSE ICS Communications and Engagement Strategy 2025-2027

Mid and South Essex Integrated Care System

NHS
Mid and South Essex
Integrated Care Board

Communications and Engagement Strategy REFRESH

2025-2027

November 2024

Contents

1. Introduction by the Chief Executive

As we face an era marked by both unprecedented opportunities and challenges in healthcare, our commitment to a transparent and collaborative approach in how we communicate and engage with our population has never been more essential.

At the Mid and South Essex Integrated Care Board (ICB), we recognise that meaningful communication and engagement lie at the heart of achieving impactful health outcomes. Our collective journey toward a more coordinated, person-centred system of care requires clear, honest conversations with our communities, staff, and partners.

This refreshed Communications and Engagement Strategy for 2025-2027 serves as a foundational tool to strengthen those conversations and foster connections across the diverse network of individuals and organisations we serve.

In an environment shaped by financial and resource limitations, we aim to be intentional and data-driven, focusing on targeted, efficient communication that resonates.

As we move forward, we remain dedicated to integrating feedback, innovating with new technologies, and continuously refining our approach.

This strategy not only guides our communications but also embodies our commitment to inclusivity, transparency, and mutual respect.

I am confident that through this approach, we will build lasting trust and work collaboratively to realise our shared vision for a resilient, inclusive, and responsive health and care system.

Tom Abell, Chief Executive, Mid and South Essex Integrated Care Board

2. Executive Summary

The 2025-2027 Communications and Engagement Strategy for the Mid and South Essex Integrated Care System (ICS) outlines our renewed focus on fostering clear, effective communication with the people we serve, our workforce, and our broader healthcare network. With this strategy, the ICS commits to a proactive, audience-driven approach that leverages insights, transparency, and adaptability to address the evolving needs of our communities and stakeholders.

Key components of the strategy include:

- **Purpose and Vision**: The strategy reaffirms our commitment to delivering high-quality, accessible communication that builds trust, understanding, and partnership with our communities. We will prioritize inclusivity and accessibility to support a health system that is accountable, transparent, and grounded in the needs of those it serves.

- **Targeted Engagement**: By segmenting our audiences and refining our channels, we aim to deliver the right messages, in the right ways, at the right times. This approach will ensure that our communication efforts are not only efficient but also impactful, promoting engagement that is both genuine and effective.

- **Strategic Priorities and Flexibility**: This strategy aligns with the ICS's broader medium-term plan, focusing on three main areas—supporting system-wide priorities, enhancing business-as-usual communications, and fostering organisational development. A triaged approach will allow us to prioritise resources effectively and respond flexibly to emerging issues.

- **Performance Measurement**: Through a structured, evidence-led evaluation framework, we will track our impact, using data to refine and adjust our approach. Quarterly reports will provide insights into our progress, helping us demonstrate our commitment to accountability and continuous improvement.

- **Commitment to Innovation and Inclusivity**: The strategy embraces digital advancements and inclusive practices, ensuring our communications meet the diverse needs of our audiences. We will support our teams and leaders in fostering a culture of open, two-way communication to build a more resilient and community-centred healthcare environment.

With a structured yet adaptable approach, the 2025-2027 strategy represents our pledge to communicate effectively and engage authentically. We are committed to working alongside our communities and partners, listening to their insights, and building a healthcare system that reflects their needs and values.

3. Introduction

Since the publication of the original ICS Communications Strategy in 2021, the ICB has had to respond to a national reduction in running cost

allowances that has seen the communications and engagement function reduce in line with the organisational change process.

To support this shift, there have been several changes to how programmes of work are resourced outside of the core corporate communications team, with wider teams asked to take on more responsibility for their own communication and engagement needs.

To support this shift, all ICB staff are supported through a self-service portal on Connect (Intranet) that provides guidelines, templates, and resources. The team has also introduced a digital team handbook that includes links to key communications documents, 'how to' assets and important information that can be accessed quickly in a single space to support team resilience.

The new structure also now encompasses a corporate communications, engagement, and partnerships function.

This function supports the ICB's strategic objectives by fostering transparency, trust, and engagement through comprehensive communication strategies and initiatives. The team also provides a delivery and coordination role across the system partnership to support the work of the Integrated Care Strategy and other cross-cutting workstreams.

This strategy has been drafted in collaboration with our NHS and wider system partners, who will share responsibility for supporting the delivery of the strategic objectives through a wide range of communications and engagement channels and techniques.

Section 1 describes the purpose, vision, approaches and responsibilities of Communications and Engagement, i.e. the role of communications and engagement in our organisation; the vision for how the team will carry out that role, using professional and principled approaches; and clarifies what the ICB is responsible for communicating and engaging on and what are the responsibilities of others.

Section 2 contains a summary of how we have listened and adapted our approach in direct response to feedback from our key audiences. It sets out the variety of internal and external stakeholders and audiences that we need to reach, and the range of channels that we can use to reach them, in order to communicate and engage with them effectively – the right messages, through the right channels, at the right time.

Section 3 sets out the detailed plan for the wide range of activities that Communications and Engagement will be undertaking over the coming two years, which is based on the ICB's stated goals, agreed system strategic priorities and the actions that flow from them.

Communication and engagement plans in 2025-27 will therefore focus on three core areas:

1. Supporting the system strategic priorities as set out in the Joint Forward Plan and the developing Medium-Term Plan through delivery of effective **proactive communications campaigns**, in partnership with other system stakeholders.

2. Supporting the ongoing business as usual activities in **managing ongoing requests to support routine and urgent communications** to key audiences.

3. Supporting the **ICBs organisational development programme**, especially in relation to engaging with our workforce to improve staff experiences.

In addition, the team will need to respond to any **emerging issues, crises, and new initiatives**.

4. Section One: Our purpose, vision, approaches and responsibilities

4.1. Our purpose

Communications and engagement do not exist for itself but are an enabler and facilitator for others. The purpose of public sector communications is defined by the national Government Communications Service approach of 'CORE' activity:

- Changing behaviours – through planning and initiating campaigns that create desired positive behaviours among targeted audience groups, based on data, insight and behavioural science.

- Operational effectiveness – supporting services by providing the information that people need to access them; informing residents in a timely and co-ordinated way about service decisions, actions and changes; being honest in recognising problems or failures; using engaging and accessible content.

- Reputation – of our organisation and the NHS in our area, by building positive relationships with partners and stakeholders; collaborating in how we communicate and engage genuinely with residents; promoting and celebrating what we do well; and dealing effectively with crises.

- Explaining – our decisions, priorities and policies, through honest and transparent communications via accessible channels, that set out the

reasoning behind decisions and proposed changes, and any impact they have on finances, services and health and care outcomes.

We have a range of **statutory duties** that we must meet under the Health and Social Care Act 2012. Most relevant to this strategy is our statutory duty to involve people, whether directly

or through representatives, in:

- planning the provision of services
- the development and consideration of proposals for changes to the way services are provided
- decisions to be made affecting the operation of services.

The Act also places a specific duty to ensure that health services are provided in a way that promotes the NHS Constitution – and to promote awareness of the NHS Constitution. NHS organisations also have a duty under section 244 of the Health and Social Care Act to consult the local Health Scrutiny Committee on any proposal for 'substantial development or variation of health services.

Other statutory duties relevant to this strategy are the Public Sector Equality Duty – Equality Act 2010 and the Accessible Information Standard.

These and other responsibilities are reflected in a dedicated 'Working with People and Communities' approach set out on the ICS website.

4.2. Our vision

The vision for our function is:

- To be seen as trusted advisers and respected by our colleagues to produce high-quality, accessible and strategically aligned communications and engagement approaches, which are tailored for target audiences and enable two-way communications.

- To support the organisation to facilitate relationships and build trust with staff, partners and communities, building and enhancing the ICBs reputation and providing contextual intelligence to help make sure communications are timely, relevant and resonate with key audiences.

- To be a leading in-house communications and engagement team, which delivers innovative approaches and attracts, retains and develops great communications and engagement professionals.

4.3. Our approaches

The fundamental approaches that the Communications and Engagement team will use to deliver our purpose, vision and the specific activities set out in section 3 are:

- We will maintain a flexible communications approach that allows for immediate reallocation of resources to address urgent and crisis situations. This will see less critical work temporarily paused as needed in line with agreed priorities.

- We will continue to build trusted relationships with leaders and managers inside the ICS and with alliance leads to ensure that we are fully informed about and engaged in issues, priorities and activities from the outset.

- We will directly link measurable communications objectives and outcomes to the ICB's strategic priorities.

- We will understand and segment audiences, by making use of behavioural, demographic, public opinion and other relevant insights, to inform how we can best communicate and engage with them.

- We will develop the wide range of direct and indirect communication channels available to us and identify which are the most effective to use for each audience and issue.

- We will provide trustworthy, timely, concise, consistent, clear, accurate and accessible information for our audiences, focusing on what they need to know, not everything that we know.

- We will develop and strengthen structures, arrangements and processes for meaningful, effective and sustainable communication and engagement with key stakeholders, including members, partners, patients, politicians, the public and local community groups, GP practices, community pharmacies, dental practices, general ophthalmic service providers and ICB staff.

- We will listen and respond to residents' and stakeholders' views, promoting a culture where the experience of residents and our communities is at the centre of everything we do, through effective, two-way engagement, to ensure both that we meet our statutory obligations and that we genuinely seek their input in developing priorities and plans.

- We will take a campaigns-based communications and engagement approach to support the ICB's priorities, adapting plans in line with

contextual intelligence.

- We will establish and continually improve communications and engagement standards in our function by listening, learning and acting on feedback and insights.

- We will continue to strengthen the role and effectiveness of the communications network from across the system to improve how we collectively plan and implement communications and engagement, exploring opportunities to support system efficiencies through joint procurements, maximising AI-generative opportunities, in line with the Government Communications Service generative AI policy and future ICB organisational policy.

- We will continually evaluate the effectiveness of our efforts and embedding a culture of continuous learning.

4.4. Our communication and engagement responsibilities

While the ICB is responsible for governance, strategy and funding of health and social care in our area, the delivery of that care is the responsibility of the many health providers, from pharmacy to hospitals. This split of responsibilities is therefore similarly reflected in who is responsible for communicating what within our health and care system.

ICB Communications and Engagement is responsible for:

- working with system partners to embed a strategic approach to communications - building common ambition across the health and care system helping promote strong partnership working. Since the establishment of the ICS, communications lead from across the system have built strong relationships, identifying activities that can be jointly planned and delivered, including system-wide campaigns and programmes with an opportunity to build on shared ways of working and jointly procured tools to help demonstrate value. This collaborative approach minimises risk and optimises the use of resources, effort, and communications impact across the health and care.

- Development of shared narrative linked to system-wide priority programmes.

- Working with partners to adopt ensure continuous relationship building with key stakeholders.

- Providing counsel, support and training to leaders and spokespeople for media, internal and public engagement events

- Raising awareness and understanding of the work of the ICB and our system priorities among all staff and key stakeholders and ensuring that people are kept informed in a timely, appropriate and consistent way.

- Supporting both proactive and reactive media relations in line with the ICB media policy and horizon scanning to widen understanding of and support for the work of the ICS and detect, prevent and contain issues.
- Providing an overarching framework for the use of social media within the Integrated Care Board. See ICB social media policy for more information.

- Delivering the internal communications programme to colleagues directly employed by the ICB

- Supporting the delivery of the key strategic programme objectives

- Functional communications to ensure the timely cascade of messages and effective crisis management in line with our responsibilities as a Category 1 responder and the ICB Communications Incident Response Plan, see Appendix 1.

- Planning and providing appropriate engagement activities that bring real opportunities for local people, communities, partners and staff to be involved and to ensure our communications and engagement work is coordinated across our partnership to avoid duplication. Please see this webpage for more information on the ICBs 'Working with People and Communities' approach.

However, it is important to recognise that communication and engagement, whether internal or facing outwards, is the responsibility of all who work in health and care, especially leaders and managers, and this will be an important feature in the culture we wish to build.

The **Mid and South Essex NHS Foundation Trust** is responsible for communications and engagement with their staff and patients about the work and performance of our three acute hospitals – Basildon, Broomfield and Southend and their satellite clinics and services.

Our three **community and mental health providers** individually and collectively– Essex Partnership University Foundation Trust, North East London NHS Foundation Trust and Provide Community Interest Company and via our **Community Collaborative** – are responsible for communicating with their staff and patients and about their services and performance.

Essex Partnership University Foundation Trust is responsible for communications to staff and patients about the work and performance of its adult and acute children's mental health services and **North East London NHS Foundation Trust** for its Emotional Wellbeing and Mental Health Service for children across Essex.

The **East of England Ambulance Services Trust** is similarly responsible for communications and engagement about its services and performance.

Our **partner local authorities** communicate with their residents on the social care services that they provide, and are also the communications lead, through their directors of public health, on a range of wider public health matters.

Our **Primary Care providers** communicate with their patient populations and for general practice in particular, must undertake community engagement through for example patient participation groups.

Finally, Healthwatch and our **voluntary and charitable sector partners** also communicate with their users and members and work closely with us to support how we engage effectively with different communities.

Who communicates what depends on several factors: what the organisation does; what statutory responsibilities it has; who its main stakeholders and users are; and the geographical level at which it works – from local neighbourhood to place to system.

This can be more easily understood in four simple communications categories, where an organisation has the following communications and engagement responsibilities, depending on the issue:

- **Own** – sole, direct (or statutory) responsibility to deliver
- **Lead** – lead responsibility to deliver, but must engage and agree with partners
- **Partner** – shared responsibility to deliver with one or more partners
- **Influence** – responsibility to engage and influence, but not directly to deliver.

The ICB communications and engagement team will ensure that we play our full role across the health system in our area, from delivering communications and engagement activities where we own or have statutory or lead responsibility for the issue, through to engaging with and influencing our partners, where they bear the specific responsibility for delivering communications and engagement.

We will also ensure that responsibility sits where it belongs, so that we do not take on the delivery of activities that should be done elsewhere.

5. Section Two: Our audiences and channels

5.1. Our audiences

Our ICS system covers 1.2 million residents. We have around 40,000 health and care staff across the NHS – around 400 of whom will work directly in the ICB, but tens of thousands more work in GP surgeries, local pharmacies, opticians, dental practices, hospitals, care homes and other partner organisations. We also work with local and national political audiences, regional and national NHS, the Department for Health and Social Care, local and national media, professional membership and regulatory bodies, voluntary, community and faith sector organisations, and trades unions. See Figure 2 for more information.

These audiences are not homogeneous – and especially our residents, who will have very different social and economic circumstances, demographics, culture, outlook, education, interests and needs.

We need to understand our audiences, so we can reach them in the right way, with the right messages, at the right time, through the right channels, so that they will hear, think and act on what we are telling them. Excellent communication and behaviour change relies on strong and sound datasets. Our work will use data and audience insight to shape our communications – both the messaging and the way in which it should be delivered.

5.2. Summary of findings from our 2024 communications surveys

To continually improve our communications strategy, it's essential to regularly evaluate what's working well and what isn't. To inform our strategy refresh, four separate surveys were issued to the below audiences:

- Staff
- Stakeholders
- Primary care
- General public

A summary of key findings and how we will adapt our approach is below. A more detailed breakdown of the feedback and methodology can be found in Appendix 2.

5.3. Key findings

There was good awareness of our corporate communications channels across most internal and primary care audiences. The effectiveness and tone of communications also scored positively. Opportunities for

improvement included promotion of the primary care channels to staff and as part of primary care/PCN induction programmes, suggestions for how we might organise and better schedule communications, plus ideas for improving search functionality and clarity of content – removing acronyms wherever possible. Feedback also included a request to involve people more, with a less top-down approach to staff briefings and transformation programmes preferred.

Outputs of the public and stakeholder surveys demonstrated a perceived lack of both awareness and effectiveness in ICB corporate communications channels. While stakeholder emails were rated positively, certain social media channels such as X (Twitter), YouTube and Instagram consistently scored lower than other methods of corporate communications with concerns expressed about an overreliance on digital media and an overall preference for more face-to-face engagement. Opportunities for improvement include exploring how we can ensure more tailored and targeted messaging across the different channels, with less 'common sense' 'patronising' generic content. Themes of public feedback also demonstrated a perception of spin and a need for more transparency and honesty.

**It is important to note the responses of the survey are likely to have been impacted by the status of a public consultation that has attracted widespread objection to proposals that risk the closure of a community hospital.*

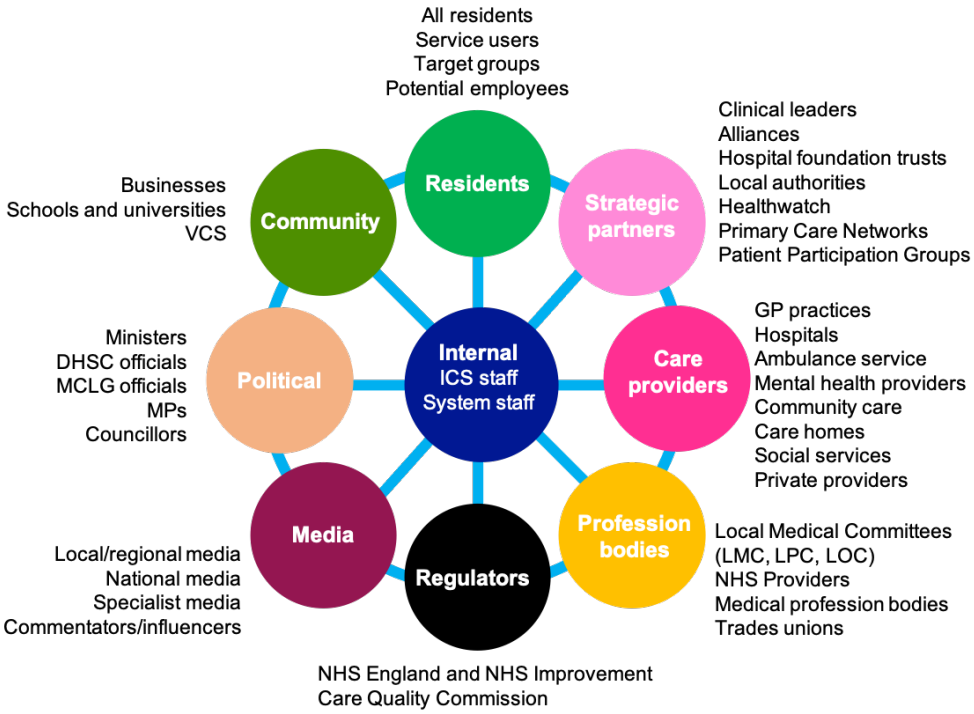
Observations about the frequency and clarity of some communications from the public and stakeholders were also consistent with feedback from internal audiences.

We will continue to develop what is working well to tailor our activities so that we reach the right audiences and will need colleagues who know those audiences best to help us to access data and insight into behaviours and preferences so that we have the best chance of getting this right.

Fairness will be integral to our approach, as we ensure that we tailor our communications well, working to avoid devoting our responsive resource to those who have the loudest voices, rather than the greatest need.

Figure 2 summarises the many different audiences that we need to engage with.

Figure 2 ICS Audience Wheel



Plain text descripton for figure 2: The infographic shows a circular network diagram with eight circles around a central circle.

The central circle represents Internal ICS Staff / System Staff.

The eight surrounding circles represent stakeholder groups connected by lines to the central circle. The lines connecting each stakeholder group to the central circle suggest interactions or relationships between them. The eight stakeholder groups are:

1. Residents
2. Strategic Partners
3. Care Providers
4. Professional Bodies
5. Regulator
6. Media
7. Political
8. Community

5.4. Our channels

Communications channels are the different ways by which we communicate and engage with our many audiences. Much of that we will do directly, although we will also communicate through third-party partners, such as hospitals and voluntary and charitable organisations, where they are best placed to reach specific audiences, and through other intermediaries, such as the media.

In selecting the right channel for the audience, we will always bear in mind both its effectiveness and cost effectiveness, and in most cases, this will mean a digital-first approach.

The main channels we use are:

- **Face-to-face** – one-to-one and group meetings, briefings, drop-ins, workshops, large events and exhibitions (either virtual or in person).

- **Media** – local and national print and online newspapers, local and specialist magazines, local and national radio and television and online-only media.

- **Print** – letters, leaflets, newsletters, print advertisements, posters, forms, magazines, printed reports, briefings and consultations.

- **Internal digital** – our own staff intranet, internal webchat, discussion forums, all-staff/team email announcements and briefings, email bulletins and lock-screen messages.

- **External digital** – our own websites, digital engagement platform, partner/campaign/interest group websites, blogs and vlogs.

- **E-marketing** – an established subscriber database continues to grow enabling us to target information to 000's of residents who have registered to receive information on specific topics.

- **Social media** – X, Facebook, Instagram and LinkedIn.

- **Marketing** – banner-type promotion messages on our website, external digital advertising, print, radio, television and out-of-home advertising, promotion via third-party/partner channels and direct mail to residents' homes

5.5. Some essential principles

Regardless of the channel we use, there are some essential principles of good communication that we will adhere to:

- Write in plain, accessible and inclusive language, in short sentences, which are free from jargon and acronyms.

- Focus on what people really need to know, not on everything we might know.

- Use data and insights into audiences and areas to tailor communication to people and place.
- Ensure messages are consistent and repeated but tailored across channels and audiences.

- Use the spokespeople most appropriate to the audience and issue – especially recognising that clinicians are best placed to communicate to residents on health matters.

- Work with our communities to help shape and inform our communications.

- Ensure our communications are inclusive and accessible, avoiding a reliance on digital media using ALT text, subtitles and other means of ensuring accessibility in our communications

- Use well-designed images and photography to bring concepts to live

- Use infographics, graphs and charts to help with the understanding of complex numbers

- Use video as a substitute for or supplement to documents, to engage those who prefer to watch and listen than read

- Empower and inform internal audiences on what good communications look like, ensure relevant policies are kept up to date and adhered to.

- Apply the organisation's brand, colour palette, font and house style rigorously and consistently, so that audiences can recognise and trust what they are receiving.

- Prioritise and schedule communications, to avoid bombarding audiences with multiple messages and topics.

- Communicate to colleagues first (wherever possible) so they are equipped with accurate information and are aware of the wider impact and how to handle queries from residents/patients.

- Actively listen and respond to stakeholder views.

6. Section Three: Communication and engagement plans

6.1. Our communication and engagement plans for 2025-2027

Our communication and engagement plans in 2025-27 will focus on three core areas:

1. Supporting the system strategic priorities as set out in the Joint Forward Plan and developing Medium-Term Plan through delivery of effective **proactive communications campaigns**, in partnership with other system stakeholders.

2. Supporting the ongoing business as usual activities in **managing ongoing requests to support routine and urgent communications** to key audiences.

3. Supporting the **ICBs organisational development programme**, especially in relation to engaging with our workforce to improve staff experiences.

With limited resources, it will never be possible to meet everyone's expectations for communications and engagement support, so we will need to prioritise our work to these three areas, with a tiered level of support, depending on the level of priority and impact. We also need the capacity to respond to emerging issues and to deal with crises.

To ensure that we focus our resources and efforts on what is critical and important, we therefore triage communications and engagement work as red, amber and green rated, as follows:

Red rated **Critical – must do**	**Amber rated** **Important – should do**	**Green rated** **Nice to have – if possible**
• Primary strategic priority • Major incident response • Statutory obligation • High reputational risk to the organisation or system • High level of outcome or impact • High level of resource allocated	• Secondary strategic priority • Minor incident response • Medium level of reputational risk to the organisation or system • Medium level of outcome or impact • Medium level of resource allocated	• Not a strategic priority • Not time sensitive • Low reputational risk to the organisation or system • Low level of outcome or impact • Low level of resource allocated

Since the scope of our work is linked to the priorities established by the ICB and the resources we have available, we expect leaders, managers and colleagues to recognise and respect our responsibility to prioritise our work and engage with us collaboratively and as early as possible, so that we can plan ahead to deliver as much as possible.

While we cannot avoid a sudden and unexpected incident or crisis, we must avoid a situation in which requests and demands are brought to the team at a very late stage, leading to knock-on impacts on other critical or important activities. Communications and engagement must be involved early in projects and workstreams, so that we can provide advice and properly plan our activities and resource to support them.

6.2. System strategic priorities as set out in the Joint Forward Plan and Medium-Term Plan

The extensive actions, initiatives, programmes and projects which flow from these system strategic priorities will determine a large part of the Communications and Engagement team's activities. Each priority will need to have a planned and implemented communication and engagement plan with a detailed campaign plan, measurable objectives and intended outcomes (see 'Our campaigns approach in section 4).

Senior responsible officers and clinical leads are still developing the detailed objectives, outcomes, actions and activities that will underpin and deliver these system strategic priorities, so we are unable to provide a breakdown of the communications and engagement objectives and activities needed to support them currently.

However, we can predict that a proportion of the work of the Communications and Engagement Team will involve these priorities, and even if we cannot be clear about precisely what is needed and when, we know that they will draw on the breadth of the team's capabilities and the spectrum of channels that we use.

6.3. Supporting the ongoing business as usual activities

The day-to-day work of communications supports our health and care colleagues to deliver their services effectively. Keeping residents aware of how to access those services, involving, engaging and where appropriate consulting with them when things are changing and advising them about what they need to do because of those changes.

This is the bread and butter of operational communications, whether for internal or external audiences, delivered through, regular bulletins, media releases, social media posts and videos, keeping websites and intranets updated, advertising, posters, leaflets, newsletters and other channels.

While we undertake a huge volume of activity to support day-to-day health and care services, a lot is also delivered by our partners (see 'our responsibilities' in section 1). Below is a summary of the day-to-day corporate communications and the business-as-usual health and care communications on which we are currently engaged.

6.4. Corporate communications

We do a lot of corporate communications and engagement as part of our everyday work, which will continue, including:

- **Internal communications** to colleagues about their role in delivering system strategic priorities, pay, HR, health and safety and other internal issues, actions needed.

- Regular liaison with **system and regional communications teams** to ensure appropriate co-ordination and consistency of messaging.

- **Drafting, editing and publishing** corporate publications including strategies, plans, consultations and reports.

- Preparing **briefings and presentations** for ICS senior leaders.

- Managing and developing the **ICS/B website, intranets (ICB staff and primary care) and corporate social media channels**.

- Dealing with day-to-day media requests and **parliamentary requests** for information, statements and interviews.

- Supporting **corporate governance/ transparency in decision making**, promoting access to board meetings, papers and opportunity to submit questions.

- Preparing and **training spokespeople** for media interviews.

- Ensuring regular flow of **proactive media releases and emails to our comprehensive subscriber** list to help communicate the work of the ICS and important information to support local health and care.

- Design and delivery of **evidence-based system campaigns** to support local priorities e.g., winter preparedness.

- Support and advice on designing and producing **graphics, branding and collateral**.

- Planning, filming, editing and publishing **audio and video material**.

- Regular **stakeholder engagement** including **MP enquiries and other briefing sessions** in partnership with system colleagues.
- Supporting and promoting **staff recognition and reward events**.
- Organising **events, conferences and webinars as necessary**.
- Regular **bulletins to key audiences** and stakeholders.
- Reputation and **incident/crisis management** communications.

6.5. GP/Primary care communications

We provide support, advice and day-to-day communications **assistance to GP practices** on a range of issues and topics in our role as delegated commissioners for these services, including:

- Supporting **communication and engagement of merger/closure of practices** or moving to new premises.
- Changes in **contracts or performance related issues**.
- **Capital investment programmes** and **procurements**.
- **Cascade of information to practices** from ICB/system and regional and national NHS bodies through **bulletins, news sections on the primary care hub and webinars**.
- **Working with and supporting Primary Care Networks**.
- Managing the **publication of practice-level CQC reports and suspension**.
- **Advising on feedback received on social media or reactive media enquiries**.
- Other reputational issues such as **serious incidents/outbreaks**.

6.6. Public engagement

In line with our statutory duties, we lead **engagement activities**, including patient participation groups, Virtual Views citizens' panel and targeted outreach sessions. We 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. Working with clinical leads, we will

seek to ensure that we consult and engage with representative and targeted patient groups, so that we do not rely on the same voices.

6.7. Programme communications and matrix working

During the 2023/24 ICB restructure, the communications, engagement and partnerships team saw a staffing reduction of over 50%. To ensure sufficient focus on key priority programmes of work, a small number of dedicated communications posts are funded separately. This includes support for the ongoing delivery of; a system wide consultation, the MSE primary care access recovery strategy, health inequalities work and key digital programmes. These posts do however work closely with the main corporate communications team to ensure appropriate co-ordination, and specialist support where needed.

A digital communications team handbook has also been developed to support awareness and resilience of cascade of information via ICB corporate communications channels and partners.

6.8. Public health campaigns:

In delivering on the CORE framework and behaviour change, the function amplifies and supports key national public health programmes as well as developing and delivering locally led programmes including:

- **Cancer awareness campaigns**, including Know the Symptoms, supporting Macmillan GPs, targeted lung health checks.

- **Mental health awareness campaigns**, including promotion of self-referral to adult psychological therapies, changes to local pathways (post procurement) and children and young people's support services in partnership with the SET CAMHS Communications and Marketing steering group.

- **Health campaigns aimed at parents and carers** e.g. Children's Health Matters

6.9. Service transformation and capital funding programmes:

The team supports across the organisation and wiser system to ensure communications and engagement is undertaken robustly and in line with our statutory responsibilities, including:

- supporting patient insight to inform new procurements e.g. MSK, dermatology
- stewardship, including changes of approach, public insight and promotion of successes

- capital investment projects, including Beaulieu Health Centre and Hedingham Medical Centre development in mid Essex

Supporting **business-as-usual services and function responsibilities**, including:

- Emergency preparedness, resilience and response (EPRR) including role as Category 1 responder in the event of an incident, design and delivery of seasonal system-wide winter campaigns, supporting action during industrial/collective action and responding to weather alerts.
- Membership of the communications group supporting the Local Resilience Forum (LRF).
- Medicines management and optimisation.
- Quality improvement training and development.
- Performance and delivery of constitutional standards.
- Service restriction/prioritisation programmes.
- Quality assurance, patient safety, regulatory compliance, reviews and audits and CQC registration/inspection
- Infection prevention and control.
- Safeguarding/ SEN.
- Operational planning cycles.
- Innovation and research.
- Anchor institutions programme.

6.10. Additional capacity and expertise

In addition to the permanent team, we recognise that at times we will need to draw on additional resources to supplement our in-house team, whether by employing temporary team members or outsourcing work to external providers.

For instance, specific, time-limited projects. And there will be instances in which we need to buy in design, audio and video skills for specialist products or capacity where we cannot meet the demand ourselves.

To ensure quality, consistency and value for money and governance, **the Director of Communications and Partnerships** is the accountable officer for all communications and engagement activities, which means that other departments and programmes are not permitted to employ or contract with communications and engagement resources independently of the unified team.

6.11. Our campaigns approach

To make the best use of our in-house communications skills and knowledge, we will take a 'campaigns approach' to communications planning and delivery against our agreed priorities, in line with the UK Government Communications Service (GCS) best practice model. In short this means implementing a planned sequence of communications and interactions that uses a compelling narrative over time to deliver a defined and measurable outcome.

Our campaigns will always have a beginning, a middle and an end. Each campaign will have set objectives, linked to the ICS's objectives, and a clear goal, to improve perception, increase understanding or change behaviour. Our campaigns will use the GCS 'OASIS' campaign planning model, as summarised below:

- **Objectives** – of the overall programme/project and SMART communications objectives

- **Audiences** – segmented with insight for appropriate targeting using the ICS 'audience wheel'

- **Strategy** – summarises resource requirement, key messages, the creative approach and the communications channels we will use

- **Implementation** – the detailed action plan of what and how we will do, and when we will do it

- **Scoring** – the evaluation of:

    - **inputs** (what we did)
    - **outputs** (the volume and reach of the activity)
    - **outtakes** (reactions and response of the target audiences to the activity) and
    - **outcomes** (effect of the communications on the audience in understanding, attitude, trust, advocacy and behaviours/actions)
    - **impacts** (the organisational outcomes that the campaign is intended to support).

6.12. Our standards and commitments

We are committed to the pursuit of excellence in our practice as a professional communications and engagement function. We will constantly seek to improve and refine our adopted operating processes and appoint the right communicators with the skills to be bold, creative and professional.

We are committed to team and individual continuous professional development, through self-learning, learning-by-doing, shared team learning and formal training.

Our team members join the Government Communications Service (GCS) and have access to the extensive professional resources and training available through the GCS website and its learning and development programmes.

We will use colleague, public and stakeholder insights to understand the attitudes, behaviours and needs of our internal and external audiences.

We will work in partnership across the organisation and with partners, sharing information and expertise freely to help services succeed.

Our communications will reflect our understanding of residents and will help to deliver sustainable change in their behaviour, in line with the ICB's objectives. It will always be relevant, targeted and accessible to those at whom it is aimed, communicating clearly and concisely, avoiding jargon and inconsistency, in tones that are helpful, informative and engaging to all our audiences. Our activities will be consistent and integrated across all channels.

We will be proactive in identifying and managing risks and issues that affect the ICB's, and NHS's reputation and we will advise leaders and colleagues on the reputational impact of decisions and demonstrate the contribution that communications can make to support services, reputation and engagement.

We will respond quickly and decisively to crisis situations.

We will develop innovative and creative communications that meet the needs of all our stakeholders, which are based on evidence and result in behavioural change. We will actively promote the development and delivery of appropriate and cost-effective communications channels.

We will support the equalities and diversity agenda by ensuring our communications and information is accessible and in appropriate formats for those who need it, and by reflecting and celebrating the diversity of our communities and stakeholders. We will call out bias and discrimination.

We will ensure that our communications with communities are culturally competent and involve two-way communications when addressing health inequalities. It is particularly important to ask communities what is important to them, and to ensure that the message that we think we are sending is the same as the message that is received.

6.13. Measuring performance

The measurement of the effectiveness of the Communications and Engagement team is in three broad areas:

Campaign performance

This means setting clear objectives for each campaign and measuring and reporting on the inputs, outputs, outtakes, outcomes and impacts of the team's activities in support of the campaign (as set out in the OASIS campaigns approach above).

Organisational performance

This means measuring the contribution of the Communications and Engagement team to the success of broader organisational objectives, generally through the measurement of its channels and the perceptions of its audiences.

It is not easy to measure the direct impact of Communications and Engagement on an organisational objective, since the team's activities will only be one element of the factors contributing to the organisation's performance. For instance, the team can facilitate, enable and support leaders and managers to engage better with their teams through high-quality briefing materials, messages, presentations and events, but employee engagement is based on a much wider range of factors than the quality and timeliness of communication.

Similarly, reputation measures will be an amalgam of patient feedback data, stakeholder perceptions, media and stakeholder perceptions, political and partner perceptions and so on.

A quarterly impact report will be developed and presented to ICB executives to demonstrate delivery against the agreed ICB communications plans. The data presented will include a breakdown of performance against key campaigns and our progress in reaching and effectively engaging with the below key audiences:

- **Internal**: ICB and key primary care audiences
- **Media and other key stakeholders**
- **External**: public facing digital channels

- **Wider community groups and those under-represented** through digital communications

Measures will include:

- **Media** – percentage of net positive, negative and neutral media coverage of the ICB.

- **Stakeholder engagement** – number and percentage of external stakeholders say they feel well informed about the things that involve them; surveys of stakeholders on the quality, timeliness and relevance of communications with them and their awareness and understanding of key issues.

- **Social media** – growth in reach and followers across platforms; growth in engagement rate in response to posts (e.g. likes/shares/comments).

- **Digital** – growth in web/intranet users; growth in subscriptions to information/news bulletins; increase in specific page hits in response to issues; increased page dwell time and reduced bounce rate (people leaving the page); increased take-up of online self-service tools, online surveys.

- **Staff and primary care engagement** – number and percentage of leaders, managers and staff who access internal information (intranet news and page hits, email open-rates, online event attendance); percentage of staff who say they feel well informed about the things that affect them; intermittent sample surveys of staff on the quality, timeliness and relevance of communications with them.

- **Events** – net positive feedback scores from attendees on events run, promoted or coordinated by Communications and Engagement.

Financial performance

This means both the effective management of the team's budget, and its cost-effective stewardship of non-payroll activity costs. The team should demonstrate where such costs have been saved or reduced, whether by providing more cost-effective in-house services in place of external suppliers (such as for graphic design and video production), or by securing better value for money from external suppliers (such as for events, printing and advertising) by operating at a system level and applying central control and coordination of such costs

This is not an exhaustive list and will be developed alongside the organisation's view of how it intends to measure its success.

7. APPENDIX 1

MSE communications incident plan

001 Media Policy - Mid and South Essex Integrated Care System (ics.nhs.uk)

002 Social Media Policy - Mid and South Essex Integrated Care System (ics.nhs.uk)

8. APPENDIX 2

Comms strategy survey - 26-9-24.pptx

10. Use of the ICB Seal

10.1. Guidance for use of the ICB Seal

Custody of Seal, Sealing of Documents and Signature of Documents

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

Sealing of Documents

The following individuals of Officers are authorised to authenticate use of the seal by their signature:

- The Chief Executive
- The ICB Chair
- The Executive Chief Finance Officer

Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two senior managers duly authorised by the Chief Executive, and not also from the originating department, and shall be attested by them.

Register of Sealing

The Chief Executive shall keep a register in which he/she, or another manager of the ICB authorised by him/her, shall enter a record of the sealing of every document. Generally, this will be the Director of Corporate Services.

Signature of documents

Where any document will be a necessary step in legal proceedings on behalf of the ICB, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive member of the ICB Board.

In land transactions, the signing of certain supporting documents will be by the Chief Executive, ICB Chair or Executive Chief Finance Officer as set out in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed) which may be signed by other ICB officers in line with their delegated authority.

11. Selection Process for Non-ICB Committee Members

11.1. Selection Process for non-ICB Committee Members

Selection of Committee Members outside the ICB

Introduction

The legislation creating ICBs enables integrated working across the ICB and partner organisations. To successfully achieve its objectives the ICB will need to ensure its governance arrangements are inclusive of partners and as such intends to include partners in the membership of some committees, such members may be employees of partner organisations. This guidance document sets out how the ICB will select those members.

Non-ICB Committee Members

For the effective running of it's Committees, the ICB may seek Committee Members from its partner organisations. For example, where the Finance & Investment Committee has oversight of the delivery of financial duties across the integrated care system, it may ask partner organisations to be involved in committee members to ensure it sufficiently considers the full needs of the system.

Selection of Non-ICB Committee Members

There will be an equitable process for the selection of non-ICB Committee members that will be confirmed by the ICB Chair in consultation with the Committee Chair having due regard to transparency and ensuring that the ICB has the best blend of skills and expertise in the roles on committees. The Committee terms of reference defines the membership requirements and the role that may need to be filled through Partner Organisations. Where appropriate the ICB will engage with all relevant and appropriate Partners to fulfil those roles to meet the needs of the ICB.

The ICB Chair shall approve the candidate as part of the process for approving committee membership, as defined below.

Role of non-ICB Committee Members

All members of ICB Committees shall attend to provide their expertise and experience of their sector and shall not be representing their organization as such, (except for Joint Committees, that are not included within this guidance). All committee members shall partake in decision making (as defined within the committee terms of reference) for the purpose of the achievement of ICB objectives.

The ICB Chair shall consider removal of committee members who do not adhere to these principles.

Approval of Committee Members

The ICB Chair shall approve the Committee Membership and any concerns relating to membership shall be managed by the ICB Chair.

The decision of the Chair shall be final.