



Meeting of the Essex Joint Committee

Thursday, 19 March 2026 at 2.00 pm to 3.30 pm

Latton Hall, Latton Bush Centre, Southern Way, Harlow, CM18 7BL

Part I Agenda

No	Time	Title	Action	Papers	Lead / Presenter	Page No
Opening Business						
1.	2.00 pm	Welcome, opening remarks and apologies for absence	Note	Verbal	Prof. M Thorne	-
2.	2.01 pm	Register of Interests / Declarations of Interest	Note	Attached	Prof. M Thorne	3
3.	2.02 pm	Questions from the Public	Note	Verbal	Prof. M Thorne	-
4.	2.12 pm	Approval of minutes of the previous Part I meeting, 22 January 2026	Approve	Attached	Prof. M Thorne	5
5.	2.13 pm	Matters arising (not on agenda)	Note	Verbal	Prof. M Thorne	-
6.	2.14 pm	Action Log (no outstanding actions)	Note	Verbal	Prof. M Thorne	-
Items for Decision / Non-Standing Items						
7.	2.15 pm	Lampard Inquiry Update	Note	Verbal	Dr M Sweeting	-
Standing Items						
8.	2.25 pm	Chief Executive's report including an update on the proposed Essex ICB governance and transition arrangements.	Note	Attached	T Abell	16
9.	2.35 pm	Quality Report	Note	Attached	Dr G Thorpe	20
10.	2.45 pm	Finance & Performance Report	Note	Verbal	J Kearton	-
11.	2.55 pm	Neighbourhood Report (Primary Care / Alliances)	Note	Attached	B Flowers	28
12.	3.10 pm	General Governance:				
		12.1 Board Assurance Framework	Note	Attached	T Abell	36
		12.2 Approved minutes of Essex Joint Sub-Committees	Note	Attached	Prof. M Thorne	55
13.	3.15 pm	Proposed Essex ICB Governance:				
		13.1 Constitution, Committee Structure, and Standing Financial Instructions	Approve	Attached	Prof. M Thorne M Watson	76
		13.2 Standards of Business Conduct Policy and update on Policy development	Approve	Attached	Prof. M Thorne M Watson	150

No	Time	Title	Action	Papers	Lead / Presenter	Page No
14.	3.28 pm	Effectiveness of Meeting	Discuss	Verbal	Prof. M Thorne	-
15.	3.29 pm	Any Other Business	Note	Verbal	Prof. M Thorne	-
16.	3.30 pm	Date and time of inaugural Part I Essex Integrated Care Board meeting: 1 April 2026, at 10.05 am to be livestreamed	Note	Verbal	Prof. M Thorne	-

**Essex Joint Committee
Register of Members' Interests - March 2026**

First Name	Surname	Job Title / Current Position	Declared Interest (Name of the organisation and nature of business)	Financial	Non-Financial Professional Interest	Non-Financial Personal Interest	Is the interest direct or indirect?	Nature of Interest	From	To	Actions taken to mitigate risk
Tom	Abell	Chief Executive Officer, Mid and South Essex ICB (MSE ICB)	Nil								
Ruth	Bailey	Non-Executive Member, SNEE ICB	HR Consultancy	x			Direct	Undertake HR consultancy within the UK and internationally. None of the projects are healthcare related.	Jan 2025	Ongoing	Interest will be declared, if relevant, so that appropriate arrangements can be implemented.
Ruth	Bailey	Non-Executive Member, SNEE ICB	UK Health Protection Agency				Indirect	Spouse is employed as Director	2016	Ongoing	Interest will be declared, if relevant, so that appropriate arrangements can be implemented.
Freda	Bhatti	Primary Care Representative (North East Essex), SNEE ICB	Suffolk Primary Care	x			Direct	Salaried GP	01/04/25	Ongoing	Interest will be declared, if relevant, so that appropriate arrangements can be implemented.
Freda	Bhatti	Primary Care Representative (North East Essex), SNEE ICB	Local Medical Council (Essex)		x		Direct	Member		Ongoing	Interest will be declared, if relevant, so that appropriate arrangements can be implemented.
Freda	Bhatti	Primary Care Representative (North East Essex), SNEE ICB	East Suffolk and North East Essex Foundation Trust			x	Indirect	Spouse employed as Consultant Gastroenterologist		Ongoing	Interest will be declared, if relevant, so that appropriate arrangements can be implemented.
Anna	Davey	MSE ICB Partner Member (Primary Care)	Coggeshall Surgery Provider of General Medical Services	x			Direct	Partner in Practice	09/01/17	Ongoing	I will not be involved in any discussion, decision making, procurement or financial authorisation involving the Coggeshall Surgery or Edgemoad Medical Services Ltd
Anna	Davey	MSE ICB Partner Member Primary Care)	Colne Valley Primary Care Network	x			Direct	Partner at The Coggeshall Surgery who are part of the Colne Valley Primary Care Network - no formal role within PCN.	01/06/20	Ongoing	I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented and will not
Anna	Davey	MSE ICB Partner Member (Primary Care)	Mid and South Essex Integrated Care Board	x			Direct	Employed as a Deputy Medical Director (Engagement).	April 2024	Ongoing	I will declare my interest if at any time issues relevant are discussed so that appropriate arrangements can be implemented
Ed	Garratt	Chief Executive Officer, Suffolk and North East Essex ICB (SNEE ICB)	University of Suffolk		x		Direct	Visiting Professor of Integrated Care	April 2021	Ongoing	Interest will be declared, if relevant, so that appropriate arrangements can be implemented.
Ed	Garratt	Chief Executive Officer, Suffolk and North East Essex ICB (SNEE ICB)	Suffolk		x		Direct	Deputy Lieutenant	Sept 2023	Ongoing	Interest will be declared, if relevant, so that appropriate arrangements can be implemented.
Ed	Garratt	Chief Executive Officer, Suffolk and North East Essex ICB (SNEE ICB)	Public Health and Wellbeing University of Essex		x		Direct	Honorary Professor	Feb 2024	Ongoing	Interest will be declared, if relevant, so that appropriate arrangements can be implemented.
Ed	Garratt	Chief Executive Officer, Suffolk and North East Essex ICB (SNEE ICB)	Norfolk & Waveney ICB	x			Direct	Chief Executive (Interim)	May 2025	Ongoing	Interest will be declared, if relevant, so that appropriate arrangements can be implemented.
Sarah	Griffiths	Executive Director of Finance, Resources and Contracts, HWE ICB	AstraZeneca				Indirect	Partner is employed as Senior Director (non-decision making)	03/03/25	Ongoing	Interest will be declared, if relevant, so that appropriate arrangements can be implemented.
Mark	Harvey	MSE ICB Board Partner Member (Southend City Council)	Southend City Council	x			Direct	Employed as Executive Director, Adults and Communities		Ongoing	Interest to be declared, if and when necessary, so that appropriate arrangements can be made to manage any conflict of interest.
Fiona	Head	Executive Clinical Director of Utilisation Management, HWE ICB.	Urgent Care Direct				Direct	Urgent Care Direct carried out a DBS check for Dr Fiona Head as part of an application to work as a GP locum.	27/11/2024	Ongoing	Interest will be declared, if relevant, so that appropriate arrangements can be implemented.
Jennifer	Kearon	MSE ICB Executive Director of Finance and Commercial	Colchester Weightlifting Limited			x	Direct	Director	01/10/24	Ongoing	No conflict anticipated. To declare as appropriate.
Howard	Martin	Chief Finance Officer, SNEE ICB	Nil								
Sarah	Muckle	ICB Partner Member (Essex County Council)	Essex County Council	x			Direct	Director of Wellbeing Public Health & Communities	24/04/25	Ongoing	To declare this interest as necessary so that appropriate arrangements can be made if required.
Lisa	Nobes	Chief Nursing Officer, SNEE ICB	Ipswich Borough Council			x	Indirect	Spouse employed by Ipswich Borough Council	2018	Ongoing	Interest to be declared, if and when necessary, so that appropriate arrangements can be implemented.
Ian	Perry	Primary Medical Services Partner Member, HWE ICB.	Maynard Court Surgery	x			Direct	GP Partner	2013	Ongoing	Interest to be declared, if and when necessary, so that appropriate arrangements can be implemented.
Ian	Perry	Primary Medical Services Partner Member, HWE ICB.	Epping Forest North PCN	x			Direct	GP Partner	2019	Ongoing	Interest to be declared, if and when necessary, so that appropriate arrangements can be implemented.
Ian	Perry	Primary Medical Services Partner Member, HWE ICB.	Stella Healthcare	x			Direct	Shareholder	2014	Ongoing	Interest to be declared, if and when necessary, so that appropriate arrangements can be implemented.
Robert	Persey	ICB Partner Member (Thurrock Council)	Thurrock Council	x			Direct	Interim Executive Director of Adults and Health		Ongoing	To declare this interest as necessary so that appropriate arrangements can be made if required.
Lynn	Stimson	Interim Director, North East Essex Alliance, SNEE ICB	Nil								
Sarah	Stanley	Executive Clinical Director of Total Quality Management, HWE ICB.	Nil								

**Essex Joint Committee
Register of Members' Interests - March 2026**

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Matthew	Sweeting	Executive Medical Director, MSE ICB	Mid and South Essex Foundation Trust			x	Direct	Part Time Geriatrician - hold no executive or lead responsibilities and clinical activities limited to one Outpatient clinic a week and frailty hotline on call.	01/04/15	Ongoing	Any interest will be declared if there are commissioning discussions that will directly impact my professional work. I will liaise with CEO or Chair, as appropriate, for mitigations. These could include removal from said discussions, not voting on any proposals or nominating a deputy. For sign off of commissioning budgets, if a conflict arises, I will delegate to the CFO.
Dr Frankie	Swords	Chief Medical Officer, SNEE ICB	Norfolk & Norwich University Hospital		x		Direct	Hold a honorary contract and work as a consultant endocrinologist / physician approximately one day per week.	01/07/22	Ongoing	Interest to be declared, if and when necessary, so that appropriate arrangements can be implemented.
Dr Frankie	Swords	Chief Medical Officer, SNEE ICB	St Martin's Norwich and private mental health counselling				Indirect	Husband works as a counsellor and undertakes sessions for St Martin's and in private practice.	01/01/23	Ongoing	Interest to be declared, if and when necessary, so that appropriate arrangements can be implemented.
Dr Frankie	Swords	Chief Medical Officer, SNEE ICB	Long Stratton Medical Centre			x	Direct	Patient		Ongoing	Interest to be declared, if and when necessary, so that appropriate arrangements can be implemented.
Jan	Thomas	Chief Executive Officer, Hertfordshire and West Essex ICB (HWE ICB)	Private medical secretary services				Indirect	Spouse provides private medical secretary services to local consultants.	01/07/22	Ongoing	
Mike	Thorne	MSE ICB Chair	Nil								N/A
Giles	Thorpe	Executive Chief Nurse, MSE ICB	Essex Partnership University NHS Foundation Trust	x			Indirect	Husband is the Associate Clinical Director of Psychology - part of the Care Group that includes Specialist Psychological Services, including Children and Adolescent Mental Health Services and Learning Disability Psychological Services which interact with MSE ICB.	01/02/20	Ongoing	Interest will be declared as necessary so that appropriate arrangements can be made if and when required.
Giles	Thorpe	Executive Chief Nurse, MSE ICB	University of Essex		x		Direct	Honorary Professorship	2023	Ongoing	Interest will be declared as necessary so that appropriate arrangements can be made if and when required.
George	Wood	Non-Executive MSE ICB Board Member	Nil								
Janet	Wood	Non-Executive Member, SNEE ICB	Chelmsford Learning Partnership		x		Direct	Member		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangements can be implemented.
Janet	Wood	Non-Executive Member, SNEE ICB	Boswells School, Chelmsford		x		Direct	Chair of Governors		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangements can be implemented.
Janet	Wood	Non-Executive Member, SNEE ICB	Essex School Governance Association		x		Direct	Committee Member		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangements can be implemented.
Janet	Wood	Non-Executive Member, SNEE ICB	Healthcare Financial Management Association (HFMA)			x	Indirect	Spouse - Part Time Senior Policy Manager		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangements can be implemented.
Janet	Wood	Non-Executive Member, SNEE ICB	Mid and South Essex Foundation Trust			x	Indirect	Son - Physiotherapist		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangements can be implemented.

Minutes of the Part I Essex Joint Committee Meeting

Held on Thursday, January 2026 at 2.00pm – 3.30pm

Function Room 1, Barleylands, Barleylands Road, Billericay, Essex
CM11 2UD

Attendance

Members

- Professor Michael Thorne (MT), Chair, Mid and South Essex Integrated Care Board (MSE ICB).
- Tom Abell (TA), Chief Executive Officer, MSE ICB.
- Jennifer Kearton (JK), Executive Director of Finance and Commercial, MSE ICB.
- Dr Matt Sweeting (MS), Executive Medical Director, MSE ICB.
- Dr Giles Thorpe (GT), Executive Director of Nursing, MSE ICB.
- George Wood (GW), Non-Executive Member, MSE ICB.
- Dr Anna Davey (AD), Partner Member, Primary Care Services.
- Sarah Muckle (SM), Partner Member, Essex County Council
- Ian Perry (IP), Partner Member, Primary Care Services, HWE ICB.

Other attendees

- Lynn Stimson (LS), Interim Director, North East Essex Alliance, SNEE ICB.
- Emily Hough (EH), Executive Director of Strategy, MSE ICB.
- Samantha Goldberg (SG), Executive Director of Performance and Planning, MSE ICB.
- Michael Watson (MW), Executive Director of Corporate Services, MSE ICB.
- Beverley Flowers (BF), Executive Director of Neighbourhood Health, MSE ICB.
- Claire Hankey (CH), Director of Communications and Partnerships, MSE ICB.
- Emma Richardson (ER), Director of Commissioning, (representing Mark Harvey, Partner Member, Southend City Council).
- Nicola Adams (NA), Associate Director of Corporate Services, MSE ICB.
- Helen Chasney (HC), Corporate Services and Governance Support Officer, MSE ICB (minutes).

Apologies

- Robert Persey (RP), Partner Member, Thurrock Council.
- Mark Harvey (MHar), Partner Member, Southend City Council
- Ruth Bailey (RB), Non-Executive Member, HWE ICB.
- Janet Wood (JW), Non-Executive Member, SNEE ICB.
- Jan Thomas (JT), Chief Executive Officer, HWE ICB.
- Sarah Griffiths (SG), Executive Director of Finance, Resources and Contracts, HWE ICB.
- Sarah Stanley (SS), Executive Clinical Director of Total Quality Management, HWE ICB.
- Lisa Nobes (LN), Chief Nursing Officer, SNEE ICB.
- Dr Freda Bhatti (FB), Partner Member, Primary Care, SNEE ICB.
- Howard Martin (HM), Chief Finance Officer, SNEE ICB.

1. Welcome and Apologies (presented by Prof. M Thorne)

MT welcomed everyone to the Essex Joint Committee (EJC) meeting and reminded members of the public that this was a meeting held in public to enable transparent decision making, not a public meeting, and therefore members of the public would be unable to interact with the committee during discussions. The meeting was livestreamed to accommodate members of the public who were unable to attend the meeting, and a recording of the livestream would also be available via the ICB website after the meeting.

MT introduced and welcomed Beverley Flowers, who had been appointed as Executive Director of Neighbourhood Health.

Apologies were noted as listed above.

2. Declarations of Interest (presented by Prof. M Thorne)

MT reminded everyone of their obligation to declare any interests in relation to the issues discussed at the beginning of the meeting, at the start of each relevant agenda item, or should a relevant interest become apparent during an item under discussion, in order that these interests could be appropriately managed.

No other declarations were made.

Note: The Board register of interests for each ICB are available on their respective websites.

3. Questions from the Public (presented by Prof. M Thorne)

MT advised that questions had been submitted by members of the public, as set out below, which would be answered during the meeting. Several other questions not related to agenda items had also been received and responses to these would be provided directly to the individuals concerned.

Peter Blackman asked given how neighbourhood health was a key priority of the NHS 10-year plan, how were Alliances, Integrated Neighbourhood Teams and Primary Care Networks going to be developed and mobilised to achieve this goal and how were patients, service users and public being engaged in this enterprise. Mr Blackman also offered the assistance of South Woodham Ferrers (SWF) Health and Social Care Group research project.

BF confirmed that the pending publication of the national Neighbourhood Framework was a pivotal milestone in the process of establishing neighbourhoods in line with the 10-year plan. This publication would make explicit asks of ICBs for delivery in both 2026/27 and beyond. The ICB would review this guidance alongside the learning from the early implementers in West Essex (WE) and North East Essex (NEE) to then formulate a local approach and would include the ICB's duty to engage with the population served. The mid Essex Alliance team were engaged with the SWF research project and looked forward to seeing the output of the work once completed.

Cllr Mike Eldred urged the ICB to communicate planned changes to the structure of the local NHS as early and frequently as possible to town and parish councils and offered the support of the Essex Association of Local Councils (EALC) in doing this. Cllr Eldred also assured the ICB of EALC's unwavering support.

MW thanked Cllr Eldred for his thoughtful submission and for sharing the perspectives of Essex town and parish councils. The ICB fully recognised the importance of early, clear, and

regular communication as the proposed changes to ICB footprints were progressed. Over recent months, the ICB had worked to identify and appraise key stakeholders, including elected representatives, to ensure they are engaged appropriately and kept informed as plans developed. This insight was informing the ICB's approach to engagement and the sequencing of communications going forward in line with the national mandate for change.

A communications and engagement plan for the new organisation was being developed and the ICB welcomed the offer of support. The ICB valued the EALC's experience in sharing public sector communications with its members and would continue to utilise this valuable conduit to local engagement. MW thanked Cllr Eldred again for his constructive input and continued support of the ICB's work.

4. Minutes of the Part I Essex Joint Committee meeting held on 20 November 2025 (presented by Prof. M Thorne)

MT referred to the draft minutes of the Part I Essex Joint Committee (EJC) meeting held on 20 November 2025 and asked members if they had any comments or questions.

There were no further comments or amendments.

Resolved: The Essex Joint Committee approved the minutes of the Part I Essex Joint Committee meeting held on 20 November 2025 as an accurate record.

5. Matters Arising (presented by Prof. M Thorne)

There were no matters raised.

6. Review of Action Log (presented by Prof. M Thorne)

The updates provided on the action log were noted and no queries were raised.

Resolved: The Essex Joint Committee noted the updates on the action log.

7. 2026/27 Planning, including Financial Plan (verbal update by J Kearton, E Hough, S Goldberg)

MT noted that, due to the pace of work required against national guidelines and timeframes, a verbal update on the most recent planning submission to NHS England (NHSE) would be given.

JK advised that in December 2025, the plan for the proposed Essex ICB was submitted against the £5.3 billion allocation, resulting in a £18 million deficit. Work continued since that submission to close the gap through provider income triangulation, review of cost pressures, and identification of further efficiencies and opportunities. Colleagues in NEE and WE were engaged in developing the plan.

The team worked closely with providers on the contracts required to deliver services for the Essex population for 2026/27 and beyond, ensuring delivery capability and alignment with national performance standards. A series of meetings had taken place to prepare the submission for 12 February 2026. The EJC was scheduled to consider the final version of the plan on 11 February 2026.

SG reported that gaps remained in activity and performance, particularly Referral to Treatment (RTT), cancer pathways, and diagnostics across providers in the Essex area. The

draft submission showed that baseline activity did not reflect potential efficiencies or demand management schemes. Consequently, several quality, contract and performance review meetings were held with each provider to understand their finances and activity. Sub-groups covering cancer, RTT, diagnostics and primary care were also working with providers to incorporate productivity opportunities, demand management initiatives, outpatient transformation and advice and guidance schemes. This work enabled the identification of any gaps, which would feed into commissioning intentions.

EH added that a group had reviewed mental health commissioning, including current plans and agreed transformation schemes. In addition to the financial submission, a strategic plan: the Population Health Improvement Plan (PHIP) must be submitted on 12 February 2026. The PHIP will set out the ICB's high level strategic ambitions, outlined delivery over the next one to five years, and included commissioning intentions for 2026/27. Work was being undertaken to align these intentions over the medium-term.

Feedback from the EJC, discussions with major providers, and input from local authority colleagues had informed the draft commissioning intentions. The draft PHIP would be considered by the EJC on 11 February 2026 prior to submission on 12 February 2026. The challenging timetable set by NHSE was noted and that the longer-term elements of the strategy would be tested and refined with partners. EH acknowledged stakeholder contributions received so far.

In response to a query from GW, JK confirmed every ICB had received a reduction to its allocation, and the adjustment had replaced the required savings, leaving a residual £19 per head of population, which formed the basis of the current consultation on the future ICB structure.

GW also asked whether external cancer support for mid and south Essex (MSE) would be commissioned immediately, and when that decision would be made. SG confirmed that the plan would be worked through to determine the required activity and associated need. Work was also underway with Cancer Alliance colleagues regarding funding for next year, alongside engagement with providers to establish their proposals and ensure alignment with the plan.

Resolved: The Essex Joint Committee noted the verbal update on 2027/27 planning submission.

8. Expiring Contracts (presented by J Kearton)

JK presented a report outlining the contracts managed by Hertfordshire and West Essex (HWE), Suffolk and North East Essex (SNEE) and MSE ICBs that were due to expire before 30 June 2026 and required procurement decisions that would impact upon the proposed Essex ICB.

NHSE supported the migration of contracts from existing to new ICBs, through the national transfer scheme. Consequently, MSE, WE and NEE colleagues had identified all contracts transferring to the proposed Essex ICB and determined which required an extension to ensure a safe transfer of legal documentation.

The report was reviewed by the Essex Joint Executive Committee and the Essex Joint Finance and Performance (F&P) Committee. Several contracts exceeded the committees' approval threshold, and therefore 11 contracts valued at over £10 million and expiring by 30 June 2026 were presented for approval, as detailed in the appendix.

Resolved: The Essex Joint Committee noted the status and procurement route for each contract and approved those contracts exceeding £10m (as detailed in the appendices).

9. Chief Executive's Report (presented by T Abell)

TA presented the Chief Executive's report, which included an update on the ICB transition. The consultation on the proposed Essex ICB structures and the voluntary redundancy (VR) process had concluded. The consultation feedback was being drafted and the final structures refined ahead of publication on 2 February 2026. The next phase would involve the application and appointments process. Work was also underway to establish the new organisation, including governance arrangements and new ways of working, for the launch of the new ICB on 1 April 2026.

TA expressed his appreciation for the resilience and commitment of all affected staff across the three ICBs. MT thanked TA and the Executive Team for their open and transparent communication throughout the transition and consultation process.

TA reported on winter pressures and noted that, despite industrial action before Christmas, the period had been well managed locally and regionally, with lower pressures reported than in previous years. However, pressure had increased again in early January, and escalation and coordination arrangements continued to operate effectively. Planning for next winter was underway, drawing on the learning from the current period from both system response and commissioning perspectives.

An update was provided on the commissioning activity. Two major contracts had been awarded in MSE: a new dermatology service commencing 1 February 2026 and a new musculoskeletal service commencing 1 April 2026. Both schemes were expected to reduce acute demand. Commissioning had also been approved for a dedicated sight testing service for special education schools, a GP-led breast pain clinic in MSEFT, and additional dental activity in NEE. The latter had received good uptake and would progress to procurement.

TA noted the uncertainty facing the voluntary and community sector, reflecting pressures from both NHS and local government changes. Contractual and grant arrangements for a wide range of voluntary and community organisations across Essex were close to being confirmed. MT emphasised the importance of protecting voluntary partners, within available resources, despite the significant change underway.

Resolved: The Essex Joint Committee noted the Chief Executive's Report.

10. Quality Report (presented by Dr G Thorpe)

GT presented the quality report. National and regional workstreams were supporting the ICB's understanding of its strategic commissioning responsibilities for quality oversight, assurance, and improvement, in line with NHS reform requirements. This included the development of the national quality strategy, expected at the end of quarter 4, and forthcoming National Quality Board (NQB) guidance aligned to the strategic commissioning framework.

The ICB would contribute to the regional Quality and Population Health Outcomes Committee, meeting quarterly with providers to review core elements of provider oversight and to support formal escalation and reporting processes.

Locally, due diligence was underway to ensure quality oversight across the new geographies from April 2026. NHSE tools were being used to ensure both continuity, and the identification

of any existing or emerging risks, mitigations and required escalations. As part of the planning round, discussions with provider chief nurses and medical directors were establishing a set of core local quality indicators for ongoing monitoring through contracting arrangements.

GT advised that since the publication of his report, a tragic incident had occurred at Broomfield Hospital and the ICB wished to express their sincere condolences to the patient's family. Initial findings had been shared with the ICB and NHSE, and the investigation was ongoing with appropriate confidentiality and family involvement.

Due to ongoing concerns in relation to quality provision at MSEFT, a quality summit was held on 12 December 2025 with NHSE regional team, Care Quality Commission (CQC), General Medical Council (GMC), Nursing and Midwifery Council (NMC), education partners, and local authorities. Follow up meetings were being held, and the ICB would join the core membership to monitor progress and provide support to the Trust.

The OFSTED and CQC special educational needs and disabilities (SEND) area inspection in Essex would conclude on 23 January 2026. The ICB had worked closely with Essex County Council (ECC) and wider agencies, in response to the key lines of enquiry. The new ICB would be responsible for any SEND related recommendations around commissioning or health provision. The Thurrock area inspection had concluded, and the ICB awaited its report and key recommendations.

SM noted that an inspection was taking place at ECC, and the findings would be shared once available.

GW noted that SEND demand appeared to be increasing and asked how waiting times and accessibility were being prioritised within spending plans, noting the wider societal impact of delayed support, and queried the extent to which the SEND programme could address these issues. GT reported that the main pressures related to the neurodivergent pathway and diagnostic capacity. Provision in Essex had been expanded, supported by an accreditation programme to ensure quality. GT emphasised that the focus was on a needs-led approach delivered in strong partnership with education and local authorities. Although demand had risen and waiting times persisted, the focus remained on supporting families as a whole and responding to needs at a family-unit level.

Resolved: The Essex Joint Committee noted the Quality Report.

11. Finance and Performance Report (presented by J Kearton and S Goldberg)

JK advised work was undertaken across Essex to understand the financial and performance position as the new ICB was formed. Future reporting for the proposed Essex ICB would differ from previous system control total reporting, with revised performance metrics.

JK provided an update for month 8 and advised that month 9 data would follow once agreement of balances work with inter-NHS authorities was completed. The MSE ICB control total finance report continued to be reviewed by MSE F&P Committee.

At month 8, and continuing into month 9, MSE ICB remained on track to deliver its agreed break-even position, with a small year-to-date deficit aligned to a trajectory to reach break-even by month 12. HWE ICB and SNEE ICB were both on plan to deliver their agreed positions to break even. All providers across Essex faced differing financial challenges. MSEFT remained in deficit beyond the level supported nationally and was expected to worsen at month 9, with the deficit and run rate crystallising into an adverse forecast outturn under

regional oversight. PAH was expected to deliver in line with its deficit plan, and ESNEFT was expected to break even as part of the SNEE system control total.

A new proposed Essex ICB finance and performance report would be developed for future committee consideration to support understanding of reporting changes as system control totals ceased and performance oversight arrangements evolved.

MT commented that the new regime would allow greater sovereign control over the distribution of funding and provide more discretion over expenditure, compared to the previous approach where support to system partners was provided. JK explained that last year, when deficit plans were agreed with providers, the national team had issued deficit support funding to enable them to return to a break-even position. Under the current cash regime, if providers failed to meet their commitments, this support would be withdrawn. The impact of this would become clearer in the month 9 forecast outturn, when both run rate position and withdrawal of deficit support funding would be assessed.

SG presented the performance update. Future performance would use revised metrics aligned to ICB plans.

Urgent Emergency Care (UEC), Elective RTT and cancer pathways in December remained challenged for MSEFT. Ambulance response times continued to be under pressure; however, the Unscheduled Care Coordination Hub (UCCH) had improved access and reduced conveyance rates into the acute sector. Work was ongoing with acute providers to develop a new redirection and streaming model, supported in partnership with NHSE. Patient flow continued to affect front door performance and ambulance offload times. Length of stay had increased slightly, although delayed discharge levels had continued to improve to below pre-COVID levels.

In relation to cancer, the Faster Diagnosis Standard (FDS) remained challenging, although some improvement had been seen. The 31-day treatment standard was on trajectory with no delivery risk identified. The 62-day treatment standard remained a concern; however, additional funding in quarter 4 from the cancer alliance and NHSE would support increased resource and capacity to reduce waiting times.

Ongoing pressure was reported in elective care relating to the 52 and 65 week wait backlogs. Additional funding had been secured for targeted inpatient and outpatient improvement cycles (sprints).

It was anticipated that the over-65-week waits would be cleared by year-end, although challenges remained in Trauma and Orthopaedics, and the ICB continued to work with providers and independent sector providers to address this.

GW commented that the operational plan appeared aspirational rather than based on confirmed activity for the year and asked how assurance would be provided that the commitments could be achieved; how the plan would be scrutinised to avoid a significant gap between planned and actual performance; and how this gap could be reduced at the start of the year. SG advised that assurance work was underway, aligned with the ICB plan. Provider meetings with executives were being held to check and challenge core activity baselines for physical capacity, workforce requirements and any potential limiting factors for estate requirements. The process would clarify any gaps and enable the development of alternative commissioning intentions, where required.

MS referred to an article in the British Medical Journal on cancer pathways, noting that while constitutional standards were measured, approximately 30% of cancers were diagnosed

through emergency pathways and this would also apply to other speciality areas. This highlighted the need for the new ICB to consider the full end-to-end pathway and understand the population needs, rather than focusing solely on standards.

AD noted that the current approach risked becoming a tick box exercise, where patients were discharged from the cancer pathway without further progress in addressing their condition. Subsequently, some patients moved around the system and were diagnosed later in the emergency department because they had not met the criteria of the urgent suspected cancer pathway. AD was concerned the focus on meeting standards meant patients could fall between pathways and suggested a review of cancer diagnostic processes to ensure patient care remained central.

IP added that not all cases were neatly channelled through GPs or standard pathways. Real life clinical presentations were often more complex than pathway definitions allowed, and any deviation from the expected pathway was too often perceived as failure.

Resolved: The Essex Joint Committee noted the Finance and Performance Report.

12. Neighbourhood Report (Primary Care and Alliances) (presented by B Flowers)

BF presented the Neighbourhood Report and advised that the report was being reviewed to ensure that the proposed Essex ICB Board received a clear understanding of primary care and the approach to neighbourhoods across Essex.

Primary care access remained a key ICB responsibility and work was underway to align this with the ten-year plan, explore new ways of delivering services, share good practice and potentially commission some activities externally. Further updates would be provided in due course.

NHSE would provide additional funding allocation of £250,000 next year for the COVID vaccination programme in addition to the £19-per-head baseline. BF emphasised the importance of using this funding effectively when resources were constrained and this would be incorporated into the consultation response.

Negotiations with the landlord of the Hollies surgery were ongoing regarding a return to the site, and engagement remained positive.

Significant work was underway within alliances and integrated neighbourhood pilots. The next step was to consolidate this activity into a clear plan for future neighbourhood models, including multi-neighbourhood arrangements. Engagement with providers would shape this work and ensure neighbourhoods were established effectively as part of wider community priorities. Early learning from neighbourhood pilots in NEE and WE were beginning to emerge. The ICB was keen to explore new funding models and work with partners to understand how future neighbourhood contacts could drive improvement and change.

AD highlighted the data for Integrated Neighbourhood Teams (INTs) in MSE and noted improvements were significant. Emergency admissions due to falls had reduced from 12.4% to 11.1% between October periods. Readmissions within 30 days of discharge had decreased from 10.7% to 8.7%, and non-elective admissions from care homes had reduced from 8.4% to 4.4%. Achieving this level of change in a frail and complex cohort was particularly impressive and annual data should evidence sustained improvement. MT agreed the results demonstrated INTs' positive impact.

MS commented that it was important for members to be aware of population-level changes achieved over several years and that a detailed review of the data showed year-on-year improvement across key markers, reflecting a multi-faceted neighbourhood approach involving stewards and targeted interventions.

SM emphasised the importance of building on what was already working well, particularly in relation to the prevention agenda. Duplication should be avoided where effective approaches could be scaled up or adapted.

MT noted that the report would be data driven and requested additional detail on the national neighbourhood pilots. It would be helpful for the committee to understand the thinking and discussions behind the pilots, as some focused on frequent healthcare users while others explored models such as triage to reduce demand and create capacity to support hospital discharges. LS highlighted considerable variation across the pilot schemes which could provide valuable learning for the Essex ICB. While populations differed, it would be important to identify which elements could be standardised and scaled and which should remain tailored. LS confirmed further detail on the pilots could be provided if required.

Resolved: The Essex Joint Committee noted the Neighbourhood Report.

13. General Governance (presented by Prof. M Thorne)

13.1 Board Assurance Framework

TA presented the Board Assurance Framework (BAF) and reported on progress in developing the BAF for the proposed Essex ICB. Extensive work across teams had been completed to compare the three existing frameworks in MSE, HWE and SNEE, ensuring greater consistency and alignment. The strategic risks were broadly similar across the three ICBs, as outlined in the report.

Several updates had been made to the current BAF, including the reduction of the primary care risk rating from red to amber.

MW assured the Board that future governance arrangements would ensure that risks were properly embedded and effectively managed, and confirmed that this would form a key part of ongoing discussions.

Resolved: The Essex Joint Committee noted the Board Assurance Framework update report.

14. Proposed Essex ICB Governance (presented by Prof. M Thorne and M Watson)

14.1 Constitution and Standing Orders

MW presented the proposed Essex ICB constitution, noting that it was required under the Health and Care Act 2022, and was based on the NHSE model constitution, meaning there would be limited variation across ICBs.

Governance teams had reviewed the constitutions of MSE ICB, HWE ICB and SNEE ICB and key elements were detailed in the report. It was highlighted that some areas, including future membership remained under review, including the appointment of a Chair for the proposed Essex ICB. It was noted that NHSE could make further amendments to the model

constitution, and any such changes must be adopted. The document remained under development but was required to be submitted to NHSE by 31 January 2026 and would return to the EJC when further developed.

MT advised discussions continued across the three proposed ICBs in the East of England regarding the most appropriate Board structure to meet government and NHSE requirements. Future arrangements would be shaped collaboratively with local authority and provider partners. MT acknowledged the support and constructive engagement already received from partners members within MSE ICB.

Resolved: The Essex Joint Committee approved the current draft of the proposed Essex ICB Constitution for submission to NHS England for their initial review.

14.2 Committee Structure (Functions and Decisions Map)

MW presented the Functions and Decisions Map for the proposed Essex ICB, which considered the appropriate governance arrangements and the ICB's changing role and function. A set of design principles, as outlined in the report, guided the work, with a focus on streamlining governance to reduce duplication and improve alignment.

The proposal delivered a reduced number of sub-committees of the Board to support alignment and avoid duplication and introduced a revised model for clinical oversight to embed clinical input throughout the structure. The approach aligned with the new NHS architecture, provided clearer delegation pathways and fewer layers of authority to support a streamlined decision-making process, to ensure decisions were evidence based.

There would further iterations as the wider operating environment and the role of the ICB matured. The proposal represented the preferred approach at this stage but would remain under review.

The next steps included concluding the process to identify the future Chair of the proposed Essex ICB and continue the development of governance documents for future submission to the EJC.

MT asked whether clinicians in attendance approved the shift from a clinical advisory group to the clinical oversight embedded in other committees as per the proposed new model. IP supported this, provided it remained representative of the whole system. MS expressed support, emphasising the importance of considering whole pathways and involving clinicians in discussions rather than making siloed decisions in separate committees. Board level and strategic functions should ensure that decisions affecting interface areas were considered system-wide, so that the impact can be identified and rectified, where necessary, before going live. AD highlighted the need to retain a strong patient-advocacy perspective, noting that routinely considering the patient experience would strengthen decision-making. The interface space was vital as pathways grew more complex, and a clear clinical voice could simplify processes and improve outcomes. GT emphasised the importance of ensuring a wider range of professional voices were heard, particularly those with frequent contact with residents, noting these perspectives were historically less prominent.

MT noted that consideration would be required when appointing members to committees to ensure they could meet the demands previously identified; that partners were positioned appropriately; and advice could be secured from those best placed to provide it. Board members should contribute their professional expertise for the benefit of the ICB, and this principle should also be embedded within the committees' work.

Resolved: The Essex Joint Committee approved:

- The proposed committee structure for the proposed Essex ICB.
- The Committee Standard Operating Protocol and the format of committee terms of reference.

15. Effectiveness of meeting (presented by Prof. M Thorne)

MT advised that, as the board moved into a new phase, it would be important to refocus its attention from operational matters toward more strategic issues and invited comments from members.

ER expressed support for the overall direction.

CH emphasised that the patient and resident voice remained essential.

16. Any Other Business

There were no items of any other business. MT thanked the members of the public for attending.

17. Date and Time of Next Part I Essex Joint Committee meeting:

Thursday, 19 March 2026 at 2.00pm – 3.30pm, in the Latton Hall, Latton Bush Centre, Southern Way, Harlow, CM18 7BL.

Part I Essex Joint Committee meeting, 19 March 2026

Agenda Number: 8

Chief Executive's Report

Summary Report

1. Purpose of Report

To provide the Board with an update from the Chief Executive of key issues, progress and priorities.

2. Executive Lead

Tom Abell, Chief Executive Officer.

3. Report Author

Tom Abell, Chief Executive Officer.

4. Responsible Committees / Impact Assessments / Financial Implications / Engagement

Not applicable

5. Conflicts of Interest

None identified.

6. Recommendation(s)

The Essex Joint Committee is asked to note the current position regarding the update from the Chief Executive and to note the work undertaken and decisions made by the Executive Committee.

Chief Executive's Report

1. Introduction

This report provides the Board with an update from the Chief Executive covering key issues, progress and priorities since the last update. The report also provides information regarding decisions taken at the weekly executive committee meetings.

2. Main content of Report

2.1 ICB transition

This will be the last meeting of this Joint Committee with the creation of NHS Essex Integrated Care Board which will succeed the three ICBs which currently cover Essex. I therefore wanted to take this opportunity to thank the Board and staff members of the three organisations for their hard work and the contributions they individually and collectively made to improving health services in Essex.

Organisational change process

By the time of the Board meeting we will have concluded the first phase of appointments to the new structure and all Essex facing staff will have received confirmation of their status.

For individuals who have been successful at securing a role we will be working with them to agree transition and handover arrangements. For those who have been unsuccessful and are therefore being placed on notice, we will continue to work to support them to identify any opportunities for suitable alternative employment either within the ICB or with other partners regionally.

For colleagues who applied and were successful in their voluntary redundancy application, the vast majority of these will finish their employment with the ICB at the end of this month.

I want to reiterate my appreciation and thanks to all our people for their continued professionalism and commitment.

Governance and the new ICB

We remain on track with the various due diligence and other requirements to enable the new ICB to be formed on 1 April 2026. The new Board will hold its inaugural meeting on 1 April 2026.

Alongside the set up of the new organisation, arrangements have been put in place to ensure successful closure of the existing ICBs.

The new organisation

We have also been working on developing a clear ambition for the new organisation and principles by which we will work as we transition to NHS Essex, which will be developed further with our people in the new financial year.

The headline ambition is that **we will make health services better in Essex**, meaning we will:

- Establish a consistent service offer.

- Reduce long waits for care.
- Implement evidence-based practice.
- Improve public perception of NHS services.
- Make the best use of public money.
- Act in cases of poor performance.

Alongside this ambition, we have established the following principles about how we will work, and what we want to be known for, namely that we will be **trusted, excellent and honest** which means:

- **Stewardship of public trust** - acting as guardians of the public pound and the public's health:
 - Taking decisions for long term population benefit.
 - Upholding quality, safety and equity.
 - Using resources wisely, transparently and fairly.
- **Professional excellence – doing the basics brilliantly, every time:**
 - Commissioning for high quality access and outcomes.
 - Using data, evidence and expertise to guide decisions.
 - Taking pride in getting the detail right.
- **Courageous candour** – every voice matters, every perspective is respected:
 - Being open, honest and clear, even when it is difficult.
 - Inviting challenge and listening properly.
 - Raising issues early and solving them together.

As part of this, we also recognise that we will win and lose together as Essex, and that will mean that we will need to continue to work together with partners, making decisions based on what is best for our population and support neighbourhood teams to succeed.

2.2 Planning

We successfully submitted a further iteration of our plans to NHS England during February and at the time of writing, are awaiting feedback.

The principle immediate area of challenge which we continue to work on is the sourcing and commissioning of additional capacity to support improvement in cancer and elective waiting times, in line with national expectations, given some specific challenges in existing commissioned services within Essex. I will provide a verbal update to the committee on the latest updates on this at our meeting.

As part of our plans, we also submitted a working version of our Population Health Improvement Plan (PHIP), which is the successor document to various other plans and strategies ICBs previously submitted. We will be discussing this elsewhere on the agenda, but I want to underline how important I believe this plan is to set priorities, focus on delivery for the residents of Essex, and to ensure we have an effective system of internal accountability and delivery.

3. Joint Essex Executive Committee

Since the last report, the Joint Essex Executive Committee which covers the new proposed footprint for Essex continued to meet. The following decisions were approved by the Executive Committee:

- Continued commissioning of the Tendring Mental Health Hub, co-facilitated with local partners.
- Approval of a pilot for Capsule Sponge testing across Mid and South Essex in collaboration with NHS Cancer Alliance.
- Continued commissioning Carers Intensive Support service within Southend on Sea.
- Review of ICB's Shared Care Record programme and future operating model, due to the ICB's revised role from 1 April 2026.
- Review of NHS Excellence submissions across the three ICBs in Essex.

The Committee continued to provide executive oversight and scrutiny of operational business, performance and financial sustainability.

4. Recommendation

The Essex Joint Committee is asked to note the current position regarding the update from the Chief Executive and to note the work undertaken and decisions made by the Joint Essex Executive Committee.

Part I Essex Joint Committee Meeting, 22 January 2026

Agenda Number: 9

Quality Report

Summary Report

1. Purpose of Report

To inform the Joint Committee of the latest national, regional and local programme of work which continues to inform the ICB's quality management system, oversight and assurance role as Strategic Commissioner for the Essex system.

The report also provides an overview of the current key issues/inspections and risks within the Essex system.

2. Executive Lead

Dr Giles Thorpe, Executive Chief Nurse

3. Report Author

Dr Giles Thorpe, Executive Chief Nurse

4. Responsible Committees

Joint Essex Quality Sub-committee

5. Link to the ICB's Strategic Objectives

- Being assured that the healthcare services we strategically commission for our diverse populations are safe and effective, using robust data and insight, and by holding ourselves and partners accountable.
- Achieve the objectives of year one of the ICB Medium Term (5 year) Plan to improve access to services and patient outcomes, by effectively working with partners as defined by the constitutional standards and operational planning guidance.
- To strengthen our role as a strategic commissioner and system leader by using data and clinical insight to make decisions that improve patient outcomes, reduce health inequalities, and deliver joined-up care through meaningful collaboration with partners and communities.

6. Impact Assessments

Not applicable

7. Financial Implications

Not applicable

8. Details of patient or public engagement or consultation

Not applicable

9. Conflicts of Interest

None Identified

10. Recommendations

The Committee is asked to:

1. Note the national update on responsibilities for oversight and assurance at ICB, regional and national level.
2. Note the outcome of the Thurrock SEND Inspection report, with areas of good practice and development for health.
3. Note the requirement of the ICB to support the development of local area SEND reform plans as part of the Schools White Paper recommendations.
4. Note the oversight and assurance of patient placement and transfer at St Andrew's Healthcare Northampton site, and ongoing surveillance of the Essex hospital site.

Quality Report

1. Introduction

The purpose of this report is to inform the Joint Committee of the most recent national programme of work which will inform the ICB's quality management system, oversight and assurance role as Strategic Commissioner for the Essex system.

The report also provides an overview of the current key issues/inspections and risks within the Essex system.

2. Main content of Report

Throughout Quarter 4 of 2025/26 multiple workstreams are underway finalising the restructure of the system's accountabilities and responsibilities for quality oversight, assurance and improvement, meeting the aims of NHS reform that will reduce duplication, strengthen strategic commissioning of healthcare services to improve efficiency, reduce inequality and improve outcomes. The following information will outline current work underway in preparation for the creation of NHS Essex Integrated Care Board.

National Workstreams for Quality

National Quality Strategy

A recent update from the National Quality Board has provided the following intelligence on the priorities of the National Quality Strategy expected to be in final draft stage by mid-March in readiness for the National Quality Board in March. The priorities have been identified as follows:

Improving safety and driving improved outcomes in priority areas

- Implement the Cancer plan
- Sustainably deliver and embed the Modern Service Frameworks (MSFs)
 - Cardiovascular disease
 - Sepsis
 - Severe mental illness
 - Frailty and dementia
 - Palliative and end-of-life care
 - Children and young people's health.
- Progress the actions of the Maternity and Neonatal Task Force

Improving experience across all parts of the NHS

- Implement the NHS Experience Excellence Framework

National Quality Board Guidance for Quality – ICBs

In line with the National Quality Board (NQB) guidance, the ICB is establishing a System Quality Group (SQG) as a core component of its emerging quality governance framework. The SQG will provide a system-wide forum for oversight, intelligence-sharing and assurance on the quality of services delivered across Essex, ensuring that quality remains central to strategic commissioning and system leadership. The SQG will report directly into the Commissioning Quality and Resource Group (CQRG), thereby strengthening the ICB's ability to monitor quality risks, drive improvement, and hold providers to account through a coherent and transparent governance structure.

Recent national workstreams have provided greater clarity regarding the distribution of quality responsibilities at national, regional, ICB and provider levels. For ease of reference, these responsibilities and the proposed quality governance architecture are set out in Appendix 1. The outline at Appendix 1 demonstrates clear alignment with both the Strategic Commissioning Framework and the 10-Year Health Plan, reaffirming the ICB's role as the strategic commissioner for health services with responsibility for ensuring quality and improved outcomes throughout the commissioning cycle.

The proposed Essex model—featuring both the SQG and an integrated committee with responsibility for quality—has been designed to reflect and operationalise this national direction. This structure ensures that quality oversight, risk escalation, and system learning are embedded within the core governance of the future Essex ICB.

Finalised NQB guidance is expected to be published in 2026/27, alongside the forthcoming National Quality Strategy, pending ministerial approval. The ICB will continue to shape and refine its approach in line with this updated national framework.

3. Current areas of focus for Essex

Ofsted/CQC Special Educational Needs and Disabilities (SEND) Area Inspection – Thurrock and Essex reports

Ofsted and the CQC have now shared the draft report for the SEND Area inspection for Essex, which is currently being reviewed as part of the factual accuracy process. They have published their report for the Thurrock SEND Area inspection.

Key areas of good practice for health services included:

- Therapy services mostly provide positive experiences and outcomes for children and young people and their families. Advice lines reduce unnecessary referrals and promote early intervention and support. Children and young people with SEND benefit from timely help in occupational therapy and physiotherapy. Therapy assessments are child-centred and lead to useful, holistic support.
- There are minimal waits for children and young people with SEND to access the specialist child and adolescent mental health services (CAMHS). This

means children who meet the higher threshold to support their mental health often receive help promptly.

- The local area partnership plans to redesign neurodevelopmental pathways. Its current capacity cannot meet the numbers requesting support. Leaders have now identified that meaningful transformation depends on engagement with adult services. The area has a tight oversight of the long waits for this service. It challenges providers where appropriate to improve services. The area understands the impact of delays on families. It monitors risk to children and young people effectively.

However, there was a key recommendation for health leaders as follows:

- Health leaders should work at pace to accelerate existing plans to maximise opportunities for early identification of needs and reduce waits for assessments.

Areas for development were already known to the ICB team, and the Babies, Children and Young People (BCYP) Commissioning team continue to work closely with Thurrock Local Authority teams to ensure that the health recommendation forms part of a wider improvement plan, with oversight and assurance of progression being delivered through the existing SEND partnership board. To note, actions are already underway to support further reductions in waiting times through the commissioning of additional provision for those children, young people and adults on a neurodevelopmental pathway.

Once the Essex partnership report has been published, a full update on SEND will be shared with the Executive Team, and the Board.

Schools White Paper and Local Area SEND Reform Plans

The Government published its Schools White Paper on 23 February 2026, setting out a plan to create an education system where every child and young person can achieve and thrive. The ambition is to raise standards, improve inclusion and broaden children's experiences so that every child leaves school with strong foundations for life and work. This is backed by over £7bn of investment over the next 3 years to embed inclusive practice in mainstream schools, deliver easy access without statutory assessments to experts including Educational Psychologists, Speech and Language Therapists and Occupational Therapists and create tens of thousands of new school places for children and young people with SEND in mainstream setting, with thousands of new inclusion bases, and in special schools.

Every local area is expected to embed a robust approach to local system leadership, financial discipline and operational delivery to bring forwards a sustainable system that delivers strong outcomes for children and families.

This means that the Government is commissioning each local area partnership to develop and submit a Local SEND Reform Plan in June 2026, underpinned by a Local Partnership Maturity Assessment. These documents should be used to clearly set out how each Partnership will improve and further strengthen the system, tilting provision towards stronger inclusive practice and early intervention, and ensuring that the conditions underpinning effective long-term outcomes are in place. This will help to identify and spread best practice as all partnerships work collectively to reform our SEND system.

NHS England (NHSE) regional leads alongside ICB SEND Executive leads have been asked to arrange local area planning meetings to support the development of the Local Area Forms Plans. These plans will act as the central mechanism for delivering the reforms at partnership level.

At the time of writing the Southend Essex and Thurrock Planning meeting is occurring on 13 March 2026. The outputs of the planning meeting and the proposed local area SEND reform plans will be shared with the ICB Executive Team and onward to the ICB Board prior to submission in June. The plan will be formally signed off by Local Authority Chief Executives, the ICB Chief Executive, the Local Authority Directors of Children's Services and the ICB SRO for SEND (Executive Chief Nurse), reflecting the joint statutory responsibilities for SEND across the system.

St Andrew's Healthcare, Northampton and Essex hospital sites

On 9 March 2026, NHS England informed relevant Integrated Care Boards that it had determined the need to arrange alternative placements for patients receiving inpatient care at the St Andrew's Healthcare Northampton site, following enforcement action taken against the provider in December. In response, Mid and South Essex ICB undertook due diligence by working with the Individual Placement Team (IPT), hosted by Suffolk and North East Essex ICB on behalf of all Essex systems, to review all Essex patients affected by this decision. Three patients were identified as currently placed at the Northampton site, and work is now underway to establish safe and appropriate transfer or discharge pathways that ensure continuity of high-quality care.

St Andrew's Healthcare's Essex site remains under the ICB's direct oversight and assurance as an independent sector provider. To strengthen this assurance, the ICB Quality Team is conducting joint visits with NHS England's East of England regional mental health, learning disability and autism teams. These visits aim to ensure that care delivery at the Essex site continues to meet required standards. In parallel, the IPT and the ICB's Neurorehabilitation Team are reviewing the care of all patients for whom the ICB has commissioned services.

At present, no similar concerns or associated enforcement actions have been identified at the Essex site. The ICB will also continue to work closely with EPUT, ensuring that any patients placed at the Essex site as part of agreed alternative arrangements are actively reviewed by EPUT as the responsible primary mental health provider.

4. Recommendations

The Committee is asked to:

1. Note the national update on responsibilities for oversight and assurance at ICB, regional and national level.
2. Note the outcome of the Thurrock SEND Inspection report, with areas of good practice and development for health.
3. Note the requirement of the ICB to support the development of local area SEND reform plans as part of the Schools White Paper recommendations.
4. Note the oversight and assurance of patient placement and transfer at St Andrew's Healthcare Northampton site, and ongoing surveillance of the Essex hospital site.

Appendix 1 – ICB responsibilities for Quality

Quality Planning	<p>Set strategic plans to deliver high-quality, cost-effective care and reduce inequalities for local communities, in collaboration with local authorities</p> <p>Commission high-quality care, co-designed with people using services, unpaid carers, staff and local communities, including neighbourhood health services.</p>
Quality Improvement	<p>Use contractual levers to drive quality improvement and address variation, including NHS Standard Contract</p> <p>Support providers to implement national standards (e.g. NHS Standard Contract, CQC requirements)</p> <p>Proactively manage and escalate risks in accordance with the National Quality Board guidance</p> <p>Delivery of statutory quality functions.</p>
Quality Control	<p>Monitor quality in contract management, including:</p> <ul style="list-style-type: none"> • Quality schedules and Service Development and Improvement Plans (SDIPs) • Quality metrics, including PROMs/PREMs • Minimum practice standards and guidelines • Service user, unpaid carer, staff and learner feedback • Patient Safety Strategy. <p>Maintain quality oversight of neighbourhood health services</p> <p>Chair System Quality Groups to share intelligence to inform improvement and risk management</p> <p>Use data/ intelligence to understand and improve the quality of services strategically commissioned. Triangulate metrics with wider intelligence and identify key themes and areas for improvement across services/ pathways.</p> <p>Commission Patient Safety Investigations and Independent Investigations, ensuring actions and learning are implemented</p>
Quality Assurance	<p>Effective and insightful governance to ensure visibility of quality, including:</p> <ul style="list-style-type: none"> • Clinical leadership • Use of data and insight, including feedback from users and staff • Equality and Quality Impact Assessments and assessments of cost-effectiveness • Incident management, audits and risk reporting. <p>Specify and assess quality in procurement activities, under the Provider Selection Regime.</p> <p>Compliance with oversight and regulatory frameworks (including NHS Oversight Framework and ICB Annual Assessment).</p>

Proposed quality governance

National Governance

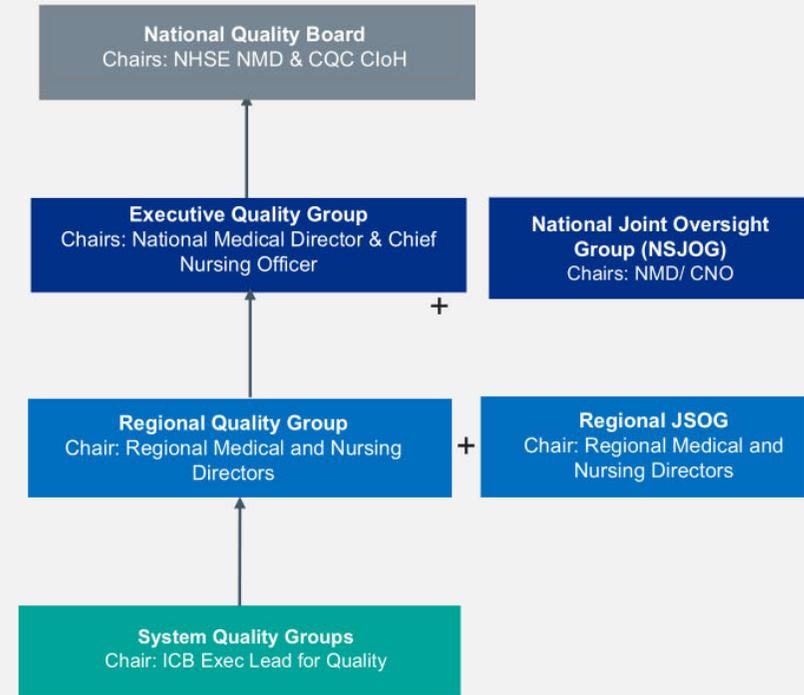
- Refreshed **National Quality Board** with new Chairs and membership
- Alignment of **Executive Quality Group** and **National Joint Strategic Oversight Group**

Regional Governance

- **Regional Quality Groups** to be maintained and aligned with Regional JSOG
- Role of RQGs to monitor regional trends; gain assurance of statutory quality functions; agree, coordinate and assure improvement support for quality; monitor and assure Modern Service Frameworks implementation; and assure and respond to generalised professional standards concerns.
- **Regions have more proactive role in managing risks**, chairing Rapid Quality Review Meetings and Quality Improvement Groups

System Governance

- ICBs to maintain a **System Quality Group**, aligned to cluster/ merger footprints.
- ICBs expected to have a **Board committee** responsible for monitoring quality (may be part of integrated committee), aligned to new quality oversight model and risk escalation framework



NQB Guidance is expected to be updated in 2026-27.

Part 1 Essex Joint Committee, 19 March 2026

Agenda Number: 11

Neighbourhood Report (Primary Care / Alliances)

Summary Report

1. Purpose of Report

To update Board members of the development of services by the Neighbourhood Teams. As part of the transition towards a single Essex ICB, this includes developments in West Essex and North East Essex.

2. Executive Lead

Beverley Flowers, Executive Director of Neighbourhood Health

3. Report Authors

Kate Butcher, Deputy Alliance Director – Mid Essex
Margaret Allen, Deputy Alliance Director – Thurrock
Caroline McCarron, Deputy Alliance Director – South East Essex
Simon Williams, Deputy Alliance Director – Basildon and Brentwood
Amy Jackson, Deputy Director of Transformation and Integration, HWE ICB and ECC
Lynn Stimson, Interim Director North East Essex Alliance
Vicki Decroo, Deputy Director of Integrated Commissioning
Paula Wilkinson, Director of Pharmacy and Medicines Optimisation
William Guy, Director of Primary Care

4. Responsible Committees

Primary Care Commissioning Committee (Primary Care elements only) and Alliance Committees

5. Impact Assessments

Not applicable to this report.

6. Financial Implications

Not applicable to this report.

7. Details of patient or public engagement or consultation

Not applicable to this report.

8. Conflicts of Interest

None identified.

9. Recommendation

The Essex Joint Committee is asked to note the Neighbourhood report.

Neighbourhood Report

1. Introduction

As part of the transition towards a single Essex ICB, this iteration of the Neighbourhood Report has been expanded from Mid and South Essex (MSE) to begin to include developments in West Essex (WE) and North East Essex (NEE).

2. Primary Care – General Practice

Access

The Primary Care Team are reviewing the details of the recently published 2026/27 GP contract changes to understand national changes for the next 12 months. The new contract will see several requirements come into effect in relation to access, in particular, urgent same day access to services. There are also proposed changes to previous schemes and funding flows that must be implemented because of the contractual announcements.

Since the last Board Report, the three constituent ICBs have continued to work with practices to ensure access models are effective and sustainable and have started to identify opportunities to share good practice as we move into a single Essex ICB.

Several follow up actions have been progressed regarding the eDec (electronic declaration) made by practices in autumn 2025/26. This work will continue into the new financial year. The eDec sets out a series of areas of the GP contract compliance that practices must self-declare their compliance with. This covers 8 areas, these being practice details, practice staff, premises and equipment, service provision, information and procedures, governance, CQC registration and digital provision.

Practices across Essex continue to submit their Capacity and Access Improvement Payment (CAIP) claims through established processes within each of the ICBs. CAIP is part of the Network Directed Enhanced Service and focusses on the implementation of Modern General Practice and the risk stratification of a population including identification of those that will benefit most from continuity of care.

Key indicators

	Consultations in January 25	Consultations in January 26	Percentage of consultations face to face Jan 2026
Mid and South Essex	625,000	640,000	66.0%
West Essex	164,000	158,000	70.1%
North East Essex	202,000	205,000	69.9%

Jan 2026	% of all activity undertaken on same day as first contact	% of all activity undertaken within 14 days of first contact
Mid and South Essex	46.2%	83.9%
West Essex	49.4%	84.1%
North East Essex	39.1%	79.9%
National	45.1%	82.7%

(Source: NHS Digital)

Chronic Kidney Disease (CKD) - Mid and South Essex

MSE ICB is starting to review the impact of a CKD Enhanced Service that it commissioned to improve the identification and management/secondary prevention of people with CKD. This service has been rolled out across 130 practices in MSE.

The Hollies Surgery, Hadleigh - Mid and South Essex)

Further to the update at the last Board meeting, the ICB continues to work closely with the caretaker provider delivering services to patients registered with The Hollies Surgery, Hadleigh. The ICB is working with the caretaker provider and other parties to open The Hollies Surgery building in March. In the meantime, the caretaker is delivering services from several registered healthcare premises across the local area.

Primary Care Due Diligence Processes

The three primary care teams from across Essex have been undertaking a series of actions as part of due diligence ahead of the formation of the new Essex ICB. This includes contractual arrangements, commissioning arrangements, communications and quality assurance. This work will continue into the new financial year.

Primary Care – Pharmacy

The community pharmacy commissioning and transformation group have started to identify priorities for the development of pharmacy services in 2026/27. This includes optimising the use of existing national schemes and pathways, specific local developments and consideration of our strategic approach for the commissioning of community pharmacy services in the new ICB.

Primary Care – Dentistry

The ICB is undertaking action to implement the recently announced contractual reforms to dental contracts. Specifically, several changes to urgent care contracting are being applied by ICBs for 2026/27. As part of our due diligence programme

consideration is also being given to our local commissioning arrangements across the three constituent parts of Essex and what will be implemented pan Essex within the new financial year.

There has been further positive coverage of the dental care home service in local and national media. Coverage has been led by the positive experience of care home managers since the service was introduced.

3. Focus of Alliance Teams

Alliance delivery for the remainder of the financial year has focused on the further develop of integrated neighbourhood working and supporting the planning for transition to the new Essex ICB.

Teams across MSE, WE and NEE continue to work within their governance and partnership arrangements to integrate care, reduce inequalities and transform how health and care is delivered. Examples of this work are set out below.

Integrated Neighbourhood teams

Alliances within MSE have continued the work to support at-scale delivery of frailty and improved end of life care via Integrated Neighbourhood Teams (INTs) to support the Medium-Term Plan.

WE and NEE teams are participating in the National Neighbourhood Implementation Programme (NNHIP) to pilot new ways of working. The focus to date has been on risk stratification of the population and the identification of opportunities to support the left shift of resources, ensuring INTs are sustainably equipped for scalable delivery as well as sharing the learning across teams to ensure no team is left behind.

The scope of the NNHIP is changing to look at wider neighbourhood health delivery, with wave 1 sites having the opportunity to work with national teams to inform policy and share learning with exemplar sites. The NNHIP is being aligned to key national strategic planning:

- NHS Medium Term Planning Guidance 26/27-28/29
- NHS Model Neighbourhood Framework (currently delayed)
- DHSC Neighbourhood Plan Guidance (not yet published)

WE continue to make strong progress as part of the NNHIP, which forms a key component of the wider WE Neighbourhood Health Programme. The work builds directly on a decade of 'care closer to home' development, established INTs and the population health-based proactive care model. These strong foundations have enabled WE to move at pace and to prepare for the broader shift to neighbourhood health delivery from April 2026.

Engagement across system partners remains high, supporting aligned ambitions and rapid development of the model. Since January, key achievements include:

- Progressing patient voice activity with the PAH patient panel and Healthwatch, ensuring lived experience shapes the cohort model and interventions.
- Completing assessment against national quarter 4 priorities and the national maturity matrix.

- Strengthening alignment with major strategic initiatives including PAHT's RISE Strategy, Pride in Place, the Sport England Place Based Partnership and wider Harlow locality programmes.
- Developing the cohort approach (frailty/multiple long term conditions (LTC) and rising risk), logic models and early intervention design, with a strong emphasis on reducing fragmentation, addressing social determinants of health and modelling new ways of working between acute, local authority, community, primary care and voluntary partners.
- Preparing to showcase WE's progress at the NHS England (NHSE) visit on 13 March 2026.
- Contributing to national work on funding flows, contracting models, neighbourhood guidance and digital capabilities, helping to shape solutions to barriers faced across England.

The programme remains on track, with clear next-step priorities around testing interventions for the multiple LTC cohort, continuing patient and community engagement, further development of INTs, and aligning governance for neighbourhood health across the future Essex system.

Similarly, The NEE Neighbourhood Health Implementation Programme continues to make strong progress, with a multi-agency board in place. The board is leading a shift in focus from neighbourhood team development to a wider, whole system ambition, that recognises the learning from the many proactive and preventative-led programmes, all having the potential to strengthen the local neighbourhood approach as highlighted below:

Key enabling workstreams have been established and through a distributed leadership model, system partners are taking lead responsibility for delivery against these. The workstreams are currently working through their mandates and areas of priority/risk, with a 'co-ordination group' that will bring partners together to ensure full collaboration, avoiding siloed working and identify opportunities at pace.

Neighbourhood Health Centres – the recent NNHIP guidance has allowed the locality to consider a hybrid approach to NHC (Neighbourhood Health Centres) development, maximising both physical and virtual assets, including existing hubs, in the agreed four local areas, rather than a reliance on new builds and increased capital and revenue expenditure. This approach is being successfully embraced particularly in Harwich, one of the least developed and deprived coastal towns, where there have been two successful workshops, focusing on an agreed multi-agency NHC local approach

At the recent NEE primary care event, the team were available to share the learning from the three national PCN pilot sites, as well as learning from the original NHHIP test and learn sites, particularly focused on a whole household approach.

The above progress has also allowed us to consider how best to coalesce our current NEE neighbourhood approach, with the recently developed NEE Pathfinder programme, ensuring we are part of the same continuum, successfully delivering with our local communities, our preventative and proactive ambition

Neighbourhood Health Hubs

Work has started on mapping potential locations for multi-neighbourhood health hubs and identifying types of services that might routinely be offered. Across the Essex footprint and in line with the NHS 10-year plan, providing support to

approximately 250,000 residents per hub, Essex is likely to need 8 to 10 neighbourhood health hubs.

Work is just starting to understand what the opportunities are in the development of the nationally required mental health neighbourhood health hubs and the potential synergies and opportunities to align their development with neighbourhood health hubs and other estates discussion as part of delivering the PHIP.

Partners in Care and Health (PCH) – Neighbourhood Delivery Hub Programme

PCH has partnered with NHS Providers and Newton to provide the neighbourhood delivery hub programme. Southend City Council successfully applied on behalf of the South East Essex Alliance to be part of the programme.

The Partners in Care and Health (PCH) program is a collaborative initiative between the Local Government Association (LGA) and the Association of Directors of Adult Social Services ([adass](#)). PCH aims to enhance the delivery of adult social care and public health services by providing councils with the necessary support and tools. The program is funded by the Department of Health and Social Care and is offered to councils without charge.

The programme aims to:

- use a sector-led, 'community of practice' approach to bring together a variety of Place teams and facilitate them to develop and accelerate models of on-the-ground delivery of INTs, as part of delivering on the neighbourhood health agenda
- address operational challenges and share learning to support the scaling-up and enhanced impact of INTs across the sector
- support the creation of assets that can be used operationally by places across the country, as well as informing national policy and direction.

This 6-month programme commenced in January 2026 and will provide valuable tools and learning to support the wider ICB neighbourhood health programme.

Coastal Navigator Network (CNN) – National Event

The Coastal Navigator Network (CNN) will host a national event on 29 April 2026 at Southend University Campus, focused on frailty and the role of technology in supporting Ageing Well. Professor Chris Whitty, who has championed the development of the CNN, will attend as guest speaker.

The CNN programme has been established to tackle health inequalities and deprivation in coastal communities and currently brings together 16 coastal areas across England, including Southend and Canvey Island. Locally, the programme is focused on Ageing Well, aligning directly with ICB and wider system priorities.

The April event will also bring together members of the emerging Coastal Industry Taskforce, which includes large national organisations and industry leaders e.g. Shell, BP, The Crown Estate, Skills for Care etc. The taskforce is exploring how partners can use social value, skills, expertise and innovation to support solutions to complex challenges.

The event provides an opportunity to showcase Southend and Canvey Island's work as part of a national network, explore practical uses of technology to support older people, and strengthen links between the system and national partners.

Better Care Fund (BCF)

As outlined in the 10 Year Health Plan, the Government is introducing initial changes to the BCF to help local areas go further in joining up the delivery of health and social care services and support the development of relevant areas of neighbourhood health, while devolving more responsibilities.

For 2026–27, the first year of reform, local areas are asked to start to align their pooled-funding plans with the wider development of relevant areas of neighbourhood health plans. There are no changes to the current system of minimum funding contributions for this year.

Local Authorities and NHS ICBs are asked to agree 2026/27 plans at Health and Wellbeing Board level for how best to use available funding to provide joined-up services for people with more complex health, social care, and housing needs for national submission on 19 May 2026.

Financial principles remain linked to the national guidance

As this is the first year of BCF reform we are asked to continue alignment with neighbourhood health priorities. It is expected that we take a pragmatic approach to linking BCF expenditure plans with local priorities for more integrated health and social care. There may be opportunities this year to:

- improve joint commissioning of integrated neighbourhood teams and bring together urgent community response, intermediate care and other community services at a multi-neighbourhood level even more closely than currently
- ensure that services funded from the BCF are part of wider plans to support people living with frailty and other people with more complex health and social care needs
- improve shared understanding and transparency locally about the outcomes and impact of the current BCF
- Improve support to unpaid carers for example, through respite support and peer support
- deepen partnerships with the voluntary, community and social enterprise sector to support more integrated care.

This will put us in a good position to lay a strong shared foundation for future reform of the BCF in future years.

We have started to review the schemes and planning work across NEE, MSE and WE but recognise that schemes in each area will impact different acute and community providers that are locality specific. Consequently, scalability might not be possible across Essex but needs to be explored further.

NHSE's published 2026-28 Planning Guidance clarifies that the uplift to the ICB's Minimum contribution to the Integrated Care Financial Framework (ICFF) is 2.1%, with contribution to Adult Social Care (ASC) uplifting by 4.4%.

The 4 ICFF metrics for 2026/28 have been nationally determined as:

- emergency admissions to hospital for people aged over 65 per 100,000 population
- average length of discharge delay for all acute adult patients
- long-term admissions to residential care homes and nursing homes for people aged 65 and over per 100,000 population

- the proportion of people aged 65 and over who were discharged from hospital into reablement and who remained in the community in the 12 weeks following discharge (as a new BCF metric for 2026-27 and an 'official statistic in development', partners are therefore not expected to set specific goals but may do so).

There is recognition that local authority (LA) re-organisation and devolution, and changes to ICB boundaries and responsibilities might affect funding flow and the work undertaken in the BCF space. Pre-planning has therefore commenced with LA colleagues within the realms of information currently available.

4. Recommendation

The Essex Joint Committee is asked to note the Neighbourhood report.

Part I Essex Joint Committee meeting, 19 March 2026

Agenda Number: 12.1

Board Assurance Framework (BAF)

Summary Report

1. Purpose of Report

To provide assurance to the Essex Joint Committee (EJC) regarding the management of strategic risks affecting Essex and how colleagues from Mid and South Essex (MSE), Hertfordshire and West Essex (HWE) ICB and Suffolk and North East Essex (SNEE) ICB are working together to develop the risk framework for Essex.

2. Executive Lead

Tom Abell, Chief Executive Officer and named Executive Directors for each risk.
Michael Watson, Executive Director of Corporate Services

3. Report Author

Nicola Adams, Associate Director Corporate Services.
Sara O'Connor, Senior Corporate Services Manager.
Executives have updated BAF slides within their remit.

4. Responsible Committees

Each sub-committee of the Board is responsible for their own areas of risk and receive risk reports to review on a bi-monthly basis.

5. Link to Strategic Objectives

Each BAF risk is linked to one or more of the ICB's strategic objectives, these being:

1. Through strict budget management and good decision making, the ICB plans and purchases sustainable services for its population and manages any associated risks of doing so within the financial position agreed with NHS England.
2. Being assured that the healthcare services we strategically commission for our diverse populations are safe and effective, using robust data and insight, and by holding ourselves and partners accountable.
3. Achieve the objectives of year one of the ICB Medium Term (5 year) Plan to improve access to services and patient outcomes, by effectively working with partners as defined by the constitutional standards and operational planning guidance.
4. To strengthen our role as a strategic commissioner and system leader by using data and clinical insight to make decisions that improve patient outcomes, reduce health inequalities, and deliver joined-up care through meaningful collaboration with partners and communities.
5. Through compassionate and inclusive leadership, consistent engagement and following principles of good governance, deliver the organisational changes required, whilst ensuring staff are supported through the change process and maintaining business as usual services.

6. Conflicts of Interest

None identified.

7. Recommendation/s

The committee is asked to:

- Note the content of this report and the emerging Joint Essex BAF at **Appendix 1**.
- Seek any further assurances required.

Board Assurance Framework

1. Introduction

ICB Boards hold overall responsibility for ensuring effective arrangements are in place to identify and manage strategic risks. This responsibility is discharged through oversight of each Board's Assurance Framework (BAF). This paper aims to provide assurance that the risk management approach being applied during transition is appropriate, aligned across the Essex footprint, and reflects system-wide learning.

Under its terms of reference, the Essex Joint Committee (EJC) assumes responsibility for oversight of risks relevant to Essex during the transition period. The Essex Executive Team (who will become the Executive Team for the proposed Essex ICB) undertakes monthly review of the BAF and all red rated risks.

The sub-committees of the Essex Joint Committee, also receive relevant extracts from the BAF, together with directorate-level risk registers aligned to their areas of responsibility.

These governance arrangements are supported by routine review and updating of risks by directorate risk owners (within MSE) who are working alongside ICB colleagues in HWE and SNEE to consider risk on the wider Essex footprint and thus develop the Essex ICB risk registers. This is being achieved through regular cross-ICB directorate meetings (such as finance, primary care, commissioning etc.) and coordinated review by governance colleagues.

2. Board Assurance Framework

The BAF includes seven strategic risks, six of which are rated red (scored between 15 and 25), with the Primary Care rated Amber (score 12).

Current BAF risks are:

- Workforce (16)
- Primary Care (12 Amber)
- Primary Care Estates - Capital (16)
- Quality Assurance of Services (reduced from 20 to 16)
- Access to Services (16)
- System Financial Performance (16)
- ICB Transition (16)

Members are reminded that BAF scores are set by Executive Leads based on their assessment of system-level impact and likelihood. They are not averages or aggregate scores derived from individual risks recorded on directorate and corporate risk registers (as noted on slide 4 of **Appendix 1**).

For context, the BAF also includes a summary of red-rated risks from key providers (taken from their last BAF reports to their Trust Board available on their websites):

- Mid and South Essex NHS Hospitals Trust (MSEFT)
- Essex Partnership University NHS Trust red-rated risks (EPUT)
- Princess Alexandra Hospital NHS Trust (PAH)
- East Suffolk and North Essex NHS Foundation Trust (ESNEFT)

3. Recommendation

The committee is asked to:

- Note the content of this report and the emerging Joint Essex BAF at **Appendix 1**.
- Seek any further assurances required.

4. Appendices

Appendix 1 - Board Assurance Framework, March 2026.

Board Assurance Framework

March 2026



Contents

- Slide 3: Summary of BAF risks
- Slide 4: Summary of underlying directorate risks for each BAF risk
- Slides 5 – 11: Individual BAF Risks – controls, barriers, assurances, actions.
- Slides 12 – 15: Main Provider risks:
 - Mid and South Essex NHS Foundation Trust (MSEFT)
 - Essex Partnership University NHS Trust (EPUT_
 - Princess Alexander Hospital NHS Trust (PAHT)
 - East Suffolk and North Essex NHS Foundation Trust (ESNEFT)

BAF Risks – Summary Report

No	Risk and Key Elements	SRO(s)	Aligned Committee / Board Report	RAG
1.	WORKFORCE: <u>There is a risk that</u> the workforce within the system (MSEFT, EPUT, Primary Care) is not sustainable or affordable to effectively deliver services. <u>This is caused by</u> inadequate strategic planning of the required workforce, coupled with difficulties in recruitment and retention leading to a heavy reliance on bank/agency staff. Services have ineffective succession planning/development, and the quality of workforce data is poor. <u>This could lead to</u> patient safety issues/harm (safer staffing), poor patient experience and increased cost.	M Watson / S Morrison	People Board / No specific Board report / People Board Minutes	4 x 4 = 16
2.	PRIMARY CARE <u>There is a risk that</u> the intentions of the primary care strategy and development of Primary Care Networks will not be realised. <u>This is caused by</u> workforce pressures and demand outstripping capacity and difficulties in the recruitment and retention of primary care staff. <u>This could lead to</u> patient experience and pathways not meeting the needs of our residents and a difficulty in delivering the 'left shift' of services from 'acute to community'.	B Flowers	Primary Care Commissioning Committee (PCCC) / Primary Care and Alliance report	4 x 3 = 12
3.	PRIMARY CARE ESTATES (CAPITAL) <u>There is a risk that</u> the primary care estate is not fit for purpose or holds sufficient capacity to deliver services appropriately. <u>This is caused by</u> limited available investment and changes to the ownership structures of surgeries over time. <u>This could lead to</u> closure of primary care premises or services, poor patient experience and potential increase in acute hospital demand	J Kearton / B Flowers	PCCC / Primary Care and Alliance report	4 x 4 = 16
4.	QUALITY ASSURANCE OF SERVICES <u>There is a risk that</u> patients experience poor quality of services, poor experience and negative outcomes or harm. <u>This is caused by</u> services falling below expected clinical quality standards, the NHS Constitution and NHS Long Term Plan requirements; and the ICB not having sufficient oversight and intervention to be assured services improve. <u>This could lead to</u> the ICB needing to manage additional demand on primary/acute hospital services, an increase in financial pressure, regulatory scrutiny and reputational damage.	Dr G Thorpe	Quality Committee / Quality report	4 x 4 = 16
5.	ACCESS TO SERVICES <u>There is a risk that</u> patients experience poor access to services (health inequality), a lack of timely intervention (according to constitutional standards), deconditioning, poor experience and outcomes or harm. <u>This is caused by</u> waiting list backlogs, non-delivery of operational planning requirements, lack of capacity in service delivery and supporting services such as diagnostics and poor data. <u>This could lead to</u> reputational damage, regulatory scrutiny, increase demand on ICB functions and increased financial pressure.	S Goldberg	Finance & Performance Committee (FPC)/ Finance and Performance Monthly update report.	4 x 4 = 16
6.	SYSTEM FINANCIAL PERFORMANCE <u>There is a risk that</u> organisations within the system control total do not deliver the required financial plans / efficiency savings. <u>This is caused by</u> grip and control, capacity to manage unforeseen cost pressures. <u>This could lead to</u> increased scrutiny by regulators, reputational damage and a potential changes to service delivery.	J Kearton	FPC / Finance and Performance Monthly update report.	4 x 4 = 16
7.	ICB TRANSITION <u>There is a risk that</u> the creation of a new ICB geography and organisation at reduced cost will not be able to deliver core functions and transformational changes required by the MTP. <u>This is caused by</u> an expected reduction in capacity, at a rapid pace that will detract staff from delivery as they engage in workforce redesign and consultation during a period of significant national change and cost saving requirements across the NHS. <u>This could lead to</u> disengagement of staff, a failure to maintain strategic commissioning functions that could ultimately result in potential harm to residents, poor experience and reputation damage, with resulting increased regulatory scrutiny.	T Abell	Transition Committee / Chief Executive Report	4 x 4 = 16

BAF

Risks recorded on Datix that make up our BAF and their scores (Consequence/Impact x Likelihood)

ID	Workforce	4 x 4 = 16
21	Primary Care Workforce Recruitment / Retention	4 x 3 = 12
145	System Workforce Sustainability	4 x 4 = 16
150	ICB Safeguarding Staff Capacity	4 x 4 = 16
ID	Primary Care (PC)	4 x 3 = 12
3	PC Demand & Capacity	4 x 3 = 12
21	Primary Care Workforce Recruitment/Retention	4 x 3 = 12
33	Primary Care Network development	3 x 2 = 6
34	General Practice QA	3 x 3 = 9
ID	Primary Care Estate (Capital)	4 x 4 = 16
58	Insufficient Capital	4 x 4 = 16
94	Risk to PC provision due to estates challenges	4 x 3 = 12
ID	Quality Assurance of Services	4 x 4 = 16
5	MH Acute quality assurance (QA)	4 x 3 = 12
6	Neurodivergent Children	4 x 4 = 16
11	All Age Continuing Care (AACC)	4 x 3 = 12
12	Complaints – backlog.	3 x 4 = 12
15	Acute quality assurance	4 x 4 = 16
17	Maternity	4 x 4 = 16
23	Eating Disorder Service QA	4 x 3 = 12
24	Patient Safety Incidents Oversight	4 x 3 = 12
25	Infection Prevention & Control	4 x 3 = 12
34	General Practice QA	3 x 3 = 9

ID	Access to Services	4 x 4 = 16
1	RTT	4 x 4 = 16
2	Diagnostics performance	4 x 4 = 16
13	Cancer performance	4 x 4 = 16
26	Ambulance Handovers	3 x 3 = 9
93	Mental Health patient flow	4 x 4 = 16
ID	System Financial Performance	4 x 4 = 16
7	Efficiency Programme	4 x 4 = 16
14	System Financial Performance	5 x 3 = 15
42	ICB Financial Performance	4 x 2 = 8
44	Risk of Fraud	4 x 2 = 8
ID	Transition	4 x 4 = 16
138	Critical Programmes/Decisions	3 x 3 = 9
139	Business as Usual Continuity	3 x 3 = 9
140	Loss of Talent/Disengagement	3 x 4 = 12
141	Gaps in Quality/Regulatory Oversight	3 x 2 = 6
142	Human Resources Capacity	3 x 3 = 9
143	Alignment with Local Government Reform	3 x 3 = 9

Risk Narrative:	Workforce: <u>There is a risk that</u> the workforce within the system (MSEFT, EPUT, Primary Care) is not sustainable or affordable to effectively deliver services. <u>This is caused by</u> inadequate strategic planning of the required workforce, coupled with difficulties in recruitment and retention leading to a heavy reliance on bank/agency staff. Services have ineffective succession planning/development, and the quality of workforce data is poor. <u>This could lead to</u> patient safety issues/harm (safer staffing), poor patient experience and increased cost.	Current Risk Score: (impact x likelihood) Target Score Risk Appetite Category	4 x 4 = 16 (Red) 4 x 2 = 8 (Amber) People (4 - Seek)
Risk Owner/Lead:	Michael Watson, Executive Director of Corporate Services Siobhan Morrison, ICB HR Advisor / Chief People Officer (Provide)	Directorate: Board Committee:	Corporate Services. People Board.
Impact on Strategic Objectives/ Outcomes:	Compassionate Leadership	Associated Risks on Datix:	ID Nos 21, 145 and 150
How is it being addressed? (Current Controls)			
<ul style="list-style-type: none"> Continued monitoring via the Finance & Performance Report to the Finance & Performance Committee and Board and via the People Board Strict controls over the use of bank and agency staff by providers. Scrutiny by ICB (triple lock) of all vacancies, contract extension requests against a predetermined criteria for onward approval of NHSE regional team. Both EPUT and MSEFT embarking on corporate staffing review Primary care workforce hub continues to support activities in primary care. Health and Care Academy and Healthcare Assistant Academy are providing a strong pipeline for future health careers and retention of existing staff. 			
Barriers (Gaps)	Next Steps (Actions)		
<ul style="list-style-type: none"> Compliance and controls will make a difference and is the right discipline. However, sustainable change will require significant decisions around size, shape and skill mix of future workforce. 	<ul style="list-style-type: none"> Ongoing compliance and control tracking within provider organisations. 2025/26 operational plan submission provides appropriate staffing levels and there is commitment to manage to that workforce plan. People Board to take a greater role in assurance of workforce plans. Opportunities for system working (eg workforce analytics) will be picked up via the system efficiency programme of the MTP. Appointments to new ICB staff structure ongoing. 		
How will we know it's working? (Internal Groups & Independent Assurance & metrics)	Is there anything else we need to know? What can't we see?		
<ul style="list-style-type: none"> Reduction of percentage of workforce that is over-establishment and unfunded. Reduction in temporary staffing spend. Evidence of better value for money where temporary staffing continues to be needed. Improved productivity and staff morale as evidenced through NHS staff survey. 	-		

Risk Narrative:	Primary Care: <u>There is a risk that</u> the intentions of the primary care strategy and development of Primary Care Networks will not be realised. <u>This is caused by</u> workforce pressures and demand outstripping capacity and difficulties in the recruitment and retention of primary care staff. <u>This could lead to</u> patient experience and pathways not meeting the needs of our residents and a difficulty in delivering the 'left shift' of services from 'acute to community'.	Risk Score: (impact x likelihood)	4 x 3 = 12 (Amber)
Risk Owner/Lead:	Beverley Flowers, Executive Director of Neighbourhood Health	Target Score:	4 x 2 = 8 (Amber)
Impact on Strategic Objectives/ Outcomes:	Commission and assure safe services / Focus on access and outcomes / Strategic Commissioner and System Leader	Risk Appetite Category:	People – 4 (Seek) and Quality – 4 (Seek)
		Directorate: Board Committee:	Neighbourhood Health. Primary Care Commissioning Committee
		Associated Risks on Datix:	ID Nos 3, 21, 33 and 34.

How is it being addressed? (Current Controls)

- Primary Care Access Recovery Programme
- Primary Care Medium Term Plan
- Development of Integrated Neighbourhood Teams
- Primary Care Estates Programme
- Primary Care Workforce Hub

Barriers (Gaps)	Next Steps (Actions)
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- Continued work following collective action, particularly prescribing, continuous monitoring.
- Resource for investment in infrastructure especially for estates improvements.
- Increase in overall demand on primary care services.
- Primary/Secondary interface. Specific work programme in place.
- Overall funding of primary care.

- Integrated Neighbourhood Teams – revised approach for the development of INTs included within the ICB's Medium Term Plan. Learning will be quickly adopted from the West Essex and North East Essex pilot sites.
- Consideration is being given on how the "Connected Pathways" function could be provided post April 2026. Decision expected to be taken in Q4.GP Provider Collaborative seeking to establish an Essex Wide footprint to reflect the forthcoming changes to ICBs.

How will we know it's working? (Internal Groups & Independent Assurance & metrics)	Is there anything else we need to know? What can't we see?
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- Patient Survey Results.
- Workforce retention rates (monthly data). Latest data indicates marginal improvement in GP retention rates.
- Improved Patient to GP Ratio (quarterly data).
- Consultation data (volume, speed of access), digital tool data (engagement and usage), monthly data currently showing upward trends.

- This risk was comprehensively reviewed by the Primary Care Commissioning Committee in November 25. In view of the impact of initiatives and improvements in indicators such as patient satisfaction, consultation numbers, recruitment combined with an overall reduction in risk of provider failure, the likelihood of this risk has been reduced to 3. This leaves the overall risk at a 12 rating.

Risk Narrative:	Primary Care Estates (Capital) : <u>There is a risk that</u> the primary care estate is not fit for purpose or holds sufficient capacity to deliver services appropriately. <u>This is caused by</u> limited available investment and changes to the ownership structures of surgeries over time. <u>This could lead to</u> closure of primary care premises or services, poor patient experience, and potential increase in acute hospital demand.	Risk Score: (impact x likelihood)	4 x 4 = 16 (Red)
Risk Owner/Lead:	Jennifer Kearton, Executive Director of Finance and Commercial. Beverly Flowers, Executive Director of Neighbourhood Health.	Target Score:	4 x 1 = 4 (Yellow)
Impact on Strategic Objectives/ Outcomes:	Commission and assure safe services / Focus on Access and Outcomes	Risk Appetite Category:	Financial – 3 (Open)
		Directorate: Board Committee:	Finance and Commercial. Primary Care Commissioning Committee
		Associated Risks on Datix:	ID Nos 58 and 94.

How is it being addressed? (Current Controls)

- Evolving Infrastructure Strategy and revised medium term prioritisation framework for pipeline of investments.
- Oversight by Finance & Performance Committee, System Finance Leaders Group, System Investment Group (SIG), and Executive Committee.
- SIG sighted on ‘whole system’ capital and potential opportunities to work collaboratively. Provider capital plans for 2026/27 being progressed through SIG and planning forums.
- Working with NHS England (NHSE) / Trusts to deliver the benefits associated with the sustainability and transformation plan capital, and accessing regionally held capital for 2026/27 onwards.
- Prioritisation framework for primary care (PC) capital now established and under regular review.
- Maximising use of developer contributions where available for general practice improvements.
- Progressing number of schemes funded via Utilisation & Modernisation Funding made available in 2025/26.
- Prioritisation & Pipeline development for schemes to progress in 2026/27.

Barriers (Gaps)	Next Steps (Actions)
<ul style="list-style-type: none"> • Medium Term prioritisation framework to guide investment. • Expectations of stakeholders outstrip the current available capital. • Requirement for ownership of schemes within General Practice to utilise available capital. • Accounting rules relating to the capitalising of leases has resulted in greater affordability risk. • Impact of system financial position (‘triple lock’ and reduction of capital departmental expenditure limits (CDEL). 	<ul style="list-style-type: none"> - Primary care projects review on-going. - Promotion of available developer contributions to support affordable developments. - Continue to progress opportunity through PC Estate Utilisation & Modernisation Fund and Plan for 26/27. - Training for Board members & executives (senior managers) on capital funding framework and consideration of future capital requirements.

How will we know it’s working? (Internal Groups & Independent Assurance & metrics)	Is there anything else we need to know? What can’t we see?
<ul style="list-style-type: none"> • Delivery of capital/estates plans. • Progress reporting on investment pipeline. • Monthly reporting of capital expenditure as an ICS to NHSE. 	<ul style="list-style-type: none"> • The changing role of the ICB and impact on system working.

Risk Narrative:	Quality Assurance of Services: <u>There is a risk that</u> people experience poor quality of services, have a poor experience and negative outcomes or harm. <u>This is caused by</u> services falling below expected clinical quality standards, the NHS Constitution and NHS Long Term Plan requirements; and the ICB not having sufficient oversight and intervention to be assured services improve. <u>This could lead to</u> the ICB needing to manage additional demand on primary/acute hospital services, an increase in financial pressure, regulatory scrutiny and reputational damage.	Risk Score: (impact x likelihood)	4 x 4 = 16 (Red)
Risk Owner/Lead:	Dr Giles Thorpe, Executive Chief Nursing Officer	Target Score:	4 x 2 = 8 (Amber)
Impact on Strategic Objectives/ Outcomes:	Commission and assure safe services / Focus on Access and Outcomes, Strategic Commissioner and System Leader	Risk Appetite Category:	Quality – 4 (Seek)
Directorate: Board Committee:		Directorate: Board Committee:	Nursing & Quality Directorate. Quality Committee.
Associated Risks on Datix:		Associated Risks on Datix:	ID Nos 5, 6, 11, 12, 15, 17, 23, 24, 25 and 34.

How is it being addressed? (Current Controls)

- Provider quality reports taken to Quality Committee, alongside monitoring via the Quality, Performance, Contracting Meeting (QCPM).
- System Quality Group focusses on the delivery of system improvements against any core quality concerns and issues
- Mental Health - check and challenge at weekly Complex Delayed Discharges Escalation meeting with EPUT, with regular Multi-Agency Discharge Events (MADE) to ensure good flow and capacity.
- Rapid Quality Reviews in place, chaired by ICB CNO, to address significant concerns/regulatory issues pertaining to provider challenges
- Quality Assurance Visits (QAV) to promote continued collaborative working, check and challenge, assurance of quality and patient safety, and compliance with regulatory requirements.
- Ongoing dialogue with Patient safety teams to allow for ICB communications and senior leadership notification, ICB patient safety specialist and quality team continue to work with Providers.

Barriers (Gaps)	Next Steps (Actions)
<ul style="list-style-type: none"> • Data Quality issues and IT systems not yet in place consistently to allow for robust data capture and analysis. • Ongoing issues related to governance frameworks, and proactive identification of emerging risks to safety, experience and quality result in ongoing harm (MSEFT specific). • Deeper understanding of quality risks with new providers required to understand totality of system risk profile. • Role clarity for ICB In quality assurance still to be finalised by national quality board. 	<ul style="list-style-type: none"> • Mitigations against data quality issues identified, ICB increasing analytics capabilities to address provider shortfalls and offer system perspective (April 2026) • Partnership work ongoing to improve psychiatric liaison/flow/escalation across MSEFT/EPUT with expected move to BAU in April 2026 without further ICB Intervention. • Exec to exec meetings underway, with new Quality Committee ToRs and membership planned (Jan 2026) • Clarity on ICB/Regional roles underway to agree model for transition – work being led by regional team (May/June 2026).

How will we know it's working? (Internal Groups & Independent Assurance & metrics)	Is there anything else we need to know? What can't we see?
<ul style="list-style-type: none"> • Improved quality and contract indicators are embedded and sustained. • Improved and sustained capacity and flow, reduced length of stay, and reduced OOA placements (for mental health). • Reduction in requirements for enhanced monitoring status of providers within the system. • Evidence of early identification of risks within system that are affecting multiple providers which allows for earlier intervention and proactive risk reduction, thereby mitigating outcome impact to residents. 	<ul style="list-style-type: none"> • Understanding of new providers into Greater Essex footprint will also determine capacity and demand risks and reshape function and form of support to primary care, optometry and dental services across Essex. • Redesign of system governance will be required to help maintain a focus on quality aspects of commissioning and planning cycles, focussed on demand utilisation, and to meet ambitions within 10 year plan. • National Quality Board guidance yet to be finalised. • Consultation of workforce within ICB not yet concluded and resources remaining and required are not yet known.

Risk Narrative:	Access to Services: <u>There is a risk that</u> patients experience poor access to services (health inequality), a lack of timely intervention (according to constitutional standards), deconditioning, poor experience and outcomes or harm. <u>This is caused by</u> waiting list backlogs, non-delivery of operational planning requirements, lack of capacity in service delivery and supporting services such as diagnostics and poor data. <u>This could lead to</u> reputational damage, regulatory scrutiny, increase demand on ICB functions and increased financial pressure.	Risk Score: (impact x likelihood)	4 x 4 = 16 (Red)
Risk Owner/Lead:	Sam Goldberg, Executive Director of Performance and Planning.	Target Score:	4 x 2 = 8 (Amber)
Impact on Strategic Objectives/ Outcomes:	Focus on Access and Outcomes	Risk Appetite Category:	Quality 4 (Seek)
		Directorate:	Strategy Directorate
		Board Committee:	Finance & Performance Committee
		Associated Risks on Datix:	ID Nos 1, 2, 13, 26 and 93.

How is it being addressed? (Current Controls)

Operational Planning and Performance Monitoring

- Integrated Operational Plans aligned with national standards and local needs. | Escalation process for underperformance or missed targets via the performance review meetings, SOAC and F&PC.
- Regular perf. reviews against constitutional standards: Weekly Elective Recovery & Transformation Board, bi-weekly Tier 1 Meeting for Cancer & Elective & monthly UEC Oversight & Performance & Diagnostic Prog Board meetings

Capacity and Demand Management

- Demand management tools, utilising Advice & Guidance to demand manage | Use of independent sector and other NHSE providers to reduce 65 week wait backlogs where appropriate.
- Service Design to implement community pathways to support demand management and maximise out of hospital pathways to reduce outpatient appointments and procedures, including maximising new CDC diagnostic capacity

Waiting List Management

- Validation and clinical triage of waiting lists to ensure accuracy and urgency. | Patient tracking systems to flag delays and trigger interventions.

Governance and Oversight

- Board-level oversight of access and performance metrics. | Risk registers and assurance frameworks to track and mitigate risks. | Internal reviews to ensure compliance and continuous improvement.

Barriers (Gaps)	Next Steps (Actions)
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- UEC: Demand management at initial assessment and triage, constraints to increase non-elective activity into SDEC due to bedded as escalation overnight capacity, specifically at Basildon and Broomfield hospitals.
- Elective & Cancer: Improved community models to reduce pathway. Inability to increase capacity in acute to support advice & guidance.
- Diagnostic: delays to CDC build and start dates
- Workforce challenges (See Workforce Risk slide).

- Continuous monitoring of daily operations
- Quality Improvement Programmes at MSEFT to improve ED and ambulance handover performance. New COO at MSEFT is resting the UEC delivery programme to focus on standardisation and specific pathway improvements to support improved performance and patients experience and outcomes.
- ED Front Door Model: Redirect to Pharmacy First with the PharmRefer app, and streaming to alternative urgent care services.
- Road map for Unscheduled Care Co-ordination Hub to widen access for service access to further let shift of urgent care activity to alternative pathways away from the Emergency Department

How will we know it's working? (Internal Groups & Independent Assurance & metrics)

- Improvement in compliance with target standards via F&PC and Board Reports
- Achievement of operational plans / programmes of work
- Improvements in patient constitutional standards and associated performance delivered.

Is there anything else we need to know? What can't we see?

- Faster Diagnostics Standards (FDS): Risk to delivery of the 2025/26 year-end standard of 76%. Forecasted December 2025 performance of 68.9%
- 31 Day Performance Standard: No risk to performance not being delivered against trajectory, and Mach 2026 national target delivered.
- 62 Day Performance Standard: Risk to delivery of the 2025/26 year-end standard of 68%. Forecasted December 2025 performance of 47%
- Leadership Support: Operational and clinical leadership resources seconded from NHSE and the Cancer Alliance to drive task force groups improving patient access and pathways.
- Targeted Funding from NHSE and Cancer Alliance (£2.024m): Strengthen leadership within cancer teams to improve/redesign pathways. Increase clinical capacity in key areas: Breast, Radiotherapy, Therapeutic Radiography & Physics, Histopathology and Thoracic Outpatients and Surgical Capacity
- Capacity Expansion (2025/26): Commissioned additional clinical capacity worth approx. £75m, including: Independent sector providers for 7,830 patients, Mutual aid with local providers (ESEOC) for 304 cases.
- Outcome of scoping and designing of community models for procurement for Dermatology, MSK & Pain and ENT and Audiology with all models providing a single point of access for Consultant and MDT led services to reduce first outpatient appointments and procedures, scheduled for deployment in February 2025

Risk Narrative:	System Financial Performance: <u>There is a risk that</u> organisations within the system control total do not deliver the required financial plans / efficiency savings. <u>This is caused by</u> grip and control, capacity to manage unforeseen cost pressures. <u>This could lead to</u> increased scrutiny by regulators, reputational damage and a potential changes to service delivery.	Risk Score: (impact x likelihood)	4 x 4 = 16 (Red)
Risk Owner/Lead:	Jennifer Kearton, Executive Chief Finance Officer	Target Score:	4 x 1 = 4 (Yellow)
Impact on Strategic Objectives/	Deliver to the agreed budget / Strategic Commissioner and System Leader	Risk Appetite Category:	Financial – 3 (Open)
		Directorate:	Finance Directorate
		Board Committee:	Finance & Performance Committee
		Associated Risks on Datix:	ID Nos 7, 14, 42 and 44.

How is it being addressed? (Current Controls)

- Escalation meetings with MSEFT, NHSE East of England (EoE) Regional Colleagues and regular review with NHSE National team.
- Central PMO focus on efficiency delivery and new ideas for continued momentum across the medium-term planning period.
- Organisational bottom-up service and division review and improvement plans.
- Continued oversight by Chief Executive Officers, Finance Committees and Executive Committees across organisations and ICB.
- Control Total Delivery Group of System Chief Finance Officers
- Engagement across the system with all disciplines to escalate the importance of financial control, value for money and improving value.
- Additional workforce controls – please see workforce slide.
- Additional spend controls – triple lock arrangements.
- Investigation and Intervention work with local implementation of identified actions. Medium Term Plan delivery support movement to financial sustainability.

Barriers (Gaps)	Next Steps (Actions)
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- | | |
|---|---|
| <ul style="list-style-type: none"> • New and emerging financial challenges being driven by workforce challenges, performance, quality and delivery. • System pressures to manage delivery (capacity). • Capacity due to vacancy chill. | <ul style="list-style-type: none"> • On-going monitoring of financial position. • Delivery of system efficiencies programme/financial sustainability programme for 2025/26. • Medium Term Plan delivery and alignment to Planning Framework. |
|---|---|

How will we know it's working? (Internal Groups & Independent Assurance & metrics)	Is there anything else we need to know? What can't we see?
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- | | |
|--|--|
| <ul style="list-style-type: none"> • Delivery of the agreed position in-year and at year-end. • Improved delivery throughout the medium term (5 years) to system breakeven. • Being overseen by the Finance Committees and the Chief Executives Forum. • Internal and External Audits planned. | <ul style="list-style-type: none"> • The changing role of the ICB and impact on system working. |
|--|--|

Risk Narrative:	ICB Transition: <u>There is a risk that</u> the creation of a new ICB geography and organisation at reduced cost will not be able to deliver core functions and transformational changes in the MTP. <u>This is caused by</u> an expected reduction in capacity, at a rapid pace that will detract staff from delivery as they engage in workforce redesign and consultation during a period of significant national change and cost saving requirements across the NHS. <u>This could lead to</u> disengagement of staff, a failure to maintain strategic commissioning functions that could ultimately result in failure to deliver on agreed plans, potential harm to residents, poor experience and reputation damage, with resulting increased regulatory scrutiny.	Risk Score: (impact x likelihood)	4 x 4 = 16 (Red)
Risk Owner/Lead:	Tom Abell, Chief Executive Officer. Michael Watson, Executive Director of Corporate Services.	Target Score:	4 x 1 = 4 (Yellow)
Impact on Strategic Objectives/ Outcomes:	Compassionate Leadership / Deliver to the agreed budget	Risk Appetite Category:	Financial – 3 (Open)
		Directorate: Board Committee:	ICB Board Executive Committee
		Associated Risks on Datix:	ID Nos 138, 139, 140, 141, 142, & 143.

How is it being addressed? (Current Controls)

- The appointment process for Chief Executive and Executive Team has concluded to provide leadership stability during the transition.
- Establishment of Essex Executive Committee to oversee transition related activity.
- VR scheme now closed.
- Engagement plan in place, including weekly staff updates, engagement with partners and provision of staff support offer.
- Essex Joint Committee fully established, now consulting on future governance plans.
- Central Programme Management Office (CPMO) continues to oversee, support and report key programmes to the Executive Committee via due diligence workstream and the MTP Delivery Boards. Now moving to fortnightly due diligence meetings.

Barriers (Gaps)	Next Steps (Actions)
<ul style="list-style-type: none"> • Challenge of assuring continued alignment with other ICBs. • Ongoing uncertainty from NHS England with regard to transferring functions. 	<ul style="list-style-type: none"> • Appointments to new ICB staff structure ongoing. • Continue staff engagement (pan-Essex and via directorates) • Pre-transfer process for staff currently in Hertfordshire and West Essex (HWE) and Suffolk and North East Essex (SNEE) ICBs that will move to the Essex ICB.

How will we know it's working? (Internal Groups & Independent Assurance & metrics)	Is there anything else we need to know? What can't we see?
<ul style="list-style-type: none"> • Successful delivery of staff consultation outcome and appointment to new structure in Q4. • Staff are supported throughout the process. • Successful establishment of Essex ICB. 	<ul style="list-style-type: none"> • Conversations happening within Essex about future operating model in a range of areas for example workforce and digital. • Potential for decisions made in HWE and SNEE without wider discussion in Essex.

Partner self-identified Red Risks (and scores)

MSEFT - 11 Red Risks ([as per BAF report to Trust Board, 12 February 2026](#))

1. Financial Sustainability (25)
2. Constrained Capital Funding Programme (25)
3. Estate Infrastructure (20)
4. Planned Care and Cancer Capacity (20)
5. Capacity and Patient Flow (20)
6. Quality and Patient Safety (20)
7. Workforce Instability (20)
8. Nova Programme (16)
9. Organisational Culture, Engagement and Wellbeing (16)
10. Delivery of Clinical and Operational Systems to support delivery of business objectives (16)
11. Cyber Security (15)

Partner self-identified Red Risks (and scores)

EPUT – 4 red risks, as per [risk dashboard reported to Trust Board on 4 February 2026](#)

- Capital and Cash (20)
- Use of Resources: control total target / statutory financial duty (20).
- Statutory Public Inquiry (16)
- Organisational Development (16)

Partner self-identified Red Risks (and scores*)

PAHT red risks as per [BAF report to Trust Board, 5 February 2026](#):

- Estates and infrastructure (20)
- Operating Plan (15)
- Staff resilience and morale (16)
- System pressures (16)
- Variation in outcomes resulting in an adverse impact on clinical quality, safety and patient experience (16)
- Risk of inability to deliver national access standards (15)
- Risks associated with adoption of Alex Health HER system post go-live (16)
- Cyber security (15)

*PAHT's residual risk scores have been used for this report.

Partner self-identified Red Risks (and scores)

ESNEFT red risks, as per BAF Board report, 8 January 2026

- Financial performance and sustainability – failure to maintain revenue financial balance in future years (16).
- Quality assurance mechanisms regarding the quality and safety of patient services (12)*
- Sustainable delivery of elective performance targets (15)
- Sustainable delivery of emergency care performance targets (15)
- Timely cancer diagnosis and treatment (15)

*RAG rated red because it is above risk appetite for a patient safety risk.

Part I Essex Joint Committee Meeting, 19 March 2026

Agenda Number: 12.2

Approved Essex Joint Sub-Committees Minutes

Summary Report

1. Purpose of Report

To provide the committee with a copy of the approved minutes of the following Essex Joint sub-committees:

- Essex Joint Finance & Performance Sub-committee – 9 December 2025 and 3 February 2026.
- Essex Joint Quality Sub-committee: 15 December 2025.

2. Chair of each Committee

- Joe Fielder, Chair of Essex Joint Finance & Performance Sub-Committee.
- Dr Neha Issar-Brown, Chair of Essex Joint Quality Sub-Committee.

3. Report Authors

Sara O'Connor, Senior Corporate Services Manager

4. Responsible Committees

As per 1 above. The minutes have been formally approved by the relevant sub-committees.

5. Conflicts of Interest

Any conflicts of interests declared during sub-committee meetings are noted in the minutes.

6. Recommendation/s

The Board is asked to note the approved minutes of the above sub-committee meetings.

Approved Essex Joint Sub-Committee Minutes

1. Introduction

Sub-committees of the Essex Joint Committee (EJC) were established to deliver specific functions on behalf of the EJC as set out within their terms of reference, these being:

- Essex Joint Executive Sub-Committee
- Essex Joint Finance and Performance Sub-Committee
- Essex Joint Quality Sub-Committee

Decisions taken by the Essex Joint Executive Sub-Committee are set out within the Chief Executives Report to the committee.

Minutes of the Finance and Performance and Quality Sub-committee meetings, once approved, are presented to the EJC to provide assurance and feedback on functions and decisions delivered on its behalf.

2. Main content of Report

The following summarises key items discussed, and decisions made by sub-committees as recorded in minutes that have been approved since the last EJC meeting.

Essex Joint Finance and Performance Sub-Committee, 9 December 2025

The following item of business was considered:

- Planning 2026/27

Essex Joint Finance and Performance Sub-Committee, 3 February 2026

The following items of business were considered:

- Finance and planning update.
- Update on progress in development of the Population Health Improvement Plan.

Essex Joint Quality Sub-Committee, 15 December 2025

The following items of business were considered:

- Executive Chief Nursing Officer's update.
- West Essex quality update.
- Essex Partnership University Foundation Trust / Mental Health update.
- Community Collaborative update.
- Local Maternity and Neonatal System Board update.
- Safeguarding (Children) update.
- Palliative and End of Life Care update.
- Babies, Children and Young Children update.
- Patient Safety and Quality risks.
- Patient Experience update.
- Patient Safety update.
- Medicines Management update.
- The next deep dive - Community Pharmacy Services.

3. Recommendation

The committee is asked to note the approved minutes of the above sub-committee meetings.

Minutes of the Essex Joint Finance and Performance Sub-Committee

Held on 9 December 2025 at 2.30pm

Microsoft Teams meeting

Attendees

Members

- Joe Fielder (JF) Non-Executive Member, Mid and South Essex Integrated Care Board (MSE ICB), **Chair**
- Tom Abell (TA) Chief Executive Officer, MSE ICB
- Mark Bailham (MB) Associate Non-Executive Member and Vice Chair, MSE ICB
- Sam Goldberg (SG) Director of Performance and Planning, MSE ICB
- Emily Hough (EH) Executive Director of Strategy, MSE ICB
- Jennifer Kearton (JK) Executive Chief Finance Officer, MSE ICB
- Nick Moberly (NB), Non-Executive Member, Hertfordshire and West Essex ICB (part)
- Matt Sweeting (MS), Executive Medical Director, MSE ICB
- Janet Wood (JW), Non-Executive Member, Suffolk and North East Essex ICB

Other attendees

- Nicola Adams (NA) Associate Director of Corporate Services, MSE ICB
- Keith Ellis (KE) Deputy Director of Financial Performance, Analysis and Reporting, MSE ICB
- Sarah Davies (SD) Financial Improvement Lead, MSE ICB
- Ashley King (AK) Director of Finance and Estates, MSE ICB
- Emma Seabrook (ES) Business Manager, MSE ICB

1. Welcome and apologies

JF welcomed everyone to the first meeting of the Essex Joint Finance and Performance sub-Committee.

In absence of representation from West Essex at the start of the meeting, the Committee were not quorate. The purpose of the meeting was for the Committee to be sighted on the initial planning submission for Essex, subsequently a decision was not required.

The Committee were quorate from 3.00pm when NM was present.

Apologies were received from Jo Cripps (JC) Executive Director of System Recovery, MSE ICB.

2. Declarations of interest

JF asked members to note the register of interests and reminded everyone of their obligation to declare any interests in order that these interests could be managed.

JW advised her declaration of interest was outdated and had submitted an updated form. It was clarified that the register of interests would be updated for the next meeting.

Outcome: The Register of Interests was noted.

Action: The updated Register of Interests would be presented at the 3 February 2026 Essex Joint Finance and Performance sub-Committee.

Assurance

3. Planning 2026/27

JK provided an overview of the progress to date to develop the medium-term plan for Essex ICB in readiness of the first submission on 17 December 2025, noting there was further work required before final submission on 12 February 2026.

An outline of Essex ICB's draft medium-term plan would be provided at the Extraordinary Essex Joint Committee on 11 December 2025 to seek a view on the Board Assurance Statements and plans for becoming an Essex ICB.

NHS England would hold plan acceptance meetings from 12 March 2026 to approve organisational level plans.

JK confirmed Essex ICB had received 2-year revenue allocations, the allocation for year 3 was yet to be issued. Essex ICB would receive a recurrent baseline of £5.2bn in 2026/27 increasing to £5.4bn in 2027/28.

Essex ICB would receive a 4-year capital allocation, this would enable better planning to utilise funds. Essex ICB would be required to deliver an in-year position for both revenue and capital.

3-year workforce plans and 3-year activity and performance plans would be required as part of the final submission on 12 February 2026. JK highlighted the need to ensure income and activity was fully triangulated within plans.

There would be an opportunity for organisations to review and discuss each other plans in between the first and final submission, this presented a level of risk in the first (draft) submission.

JK did not anticipate further allocations except for areas stipulated within the planning guidance including determination of the GP Contract, changes to the pay inflation above 2% and high-cost drugs commissioner changes.

Following a query from MB on the impact on Essex ICB of increased drug costs anticipated nationally, JK explained work was underway within NHS England to balance at source, where there were increases the ICB would receive a rebate to cover such costs.

NM joined the meeting; the Committee was noted as quorate.

Future deficit support funding would not be available, organisations would be issued with plan limits; there was an ambition nationally to get most organisations back to breakeven in the next 3 years.

JK outlined the approach to present a first draft Essex ICB's revenue position for 2026/27 and 2027/28 and discussed the nationally set assumptions. The plan identified a £33m deficit. There was further work to do to close the gap in readiness of the final submission including the need to identify further efficiencies above 1.8% currently included within the plan.

AK provided further detail on the 4-year capital allocation and advised further funding would be retained regionally for a range of national programmes including community, CDC and urgent and emergency care; a process was underway for provider and ICBs to submit a return outlining the request for Essex ICB.

NM asked how neighbourhood service development was factored into the capital plan. AK confirmed there were several funding options to shape neighbourhood centres including the Primary Care Utilisation and Modernisation Fund (UMF) and the funding retained at a regional level.

Work was underway to identify the risk exposure following previous commitment from the MSE ICB Board on capital support for the electronic patient record.

SG presented the position on performance for Essex against the requirements for 2026/27 and

clarified the plan was based on the financial outturn of 2025/26. Meetings would take place with Providers during January 2026 to triangulate and assess the delivery of performance against the financial allocation. It was noted the plan did not include demand management schemes currently in place. Work was then required to consider what was commissioned differently to close the gap.

Following a request from JF, KE confirmed a dashboard was in development for an Essex ICB.

Outcome: The Essex Joint Finance and Performance sub-Committee noted the progress to date to develop the medium-term plan for Essex ICB in readiness of the first submission on 17 December 2025, noting there was further work required before final submission on 12 February 2026.

Action: JK to share the presentation slides (noted they are working progress).

4. Any other Business

The Committee noted a paper on expiring contracts would be circulated virtually in between meetings in advance of the paper being presented at the Essex Joint Committee on 22 January 2026.

5. Date of Next Meeting

Tuesday 3 February 2026
2.00pm - 4.30pm
Microsoft Teams Meeting

Minutes of the Essex Joint Finance and Performance Sub-Committee

Held on 3 February 2026 at 2.00pm

Microsoft Teams meeting

Attendees

Members

- Joe Fielder (JF) Non-Executive Member, Mid and South Essex Integrated Care Board (MSE ICB), **Chair**
- Tom Abell (TA) Chief Executive Officer, MSE ICB
- Mark Bailham (MB) Associate Non-Executive Member and Vice Chair, MSE ICB
- Sam Goldberg (SG) Director of Performance and Planning, MSE ICB
- Emily Hough (EH) Executive Director of Strategy, MSE ICB
- Jennifer Kearton (JK) Executive Chief Finance Officer, MSE ICB
- Thelma Stober (TS) Non-Executive Director, Hertfordshire and West Essex (HWE) ICB
- Matt Sweeting (MS) Executive Medical Director, MSE ICB
- Janet Wood (JW) Non-Executive Member, Suffolk and North East Essex (SNEE) ICB

Other attendees

- Nicola Adams (NA) Associate Director of Corporate Services, MSE ICB
- Keith Ellis (KE) Deputy Director of Financial Performance, Analysis and Reporting, MSE ICB
- Ashley King (AK) Director of Finance and Estates, MSE ICB
- Anthony West (AW) Head of Primary Care and Alliance Transformation, SNEE ICB (agenda item 7)
- Alfie Bandakpara-Taylor (AB-T) Deputy Director Mental Health, LD, Spec Comm, MSE ICB (agenda item 8)
- Emma Seabrook (ES) Business Manager, MSE ICB

1. Welcome and apologies

JF welcomed everyone to the meeting and confirmed the meeting quorate.

Apologies were received from Nick Moberly, Non-Executive Member, HWE ICB noting Thelma Stober was attending on his behalf.

2. Declarations of interest

JF asked members to note the register of interests and reminded everyone of their obligation to declare any interests in order that these interests could be managed.

There were no declarations of interest raised in relation to the agenda items.

Outcome: The Register of Interests was noted.

3. Minutes of the previous meeting

The minutes of 9 December 2025 were approved.

Outcome: The minutes of 9 December 2025 were approved.

4. Action Log / Matters arising

All actions were noted as complete.

JF queried the progress of the NHS England return outlining the capital requirements for Essex ICB. It was clarified Essex ICB had received its 4-year capital funding allocation and as part of the planning process were working through the distribution of funding with Providers. Providers were awaiting confirmation from NHS England whether they were successful in their bid to secure funding for the return to constitutional standards.

Following a question from JF on the development of an Essex ICB dashboard, JK expected the Essex ICB would have sufficient data to populate and develop a dashboard from May 2026.

The Committee ratified the decision to approve 4 papers circulated on 9 January 2026 for virtual approval noting approval was received from all members.

Outcome: The Essex Joint Finance and Performance sub-Committee ratified the decision to approve the papers circulated on 9 January 2026 for virtual approval.

Assurance

5. Finance and Planning update

Finance update

JK provided an overview of progress for Essex for year end and reported Mid and South Essex NHS Foundation Trust (MSEFT) had enacted the forecast change protocol to change its financial forecast for 2025/26 increasing its anticipated deficit by £35m to a deficit of £63.6m

Essex Partnership University NHS Foundation Trust (EPUT) were liaising with NHS England on decoupling Deficit Support Funding (DSF) following DSF being withheld as consequence of the MSE System being off plan. Discussions were also taking place on costs associated to the Lampard Inquiry.

MSE ICB and HWE ICB were delivering in line with plan. The Princess Alexandra Hospital (PAH) NHS Foundation Trust were on track to deliver in line with its deficit plan.

East Suffolk and North Essex NHS Foundation Trust (ESNEFT) would deliver its forecast outturn as part of the wider System control total.

JK advised Essex ICB would be proportioned a share of deficit or surplus that arose from SNEE ICB and HWE ICB, this would impact the opening position of the Essex ICB in April 2026. As part of planning for 2026/27 and beyond, JK noted sight of commitments from MSE, north east Essex (NEE) and west Essex; this would aid discussion on the contractual splits to ensure this aligned with patient flow.

In response to a query from JW on the process for balance sheets, JK confirmed the 6 ledgers across the east of England would remain open. NHS England were supporting Essex ICB on the transfer of balances and any accruals. It was noted a Memorandum of Understanding (MoU) may be required across NEE, MSE and west Essex.

Planning

Since the draft planning submission on 17 December 2025, work had taken place in readiness of final submission on 12 February 2026. To support this, Quality Contract Performance Review Meetings (QCPRM's) had taken place with each Provider to discuss the granular detail of plans to align key financial, activity and workforce assumptions.

For Essex ICB, a final position for activity on Dentistry, Pharmacy and Primary Care was agreed. The plan met or exceeded the expected asks for performance.

SG reported a compliant plan for Adult Mental Health Services (EPUT). The plan met or exceeded the expected asks for performance with exception of Community Perinatal Mental Health. This would bring EPUT back to baseline following the Trust overdelivering in Perinatal Mental Health in

previous years.

Plans for the Community Collaborative and ESNEFT were not yet finalised.

Work was underway to cost and triangulate MSEFT's plan, further discussion was required to bridge the gap on performance.

In response to a query from JF on longer term planning and left shift opportunities, SG confirmed opportunities were being considered. It was clarified neighbourhood assumptions were not reflected in the plan unless the left shift was demonstrated in-year.

PAH had submitted a 2-year accelerated activity plan and were remodelling to show activity assumptions over 3 years. Their final plan would be submitted by the end of the week.

JK advised work was taking place to find a route to breakeven, this included freezing areas of spend at run rate that were traditionally underspent in previous years. This would be reviewed quarterly by the Executive Committee to ascertain as and when the budget could be released. The Essex ICB would submit a breakeven 3-year plan.

The Committee were informed the approach to allocating Community Diagnostic Centre (CDC) funding had changed. As a result, Essex ICB would receive £4m less funding than anticipated. Discussions were ongoing with NHS England, SNEE and HWE ICB to ensure funding represented patient flow.

Following a query from MB on the repayment of deficit support funding, JK provided further detail noting that while there was no System control total there would be a Regional control total across the east of England. If Essex ICB were to breakeven in the next 2 financial years, the inherited System deficit would be written off.

Outcome: The Essex Joint Finance and Performance sub-Committee noted the progress to date to develop the medium-term plan for Essex ICB in readiness of final submission on 12 February 2026. The Extraordinary Joint Essex Committee would approve the plan on 11 February 2026.

6. Population Health Improvement Plan

EH provided an update on current progress to develop the Population Health Improvement Plan for Essex ICB. The Committee were presented with an outline of ICB priorities for 2026/27 and beyond.

Essex ICB would undertake strategic and programme commissioning reviews for several core services including specialities within planned care to address population health needs and long waits within the health system. The plan focused on the 3 national shifts: Hospital to Community, Analogue to Digital and Sickness to Prevention to best deliver services.

Working alongside local government partners, there was a continued focus to develop the Neighbourhood Health programme for Essex.

The Population Health Improvement Plan would be presented to the Extraordinary Essex Joint Committee on 11 February 2026 in readiness of submission to NHS England on 12 February 2026 for feedback.

JW emphasised the importance of a robust communications plan and proactive public engagement to define desired outcomes. EH clarified the team would engage with Health and Wellbeing colleagues for input prior to finalisation of the plan.

An easy-read summary focusing on key highlights would accompany the plan.

Outcome: The Essex Joint Finance and Performance sub-Committee noted the progress to develop the Population Health Improvement Plan.

7. This item has been minuted confidentially

8. This item has been minuted confidentially

9. Any other Business

Noting decisions were required prior to 1 April 2026, a meeting would be convened at the end of March 2026.

Following endorsement by the Essex Joint Committee on the proposed Committee structure for Essex ICB, the Finance and Performance Committee would be incorporated into a wider committee Commissioning, Quality and Resource Committee, responsible for finance, contract performance, quality and strategic commissioning. A Neighbourhood Health Committee would also be introduced to reflect the evolving role of the ICB as strategic commissioner.

10. Items for Escalation

The following items would be presented to the Essex Joint Committee

- Planning submission
- Population Health Improvement Plan
- EPUT Essex Wide Adult Mental Health Contract Extension paper (due to the financial value)



Minutes of Essex Joint Quality Sub-committee Meeting

Held on 15 December 2025 at 1.00pm – 3.00pm

Via MS Teams

Members

- Dr Neha Issar-Brown (NIB), Non-Executive Member, Mid and South Essex Integrated Care Board (MSE ICB) and Chair of Quality Committee.
- Dr Giles Thorpe (GT), Executive Chief Nursing Officer, MSE ICB.
- Fiona Crump (FC), Patient Safety Partner, MSE ICB.
- Diane Searle (DS), Director of Nursing, North East London Foundation Trust (NELFT).
- Joanne Ward (JW), Interim Chief Nursing Officer, The Princess Alexandra Hospital NHS Trust (PAH).

Attendees

- Stephen Mayo (SM), Director of Nursing for Patient Experience, MSE ICB (up to item 7).
- Vicky Cline (VC), Senior Nurse for Acute/Community, MSE ICB.
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation, MSE ICB.
- Gemma Hickford (GH), Consultant Midwife, MSE ICB.
- Yvonne Anarfi (YA), Deputy Director of Nursing for Safeguarding, MSE ICB.
- Karen Flitton (KF), Patient Safety Specialist, MSE ICB.
- Sarah Zaidi (SZ), System Clinical Lead for End of Life, MSE ICB (for Item 11).
- Lucy Beach (LB), Director of Safety, EPUT (deputising for Ann Sheridan), up to item 14.
- Lucy Wightman (LW), Chief Executive Officer, Provide Community Interest Company (from item 9).
- Sara O'Connor (SOC), Senior Manager Corporate Services, MSE ICB.
- Helen Chasney (HC), Corporate Services and Governance Support Officer, MSE ICB (minutes).
- Michael Watson (MW), Executive Director of Corporate Services, MSE ICB (observing).

Apologies

- Prof. Shahina Pardhan (SP), Associate Non-Executive Member, MSE ICB.
- Dr Matt Sweeting (MS), Executive Medical Director, MSE ICB.
- Sharon McNally (SMc), Interim Chief Nursing Officer, Mid and South Essex Foundation Trust (MSEFT).
- Ann Sheridan (AS), Executive Nurse, Essex Partnership University NHS Foundation Trust (EPUT).



- Joanne Foley (JF), Patient Safety Partner, MSE ICB.
- Dr Christine Blanshard (CB), Chief Medical Officer, MSEFT.
- Kim James (KJ), Healthwatch.
- Clare Angell (CA), Deputy Director for Babies, Children and Young People, MSE ICB.
- Alison Clark (AC), Head of Safeguarding Adults and Mental Capacity, Essex County Council.

1. Welcome and Apologies

NIB welcomed everyone to the meeting. Apologies were noted as listed above. The meeting was confirmed as quorate.

2. Declarations of Interest

NIB noted the committee register of interests and reminded everyone of their obligation to declare any interests in relation to the issues discussed at the beginning of the meeting, at the start of each relevant agenda item, or should a relevant interest become apparent during an item under discussion, in order that these interests could be managed.

3. Minutes & Matters Arising

The minutes of the last Quality Committee meeting held on 7 November 2025 were approved via Chair's action, due to the current interim committee structure implemented during transition to the proposed Essex ICB.

Resolved: The minutes of the Quality Committee meeting held on 7 November 2025 were approved via Chairs action.

4. Review of Action log

The action log was reviewed, and the following update was provided:

Action 89 – GT advised that the proposed Essex ICB would develop a joint Quality and Equality Impact Assessment (QEIA) process in line with national guidance. This action was therefore superseded. The Quality Committee would receive the proposal following review by the Executive Committee of the new system level QEIA process. The action was therefore closed, to be replaced with an updated version.

Resolved: The Committee noted the Action Log.

5. Executive Chief Nurse Update

5.1 System Quality Group – Escalations

The System Quality Group (SQG) had been suspended due to development of the National Quality Strategy and the National Quality Board finalising future expectations of ICBs regarding quality oversight and assurance. It was therefore agreed to await national guidance rather than continue with a SQG that may not meet requirements for the proposed Essex ICB. The forthcoming clarity on accountability and responsibility would inform the



workplan for 2026/27.

Directors of Nursing from the proposed ICBs met with the regional team. A regional quality scorecard was being developed, to be held by NHS England (NHSE), to provide oversight of all NHS providers based on the National Oversight Framework ratings and associated quality metrics. This would determine the frequency of provider meetings with NHSE to address quality concerns.

To avoid duplication, ICBs would attend quarterly regional meetings, feeding system-level intelligence into these sessions. Attendance was expected from Medical Directors and Chief Nurses from providers and ICBs, alongside meetings with the regional executive team and provider update sessions. The ICB would consider population health outcomes, review core quality metrics, and ensure alignment with contracting and strategic commissioning frameworks. The quality structure was expected to be finalised in the coming months ahead of the new proposed ICB launches on 1 April 2026.

5.2 Emerging Safety Concerns/National Update

The Quality Summit held by the Care Quality Commission (CQC) had representation from the ICB, NHSE, General Medical Council (GMC) and Nursing and Midwifery Council (NMC). The meeting, chaired by the regional director, was productive and generated actions to support organisational stability and continuous improvement. Learning from the process would be shared widely across the system.

NHSE would not assume responsibility for performance management and oversight of non-NHS providers, such as Community Interest Companies, which would remain the responsibility of ICBs. ICBs would also currently retain responsibility for primary care, including pharmacy, optometry and dentistry. Future arrangements would be shaped by national guidance expected in Quarter 4, influencing the committee's future form and function. NIB requested that a report on the new provider oversight arrangements and responsibilities of the ICB was provided to the committee following publication of national guidance.

In response to a query from NIB, GT advised it would be unlikely that NHSE regional teams had capacity to manage primary care performance oversight given the scale of activity and number of providers, and removing responsibility from ICBs could be detrimental to system relationships and strategic commissioning. Specialised commissioning would add further complexity and ICBs needed to focus on contractual standards, strategic commissioning and making potentially difficult decisions around changes to service delivery to support 'left shift' and integration. PW commented that ICBs should set clear standards and ensure providers demonstrated compliance without undue burden.

Outcome: The committee noted the verbal update on Emerging Concerns and National update.

Action: GT to provide a summary report on the new provider oversight arrangements and future responsibilities of ICBs, following publication of national guidance.

5.3 ICB Board/SOAC concerns and actions

There were no escalations reported.

6. West Essex Quality Update

JW took the report as read and highlighted the following key points.

Princess Alexandra Hospital NHS Trust was undergoing a CQC inspection and would conclude with a 'Well-Led' review in January 2026. An initial warning notice regarding corridor care in the Emergency Department was avoided following actions taken, including closing corridors and repurposing space to maintain patient flow. No other safety concerns had been raised. Core service inspections for medicine, emergency care and surgery had been completed, with further inspections expected during this period.

Submissions for the maternity incentive scheme had closed on 30 November 2025. Key assurance points had been noted, and mitigations were in place for unmet actions, with plans to address these in the next cycle.

Two significant learning points were reported: a Prevention of Future Deaths notice following an inaccurate morphine prescription, leading to mandatory refresher training for registered nurses, and a Never Event, for which immediate actions were taken to prevent recurrence.

NIB recommended that future reports should include assurance on completed actions, with timelines for actions in progress to enable system-wide support to be provided if required.

GT noted regional concerns regarding an increase in Never Events and asked if any themes or quality improvement actions could be shared across the system. JW confirmed that no themes had been identified with these particular cases, however when any themes were identified, they were reviewed and learning cascaded.

Outcome: The Committee noted the West Essex Quality update report.

7. EPUT / Mental Health Update

LB took the report 'as read' and highlighted the following key points.

Following on from the independent review commissioned by NHSE in Manchester, recommendation 1 focused on developing a peer led workforce, with two relevant projects ongoing. In Southend, a project had been launched with Compass, which supported men at high risk of hospital admission through peer monitoring to help prevent admissions. At Byron Court, the Summit Project promoted peer advocacy, engaging service users and staff to improve patient outcomes, encourage meaningful conversations to tailor services, and to address inequalities experienced by patients with learning disabilities. The coproduction conference, held with local authorities, looked likely to be held in 2026, marking the fourth year of successful partnership working.

In relation to recommendation 3, improvements in culture were highlighted, particularly around psychological safety and enabling staff to speak up and feel supported. A clear message was being communicated that the Patient Safety Investigation Response Framework (PSIRF) aimed to establish standards and expectations for system working.



Work continued to review the investigation process and support staff in delivering safe care, while balancing professional responsibility and accountability. It was noted that PSIRF should also focus on understanding issues from both system and individual perspectives.

The vacancy rate had reduced to 15%, which was a significant achievement given the high reliance on temporary staffing which adversely impacted on the quality of care. Turnover and agency use had also decreased, which was also positive.

Work had commenced to ensure carers and families were involved in shaping patient safety processes. A working group was being established in collaboration with the NHSE national team to incorporate carer, patient and family member feedback throughout the patient safety process.

In relation to the Nottingham review, assurance was provided that caseloads had been identified, care plans were in place, and patients were cared for within the existing system. Changes were noted in support levels and processes following the review of Assertive Outreach, with ongoing work to align these with current service provision and the Community First initiative.

KF commended the work with the national team and the focus on understanding the experience of those involved in investigations. MSEFT had recently launched the 'Can I ask a question?' campaign, which had positively influenced organisational culture. LB confirmed discussions were held with MSEFT regarding the campaign and that further work was required with teams to build confidence in engaging with patients and families, including having difficult conversations. This would run in parallel with efforts to strengthen psychological safety for staff.

NIB highlighted the importance of the peer programme in addressing gaps in formal care but noted challenges for individuals without a peer network, such as those with learning disabilities. LB acknowledged this issue and advised that a single solution would not address and meet all needs. An example was provided of a proposed project in Basildon aimed at engaging socially isolated individuals through education and training. Various approaches had been implemented and emphasised the need for evaluation to ensure resources were directed to effective strategies. Successful projects, such as the Basildon initiative, could be extended to other areas.

NIB welcomed the focus on psychological safety for staff but queried the level of training and support provided to ensure accurate reporting. LB confirmed that work was ongoing to clarify harm levels and promote and improve the incident management system. Small teaching sessions were being introduced to build staff confidence in reporting and to reinforce its importance for organisational learning and improvement.

Resolved: The Committee noted the EPUT / Mental Health update report.

8. Community Collaborative Update

DS took the paper 'as read' and highlighted the following key points.

Four key risks were identified regarding capacity and demand in community nursing. Work was ongoing with ICB colleagues within agreed processes, with community nursing



identified as one of the top three areas for service specification review.

Concerns had also been escalated regarding primary care opting out of prescribing for patients, which had resulted in avoidable Emergency Department attendances due to lack of appropriate prescriptions. Work continued to address these concerns.

The collaborative's current focus was on community paediatric reviews to reduce risks for children and young people with Attention Deficit Hyperactivity Disorder (ADHD). Increased referrals had led to the prioritisation of repeat prescriptions, which extended waiting lists. Clinical harm reviews were being undertaken and support provided.

Two CQC inspections were noted. North East London Foundation Trust (NELFT) received a 'Good' rating for community health services for adults, end of life care and community health inpatients. Areas for improvement included record keeping and medication authorisation, with plans in place to address these. Colleagues had raised concern during the inspection regarding patient transport and equipment delays, which affected care. This was identified as a risk across the MSE collaborative, and actions were being taken. A presentation on patient transport was delivered at the last contract meeting, and a comprehensive review was requested with ICB support. Provide also received a CQC visit to Halstead and Bayman inpatient wards, with the outcome awaited.

Patient safety themes identified through PSIRF included issues related to risk assessments, documentation, professional curiosity, workforce and high caseloads. Joint working and learning was underway.

A holistic style approach to physical and mental health was being considered. A collaborative learning event was held in November, attended by patients with lived experience, to inform future improvements. LB noted that one of the biggest challenges was addressing physical health needs of mental health patients and recommended a system-wide approach should be considered for the future.

PW reported that the ICB had worked with the community collaborative (CC) to develop the CC medicines management standards, to provide a service specification outlining provider responsibilities and system collaboration. Clear expectations within contracts were essential for effective joint working. It was acknowledged that the number of non-medical prescribers in community services had not met requirements, leading to reliance on GPs for prescriptions. Work was ongoing to improve communication, clarify prescribing responsibilities, and ensure appropriate transfer of care and support for patients to ensure access to medication. DS agreed and highlighted the need to progress non-medical prescribing across providers, community services, pharmacy, and wider professional groups to prevent escalation of issues. DS also noted the importance of managing side effects with support from medical colleagues, emphasising that prescribing and its outcomes required a whole system approach.

NIB noted that the British Pharmaceutical Society's assessment arm provided a simulator for prescribing scenarios and suggested the need for more realistic simulations reflecting challenges faced by medical and primary care colleagues. Such tools would be essential for understanding patient needs and managing care effectively, particularly given complexities such as resource constraints and contraindications between mental and physical health.



NIB supported a whole system approach to ensure medical and non-medical interventions were effective.

DS stated that workforce planning needed to include more advanced nurse practitioners and nurse consultants with broad knowledge to manage complex situations and emphasised the importance of developing colleagues into these roles.

VC referred to patient transport and noted that the presentation was shared by the collaborative and was an escalation tool in the ongoing internal ICB meetings held as part of contractual conversations.

Resolved: The Committee noted the Community Collaborative update report.

9. Local Maternity and Neonatal System Board Update

GH took the report as read and highlighted the following key points.

In relation to maternity and neonatal services, MSE were reporting a stillbirth rate above the regional threshold but below the Trust's internal threshold. This was being monitored, as the elevation was noted in August 2025 and small numbers could be subject to variation and change. The Trust had reported a significant increase of neonatal deaths against its previous threshold, although rates remained lower than the regional threshold. This had raised concern, and the Trust agreed to review its threshold to ensure a better understanding of whether this continued to reflect a concern. Several actions had been undertaken, including a thematic review earlier in the year, ongoing progress against the Saving Babies Lives Care Bundle (SBLCB) and local multidisciplinary reviews of all cases using the Perinatal Mortality Review tool.

The action regarding ethnicity was noted, which requested consideration of the impact and experience of global majority service users. Within the Maternity and Neonatal Voices Partnership (MNVP), a targeted approach to service user engagement had been adopted. Recent focus groups were held with Orthodox Jewish communities in Southend and Muslim and Bengali representatives. A proposal was planned to engage Black African and Black Caribbean mixed heritage women in the Basildon area in partnership with B3. These actions aimed to ensure those service user insights informed next steps to improve experiences and outcomes locally in MSE.

NIB raised concern regarding how sustained scrutiny would be maintained under new arrangements and where this oversight would occur in the interim period. GT advised oversight and assurance would transfer to regional responsibility. The proposed Essex ICB was reviewing a perinatal function within the nursing and quality team to maintain focus on contractual, service specification and quality of local services, however the final structure was yet to be determined.

In response to a query from LW, GH confirmed that the Operational Pressures Escalation Levels (OPEL) framework had launched, requiring all Trusts to report their status daily against set measures to inform regional and national oversight. Whilst some monitoring had already been in place within MSE, the new requirements were more detailed and highlighted the need for greater scrutiny due to service users' concerns about outcomes and experiences.

Resolved: The Committee noted the Local Maternity and Neonatal System Board update report.

10. Safeguarding (Children) Update

YA took the paper 'as read' and highlighted the key points.

MSE ICB had recently become involved in the Family First Partnership programme which aimed to reform safeguarding, social care and partnership arrangements for vulnerable families that may have child protection concerns. Three priorities were identified: early help, reducing health inequalities, and strengthening multi-agency safeguarding arrangements. Southend, Essex and Thurrock local authorities (LAs) were approaching this individually, although the ICB encouraged and promoted a system-wide approach. YA noted the ICB's statutory responsibility to ensure health partners were consistently involved and that the ICB's views and decision-making were also considered as an equal partner. Clare Angell and Paris Innes met with the three LAs and developed a paper proposing the way forward. Thurrock have agreed the approach and responses from Southend and Essex were awaited.

Due to capacity challenges, the ICB safeguarding team was operating under a business continuity plan and was due for review in March. Providers reported similar risks, with some reducing safeguarding teams in half. This raised concern about system-wide capacity, particularly considering the ICB consultation and the potential for unpredictable complex vulnerabilities ahead.

The increase in the Sudden Unexpected Death in Infancy (SUDI) cases was highlighted. Thematic reviews were conducted for cases in 2022 and from 2023 to 2025, identifying 36 cases. The rise was unprecedented, with 53% of families known to social care and 68% linked to drugs, alcohol or tobacco as a risk factor. Mitigations included distributing flyers, communication with agencies, partnership and families and promoting safer sleep conversations across services, with a potential for education through LAs. 84% of cases involved co-sleeping, indicating a public health issue requiring continued awareness and multi-agency involvement.

MSEFT had undergone a well led CQC inspection, and support was being provided by the ICB's safeguarding team supported MSEFT following the inspection. The report, published in November, raised concerns with organisational culture and staff reluctance to escalate issues. Quality support visits were undertaken with the safeguarding team and wider directorate to address CQC recommendations to improve the 'Requires Improvement' rating.

GT referred to the Family First Partnership and advised concerns had been raised regarding capacity to deliver the proposed multi-agency children's partnership protection teams (MACPTs). LAs had received significant funding for the programme and were expected to share resources across health and police to ensure multi-agency representation. Discussions with directors of children services highlighted that health services and police could not provide additional resources, and funding would need to be sourced by LAs. GT acknowledged the challenges posed by stretched safeguarding resources across providers and the ICB, which may require a risk-based approach and high

level decisions regarding funding or risk tolerance.

NIB noted the potential for high-risk cases to result in serious outcomes if not addressed promptly and questioned whether a forum existed for prioritisation. GT confirmed that three statutory safeguarding boards were in place and the ICB was engaged in discussions with the accountable officers for children's safeguarding. The new safeguarding structure would be shared following the completion of the ICB staff consultation. It was noted that some operational safeguarding activities currently undertaken by the ICB would cease, placing additional responsibility on providers. Provider chief nurses would be required to review safeguarding resource requirements within their organisations. The ICB's statutory safeguarding function would focus on child safeguarding reviews, Domestic Abuse Related Death Reviews (DARDRs), Safeguarding Adult Reviews (SARs) and strategic input.

LW reflected that although safeguarding responsibilities for non-NHS providers remained under the NHS contract, funding for overheads would reduce, creating challenges in maintaining corporate functions, including safeguarding. LW suggested exploring strategic opportunities with LAs to achieve economies of scale for training and oversight. GT agreed and highlighted that Local Government Reorganisation (LGR) could be a distraction, with uncertainties around future structures and proposals for a mayoral-level safeguarding function. GT stressed the need to remain focused on statutory responsibilities, learning as a system and reducing risk. It was noted that safeguarding vulnerabilities and risks remained significant, requiring system-wide assurance and early intervention to prevent harm.

Resolved: The Committee noted the Safeguarding (Children) update report.

11. Palliative and End of Life Care (PEoLC)

SZ took the report as read and highlighted the following key points.

Priorities focused on improving early identification of people with palliative and end of life care (PEoLC) needs by 2027 and over the next 5 years, to deliver earlier personalised advanced care planning, and ensure equitable 24/7 access to both generalist and specialist services.

The system adult end of life performance position continued to improve in early identification and advanced care planning, particularly in the South East Alliance, with notable improvements in Basildon and Brentwood Alliance, though variation persisted in Mid Essex and Thurrock. Public health data indicated there had been an increase in people dying whilst at home rather than in hospital.

'Task and finish groups' continued work in both generalist and specialist spaces, including pilots at Broomfield Hospital to improve discharge and early recognition of end of life (EOL) needs in geriatric wards and within the first 72 hours of arrival to acute hospital care.

Education and training resources for staff had been updated on the 'Our People, Your Future' website, and providers were asked to promote these to frontline staff to improve training and competency. This was recognised as the biggest challenge to support cultural shift as well as EOL awareness of new urgent care models of care, such as pathways for Unscheduled Care Community Hubs (UCCH), virtual wards and Urgent Care Response Teams (UCRT).



A 'live' data sharing platform was in place for Babies, Children and Young People (BCYP) and a subgroup was exploring the transition for younger people going into adult services.

The report also referenced links, including a recent publication from Healthcare Leader, highlighting MSE's progress in digital and data sharing tools, including the adoption of Frailty End of Life Dementia Assessment (FREDA).

Resolved: The Committee noted the Palliative and End of Life Care update report.

12. Babies, Children and Young People

GT took paper as read and highlighted the key points.

Thurrock's Special Educational Needs and Disabilities (SEND) partnership inspection had concluded, and the formal report was awaited. Key areas of learning and good practice had been identified.

All MSE paediatric audiology services had received Paediatric Audiology Services Quality Assurance Tool (PASQAT) visits from the regional audiology team, which were largely positive. MSE had supported Hertfordshire during recent challenges in paediatric audiology by providing access to local services.

Work continued across Southend, Essex and Thurrock therapies, including approval of funding for enhanced speech and language therapy in the learning disabilities space.

Winter planning remained a priority, with campaigns to build confidence among parents and carers in recognising mild to serious symptoms of flu and addressing myths. Vaccine hesitancy continued to be a challenge, impacting both children's and adult services.

Resolved: The Committee noted the Babies, Children and Young People update report.

13. Patient Safety & Quality Risks

SOC took the report as read.

The report set out those risks within remit of the Essex Joint Quality Sub-committee. There were currently 26 risks, of which 6 were rated red. At the time of writing the report there were no outstanding updates.

Since the last meeting, one new risk had been added relating to a gap in bereavement and psychological support services for PEO LC.

One risk (ID127) was recommended for closure relating to CQC registration for the treatment of disease, disorder or injury, which was opened following an incident earlier in the year but was now being managed as business as usual. No concerns were raised regarding closure of this risk.

The latest iteration of quality related risks on the Board Assurance Framework submitted to the ICB Board in November was attached. As there was no MSE ICB Board meeting being held in January, the BAF would be presented to the Essex Joint Committee on 22 January

2026. Work had commenced to compare the MSE ICB BAF and risk registers with those in place at Suffolk and North East Essex ICB and Hertfordshire and West Essex ICB to ensure any additional 'Essex facing' risks were taken into account in future iterations.

Resolved: The Committee noted the Patient Safety and Quality Risk report approved closure of the Treatment of Disease, Disorder or Injury risk (Risk ID27).

14. Patient Experience Update

The paper was presented for noting.

There were no comments raised.

Resolved: The Committee noted the Patient Experience update report.

15. Patient Safety Update

The paper was presented for noting.

KF reported that an analysis of Patient Safety Investigations (PSIs) from the first full year had been completed. Investigations were taking longer but progress was being made. The system was not an outlier compared to others. The feedback was that delays were partly attributed to the involvement of patients and families; however this was considered an important part of the process.

There were no further comments raised.

Resolved: The Committee noted the Patient Safety update report.

16. Medicines Management Update

The paper was presented for noting.

PW highlighted two changes in the measurement criteria. For opioids, the oral morphine equivalent threshold had been reduced from 120mg to 90mg, which would increase the number of patients affected and result in reporting of a worsened position. Additionally antimicrobial measurement had shifted to five daily doses, which would also report a worsened position. Work continued to address these changes through previously outlined actions.

There were no further comments raised.

Resolved: The Committee noted the Medicines Management update report.

17. Discussion, Escalations to ICB Board and agreement on next deep dive.

17.1 Escalations to or from other Forums:

- **Other ICB main committees (including SOAC)**

There were no escalations to or from other ICB main committees.

- **ICB Board**

There were no escalations to or from ICB Board.

- **Safety Quality Group**

There were no escalations from Safety Quality Group.

17.2 Agreement on next deep dive

A deep dive on community pharmacy would be presented at the next Essex Joint Quality Community meeting in February.

Resolved: The committee noted that the next deep dive at the February meeting would focus on Community Pharmacy.

18. Any Other Business, including discussion on effectiveness of meeting

In response to a query from NIB, SOC confirmed that the annual review of committee effectiveness would be undertaken in January 2026 and reported back to the committee at its February meeting. NIB encouraged committee members to complete the survey when issued.

19. Date of Next Meeting

Friday, 27 February 2026 at 10.00 am to 1.00 pm via MS Teams, but may be subject to change.

Part I Essex Joint Committee Meeting, 19 March 2026

Agenda Number: 13.1

Essex Integrated Care Board Governance

Summary Report

1. Purpose of Report

To provide the Essex Joint Committee with assurance regarding the development of the draft governance framework for the proposed Essex Integrated Care Board and present the latest iteration of the Constitution and Standing Orders, Functions and Decisions Map and Standing Financial Instructions.

2. Executive Lead

Michael Watson, Executive Director of Corporate Services

3. Report Author

Nicola Adams, Associate Director of Governance

4. Responsible Committees

The Essex ICB Board will be responsible for approving the governance arrangements of the ICB (with the exception of the Constitution which is approved by NHS England). However, the Essex Joint Committee will recommend arrangements to the Board, having reviewed them on behalf of the ICBs commissioning across Essex.

5. Link to the ICB's Strategic Objectives

1. Through strict budget management and good decision making, the ICB plans and purchases sustainable services for its population and manages any associated risks of doing so within the financial position agreed with NHS England.
2. To strengthen our role as a strategic commissioner and system leader by using data and clinical insight to make decisions that improve patient outcomes, reduce health inequalities, and deliver joined-up care through meaningful collaboration with partners and communities.
3. Through compassionate and inclusive leadership, consistent engagement and following principles of good governance, deliver the organisational changes required, whilst ensuring staff are supported through the change process and maintaining business as usual services.

6. Impact Assessments

The Constitution impact assessment identified no impact to mitigate.

7. Financial Implications / engagement / conflicts of interest

None.

8. Recommendation/s

The Essex Joint Committee are asked to:

- Note the approval of the constitution and standing orders by NHS England and recommend their adoption by the Essex ICB.
- Support and recommend to the Essex ICB, the approval of the Functions and Decisions Map and Standing Financial Instructions.
- Note the progress in developing the governance for the Essex ICB, and that an extraordinary meeting of the EJC may be convened, or alternatively, any outstanding matters may be considered virtually prior to 31 March 2026.

Essex Integrated Care Board Governance Framework

1. Introduction

The establishment of the Essex Integrated Care Board (ICB) on 1 April 2026 marks a significant transition in the statutory arrangements for planning, commissioning, and overseeing NHS services across Essex. A comprehensive governance framework is essential to ensure that the new ICB operates in a lawful, transparent, and effective manner and fulfils the statutory functions set out in national policy and the expectations of NHS England.

This paper provides an update on the governance documents required for day one of the new Essex ICB, outlines where approvals are now sought and identifies the remaining areas of development to be completed prior to establishment.

2. Main content of Report

The Health and Care Act 2022 requires each Integrated Care Board (ICB) to have a constitution, based on the model Constitution published by NHS England to enable its establishment.

The Constitution sets out the governance framework of the ICB that includes:

- Standing orders – included within the Constitution and setting out the processes employed to undertake its business.
- Scheme of Reservation and Delegation (SoRD) – setting out the functions reserved to the Board, delegated to an individual or committee or sub-committee, and the functions delegated to or from or exercised jointly with another body.
- Functions and Decisions Map – setting out its key functions and how it exercises them in accordance with the SoRD.
- ICB Governance Handbook – bringing together all of the ICBs governance documents so that it is easy for interested parties to navigate. It includes:
 - The above documents.
 - Terms of reference for all committees and sub-committees of the board that exercise ICB functions.
 - Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act.
 - Terms of reference of any joint committee.
 - The up-to-date list of eligible providers of primary medical services under clause 3.7.2 of the Constitution.
 - Detailed arrangements for the nomination and selection process of board members, as required.

3. Findings/Conclusion

Constitution and Standing Orders

Following EJC approval of the draft Constitution on 22 January 2026, NHS England has reviewed and approved the revised Essex ICB Constitution and Standing Orders, reflecting statutory requirements and the updated national model constitution. The updated Constitution (attached) includes minor changes required by NHS England, alongside clarification of the number of Non-Executive Members on the Board, now set at 4.

Functions and Decisions Map

The Functions and Decisions Map has been refreshed to align with the committee structure being implemented from 1 April 2026. This map reflects:

- Key Board-level decision areas,
- Delegated authorities to sub-committees,
- Clear pathways for assurance and escalation.

The rationale for development of the Functions and Decisions Map was presented to the EJC in January, the attached update reflects minor changes to sub-committees of the main Board sub-committees and will remain in draft until the final arrangement of sub-committees and committee terms of reference have been approved.

The proposed corporate calendar listing dates for committee and sub-committee meetings has been included for information.

Standing Financial Instructions

Standing Financial Instructions (SFIs) have been prepared to support financial governance from the date the ICB becomes operational. National frameworks emphasise prudent financial management, assurance arrangements, and alignment with wider procurement requirements such as the Provider Selection Regime. The SFIs reflect national templates that have been localised to reflect the operations of the Essex ICB.

Standards of Business Conduct (including conflicts of interest)

The Standards of Business Conduct Policy, including conflicts of interest, gifts and hospitality, commercial sponsorship and related compliance processes form a core part of the required governance suite and will be considered in a dedicated paper later on the agenda. This has been supported by the Audit Committee at its meeting on 3 March.

Scheme of Reservation and Delegation

The SoRD has been drafted and is currently under refinement to reflect the delegations to each of the established sub-committees and is therefore under consideration by the Executive Committee. This will be presented to the EJC at either an extra-ordinary meeting or to be considered virtually for their support and recommendation to the Essex ICB.

Governance Handbook

The Governance Handbook is close to completion. The Executive Committee are considering the draft committee Terms of Reference and other supporting documents that will be presented to the EJC prior to 31 March 2026.

4. Recommendation(s)

The Essex Joint Committee are asked to:

- Note the approval of the constitution and standing orders by NHS England and recommend their adoption by the Essex ICB.
- Support and recommend to the Essex ICB, the approval of the Functions and Decisions Map and Standing Financial Instructions.
- Note the progress in developing the governance for the Essex ICB, and that an extraordinary meeting of the EJC may be convened, or alternatively, any outstanding matters may be considered virtually prior to 31 March 2026.

5. Appendices

Appendix A - Essex ICB Constitution

Appendix B - Functions and Decisions Map and Corporate Calendar

Appendix C - Standing Financial Instructions



Essex

**NHS Essex
Integrated Care Board**

DRAFT CONSTITUTION

Version History

Version	Date approved by the ICB	Effective date
1.0	N/A	1 April 2026

DRAFT

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1 Introduction

1.1 Foreword

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

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

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

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

1.2 Name

1.2.1 The name of this Integrated Care Board is the NHS Essex Integrated Care Board (“the ICB”).

1.3 Area covered by the Integrated Care Board

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

1.4 Statutory Framework

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

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

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

- 1.4.4 In accordance with section 14Z25(5) of, and paragraph 1 of Schedule 1B to, the 2006 Act the ICB must have a constitution which must comply with the requirements set out in that Schedule. The ICB is required to publish its constitution (section 14Z29). This constitution is published at www.essex.icb.nhs.uk
- 1.4.5 The ICB must act in a way that is consistent with its statutory functions, both powers and duties. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to ICBs. Examples include, but are not limited to, the Equality Act 2010 and the Children Acts. Some of the statutory functions that apply to ICBs take the form of general statutory duties, which the ICB must comply with when exercising its functions. These duties include but are not limited to:
- a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act).
 - b) Exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act).
 - c) Duties in relation children including safeguarding, promoting welfare etc. (including the Children Acts 1989 and 2004, and the Children and Families Act 2014).
 - d) Adult safeguarding and carers (the Care Act 2014).
 - e) Equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35).
 - f) Information law, (for instance, data protection laws such as the UK General Data Protection Regulation 2016/679 and Data Protection Act 2018 and the Freedom of Information Act 2000).
 - g) Provisions of the Civil Contingencies Act 2004.
- 1.4.6 The ICB is subject to an annual assessment of its performance by NHS England, which is also required to publish a report containing a summary of the results of its assessment.
- 1.4.7 The performance assessment will assess how well the ICB has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under:
- a) Section 14Z34 (improvement in quality of services).
 - b) Section 14Z35 (reducing inequalities).
 - c) Section 14Z38 (obtaining appropriate advice).
 - d) Section 14Z40 (duty in respect of research)
 - e) Section 14Z43 (duty to have regard to effect of decisions).
 - f) Section 14Z45 (public involvement and consultation)
 - g) Sections 223GB to 223N (financial duties).
 - h) Section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).
- 1.4.8 NHS England has powers to obtain information from the ICB (section 14Z60 of the 2006 Act) and to intervene where it is satisfied that the ICB is failing,

or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so (section 14Z61).

1.5 Status of this Constitution

- 1.5.1 The ICB was established on 1 April 2026 by The Integrated Care Boards (Establishment and Abolition) Order 2026, which made provision for its Constitution by reference to this document.
- 1.5.2 Changes to this Constitution will not be implemented until, and are only effective from, the date of approval by NHS England.

1.6 Variation of this Constitution

- 1.6.1 In accordance with paragraph 15 of Schedule 1B to the 2006 Act this Constitution may be varied in accordance with the procedure set out in this paragraph. The Constitution can only be varied in two circumstances:
 - a) Where the ICB applies to NHS England in accordance with NHS England's published procedure and that application is approved; and
 - b) Where NHS England varies the Constitution of its own initiative (other than on application by the ICB).
- 1.6.2 The procedure for proposal and agreement of variations to the Constitution is as follows:
 - a) The Chief Executive may periodically propose amendments to the Constitution, which shall be considered and approved by the Integrated Care Board prior to making an application to vary the Constitution to NHS England.
 - b) Proposed amendments to this Constitution will not be implemented until an application to NHS England for variation has been approved.

1.7 Related Documents

- 1.7.1 This Constitution is also supported by a number of documents which provide further details on how governance arrangements in the ICB will operate.
- 1.7.2 The following are appended to the Constitution and form part of it for the purpose of clause 1.6 and the ICB's legal duty to have a Constitution:
 - a) **Standing orders** – which set out the arrangements and procedures to be used for meetings and the processes to appoint the ICB committees.
- 1.7.3 The following do not form part of the Constitution but are required to be published:
 - a) **The Scheme of Reservation and Delegation (SoRD)** – sets out those decisions that are reserved to the board of the ICB and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the

Constitution. The SoRD identifies where, or to whom, functions and decisions have been delegated to.

- b) **Functions and Decision map** - a high-level structural chart that sets out which key decisions are delegated and taken by which part or parts of the system. The Functions and Decision map also includes decision making responsibilities that are delegated to the ICB (for example, from NHS England).
- c) **Standing Financial Instructions** – which set out the arrangements for managing the ICB’s financial affairs.
- d) **The ICB Governance Handbook** – this brings together all the ICB’s governance documents, so it is easy for interested people to navigate. It includes:
 - The above documents a) – c).
 - Terms of reference for all committees and sub-committees of the board that exercise ICB functions.
 - Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act.
 - Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act.
 - The up-to-date list of eligible providers of primary medical services under clause 3.7.2.
- e) **Key policy documents** - which should also be included in the Governance Handbook or linked to it, including:
 - Standards of business conduct policy.
 - Conflicts of interest policy and procedures.
 - Patient and public engagement policy.

2 Composition of the Board of the ICB

2.1 Background

- 2.1.1 This part of the constitution describes the membership of the Integrated Care Board. Further information about the criteria for the roles and how they are appointed is in section 3.
- 2.1.2 Further information about the individuals who fulfil these roles can be found on our website at www.essex.icb.nhs.uk
- 2.1.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB (referred to in this constitution as “the board” and members of the ICB are referred to as “board members”) consists of:
- a) A Chair.
 - b) A Chief Executive.
 - c) At least three Ordinary members.
- 2.1.4 The membership of the ICB (the board) shall meet as a unitary board and shall be collectively accountable for the performance of the ICB’s functions.
- 2.1.5 NHS England Policy requires the ICB to appoint the following additional Ordinary Members:
- a) Three executive members, namely:
 - Director of Finance (known locally as the Executive Director of Finance and Commercial).
 - Executive Medical Director.
 - Executive Director of Nursing
 - b) At least two non-executive members.
- 2.1.6 The Ordinary Members include at least three members who will bring knowledge and a perspective from their sectors. These members (known as Partner Members) are nominated by the following and appointed in accordance with the procedures set out in Section 3 below:
- NHS trusts and foundation trusts who provide services within the ICB’s area and are of a prescribed description.
 - The primary medical services (general practice) providers within the area of the ICB and are of a prescribed description.
 - The upper tier local authorities that are responsible for providing social care and whose area coincides with or includes the whole or any part of the ICB’s area.
- 2.1.7 While the Partner Members will bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the board, they are not to act as delegates of those sectors. The ICB is

seeking knowledge and experience covering the full breadth of the ICB geography, its range of health and care services and professions.

2.2 Board membership

2.2.1 The ICB has Seven Partner Members:

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

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

- a) Two additional Non-executive Members.

2.2.3 The board is therefore composed of the following members:

- a) Chair.
- b) Chief Executive.
- c) Three Partner members NHS trusts and foundation trusts.
- d) One Partner member primary medical services.
- e) Three Partner members local authorities.
- f) Four Non-executive Members (one of which, but not the Audit Chair, will be appointed the Deputy Chair and one of which, who may be the Deputy Chair or the Audit Chair, will be appointed the Senior Non-Executive Member).
- g) Executive Director of Finance and Commercial.
- h) Executive Medical Director.
- i) Executive Director of Nursing.

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

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

2.3 Regular participants and observers at board meetings

- 2.3.1 The board may invite specified individuals to be Participants or Observers at its meetings to inform its decision-making and the discharge of its functions as it sees fit.
- 2.3.2 Participants will receive advanced copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair, to ask questions and address the meeting but may not vote. Participants will be:
- a) Executive Director of Strategy
 - b) Executive Director of Neighbourhood Health
 - c) Executive Director of Corporate Services
 - d) Chief Executive of Partner Organisations not represented on the Board
 - e) Associate Non-Executive Members (where appropriate)
- 2.3.3 Observers will receive advanced copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting by the Chair. Any such person may not address the meeting and may not vote.
- 2.3.4 Participants and/or observers may be asked to leave the meeting by the Chair in the event that the board passes a resolution to exclude the public as per the standing orders.

3 Appointments Process for the Board

3.1 Eligibility criteria for board membership

- 3.1.1 Each member of the ICB must:
- a) Comply with the criteria of the “fit and proper person test”.
 - b) Be committed to upholding the Seven Principles of Public Life (known as the Nolan Principles).
 - c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

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, Part 13 of the Bankruptcy (Scotland) Act 2016 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).
- 3.2.5 A person who has been dismissed within the period of five years immediately preceding the date of the proposed appointment, otherwise than because of redundancy, from paid employment by any Health Service Body.
- 3.2.6 A person whose term of appointment as the Chair, a Member, a Director or a Governor of a health service body, has been terminated on the grounds:
- a) That it was not in the interests of, or conducive to the good management of, the health service body or of the health service that the person should continue to hold that office.
 - b) That the person failed, without reasonable cause, to attend any meeting of that health service body for three successive meetings.
 - c) That the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest.
 - d) Of misbehaviour, misconduct or failure to carry out the person's duties.
- 3.2.7 A Healthcare Professional, meaning an individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002, 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, or

- d) A decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.

3.2.8 A person who is subject to:

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

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

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

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

3.3 Chair

3.3.1 The ICB Chair is to be appointed by NHS England, with the approval of the Secretary of State for Health and Social Care.

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

- a) The Chair will be independent.

3.3.3 Individuals will not be eligible if:

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

3.3.4 The term of office for the Chair will be a maximum of three years and the total number of terms a Chair would normally serve is two terms (a maximum of six years).

3.3.5 The chair may serve a further term (three years) following a rigorous review and agreement with NHS England (not exceeding a total of nine years).

3.4 Deputy Chair and Senior Non-executive Member

3.4.1 The Deputy Chair is to be appointed from amongst the non-executive members by the board subject to the approval of the Chair.

3.4.2 No individual shall hold the position of Chair of the Audit, Risk and Compliance Committee and Deputy Chair at the same time.

3.4.3 The Senior Non-executive Member is to be appointed from amongst the non-executive members by the board subject to the approval of the Chair.

3.5 Chief Executive

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

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

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

- a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.
- b) Meets the requirements as set out in the Chief Executive person specification.

3.5.4 Individuals will not be eligible if:

- a) Any of the disqualification criteria set out in 3.2 apply.
- b) Subject to clause 3.5.3(a), they hold any other employment or executive role other than chief executive of another Integrated Care Board (ICB).

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

3.6.1 These Partner Members are jointly nominated by the NHS trusts and/or FTs that provide services for the purposes of the health service within the ICB's area and meet the Forward Plan Condition or (if the Forward Plan Condition is not met) the Level of Services Provided Condition:

- a) East of England Ambulance Service NHS Trust.
- b) East Suffolk and North Essex NHS Foundation Trust.
- c) Essex Partnership University NHS Foundation Trust.
- d) Mid and South Essex NHS Foundation Trust.
- e) North East London NHS Foundation Trust.
- f) The Princess Alexandra Hospital NHS Trust

3.6.2 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) One member shall have specific knowledge, skills and experience of the provision of community services.
- e) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.6.3 Individuals will not be eligible if:

- a) Any of the disqualification criteria set out in 3.2 apply.
- b) Any other disqualification criteria prescribed through NHS England guidance or supporting legislation apply.
- c) A conflict of interest is evident, as determined by the Chair of the ICB board appointment panel, which results in the individual being unable to fulfil the role.

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

3.6.5 The appointment process will be as follows:

- a) Joint Nomination:
 - When a vacancy arises, each eligible organisation listed at 3.6.1 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 3.6.2 and 3.6.3.
- 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).

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

3.7 Partner Member - providers of primary medical services

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

3.7.2 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.

3.7.3 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.

3.7.4 Individuals will not be eligible if:

- a) Any of the disqualification criteria set out in 3.2 apply.
- b) A conflict of interest is evident, as determined by the Chair or the ICB board appointment panel, which results in the individual being unable to fulfil the role.

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

3.7.6 The appointment process will be as follows:

a) Joint Nomination:

- When a vacancy arises, each eligible organisation described at 3.7.1 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 3.7.1 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 3.7.3 and 3.7.4.
- 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).

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

3.8 Partner Members - local authorities

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

- a) Essex County Council
- b) Southend on Sea City Council
- c) Thurrock Council

3.8.2 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 3.8.1.
- b) The ICB is seeking knowledge and experience covering the full breadth of the ICB geography, its range of health and care services and professions.
- a) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.8.3 Individuals will not be eligible if:

- a) Any of the disqualification criteria set out in 3.2 apply.
- b) A conflict of interest is evidence, as determined by the Chair or the ICB board appointment panel, which results in the individual being unable to fulfil the role.

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

3.8.5 The appointment process will be as follows:

- a) Joint Nomination:
 - When a vacancy arises, each eligible organisation listed at 3.8.1 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 3.8.2 and 3.8.3.
 - 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).

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

3.9 Executive Medical Director

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

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

3.9.2 Individuals will not be eligible if:

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

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

3.10 Executive Director of Nursing

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

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

- b) Be a registered Nurse.
- c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.10.2 Individuals will not be eligible if:

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

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

3.11 Executive Director of Finance and Commercial

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

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

3.11.2 Individuals will not be eligible if:

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

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

3.12 Four Non-Executive Members

3.12.1 The ICB will appoint four Non-Executive Members.

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

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

- a) Not be employee of the ICB or a person seconded to the ICB.
- b) Not hold a role in another health and care organisation in the ICB area.
- c) One member shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit, Risk and Compliance Committee.
- d) One other member should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration Committee.
- e) Two further members with specific knowledge, skills and experience that makes them suitable for their role.

- f) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.12.4 Individuals will not be eligible if:

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

3.12.5 The term of office for a non-executive member will be three years and the total number of terms an individual would usually serve is two, although a further term may be served at the discretion of the Chair to a maximum of three terms (nine years), after which they will no longer be eligible for re-appointment.

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

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

3.13 Board Members: Removal from Office

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

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

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

- e) If they are deemed to have failed to uphold the Nolan Principles of Public Life.
- f) Are subject to disciplinary proceedings by a regulator or professional body.

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

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

3.13.5 The Chair of the ICB may be removed by NHS England, subject to the approval of the Secretary of State for Health and Social Care

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

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

3.14 Terms of Appointment of Board Members

3.14.1 A proposal for the Chair or non-executive to serve on the board for longer than six years will be subject to rigorous review to ensure their ongoing independence, and they will not serve as a board member for longer than nine years in total.

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

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

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

4 Arrangements for the exercise of our functions

4.1 Good Governance

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

4.2 General

4.2.1 The ICB will:

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

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

4.3 Authority to Act

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

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

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

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

4.4 Scheme of Reservation and Delegation (SoRD)

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

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

4.4.3 The SoRD sets out:

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

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

4.5 Functions and Decision Map

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

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

4.5.3 The map includes:

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

4.6 Committees and Sub-Committees

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

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

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

4.6.4 The board remains accountable for all functions, including those that it has delegated to committees and sub-committees and therefore appropriate reporting and assurance arrangements are in place and documented in

terms of reference. All committees and sub-committees that fulfil delegated functions of the ICB will be required to:

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

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

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

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

4.6.8 The following committees will be maintained:

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

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

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

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

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

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

4.7 Delegations made under section 65Z5 of the 2006 Act

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

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

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

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

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

5 Procedures for Making Decisions

5.1 Standing Orders

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

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

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

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

5.2 Standing Financial Instructions (SFIs)

- 5.2.1 The ICB has agreed a set of Standing Financial Instructions (SFIs) which include the delegated limits of financial authority set out in the SoRD.
- 5.2.2 A copy of the SFIs is published in the Governance Handbook on the ICB website.

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

6.1 Conflicts of Interest

- 6.1.1 As required by section 14Z30 of the 2006 Act, the ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.
- 6.1.2 The ICB has agreed policies and procedures for the identification and management of conflicts of interest which are published on the ICB's website.
- 6.1.3 All board, committee and sub-committee members and employees of the ICB will comply with the ICB policy on conflicts of interest in line with their terms of office and/or employment. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.
- 6.1.4 All delegation arrangements made by the ICB under Section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures comparable with those of the ICB.
- 6.1.5 Where an individual, including any individual directly involved with the business or decision-making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict and is subject to the provisions of this constitution, the Conflicts of Interest Policy and the Standards of Business Conduct Policy.
- 6.1.6 The ICB has appointed the Audit Chair to be the Conflicts of Interest Guardian. In collaboration with the ICB's governance lead, their role is to:
 - a) Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest.
 - b) Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest.

- c) Support the rigorous application of conflict of interest management principles and policies.
- d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation.
- e) Provide advice on minimising the risks of conflicts of interest.

6.2 Principles

6.2.1 In discharging its functions, the ICB will abide by the following principles:

- a) The ICB acts as strategic commissioner and payer, setting long-term, evidenced-based population health strategy and translating it into outcomes-focussed purchasing, contracting and payment models.
- b) Decisions by the ICB shall:
 - be data driven and ensure benefits realisation
 - be driven by population need, with explicit goals to improve outcomes, reduce unwarranted variation and tackle health inequalities.
 - be taken at the most appropriate level to meet local needs and statutory responsibilities (commissioning at scale only where it adds value)
 - clinically led, with multi-professional input shaping strategy
 - recognise the need to deliver financial sustainability
- c) Co-design and co-production will be an underpinning principle of service design and commissioning.
- d) Clear accountability and transparent governance underpins the ICB operating model.
- e) Partnership working and collaboration to deliver the 'three shifts'.

6.3 Declaring and Registering Interests

6.3.1 The ICB maintains registers of the interests of:

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

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

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

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

- 6.3.5 All declarations will be entered in the registers as per 6.3.1.
- 6.3.6 The ICB will ensure that, as a matter of course, declarations of interest are made and confirmed or updated at least annually.
- 6.3.7 Interests (including gifts and hospitality) of decision-making staff will remain on the public register for a minimum of six months. In addition, the ICB will retain a record of historic interests and offers/receipt of gifts and hospitality for a minimum of six years after the date on which it expired. The ICB's published register of interests states that historic interests are retained by the ICB for the specified timeframe and details of whom to contact to submit a request for this information.
- 6.3.8 Activities funded in whole or in part by third parties who may have an interest in ICB business such as sponsored events, posts and research will be managed in accordance with the ICB policy to ensure transparency and that any potential for conflicts of interest are well-managed.

6.4 Standards of Business Conduct

- 6.4.1 Board members, employees, committee and sub-committee members of the ICB will at all times comply with this constitution and be aware of their responsibilities as outlined in it. They should:
- a) Act in good faith and in the interests of the ICB.
 - b) Follow the Seven Principles of Public Life set out by the Committee on Standards in Public Life (the Nolan Principles).
 - c) Comply with the ICB Standards of Business Conduct Policy and any requirements set out in the policy for managing conflicts of interest.
- 6.4.2 Individuals contracted to work on behalf of the ICB or otherwise providing services or facilities to the ICB will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the ICB's Standards of Business Conduct policy.

7 Arrangements for ensuring Accountability and Transparency

7.1 Principles

- 7.1.1 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 12(2) of Schedule 1B to the 2006 Act.
- 7.1.2 Please also refer to paragraph 6.2 above.

7.2 Meetings and publications

- 7.2.1 Board meetings, and committees composed entirely of board members or which include all board members, will be held in public except where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest.
- 7.2.2 Papers and minutes of all meetings held in public will be published.
- 7.2.3 Annual accounts will be externally audited and published.
- 7.2.4 A clear complaints process will be published.
- 7.2.5 The ICB will comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the ICB.
- 7.2.6 Information will be provided to NHS England as required.
- 7.2.7 The constitution and Governance Handbook will be published as well as other key documents including but not limited to:
- a) Conflicts of interest policy, standards of business conduct policy and procedures.
 - b) Registers of interests.
 - c) Other key documents and policies, as appropriate.
- 7.2.8 The ICB will 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. The plan will, in particular:
- a) Describe the health services for which the ICB proposes to make arrangements in the exercise of its functions
 - b) Explain how the ICB proposes to discharge its duties under sections 14Z34 to 14Z45 (general duties of integrated care boards), and sections 223GB and 223N (financial duties).
 - c) Set out any steps that the ICB proposes to take to implement the three joint local health and wellbeing strategies.
 - d) Set out any steps that the ICB proposes to take to address the particular needs of children and young persons under the age of 25.
 - e) Set out any steps that the ICB proposes to take to address the particular needs of victims of abuse (including domestic abuse and sexual abuse, whether of children or adults).

7.3 Scrutiny and Decision Making

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

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

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

- a) Retaining evidence to underpin the proper exercise of the ICB's responsibilities for arranging healthcare.
- b) Publishing notices required for the arranging and awarding of relevant healthcare services.
- c) The establishment of a provider selection regime review group and governance structure to deal with any challenges to decisions about provider selection.
- d) Maintaining the audit trail of decision making for transparency purposes.

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

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

7.4 Annual Report

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

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

8 Arrangements for Determining the Terms and Conditions of Employees.

- 8.1 The ICB may appoint employees, pay them remuneration and allowances as it determines and appoint staff on such terms and conditions as it determines.
- 8.2 The board has established a Remuneration Committee which is chaired by a Non-executive member other than the Chair or Audit Chair.
- 8.3 The membership of the Remuneration Committee is determined by the board. No employees may be a member of the Remuneration Committee, but the board ensures that the Remuneration Committee has access to appropriate advice by:
 - a) HR advisers being in attendance at meetings.
- 8.4 The board may appoint independent members or advisers to the Remuneration Committee who are not members of the board.
- 8.5 The main purpose of the Remuneration Committee is to exercise the functions of the ICB regarding remuneration included in paragraphs 18 to 20 of Schedule 1B to the 2006 Act. The terms of reference agreed by the board are published in the Governance Handbook on the ICB website.
- 8.6 The duties of the Remuneration Committee include:
 - a) Determining the remuneration of the Chief Executive, Directors and other Very Senior Managers and board members (other than Non-executive Members).
 - b) Determining arrangements for the termination of employment and other contractual and non-contractual terms of the Chief Executive, Directors and other Very Senior Managers and board members (other than Non-executive Members).
 - c) Agreeing the pay framework for clinical staff working within the ICB but outside of Agenda for Change Terms and Conditions.
 - d) Overseeing any discretionary payments outside of Agenda for Change pay policy for all staff.
 - e) Determining the arrangements for termination payments and any special payments for all staff.
- 8.7 The ICB may make arrangements for a person to be seconded to serve as a member of the ICB's staff.

9 Arrangements for Public Involvement

- 9.1 In line with section 14Z45(2) of the 2006 Act, the ICB has made arrangements to secure that individuals to whom services which are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and

their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:

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

9.2 In line with section 14Z54 of the 2006 Act, the ICB has made arrangements to consult the local population on its strategic plan, following best practice for the conduct of public consultation published by HM Government.

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

- a) Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.
- b) Start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions.
- c) Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.
- d) Build relationships with excluded groups – especially those affected by inequalities.
- e) Work with Healthwatch and the voluntary, community and social enterprise sector as key partners.
- f) Provide clear and accessible public information about vision, plans and progress to build understanding and trust.
- g) Use community development approaches that empower people and communities, making connections to social action.
- h) Use co-production, insight and engagement to achieve accountable health and care services.
- i) Co-produce and redesign services and tackle system priorities in partnership with people and communities.
- j) Learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places.

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

9.5 These principles will be used when developing and maintaining arrangements

for engaging with people and communities.

- 9.6 These arrangements include a range of engagement activities, including, but not limited to patient participation groups, 'Virtual Views' citizens' panel and targeted outreach sessions. The ICB will encourage a culture of co-production among wider teams to support its delivery as close to our communities as possible.

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Appendix 1: Definitions of terms used in this Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022.
ICB board	Members of the ICB.
Area	The geographical area that the ICB has responsibility for, as defined in clause 1.3 of this constitution.
Committee	A committee created and appointed by the ICB board.
Sub-committee	A committee created and appointed by and reporting to a committee.
Forward Plan Condition	The 'Forward Plan Condition' as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance.
Level of Services Provided Condition	The 'Level of Services Provided Condition' as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance.
Integrated Care Partnership	The joint committee for the ICB's area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's area.
Place-Based Partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the Integrated Care Board, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities, as well as primary care provider leadership, represented by Primary Care Network clinical directors or other relevant primary care leaders. These may also be referred to as 'Alliances'.
Ordinary Member	The board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the board are referred to as Ordinary Members.
Partner Members	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are and appointed in

	<p>accordance with the procedures set out in Section 3 having been nominated by the following:</p> <ul style="list-style-type: none"> • NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description. • The primary medical services (general practice) providers within the area of the ICB and are of a prescribed description. • The local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.
Health Service Body	Health Service Body as defined by (a) section 9(4) of the NHS Act 2006 or (b) NHS foundation trusts.
Health Care Professional	An individual who is a member of a professional regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.

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Appendix 2: Standing Orders

1 Introduction

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

2 Amendment and review

- 2.1 The Standing Orders are effective from 1 April 2026.
- 2.2 The Standing Orders will be reviewed on an annual basis or sooner if required.
- 2.3 Amendments to these Standing Orders will be made as per clause 1.5.2 of the Constitution.
- 2.4 All changes to these Standing Orders will require an application to NHS England for variation to the ICB Constitution and will not be implemented until the Constitution has been approved.

3 Interpretation, application and compliance

- 3.1 Except as otherwise provided, words and expressions used in these Standing Orders shall have the same meaning as those in the main body of the ICB constitution and as per the definitions in Appendix 1.
- 3.2 These Standing Orders apply to all meetings of the board, including its committees and sub-committees, unless otherwise stated. All references to the board are inclusive of committees and sub-committees unless otherwise stated.
- 3.3 All members of the board, members of committees and sub-committees and all employees should be aware of the Standing Orders and comply with them. Failure to comply may be regarded as a disciplinary matter.
- 3.4 In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from the relevant Director, will provide a settled view which shall be final.
- 3.5 All members of the board, its committees and sub-committees and all employees have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.
- 3.6 If, for any reason, these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the board for action or ratification and the Audit, Risk and Compliance for review.

4 Meetings of the Integrated Care Board

4.1 Calling Board Meetings

- 4.1.1 Meetings of the board of the ICB shall be held at regular intervals at such times and places as the ICB may determine.
- 4.1.2 In normal circumstances, each member of the board will be given not less than one month's notice in writing of any meeting to be held. However:
- a) The Chair may call a meeting at any time by giving not less than 14 calendar days' notice in writing.
 - b) One third of the members of the board may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the board members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the board specifying the matters to be considered at the meeting.
 - c) In emergency situations the Chair may call a meeting with two calendar days' notice by setting out the reason for the urgency and the decision to be taken.
- 4.1.3 A public notice of the time and place of meetings to be held in public and how to access the meeting shall be given by posting it at the offices of the ICB body and electronically at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.
- 4.1.4 The agenda and papers for meetings to be held in public will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting that is not likely to be open to the public.

4.2 Chair of a meeting

- 4.2.1 The Chair of the ICB shall preside over meetings of the board.
- 4.2.2 If the Chair is absent, or is disqualified from participating by a conflict of interest, the Deputy Chair shall preside over meetings in the Chair's stead.
- 4.2.3 If both the Chair and Deputy Chair are absent or disqualified from participating by a conflict of interest, the assembled members are to appoint a temporary Deputy for the purpose of chairing the meeting.
- 4.2.4 The ICB board, acting on the advice of the Chair, shall appoint a Chair to all committees and sub-committees that it has established. The appointed committee or sub-committee Chair will preside over the relevant meeting. Terms of reference for committees and sub-committees will specify arrangements for occasions when the appointed Chair is absent.

4.3 Agenda, supporting papers and business to be transacted

- 4.3.1 The agenda for each meeting will be drawn up and agreed by the Chair of the meeting.
- 4.3.2 Except where the emergency provisions apply, supporting papers for all items must be submitted at least seven calendar days before the meeting takes place. The agenda and supporting papers will be circulated to all members of the board at least five calendar days before the meeting.
- 4.3.3 Agendas and papers for meetings open to the public, including details about meeting dates, times and venues, will be published on the ICB's website at www.essex.icb.nhs.uk

4.4 Petitions

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

4.5 Nominated Deputies

- 4.5.1 With the permission of the person presiding over the meeting, the Executive Directors and the Partner Members of the board may nominate a deputy to attend a meeting of the board that they are unable to attend. The deputy may speak and may vote on their behalf.
- 4.5.2 The decision of the person presiding over the meeting regarding authorisation of nominated deputies is final.
- 4.5.3 If a member of the ICB is unable to attend two consecutive meetings, other than as a result of illness or other exceptional circumstances, the member will meet with the Chair to determine their future ability to fulfil their role.

4.6 Virtual attendance at meetings

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

4.7 Quorum

- 4.7.1 The quorum for meetings of the board will be seven members, including at least the following:
 - a) Either the Chair or Deputy Chair.
 - b) Either the Chief Executive or the Executive Director of Finance and Commercial.
 - c) Either the Executive Medical Director or the Executive Director of Nursing.
 - d) At least one other independent member

e) At least one Partner Member.

4.7.2 For the sake of clarity:

- a) No person can act in more than one capacity when determining the quorum.
- b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest shall no longer count towards the quorum.
- c) A nominated deputy permitted in accordance with standing order 4.5 will count towards quorum for meetings of the board.

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

4.8 Vacancies and defects in appointments

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

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

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

4.9 Decision making

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

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

- a) All members of the board who are present at the meeting will be eligible to cast one vote each.
- b) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote, but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.
- c) For the sake of clarity, any additional participants and observers will not have voting rights.
- d) A resolution will be passed if more votes are cast for the resolution than against it.

- e) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.
- f) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

Disputes

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

Urgent Decisions

- 4.9.4 In the event of extraordinary circumstances requiring urgent decisions to be taken, every attempt will be made for the board to meet virtually. Where this is not possible the following will apply:
- 4.9.5 The powers which are reserved or delegated to the board may for an urgent decision be exercised by the Chair and Chief Executive (or relevant lead director in the case of committees) subject to every effort having made to consult with as many members as possible in the given circumstances (minimum of one other member).
- 4.9.6 The exercise of such powers shall be reported to the next formal meeting of the board (or committee in the case of committee urgent decisions) for formal ratification and board urgent decisions will be reported to the Audit, Risk and Compliance Committee for oversight.

4.10 Minutes

- 4.10.1 The names and roles of all members present shall be recorded in the minutes of the meetings.
- 4.10.2 The minutes of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be approved by the person presiding at it.
- 4.10.3 No discussion shall take place upon the minutes except upon their accuracy or where the person presiding over the meeting considers discussion appropriate.
- 4.10.4 Where providing a record of a meeting held in public, the minutes shall be made available to the public.

4.11 Admission of public and the press

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

- 4.11.2 The board may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.
- 4.11.3 The person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the board's business shall be conducted without interruption and disruption.
- 4.11.4 As permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 as amended from time to time the public may be excluded from a meeting to suppress or prevent disorderly conduct or behaviour.
- 4.11.5 Matters to be dealt with by a meeting following the exclusion of representatives of the press and other members of the public shall be confidential to the members of the board.

5 Suspension of Standing Orders

- 5.1 In exceptional circumstances, except where it would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or NHS England, any part of these Standing Orders may be suspended by the Chair in discussion with at least two other members.
- 5.2 A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.
- 5.3 A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Audit, Risk and Compliance Committee for review of the reasonableness of the decision to suspend the Standing Orders.

6 Use of seal and authorisation of documents

- 6.1 The ICB will use a seal for executing documents where necessary.
- 6.2 The seal shall be kept by the Chief Executive or a nominated manager in a secure place.
- 6.3 The following individuals or officers are authorised to authenticate use of the seal by their signature:
- The Chief Executive.
 - The ICB Chair.
 - The Executive Director of Finance and Commercial.

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

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Essex Integrated Care Board

The Board is responsible for planning and commissioning health services for its local population. As strategic commissioner, the focus is on delivering three strategic shifts: sickness to prevention, hospital to community, analogue to digital thereby improving population health, reducing health inequalities, and ensuring access to high-quality care. The ICB leads system-wide planning by developing long-term, evidence-based strategies, allocating resources effectively, and overseeing performance, functioning as healthcare “payer,” ensuring value for money and accountability, supported by strong partnerships with local authorities and data-driven decision-making.

Membership: Chair, CEO, EDFC, ECNO, EMD, 4 NEMs, 3 LA Partner Members, 1 General Practice Member, 3 Provider Partner Members

Quoracy: 8 Members including a NEM, Clinical, Partner Member and CEO/CFO **Frequency:** Quarterly in public, + monthly seminars

Essex Integrated Care Partnership

Accountable to the ICB and Essex, Thurrock, Southend Health and Wellbeing Boards

The ICP brings together NHS, Local Authorities and other partners to develop a shared strategy for improving health and wellbeing across the local population. Focussing on tackling health inequalities, promoting prevention, and aligning services to deliver better outcomes through collaboration.

Membership: Chair, CEO, EDNH, 3x Healthwatch, 3x LA Partners, 3x Provider Members

Quoracy: 6 including Chair, 1 Provider, 1 LA Partner **Frequency:** Twice per annum

Audit, Risk and Compliance Committee

Provide oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB, driven by organisational objectives and associated risks.

Sub Groups: Health and Safety Group, IG Steering Group

Frequency: Quarterly (+ Annual Report and Accounts meeting)

Remuneration Committee

Agrees ICB policy on pay/pay framework and recommends Pay, terms and conditions for board members. Provides assurance to the Board on the discharge of this ICB statutory duty.

Sub Groups: Non-Executive Member Remuneration Panel

Frequency: Twice per annum, plus ad hoc meetings as required.

Executive Committee

Development and oversight of strategy and operational decisions. Considers approval of business case / investment / disinvestment decisions up to £5m. Responsible for organisational and staff developing and the equality agenda.

Sub Groups: Senior Leadership Team, Strategic Delivery Group, Inclusion and Belonging Steering Group, ICB People Group

Frequency: Monthly (decision making), Weekly (operational)

Commissioning, Quality and Resource Committee

Agrees the commissioning, contracting and financial framework, makes investment decisions / recommendations, receives assurance on delivery of financial performance, contract management and quality outcomes in accordance with the Quality Strategy set by the National Quality Board.

Sub Groups: PSR Review Group, QCPM, Medicines Commissioning Group, System Quality Group, Estates and Capital Group

Frequency: Quarterly

Neighbourhood Health Committee

Responsible for oversight of the deliver of neighbourhood health, developing commissioning models for the shift of care into the community, analogue to digital, development of the prevention agenda and ensuring the ICB addresses health inequalities.

Sub Groups: Primary Care Commissioning Group, Alliances x 5, Health Inequalities and Prevention Group

Frequency: Quarterly

Key:

Statutory & Assurance

Decision Making

Assurance

Developing Decision Making & Assurance

Key:

CEO: Chief Executive Officer

ECNO: Executive Chief Nursing Officer

EMD: Executive Medical Director

EDFC: Executive Director of Finance and Commercial

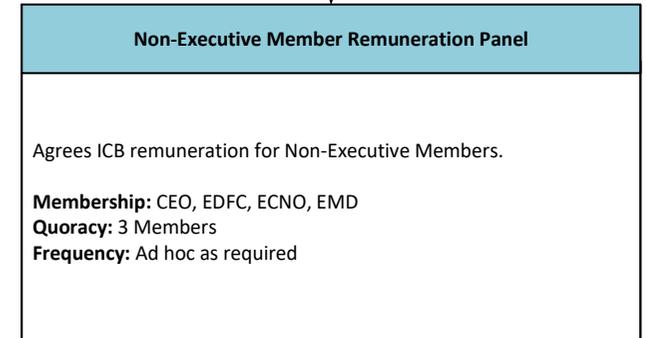
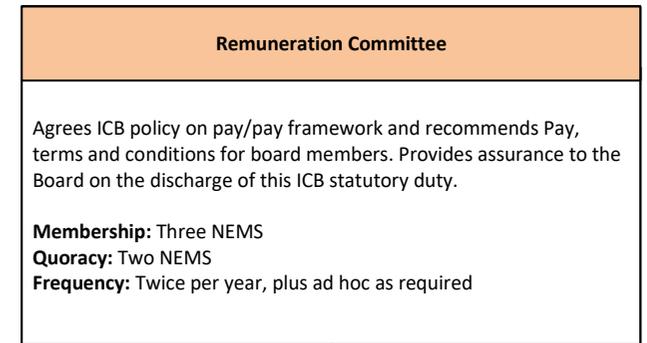
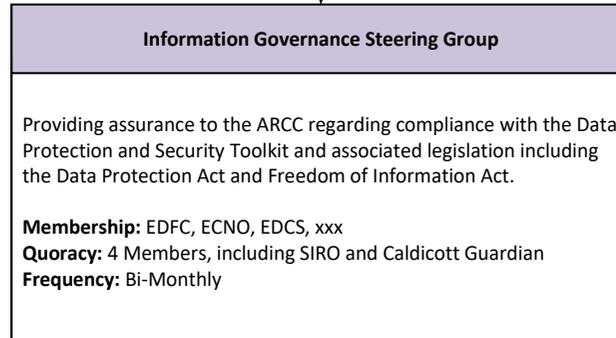
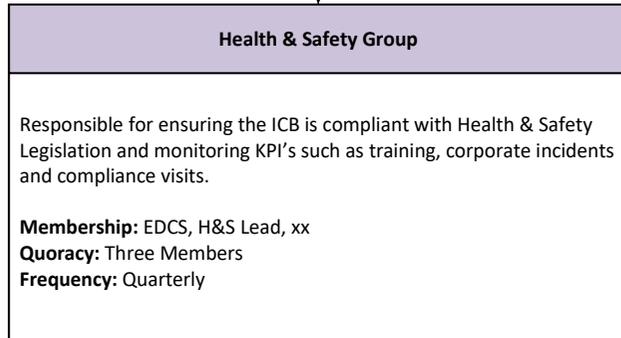
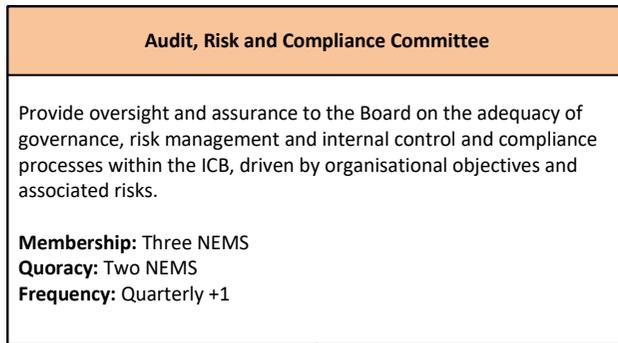
EDCS: Executive Director of Corporate Services

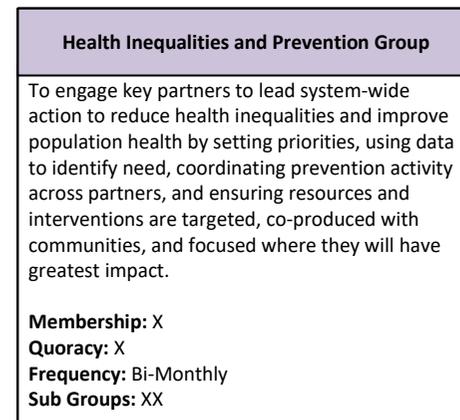
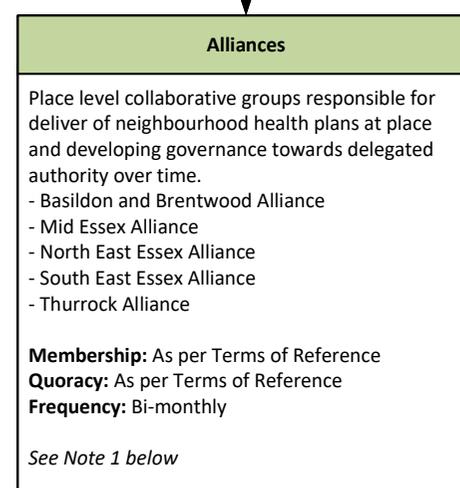
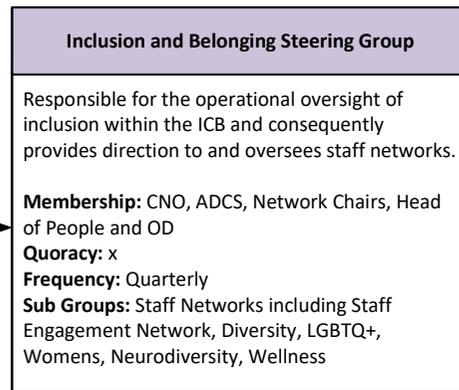
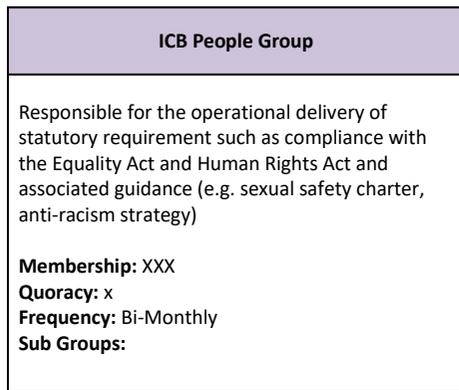
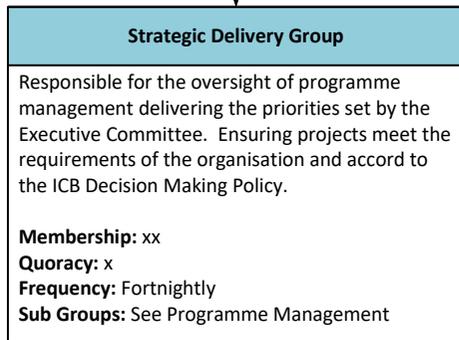
EDNH: Executive Director of Neighbourhood Health

EDS: Executive Director of Strategy

NEM: Non-Executive Member

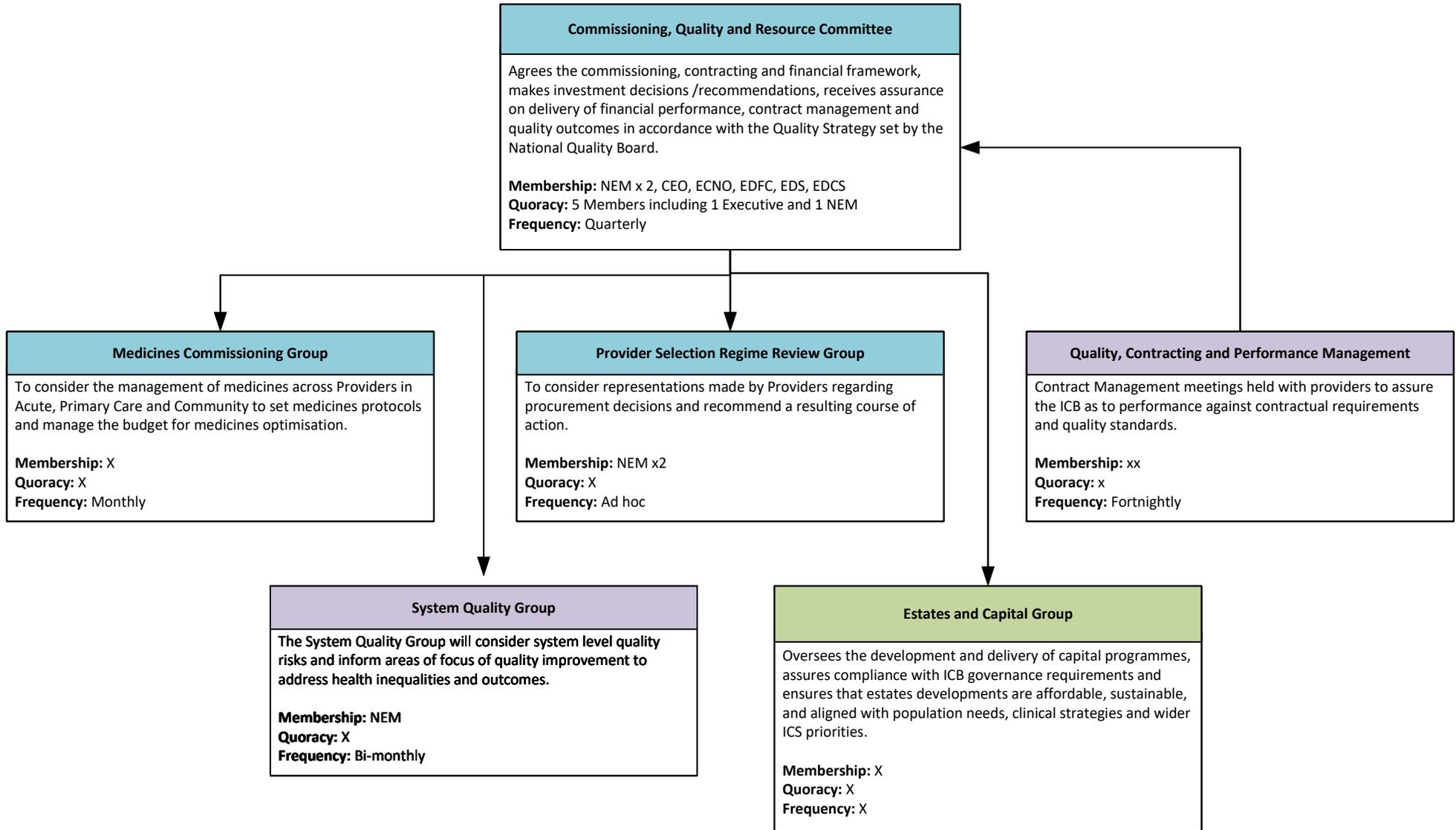
Bi-Monthly: Every two months





Better Care Fund Governance

Note 1: The existing Alliance structures inherited from the former Mid and South Essex, Suffolk and North East Essex, and Hertfordshire and West Essex ICBs will be retained within the Essex ICB for a transition period of up to six months. Maintaining the current arrangements during this period is intentional and ensures that the subsequent restructure is fully informed and appropriately aligned with emerging Neighbourhood Health guidance (pending at the time of publication) and the implications of Local Government Reform. This approach will support a cohesive and well-sequenced transition to the future operating model.



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NB: Dates may be subject to change.

				2026									2027		
MEETING (Officer providing support)	Frequency	Committee Admin	Reporting Committee	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
ICB / ICP MEETINGS															
Public Board Venues				(Southend TBC)			(Chelmsford TBC)			(Basildon/Brentwood or Thurrock TBC)					
Part I Board NB: Part II held same day if required	Quarterly	8a	-	1 (virtual), 23 (Colchester TBC)	-	-	16	-	-	15	-	-	21	-	-
Board Strategy Seminars	Monthly	8a	-	23	21	18	16	20	17	15	19	17	21	18	18
Executive Committee	Monthly - decision making Weekly - operational	TC	Board	7,14,21,28	5,12,19,26	2,9,16,23,30	7,14,21,28	4,11,18,25	1,8,15,22,29	6,13,20,27	3,10,17,24	1,8,15,22,29	5,12,19,26	2,9,16,23	2,9,16,23,30
Commissioning, Quality and Resource Committee (CQRC)	Quarterly	BM (Finance)	Board	7	-	-	7	-	-	6	-	-	5	-	-
Neighbourhood Health Committee	Quarterly	JK	Board	-	28	-	-	27	-	-	26	-	-	25	-
Audit, Risk and Compliance Committee (ARCC) (2nd Tues PM, month before Board)	Quarterly (+1 ARA)	6	Board	22 (EO) TBC	-	9	-	-	8	-	-	8	-	-	9
Remuneration Committee (RemCom)	Bi-annual (plus ad hoc as required)	8a	Board	1	6	3	1	5	2	7	4	2	6	3	3
Integrated Care Partnership	Bi-annual	TC	[Board & Essex Thurrock, Southend Health & Wellbeing Boards + ANOs TBC] Thurrock & Basildon venues - TBC	TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA
Senior Leadership Team	Fortnightly	B5 (CS)	Executive Committee	8, 22	6, 20	10, 24	8, 22	5, 19	2, 16, 30	14, 28	11, 25	9, 23	6, 20	3, 17	3, 17, 31
Strategic Oversight Group	Fortnightly	BM (Strategy)	Executive Committee	6, 20	4, 18	1, 15, 29	13, 27	10, 24	14, 28	12, 26	2, 16, 30	14, 28	11, 25	8, 22	8, 22
Inclusion & Belonging Steering Group	Quarterly	B5 (Nursing)	Executive Committee	-	28	-	-	27	-	-	26	-	-	25	-
Health & Safety Group	Quarterly	B4 (CS)	Audit, Risk & Compliance Committee	-	19	-	-	18	-	-	17	-	-	18	-
Information Governance Steering Group	Bi-monthly	B5 (CS)	Audit, Risk & Compliance Committee	-	14	-	9	-	10	-	12	-	14	-	11
Non-Executive Member Remuneration Panel	Ad hoc as required	8a	Remuneration Committee	TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA
Provider Selection Regime (PSR) Review Group	Ad hoc	BM (Finance)	Commissioning, Quality & Resource Committee	TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA
Medicines Commissioning Group	Monthly	B5 (Medical)	Commissioning, Quality & Resource Committee	13	11	8	13	10	14	12	9	14	11	8	8
Quality & Contract Performance Management (QCPM)	Fortnightly	B5 (Finance)?	Commissioning, Quality & Resource Committee	10, 24	8, 22	5, 19	3, 17, 31	14, 28	11, 25	9, 23	6, 20	4, 18	8, 22	5, 19	5, 19

Quality Improvement Group	Bi-monthly	BM (Nursing)	Commissioning, Quality & Resource Committee	9	-	11	-	13	-	8	-	10	-	11	-
Estates & Capital Group	Quarterly	B5 (Finance)	Commissioning, Quality & Resource Committee	-	-	2	-	-	1	-	-	1	-	-	2
Primary Care Commissioning Group	Bi-monthly	BM (NH)	Neighbourhood Health Committee	8	-	10	-	12	-	14	-	9	-	10	-
Alliances x6	Bi-monthly	B5/4	Neighbourhood Health Committee	-	7	-	2	-	10	-	5	-	7	-	4
Health Inequalities and Prevention Group	Quarterly	B5 (NH)	Neighbourhood Health Committee	15	-	-	15	-	-	15	-	-	20	-	-

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Standing Financial Instructions

Document Control:

Policy Name	Standing Financial Instructions
Policy Number	
Version	0.1
Status	First Draft Final Version
Author / Lead	Finance Team
Responsible Executive Director	Executive Director of Finance & Commercial
Responsible Committee	Audit, Risk and Compliance Committee Commissioning, Quality and Resource Committee
Date Ratified by Responsible Committee	
Date Approved by Board/Effective Date	
Next Review Date	
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 Impact Assessment

Version History

Version	Date	Author (Name and Title)	Summary of amendments made
0.1	Dec 2025	Ashley King – Director Finance & Estates	First draft – base version MSEICB SFI Jan 24 Section 7 requires review once ICB governance agreed
0.2	Jan 2026	Nicola Adams	Updating governance sections
1.0			
1.1			
2.0			

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1. Introduction

- 1.1. From 1 April 2026, the Integrated Care Board (ICB) operates as the strategic commissioner for NHS services within its statutory footprint, responsible for long-term population health improvement, reducing inequalities, and ensuring value from the NHS budget. These Standing Financial Instructions support the delivery of the 10-Year Health Plan, the Strategic Commissioning Framework, and the statutory duties of the ICB.

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 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 Executive Director of Finance & Commercial (EDFC) 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.

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 Risk & Compliance Committee

- 5.2.1. The board and accountable officer should be supported by an audit risk & compliance 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. Commissioning, Quality and Resource Committee

- 5.3.1. The commissioning, quality and resource committee is responsible for ensuring that this governance document is followed, along with other relevant governance policies, when making commissioning decisions.
- 5.3.2. The committee will also hold accountability for the financial stewardship of the ICB and ensuring it meets its financial statutory duties.

5.4. Other Committees'

- 5.4.1. The ICB Board may create other committees to discharge its responsibilities as set out and defined within the scheme of reservation and delegation. Where such committees exist and have delegated responsibility for decision making, they shall also ensure this governance document is followed.

5.5. Chief Executive

- 5.5.1. 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.
- 5.5.2. The Executive Director of Finance & Commercial (EDFC)) reports directly to the ICB chief executive officer and is professionally accountable to the NHS England regional finance director.
- 5.5.3. The chief executive will delegate to the EDFC 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 EDFC 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.

5.6. All Staff

5.6.1. 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 EDFC is responsible for maintaining policies and processes relating to the control, management, and use of resources across the ICB.

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

6.1.3. The EDFC will ensure:

- the promotion of compliance to the SFIs through an assurance certification process
- the promotion of long-term financial health for the NHS system
- 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 10-Year Health Plan objectives.

6.1.4. In addition, the EDFC should have financial leadership responsibility for the following statutory duties:

- 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 EDFC 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 EDFC 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 EDFC 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 EDFC 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 EDFC 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 EDFC 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 EDFC 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 EDFC shall periodically seek assurances that adequate controls are in operation.

6.4. Procurement and Purchasing

- 6.4.1. The EDFC 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 decision making 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, risk and compliance committee.

6.5. Staff Costs and Staff Related non-Pay Expenditure

Executive Director of Corporate Services

- 6.5.1. The executive director of corporate services [EDCS] will lead the development and delivery of a people strategy to deliver the requirements of the 10-year workforce plan (due 2026).
- 6.5.2. Operationally the EDCS 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 EDCS 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 EDCS shall closely manage this supplier through effective contract management.
- 6.5.5. The EDCS is responsible for management and governance frameworks that support the ICB employees' life cycle.

6.6. Annual Reporting and Accounts

- 6.6.1. The EDFC 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 strategy 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 EDFC to ensure that:

- all internal audit services provided under arrangements proposed by the EDFC are approved by the audit, risk and compliance 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, risk and compliance 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, risk and compliance committee meetings and have a right of access to all audit, risk and compliance 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 EDFC 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, 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 EDFC 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 compliance and control procedures, ICBs must submit an annual assurance statement confirming the following:

- details of all exit packages (including special severance payments, as defined by NHS England) that have been agreed and/or made during the year
- that NHS England and HM Treasury 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 as defined by NHS England) must be reported to the ICB audit, risk and compliance 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 EDFC 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, risk and compliance 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 EDFC 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 Integrated Care Board(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 EDFC 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 EDFC 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 EDFC 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, risk and compliance Committee and the Commissioning, Quality and Resource 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. 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 approved by the relevant committee, and will be notified to 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.

DRAFT

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: Ashley King – Director of Finance & Estates (MSEICB)	Date: 22/12/2025

OUTCOMES
<i>Briefly describe the aim of the policy and state the intended outcomes for staff</i>
To govern financial processes. This document ensures that staff follow statutory guidance and ICB Policy.
EVIDENCE
<i>What data / information have you used to assess how this policy might impact on protected groups?</i>
General assessment.
<i>Who have you consulted with to assess possible impact on protected groups? If you have not consulted other people, please explain why?</i>
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

Part I Essex Joint Committee Meeting, 19 March 2026

Agenda Number: 13.2

Policy Development Update and Draft Standards of Business Conduct Policy for the proposed Essex Integrated Care Board.

Summary Report

1. Purpose of Report

To provide an update on policy development for the proposed Essex Integrated Care Board and seek the committee's approval of the draft Standards of Business Conduct Policy for the new organisation.

2. Executive Leads

Michael Watson, Executive Director of Corporate Services

3. Report Author

Sara O'Connor, Senior Manager Corporate Services

4. Responsible Committees

Audit Committee maintains oversight of the ICB's Policy Framework.

5. Link to the ICB's Strategic Objectives

The Standards of Conduct Policy will help to support all ICB strategic objectives. Strategic Objectives for the proposed Essex ICB are under development.

6. Conflicts of Interest

None identified.

7. Recommendations

The committee is asked to:

- **Note** ongoing work being undertaken to develop new policies for the proposed Essex ICB, including that virtual approval of some policies by the relevant committees will be required prior to 31 March 2026.
- **Approve** the draft Standards of Business Conduct Policy, at **Appendix A**, for the proposed Essex ICB and recommend it for adoption by the new organisation at its inaugural meeting on 1 April 2026.

Revised ICB Policies

1. Introduction

The ICB has a policy framework to ensure that it has properly documented the controls in place to achieve its objectives, manage its risk and guide the work it does in accordance with legislation, statutory guidance and best practice. Each policy must be periodically reviewed or updated following any changes in legislation/best practice, and has a designated 'sponsoring committee' responsible for overseeing its implementation and approving any updates to the policy.

2. Development of policies for the proposed Essex ICB

Since the last committee meeting, work has been ongoing to develop a new policy framework for the proposed Essex ICB (EICB). This included a review of current policy templates used by MSE ICB, HWE ICB and SNEE ICB, to develop a new policy template for EICB. The new template incorporated good practice from HWE and SNEE into the existing MSE template to enable a smooth transition of policies into the new Essex ICB.

The Executive Team / policy leads were asked to review the current MSE policy framework to identify any policies no longer required due to a change in ICB responsibilities, and to advise if any current policies could be amalgamated, or if any additional policies needed to be urgently developed.

Policy leads were then asked to review/update existing MSE policies taking account of the following:

- Minor changes to reflect the new EICB policy template.
- Update job titles/directorates, etc. to reflect the new organisational staff structure.
- Update the 'sponsoring committee' in line with the proposed EICB committee structure
- Update the policy to consider any local issues relevant to West and North East Essex
- Review the policy to take account of the ICB's future responsibilities and any changes to legislation/processes.

Policy development work is progressing well. All draft EICB policies will be submitted to the relevant MSE ICB committee for review prior to their adoption by the new organisation at the inaugural EICB Part I Board meeting on 1 April 2026.

Several policies within the remit of the Finance & Performance Committee and Audit Committee have already been approved, as detailed below:

Responsible Committee	EICB Policy Name
Audit Committee	<ul style="list-style-type: none"> • Standards of Business Conduct, including Conflicts of Interest, Gifts and Hospitality and Sponsorship • Media Policy • Social Media Policy • Commissioning (Service Restrictions) Policy • Individual Funding Request Policy • Information Governance Framework and Policy • Access to Information Policy • Information and Cyber Security Policy • Information Sharing Policy
Finance & Performance Committee	<ul style="list-style-type: none"> • Accounting and Financial Management Policy • Banking Cash Management Policy • Creditor and Purchase Policy • Debtor and Sales Order Policy • Standing Financial Instructions

Remaining policies will be considered by at the following committee meetings:

- Essex Joint Quality Sub-Committee, 17 March 2026 (quality, patient safety, safeguarding, all age continuing care policies)
- Remuneration Committee 19 and 27 March 2026 (people policies).
- Audit Committee on 24 March 2026 (corporate governance policies).

However, due to the large number of policies, virtual committee approval of some policies might be required if it is not possible to meet committee meeting deadlines.

Hyperlinks to the new EICB website/intranet within draft policies will be added in due course, and some email addresses / contact details plus the EICB logo and new policy reference numbers will be added prior to publication.

Members are asked to note that the Risk Management Policy will be included within the EICB Governance Handbook and will receive initial review by the Audit Committee on 24 March and will also be submitted to this committee for virtual approved once finalised.

3. Draft Standards of Business Conduct Policy for EICB

The Standards of Business Conduct Policy (**Appendix A**) is a core corporate governance policy and will be included within the Governance Handbook being prepared for the proposed Essex ICB. The new policy includes guidance on the following:

- standards of business conduct
- management of conflicts of interest
- outside/secondary employment
- gifts and hospitality
- commercial sponsorship
- other situations where conflicts might arise

The policy was submitted to the MSE ICB Audit Committee on 5 March 2026 for review and is now provided to this committee for consideration. Subject to any comments received, the committee is asked to recommend the final draft for adoption by EICB at its inaugural Part I Board meeting on 1 April 2026.

As mentioned in the last paragraph of section 2 above, some information will be added to the final version of the policy (relevant text is highlighted yellow) prior to it being published on the new organisation's website.

4. Recommendations

The committee is asked to:

- **Note** ongoing work being undertaken to develop new policies for the proposed Essex ICB, including that virtual approval of some policies by the relevant committees will be required prior to 31 March 2026.
- **Approve** the draft Standards of Business Conduct Policy, at **Appendix A**, for the proposed Essex ICB and recommend it for adoption by the new organisation at its inaugural meeting on 1 April 2026.

5. Appendices

Appendix A – Draft Standards of Business Conduct Policy for the proposed Essex Integrated Care Board.

Standards of Business Conduct Policy

(Including Management of Conflicts of Interest, Gifts and Hospitality, Outside Employment, Commercial Sponsorship and other situations where conflicts might arise)

Policy No: EICB ###

Document Control:

Policy Name	Standards of Business Conduct Policy
Policy Number	EICB ###
Version	0.2
Status	Draft
Policy Lead	Associate Director of Corporate Services
Responsible Executive Director	Executive Director of Corporate Services
Responsible Committee	Audit, Risk and Compliance Committee
Date Ratified by Responsible Committee	5 March 2026 (Audit Committee) 19 March 2026 (Essex Joint Committee)
Date Ratified by EICB Board	1 April 2026
Next Review Date	April 2027
Target Audience	<ul style="list-style-type: none"> Essex Integrated Care Board (EICB) members and staff (including temporary/bank/agency/voluntary/work experience staff). Contractors engaged by the ICB. Staff from other Essex Integrated Care Partnership (ICP) organisations who are members of EICB committees/sub-committees and other groups.
Stakeholders engaged in development of original Policy (internal and external)	<ul style="list-style-type: none"> Governance Team Kevin Edwards, Associate Director, Attain. Director of Pharmacy, Medicines and Clinical Policies Staff Engagement Group. Staff Side ICB Executive Team Audit Committee
Impact Assessments Undertaken	<ul style="list-style-type: none"> Equality Impact Assessment (see Appendix A)

Version History

Version	Date	Author (Name and Title)	Summary of amendments made
0.1	03/02/26	Michael Watson	First draft
0.2	20/06/23	Sara O'Connor	Draft policy added to agreed EICB policy template and other updates

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1. Introduction

- 1.1. This is a controlled document. Whilst this document may be printed (please consider if this is necessary), the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the website (or requested from the Governance Lead/Team) to ensure the most up-to-date version is used.
- 1.2. The Standards of Business Conduct policy describes the standards and public service values which underpin the work of the NHS and reflects current guidance. Effective management of conflicts of interest is crucial to give confidence to patients, taxpayers, healthcare providers and Parliament that ICB commissioning decisions are robust, fair, transparent, and offer value for money. ICBs are also required under the NHS Act 2006 (as amended by the Health and Care Act 2022) to manage conflicts of interest.
- 1.3. The major focus of this policy is the management of conflicts of interest and is intended to ensure that Essex Integrated Care Board ('the ICB') complies with NHS England's 'Managing Conflicts of Interest in the NHS' guidance (September 2024) which considers changes introduced by the Health and Care Act 2022, specifically the establishment of Integrated Care Boards and the introduction of the Provider Selection Regime.
- 1.4. Decision-making must be geared towards meeting the ICB's statutory duties, including the 'triple aim'. 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 furthering direct or indirect financial, personal, professional or organisational interests.
- 1.5. ICBs were created to give statutory NHS providers, local authority and primary medical services nominees a role in decision-making. These individuals will be expected to act in accordance with the first principle (as described in paragraph 1.3 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 these 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 that outweighs the value of the knowledge they bring to the process.
- 1.6. The personal and professional interests of all ICB board members, ICB committee members and ICB staff who are involved in the marking of decisions within this ICB need to be declared, recorded and managed appropriately. Declarations must be made as soon as practicable after the person becomes aware of the conflict or potential conflict and, in any

event, within 28 days of the person becoming aware. This includes being clear and specific about the nature of any interest, and about the nature of any conflict that may arise regarding a particular decision.

- 1.7. If an interest is declared but there is no risk of a conflict arising, then no further action need be taken (although this will still need to be recorded). However, if a material interest is declared, then it should be considered to what extent this material interest affects the balance of the discussion and decision-making process. In doing so the ICB should ensure conflicts of interest (and potential conflicts of interest) do not, (and do not appear), to affect the integrity of the ICB's decision making processes.
- 1.8. ICBs should consider the composition of decision-making forums and should clearly distinguish between those individuals who should be involved in formal decision taking, and those whose input informs decisions. ICBs should consider the perspective the individual brings and the value they add to both discussions around particular decisions and in actually taking part in the decision including the ability to shape the ICB's understanding of how best to meet patients' needs and deliver care for their populations. The way conflicts of interests are managed should reflect this distinction. For example, where independent providers (including the voluntary, community, faith and social enterprise (VCFSE) sector) hold contracts for services it would be appropriate and reasonable for the body to involve them in discussions, for example about pathway design and service delivery, particularly at place-level. However, this would be clearly distinct from any considerations around contracting and commissioning, from which they would be excluded.
- 1.9. Actions to mitigate a conflict 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 decision, and the risks and benefits of having a particular individual involved in making the decision. Potential options in relation to mitigation are outlined in section 6.25.24 below.
 - i. Including a conflicted person in the discussion but not in decision making;
 - ii. Excluding a conflicted person from both the discussion and the decision making;
 - iii. 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.
 - iv. Excluding the conflicted individual and securing technical or local

expertise from an alternative, unconflicted source

- 1.10. The way conflicts of interest are declared and managed should contribute to a culture of transparency about how decisions are made. In particular when adopting a specific approach to mitigate any conflicts of interest (including perceived conflicts) ICBs should ensure that the reason for the chosen action is documented in minutes or records.
- 1.11. These factors should be read in conjunction with other relevant NHSE statutory guidance, including guidance on the Provider Selection Regime and guidance on joint working and delegation arrangements. In relation to the Provider Selection Regime, as is already established practice in the NHS, 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.
- 1.12. This policy, in conjunction with the **ICBs Procurement and Contracting Policy**, elaborates on these principles, explaining the processes to be followed in order to maintain them.

2. Purpose

- 2.1. The purpose of this policy is to ensure that the ICB maintains the highest standards of probity and that all business relationships lead to clear benefits for patients, and intends to:
 - (a) Enable the ICB to deliver its statutory duty to manage conflicts of interest
 - (b) Enable individuals to demonstrate that they are acting fairly and transparently and in the best interest of patients and the local population
 - (c) Uphold confidence and trust in the NHS
 - (d) Safeguard commissioning, whilst ensuring objective decision-making
 - (e) Support individuals to understand when conflicts of interest (whether actual or potential) may arise and how to manage them if they do
 - (f) Ensure that the ICB operates within the legal framework.
 - (g) Uphold the reputation of the ICB and its staff in the way it conducts business.

3. Scope

- 3.1. This policy applies to, including and without limitation, whether permanent, temporary, seconded, students/trainees/apprentices or contracted-in (either as an individual or through an agency/third party supplier):
 - (a) all ICB staff members and those of hosted organisations

- (b) members of the Board, committees/sub-committees and practice representatives involved in the ICB's policy-making processes (including co-opted members, appointed deputies, temporary appointments, members of committees/groups from other organisations and 'regular attendees' of these meetings.
- (c) self-employed consultants.

3.2. Some individuals are more likely than others to have a decision-making role or influence on the use of public money because of the requirements of their role. In the context of this policy, the officers listed below are referred to as 'decision making officers':

- Board and sub-committee members
- Place based directors
- Executive and senior managers as outlined in the Scheme of Reservation and Delegation and Standing Financial Instructions
- Level 4 Patient and Public Voice partners

4. Definitions and Categories of Interests

4.1. **Commercial Sponsorship** - An arrangement where the ICB receives financial support or support in kind for staff, research, training, equipment, premises or conferences.

4.2. **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 imputation of improper conduct.

'Interests' can arise in a number of different contexts. A benefit may arise from the making of a gain or the avoidance of a loss.

4.3. **Financial interest** - Where an individual may get direct financial benefit (this may be a financial gain, or avoidance of a loss) from the consequences of a decision they are involved in making.

- 4.4. **Gifts** - Any item of cash or goods, or any service, which is provided for personal benefit, free of charge or less than its commercial value.
- 4.5. **Hospitality** - Food, drink, travel, accommodation, or entertainment offered or provided in the nature of the organisation's business by anyone other than the employer.
- 4.6. **'Material interest'** – is an interest which a reasonable person would take into account when making a decision regarding the use of taxpayers' money because the interest has relevance to that decision. Consequently, all such interests should be declared and assessed as appropriate for inclusion in the ICB's register of interests.
- 4.7. **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.
- 4.8. **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.
- 4.9. **Indirect interests:** Where an individual has a close association¹ 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. These associations may arise through relationships with close family members and relatives, close friends and associates, and business partners. A common-sense approach should be applied to these terms. It would be unrealistic to expect staff to know of all the interests that people in these classes might hold. However, if staff do know of material interests (or could be reasonably expected to know about these) then these should be declared. Further guidance on how to interpret these categories can be found in Appendix B.
- 4.10. **Decision-Making Staff:** Those staff in roles 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 (equivalent roles in different organisations carry different titles and these should be considered on a case-by case basis).

¹ 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.

- 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 (reflecting guidance issued by the Information Commissioner's Office with regard to freedom of information legislation).
- Administrative and clinical staff who have the power to enter into contracts on behalf of their organisation.
- Administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment, and formulary decisions.

4.11. **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 during 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.

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.

4.12. **Joint Working** - Situations where, for the benefit of patients, organisations pool skills, experience and/or resources for the joint development and implementation of patient centred projects and share a commitment to successful delivery. Joint working agreements and management arrangements are conducted in an open and transparent manner.

Joint working differs from sponsorship, where pharmaceutical companies simply provide funds for a specific event or work programme.

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

4.14. **Pharmaceutical Industry** - Includes:

- Companies, partnerships or individuals involved in the manufacturing, sale, promotion or supply of medicinal products subject to the licensing provision of the Medicines Act 1968/16.

- Companies, partnerships or individuals involved in the manufacture, sale, promotion or supply of medical devices, appliances, dressings, and nutritional supplements which are used in the treatment of patients within the NHS.
- Trade associations and agencies representing companies involved with such products.
- Companies, partnerships or individuals who are directly concerned with research, development or marketing of a medicinal product, device, appliance, dressing or supplement that is being considered by, or would be influenced by, decisions taken by the ICB.
- Pharmaceutical industry related industries, including companies, partnerships or individuals directly concerned with enterprises that may be positively or adversely affected by decisions taken by the ICB.

4.15. **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. ICB Board

In the context of this policy members of the Board are:

- required to comply with all relevant elements of this policy
- ensure that the ICB's policies and procedures reflect best practice particularly in relation to the procurement of services
- ensure that arrangements for audit and reporting are open, robust and effective.

5.2. 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.

5.3. Executive Director of Corporate Services

The Chief Executive has delegated responsibility for the organisation's compliance with this policy to the Executive Director of Corporate Services including investigation into any breaches of this policy.

5.4. Audit, Risk and Compliance Committee

5.4.1. The Audit, Risk and Compliance Committee will have responsibility for

- Overseeing the arrangements for the management of conflict of interest, gifts, hospitality and commercial sponsorship, and advise the Board as required.
- Receive a Decision Register report on a quarterly basis which will include all decisions made by the Board and Board Committees inclusive of any declaration of interests made against each decision and how those conflicts were managed.
- Ensure that the registers of interests and gifts, hospitality and sponsorship are reviewed regularly and updated as necessary.
- Ensure that for every interest declared, arrangements are in place to manage the conflict of interests or potential conflict of interests, to ensure the integrity of the ICB's decision making process.
- The arrangements will confirm the following:
 - When an individual should withdraw from a specified activity, on a temporary or permanent basis.
 - Monitoring of the specified activity undertaken by the individual, either by a line manager, colleague or other designated individual.

5.5. Conflicts of Interest Guardian

5.5.1. The Chair of the Audit Committee will be the ICB's Conflict of Interest Guardian and, in collaboration with the ICB Governance Lead, will:

- Act as a conduit and safe point of contact for staff, members of the public and healthcare professionals who have any concerns with regards to conflicts of interest.
- 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 to staff and members 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.

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

5.6. Policy Author

5.6.1. The policy author will have responsibility for reviewing and updating the policy in line with Section 9 below.

5.7. Associate Director of Corporate Services (ICB Governance Lead)

5.7.1. The ICB Governance Lead, with the support of other governance team staff, is responsible for:

- Ensuring the ICB has a conflicts of interest policy in place which is accessible to staff.
- Ensuring a formal review of all individuals' declarations of interest is undertaken annually.
- Providing staff and other relevant individuals with advice, support, and guidance to enable them to manage conflicts of interest.
- Maintaining the register of interest, register of gifts and hospitality and other records relating to the management of conflicts of interest
- Ensuring that registers of interest and registers of gifts and hospitality are published on the ICB's public website.
- Ensuring that appropriate administrative 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.
- Maintain the Decision Register of all decisions made by the Board and Board Committees inclusive of any declarations made against each action, provide to Audit, Risk and Compliance Committee meetings on a quarterly basis and subsequently published on the ICB public website, unless exempt due to reasons of commercial sensitivity or personal confidentiality.
- Ensuring that senior managers provide adequate, appropriate and transparent reporting to the ICB Board, its committees, stakeholders and the public as required by the Health and Social Care Act 2012 and the Health and Care Act 2022.

5.8. Executive Director of Finance and Commercial

5.8.1. The Executive Director of Finance and Commercial is a designated contact to whom any suspicious of fraud may be reported, as per the Counter Fraud, Bribery and Corruption Policy, and is also the lead Executive Director for procurement.

5.9. Line Managers

5.9.1. 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.

5.9.2. 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, including during annual appraisal of members of their team.

5.10. Local Counter Fraud Specialist

5.10.1. The ICB Local Counter Fraud Specialist should be contacted in the first instance if you have any genuine suspicions or concerns over fraud or bribery, in accordance with the **ICB Counter Fraud Bribery and Corruption Policy**.

5.10.2. The LCFS is responsible for investigating allegations of fraud, bribery, and corruption. In consultation with the Executive Director of Finance and Commercial, the LCFS will report any case to the NHS Counter Fraud Authority and / or the police, as agreed, 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 Director of Finance and Commercial.

5.11. All ICB Employees, Committee members and Contractors.

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 are collectively referred 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 Essex Integrated Care Partnership).

As a member of staff you should:

- Familiarise yourself with this policy and associated policies, including the **Counter Fraud and Bribery and Corruption Policy** and follow them.
- 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. (NB: There may be occasions where staff declare an interest but upon closer consideration it is clear it is not material and so does not give rise to the risk of a conflict of interest.

The governance lead/team will decide whether it is necessary to transfer such declarations to the ICB's registers of interests).

- **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 your outside interests to inappropriately affect the decisions you make when using taxpayers' money.
- Seek clarification from your line manager on any points which are not clear.
- Speak up if you have any concerns about how conflicts of interest are being managed.
- Support others to identify and manage conflicts of interest.
- Undertake mandatory online conflicts of interest training.
- 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 Director of Finance and Commercial, or to the [NHS Counter Fraud Authority \(NHS CFA\)](#).

6. Standards of Business Conduct

6.1. Principles of Good Business Conduct

6.1.1. The ICB expects Board and committee members, staff, contractors and all involved in the business of the ICB to observe the principles of good governance in how they do business. These include:

- The Seven Principles of Public Life (the 'Nolan Principles').
- The Good Governance Standards for Public Services (CIPFA 2004)
- The seven key principles of the NHS in England
- The Equality Act 2010
- The UK Corporate Governance Code 2024
- Guidance on Integrated Care Board Constitutions and Governance

6.1.2. In addition, as an ICB we will:

- Do business appropriately: conflicts of interest become much easier to identify, avoid and/or manage when the processes for needs assessments, consultation mechanisms, commissioning strategies and procurement procedures are right from the outset, because the rationale for all decision-making will be clear and transparent and should withstand scrutiny.
- Be proactive, not reactive: commissioners should seek to identify and minimise the risk of conflicts of interest at the earliest possible opportunity.

- Be balanced and proportionate: rules should be clear and robust but not overly prescriptive or restrictive. They should ensure that decision-making is transparent and fair whilst not being overly constraining, complex or cumbersome.
 - Be transparent: document clearly the approach and decisions taken at every stage in the commissioning cycle so that a clear audit trail is evident.
 - Create an environment and culture where individuals feel supported and confident in declaring relevant information and raising any concerns.
- 6.1.3. The ICB recognises that:
- A perception of wrongdoing, impaired judgement or undue influence can be as detrimental as them actually occurring.
 - If in doubt, it is better to assume the existence of a conflict of interest and manage it appropriately rather than ignore it.
 - For a conflict of interest to exist, financial gain (including avoidance of loss) is not necessary.
- 6.1.4. The ICB understands the requirement to consult upon major changes before decisions are reached and will be open with the public, patients and staff. Information supporting decisions will be made available in a way that is understandable. Responses to requests for information in accordance with the Freedom of Information Act 2000 will be provided in this spirit.
- 6.1.5. Our business will be conducted in a way that is socially responsible, forging an open and positive relationship with the local community and in consideration of the impact of the organisation's activities on the environment.

6.2. Identification & Declaration of Interests

- 6.2.1. 'Interests' can arise in several different contexts. A material interest is one which a reasonable person would take into account when making a decision regarding the use of taxpayers' money because the interest has relevance to that decision.
- 6.2.2. The definition of 'conflict of interest' and the types/categories are defined in Section 4 above and within the Declaration of Interest Form. A common-sense approach should be applied to these terms. It would be unrealistic to expect staff to know of all the interests that people in these categories might hold. However, if staff do know of material interests (or could be reasonably expected to know about them) then these should be declared.
- 6.2.3. Staff may hold interests for which they cannot see any potential conflict. However, caution is always advisable because others may see it differently. It will be important to exercise judgement and to declare such interests where there is otherwise a risk of imputation of improper conduct.

- 6.2.4. Conflicts of interest can arise in many situations, environments and forms of commissioning, with an increased risk in primary care commissioning, out-of-hours commissioning and involvement with integrated care organisations, as clinical commissioners may here find themselves in a position of being at once commissioner and provider of services. Conflicts of interest can arise throughout the whole commissioning cycle: from needs assessment, to procurement exercises, to contract monitoring.
- 6.2.5. All staff must identify and declare material interests at the earliest opportunity, and by law within 28 days after the interest arises/is known. The ICB also expects individuals to declare new interests they are pursuing.
- 6.2.6. Declarations received may be checked against publicly accessible sites including those hosted by Companies House, Disclosure UK, and social media - with particular focus being directed to Board members and other individuals holding decision making roles within the ICB. The annual audit of conflicts of interest will also include checks against random sample declarations of interests.
- 6.2.7. If staff are in any doubt as to whether an interest is material, they should declare it, or seek advice from the Governance Lead so it can be considered.
- 6.2.8. Declarations should be made, using the declaration of interest form available at **Appendix B** and as a separate document on the **ICB's intranet**, as below:
- 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 and/or during the staff appraisal process. 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 on each meeting's agenda.
 - All board or committee members are required to declare any interests in agenda items in advance of the meeting. The Governance Team will assist with identification of relevant interests. During Board and other meetings, members/attendees are required to declare their interests as a standing agenda before the item is discussed. Even if an interest has been recorded in the register of interests, it should still be declared in meetings where matters relating to that interest are discussed. Declarations of interest and how they were managed must be recorded in minutes of meetings.

- If a specialist or expert is invited to comment on a meeting paper in order to help the committee or group with their discussions, that individual must be asked to complete a declaration of interest.
- When staff move to a new role or their responsibilities change significantly.
- **At the beginning of a new project/piece of work/procurement process/contract monitoring:** Conflicts of interest must be managed appropriately throughout the whole commissioning cycle and then within the ongoing management of existing contracts. You must complete a declaration of interest form at the outset of any commissioning process, even if you have nothing to declare, and a record of this should be made available to relevant stakeholders as per the ICB policy around register of interests. Where a potential conflict of interest has been identified, you must take steps to declare this as soon as possible and work with the commissioning lead and/or the Governance Lead to agree the extent to which it is appropriate for you to be involved in the ongoing process and, in some circumstances, whether it is appropriate to be involved at all. Similarly, should your circumstances change at any point during the commissioning cycle, you must declare any potential conflict of interest as soon as possible and follow steps identified in this policy.

Please also refer to the ICB's **Procurement and Contracting Policy** which has specific requirements for managing conflicts of interest.

- **Whenever an individual's role, responsibility or circumstances change** in a way that affects the individual's interests (e.g. where an individual takes on a new role outside the ICB or enters a new business or relationship), a further declaration must be made to reflect the change in circumstances as soon as possible, and in any event within 28 days. This could involve a conflict of interest ceasing to exist or a new one materialising. The onus is on the individual to make this declaration, rather than waiting to be asked

- 6.2.9. 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.
- 6.2.10. Declarations of Interest forms submitted outside of recruitment processes should be returned to the Governance team for inclusion on the register of interests.
- 6.2.11. 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.

6.3. Appointment of board members, committee members and senior employees.

- 6.3.1. On appointment of board members, committee members and senior employees, the ICB will consider whether conflicts of interest should exclude individuals from being appointed to the relevant role. This will be considered on a case-by-case basis, with advice being sought from the Conflicts of Interest Guardian. In relation to any committees or sub-committees exercising ICB commissioning functions, and in compliance with the ICB Constitution - approval and appointment of members to such committees or sub-committees will be made by the ICB chair.
- 6.3.2. The ICB will assess the materiality of the interest, particularly whether the individual (or any person with whom they have a close association) could benefit (whether financially or otherwise) from any decision the ICB might make.
- 6.3.3. The ICB will determine the extent of the interest and the nature of the appointee's proposed role within the ICB. If the interest is related to an area of business significant enough that the individual would be unable to operate effectively and make a full and proper contribution in the proposed role, the individual will not be appointed to the role.
- 6.3.4. Any individual who has a material interest in an organisation which provides, or is likely to provide, substantial services to an ICB should recognise the inherent conflict of interest risk that may arise and should not be a member of the Board or of a committee or sub-committee of the ICB. This is applicable if the nature and extent of their interest and the nature of their proposed role is such that they are likely to need to exclude themselves from decision-making on so regular a basis that it significantly limits their ability to effectively perform that role.
- 6.3.5. Additionally, the ICB constitution specifically prohibits appointment of individuals to the ICB board, committees or sub-committees if the appointment could reasonably be regarded as undermining the independence of the health services because of the candidate's involvement with the private healthcare sector or otherwise.
- 6.3.6. This would prevent, for example, directors of private healthcare companies or significant stakeholders of private healthcare companies from sitting on any board, committee or sub-committee exercising ICB commissioning functions.
- 6.3.7. However, employees/directors of voluntary organisations, social enterprises, and GPs and other clinicians may be appointed as members of the ICB board, committees or sub-committees provided they are not regarded as undermining the independence of the health services.

6.4. Proactive Review of Interests

- 6.4.1. The ICB will require all staff to formally review and, if necessary, update their declaration of interest annually.
- 6.4.2. Reminders for staff to review and update their declarations of interest will be provided in several ways, including reminders based on the anniversary of the last declaration and via the staff appraisal process.
- 6.4.3. 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.

6.5. Maintenance of Records

- 6.5.1. The ICB will maintain the following registers:
- Register of Interests.
 - Register of Gifts and Hospitality.
 - Register of Commercial Sponsorship.
 - Register of Procurement Decisions.
- 6.5.2. All declared interests that are material will be promptly transferred to the register by the Governance team.
- 6.5.3. Where the ICB is participating in a joint committee, any interests which are declared by the committee members should be recorded on the register(s) of interest of each participating organisation.

6.6. Publication

- 6.6.1. The ICB will publish the interests declared by decision-making staff in the relevant registers available on the **ICB website**.
- 6.6.2. This information will be refreshed at least annually.
- 6.6.3. Registers of interests for publicly held Board or committee meetings will be made available within meeting papers available on the **ICB website**.

- 6.6.4. Registers will also be made available for inspection, via telephoning 01268 594350 to make an appointment with the Governance team, at Seax House, Victoria Road South, Chelmsford, Essex CM1 1QH.
- 6.6.5. 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.

6.7. Wider Transparency Initiatives

- 6.7.1. The ICB fully supports wider transparency initiatives in healthcare and encourages staff to engage actively with these.
- 6.7.2. 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.
- 6.7.3. Further information about the scheme can be found on the ABPI website.

6.8. Management of Interests - General

- 6.8.1. The ICB will manage interests sensibly and proportionately. Each case will be different. The general management actions listed below, along with relevant industry/professional guidance should complement the exercise of good judgement. It will always be appropriate to clarify circumstances with individuals involved to assess issues and risks.
- 6.8.2. 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.

6.8.3. Each case will be different and context-specific, and the ICB will always clarify the circumstances and issues with the individuals involved to assess issues and risks. Staff should maintain a written audit trail of information considered and actions taken.

6.8.4. Staff who declare material interests should make their line manager or the person(s) they are working to aware of their existence.

6.8.5. 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

6.9. Managing conflicts of interests at meetings

6.9.1. The chair of a meeting of the ICB's Board or any of its committees, sub-committees or groups has ultimate responsibility for deciding whether there is a conflict of interest and for taking the appropriate course of action to manage the conflict.

6.9.2. The chair, with support of the ICB's Head of Governance or their representative, should proactively consider ahead of meetings what conflicts are likely to arise and how they should be managed, including taking steps to ensure that supporting papers for particular agenda items of private sessions/meetings are not sent to conflicted individuals in advance of the meeting where relevant. This also applies to the minutes of discussions held relating to relevant item(s).

6.9.3. On circulation of the meeting agenda, delegates should be asked to confirm in writing prior to the meeting whether they believe themselves to be conflicted or potentially conflicted regarding one or more of the agenda items.

6.9.4. The chair should ask at the beginning of each meeting if anyone has any conflicts of interest to declare in relation to the business to be transacted at the meeting. Each member of the group should declare any interests which are relevant to the business of the meeting, whether or not those interests have previously been declared. Any new interests declared at a meeting must be notified to the Governance Team for inclusion on the ICB's register of interests to ensure it is up-to-date.

- 6.9.5. Any new offers of gifts or hospitality (whether accepted or not) which are declared at a meeting must be included on the ICB's register of gifts and hospitality to ensure it is up-to-date.
- 6.9.6. It is the responsibility of each individual member of the meeting to declare any relevant interests which they may have. However, should the chair or any other member of the meeting be aware of facts or circumstances which may give rise to a conflict of interests, but which have not been declared, then they should bring this to the attention of the chair who will decide whether there is a conflict of interest and the appropriate course of action to take in order to manage the conflict of interest.
- Declarations of interest in respect to board and committee meeting agenda items should be declared at the time the agenda and papers are circulated to enable the chair to plan how any conflicts should be managed at the meeting.
 - Perceptions of conflicts of interests should be considered even if an actual conflict does not exist: if there is perception of a conflict of interest, the individual should consider recusing themselves from the meeting.
 - On reviewing the committee or board agenda and accompanying papers, members should inform the chair and secretariat of details on the specific agenda items and the type of conflict
- 6.9.7. Interests that have previously been declared should also be included in the pre-meeting declaration. There is no need for partner members to make a general statement regarding the fact that they are practicing local clinicians or professionals. However, if their status in that role places them in conflict regarding a specific agenda item then they should state this, along with the type of interest, as listed above.
- 6.10. Managing conflicts when making joint decisions with other partners.**
- 6.10.1. Conflicts of interest management is important in the context of joint decision-making processes, especially working with local partners, other ICBs or NHSE to jointly commission services. Promising the ICB's ability to make robust commissioning decisions.
- 6.10.2. Appropriate governance arrangements must be put in place that ensure that conflicts of interest are identified and managed. Where independent providers (including the voluntary sector) hold contracts for services (for example, community services) it would be appropriate and reasonable for the body to involve them in discussions (for example, about pathway design and service delivery, particularly at place-level). However, this would be clearly distinct from any considerations around contracting and commissioning, from which they would be excluded.

- 6.10.3. The chair of the meeting has ultimate responsibility for deciding whether there is a conflict of interest and for taking the appropriate course of action, in order to manage the conflict of interest.
- 6.10.4. When a member of the meeting (including the chair or deputy chair) has a conflict of interest in relation to one or more items of business to be transacted at the meeting, the chair (or deputy chair or remaining non-conflicted members where relevant as described above) must decide how to manage the conflict. The appropriate course of action will depend on the circumstances but could include one or more of the following:
- Chairing by non-conflicted member - Where the chair has a conflict of interest, deciding that the deputy chair (or another non-conflicted member of the meeting if the deputy chair is also conflicted) should chair all or part of the meeting
 - Not attend - Requiring the individual who has a conflict of interest (including the chair or deputy chair if necessary) not to attend the meeting.
 - Not receive papers or minutes - Ensuring that the individual concerned does not receive the supporting papers or minutes of the meeting which relate to the matter(s) which give rise to the conflict.
 - Leave discussion - Requiring the individual to leave the discussion when the relevant matter(s) are being discussed and when any decisions are being taken in relation to those matter(s). In private meetings, this could include requiring the individual to leave the room and in public meetings to either leave the room or join the audience in the public gallery.
 - Partial attendance - Allowing the individual to participate in some, or all, of the discussion when the relevant matter(s) are being discussed but requiring them to leave the meeting when any decisions are being taken in relation to those matter(s). This may be appropriate where, for example, the conflicted individual has important relevant knowledge and experience of the matter(s) under discussion, which it would be of benefit for the meeting to hear, but this will depend on the nature and extent of the interest which has been declared.
 - Remain and participate - Noting the interest and ensuring that all attendees are aware of the nature and extent of the interest but allowing the individual to remain and participate in both the discussion and in any decisions. This is only likely to be the appropriate course of action where it is decided that the interest which has been declared is either immaterial or not relevant to the matter(s) under discussion. The conflicts of interest case studies include examples of material and immaterial conflicts of interest.

6.10.5. At the start of meetings, the chair should summarise all interests received prior to the meeting and call for any other interests in respect of the agenda items. Just prior to individual agenda items being discussed, the chair should confirm any declarations of interest referred to earlier in the meeting. The chair, in discussion with meeting attendees if appropriate, should agree on a course of action to manage those conflicts. This very much depends on an assessment of the facts at the time but several options are available to the chair of the meeting:

- Ask the individual to leave the meeting when the agenda item on which an individual is conflicted is discussed.
- Allow the individual to take part in the discussion but leave the meeting when the decision is made.
- Note the interest but allow them to take part in the discussion and the decision making.

6.10.6. Details on how individual conflicts of interest were managed should be reflected in the minutes of the meeting. Examples of where it may be appropriate to exclude the public include:

- Information about individual patients or other individuals which includes sensitive personal data is to be discussed.
- Commercially confidential information is to be discussed, for example the detailed contents of a provider's tender submission.
- Information in respect of which a claim to legal professional privilege could be maintained in legal proceedings is to be discussed.
- To allow the meeting to proceed without interruption and disruption.

6.11. Minutes of meetings

6.11.1. If any conflicts of interest are declared or otherwise arise in a meeting, the chair must ensure the following information is recorded in the minutes:

- Who has the interest?
- The nature of the interest and why it gives rise to a conflict, including the magnitude of any interest.
- The items on the agenda to which the interest relates.
- How the conflict was agreed to be managed.
- Evidence that the conflict was managed as intended (for example recording the points during the meeting when individuals left or returned to the meeting).

6.12. Management of Interests – Common Situations

6.12.1. The following sections set out the principles and rules to be adopted by staff in common situations, and what information should be declared.

6.13. Gifts

6.13.1. This policy prohibits the offer or receipt of gifts, hospitality, payment or expenses whenever these could affect or be perceived to affect the outcome of business transactions and are not reasonable and bona fide expenditure. All staff should be aware that gifts and hospitality can be used as a subterfuge for bribery and, if this is suspected it should be reported immediately to the **Local Counter Fraud Specialist**.

6.13.2. 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.

6.13.3. Staff should not accept gifts that may affect, or be seen to affect, their professional judgement. If you are in any doubt as to whether to accept a gift, it is better to politely decline the offer.

6.13.4. 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).

6.13.5. Gifts from other sources (e.g. patients, families, service users):

- Staff must not ask for any gifts.
- Personal gifts of cash or cash equivalents (e.g. vouchers, tokens, offers of remuneration to attend meetings whilst in a capacity working for or representing the ICB) to individuals must always be declined whatever their value and whatever their source, and the offer which has been declined must be declared and recorded on the register.
- Gifts valued at over £50 should be treated with caution and only be accepted on behalf of the ICB and not in a personal capacity. These should be declared by staff, providing a clear reason as to why it was considered permissible to accept the gift, alongside the actual or estimated value, 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.

- 6.13.6. 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).
- 6.13.7. 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.
- 6.13.8. The acceptance or rejection of gifts should be declared on the form provided at **Appendix C**, which summarises the above rules, and submitted to the [Governance Team](#).

6.14. Hospitality (including Meals, Refreshments, Travel and Accommodation)

- 6.14.1. Delivery of services across the NHS relies on working with a wide range of partners (including industry and academia) in different places and, sometimes, outside of 'traditional' working hours. As a result, staff will sometimes appropriately receive hospitality. Staff receiving hospitality should always be prepared to justify why it has been accepted and be mindful that even hospitality of a small value may give rise to perceptions of impropriety and might influence behaviour.
- 6.14.2. The total value of hospitality provided by any specific company to the ICB must not exceed £1,000 in one financial year.
- 6.14.3. Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement.
- 6.14.4. Hospitality must only be accepted when there is a legitimate business reason, and it is proportionate to the nature and purpose of the event.
- 6.14.5. Caution must 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, but caution should be exercised if a contract re-tender is imminent. Advice should be sought from the Governance Lead and prior approval by the relevant Executive Director must be obtained.
- 6.14.6. 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. The £75 value has been selected with reference to existing industry guidance issued by the [ABPI](#).
 - 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.

- In the case of modest hospitality offered by pharmaceutical companies, the ICB requires clarity on what products are to be promoted. If the product(s) has been rejected for use in the Essex ICB area, the offer should be declined. Advice should be sought from the Pharmacy and Medicines Optimisation Team where appropriate.
- 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).

6.14.7. 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 should be politely refused. However, there might be some **limited and exceptional circumstances** where accepting these types of hospitality may be contemplated. In these circumstances, prior approval by the relevant Director is required 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:
 - hospitality of a value above £75 per attendee.
 - offers of business class or first-class travel and accommodation (including domestic travel).
 - offers of foreign travel and accommodation.

6.14.8. The acceptance or rejection of hospitality should be declared on the form provided at **Appendix C**, which summarises the above rules, and submitted to the [Governance Team](#).

6.14.9. With regard to the provision of hospitality by the Integrated Care Board, The Code of Conduct: Code of Accountability in the NHS advises that the use of NHS monies for hospitality and entertainment, including hospitality at conferences or seminars, should be carefully considered. Expenditure on these items should be capable of justification, as reasonable in the light of general practice in the public sector. The provision of hospitality or entertainment is open to challenge by auditors and ill-considered actions can damage public perception and respect for the NHS.

6.15. Outside Employment

- 6.15.1. The NHS relies on staff with good skills, broad knowledge and diverse experience. Many staff bring expertise from sectors outside the NHS, such as industry, business, education, government and beyond. The involvement of staff in these outside roles alongside their NHS role can therefore be of benefit, but the existence of these should be well known so that conflicts can be either managed or avoided.
- 6.15.2. Outside employment means employment and other engagements, outside of formal ICB employment arrangements. This can include employment within another NHS organisation, directorships, non-executive roles, self-employment, consultancy work, charitable trustee roles, political roles and roles within not-for-profit organisations, paid advisory positions and paid honorariums which relate to bodies likely to do business with the ICB.
- 6.15.3. 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.
- 6.15.4. Staff must declare any existing outside employment/engagement on their appointment and any new outside employment/engagement when it arises.
- 6.15.5. Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks.
- 6.15.6. 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.
- 6.15.7. 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. Nothing within this policy prevents such enquiries being made.
- 6.15.8. The ICB requires that individuals obtain prior written permission from a director to engage in outside employment. 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.
- 6.15.9. In particular, it is unacceptable for pharmacy advisers or other advisers, employees or consultants to the ICB on matters of procurement to themselves to be in receipt of payments from the pharmaceutical or devices sector.
- 6.15.10. 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 / logos should not be used for private enterprise and may constitute an offence of fraud.

- 6.15.11. 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.

6.16. Shareholdings and other ownership issues

- 6.16.1. Holding shares or other ownership interests can be a common way for staff to invest their personal time and money to seek a return on investment. However, conflicts of interest can arise when staff personally benefit from this investment because of their role with the ICB. For instance, if they are involved in their organisation's procurement of products or services which are offered by a company they have shares in then this could give rise to a conflict of interest.
- 6.16.2. 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.
- 6.16.3. 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.
- 6.16.4. There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.
- 6.16.5. Shareholdings and other ownership issues should be declared on the form provided at Appendix B and will be recorded within the register of interests.

6.17. Patents

- 6.17.1. The development and holding of patents and other intellectual property rights allows individuals to protect something that they create, preventing unauthorised use of products or the copying of protected ideas. However, conflicts of interest can arise when staff that hold patents and other intellectual property rights are involved in decision making and procurement.
- 6.17.2. 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.

- 6.17.3. 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.
- 6.17.4. 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.
- 6.17.5. 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.

6.18. Loyalty Interests

- 6.18.1. Conflicts of interest can arise when decision making is influenced through association with colleagues or organisations out of loyalty to the relationship they have, rather than through an objective process.
- 6.18.2. 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.
- 6.18.3. Where holding loyalty interests gives rise to a conflict of interest then the general management actions outlined in this guidance should be considered and applied to mitigate risks
- 6.18.4. Loyalty interests must be declared on the form provided at **Appendix B** and submitted to the Governance Team for recording within the register of interests.

6.19. Donations

- 6.19.1. A donation is a charitable financial payment, which can be in the form of direct cash payment or through the application of a will or similar directive. Charitable giving and other donations are often used to support the provision of health and care services. As a major public sector employer the NHS holds formal and informal partnerships with national and local charities. Staff will, in their private lives, undertake voluntary work or

fundraising activities for charity. A supportive environment across the NHS and charitable sector should be promoted. However, conflicts of interest can arise.

- 6.19.2. 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.
- 6.19.3. 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.
- 6.19.4. 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.
- 6.19.5. Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued.
- 6.19.6. 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.
- 6.19.7. The ICB will maintain records in line with the above principles and rules and relevant obligations under charity law.
- 6.19.8. The ICB will not recommend alternative organisations or charities as recipients of the donation where it has deemed the offer as something the ICB will not accept. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.

6.20. Commercial Sponsorship

- 6.20.1. This section should be read in conjunction with section 6.28, Joint working with the pharmaceutical industry.
- 6.20.2. ICB staff, the Board and committee members may be offered commercial sponsorship for events such as courses, conferences, post/project funding, meetings and publications in connection with the activities which they carry out for or on behalf of the ICB. All such offers (whether accepted or declined) must be declared so that they can be included on the ICB's register of gifts, hospitality and commercial sponsorship, and the Head of Governance should provide advice on whether or not it would be appropriate to accept any such offers. If such offers are reasonably justifiable then they may be accepted, with the written approval of a director or the Head of Governance.

- 6.20.3. Acceptance of commercial sponsorship should not in any way compromise commissioning decisions of the ICB or be dependent on the purchase or supply of goods or services. Any payment that is received for speaking at events in organisation time should be paid to the NHS organisation.
- 6.20.4. Sponsors should not have any influence over the content of an event, meeting, seminar, publication or training event. The ICB should not endorse individual companies or their products. It should be made clear that the fact of sponsorship does not mean that the ICB endorses a company's products or services. Sponsorship of ICB events by appropriate external bodies should only be approved if a reasonable person would conclude that the event will result in clear benefit for the ICB and the NHS.
- 6.20.5. During dealings with sponsors there must be no breach of patient or individual confidentiality or data.
- 6.20.6. No information should be supplied to a company for their commercial gain and information which is not in the public domain should not normally be supplied unless there is a clear benefit to the NHS or patients.
- 6.20.7. 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. The involvement of a sponsor in an event should always be clearly identified in the interest of transparency.
- 6.20.8. For further information on what to do if offered sponsorship, see **Appendix C.**

6.21. Sponsored events

- 6.21.1. Line manager and governance advice must be sought before accepting any type of sponsorship as this can be a controversial issue.
- 6.21.2. Sponsorship of NHS events by external parties is valued. Offers to meet some or part of the costs of running an event secures their ability to take place, benefiting NHS staff and patients. Without this funding there may be fewer opportunities for learning, development and partnership working. However, there is potential for conflicts of interest between the organiser and the sponsor, particularly regarding the ability to market commercial products or services. As a result, there should be proper safeguards in place to prevent conflicts occurring.
- 6.21.3. 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.

- 6.21.4. 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.
- 6.21.5. During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.
- 6.21.6. 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.
- 6.21.7. 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.
- 6.21.8. The involvement of a sponsor in an event should always be clearly identified in the interest of transparency.
- 6.21.9. 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.
- 6.21.10. Staff arranging sponsored events must declare this to the organisation by using the form at **Appendix C**.
- 6.21.11. The organisation will maintain records regarding sponsored events in line with the above principles and rules.

6.22. Sponsored Research

- 6.22.1. Research is vital in helping the NHS to transform services and improve outcomes. Without sponsorship of research some beneficial projects might not happen. More broadly, partnerships between the NHS and external bodies on research are important for driving innovation and sharing best practice. However, there is potential for conflicts of interest to occur, particularly when research funding by external bodies does or could lead to

a real or perceived commercial advantage. There needs to be transparency, and any conflicts of interest should be well managed.

- 6.22.2. Funding sources for research purposes must be transparent.
- 6.22.3. Any proposed research must go through the relevant health research authority or other approvals process.
- 6.22.4. 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.
- 6.22.5. The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service.
- 6.22.6. Staff should declare involvement with sponsored research to the ICB by using the form at **Appendix B**.
- 6.22.7. The ICB will retain written records of sponsorship of research, in line with the above principles and rules.

6.23. Sponsored Posts

- 6.23.1. Sponsored posts are positions with an organisation that are funded, in whole or in part, by organisations external to the NHS. Sponsored posts can offer benefits to the delivery of care, providing expertise, extra capacity and capability that might not otherwise exist if funding was required to be used from the NHS budget. However, safeguards are required to ensure that the deployment of sponsored posts does not cause a conflict of interest between the aims of the sponsor and the aims of the organisation, particularly in relation to procurement.
- 6.23.2. External sponsorship of a post requires prior approval from the ICB. Requests should be submitted to the Executive Chief People Officer.
- 6.23.3. Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and withdraw if appropriate.
- 6.23.4. 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.
- 6.23.5. Sponsored post holders must not promote or favour the sponsor's products, and information about alternative products and suppliers should be provided.

- 6.23.6. 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.
- 6.23.7. The ICB will retain written records of sponsorship of posts, in line with the above principles and rules.
- 6.23.8. 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.

6.24. Clinical Private Practice

- 6.24.1. Service delivery in the NHS is done by a mix of public, private and not-for-profit organisations. The expertise of clinicians in the NHS is in high demand across all sectors and the NHS relies on the flexibility that the public, private and not-for-profit sectors can provide. It is therefore not uncommon for clinical staff to provide NHS funded care and undertake private practice work either for an external company, or through a corporate vehicle established by themselves.
- 6.24.2. Existing provisions in contractual arrangements make allowances for this to happen and professional conduct rules apply. However, these arrangements do create the possibility for conflicts of interest arising. Therefore, these provisions are designed to ensure the existence of private practice is known so that potential conflicts of interest can be managed. These provisions around declarations of activities are equivalent to what is asked of all staff in the section on outside employment.
- 6.24.3. Clinical staff should declare all private practice on appointment, and/or any new private practice when it arises including:
- Where they practise (name of private facility).
 - What they practise (specialty, major procedures).
 - When they practise (identified sessions/time commitment).
 - Hospital consultants are already required to provide their employer with this information by virtue of paragraph 3, schedule. 9 of Terms and conditions – consultants (England)
 - Action taken to mitigate against a conflict, including details of any approvals given to depart from the terms of this policy.
- 6.24.4. 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.² (these provisions already apply to hospital consultants by virtue of paragraphs 5 and 20, schedule 9 of the Terms and conditions – consultants (England)).

- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines: [Non-Divestment Order amended.pdf](#)

6.24.5. 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 (these provisions already apply to hospital consultants by virtue of paragraphs 5 and 20, schedule 9 of the Terms and conditions – consultants (England)).

6.24.6. Staff should declare involvement with clinical private practice to the ICB by using the form at **Appendix B** which should be submitted to the Governance Team for inclusion on the relevant register.

6.25. Strategic Decision Making Groups

6.25.1. 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.

6.25.2. 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 include:

- The ICB Board
- The ICB's main Committees as set out in its Constitution
- Mid and South Essex Medicines Optimisation Committee

6.25.3. 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.

² 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

- 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.
- Terms of reference for such groups should refer to the organisation's policy and procedures for managing conflicts of interest and should set out any specific requirements which apply to the group.

6.25.4. 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.

6.25.5. 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.

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

6.26. Procurement

6.26.1. 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.

6.26.2. 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.

- 6.26.3. 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.
- 6.26.4. The procedure for managing conflicts of interest during procurements is set out in the **ICB's Procurement and Contracting Policy**. Further information about the PSR, including about the management of conflicts of interest, can be found within the [PSR statutory guidance](#).

6.27. Contract management

- 6.27.1. Any contract monitoring meeting needs to consider conflicts of interest as part of the process. The chair of a contract management meeting should: invite declarations of interests; record any declared interests in the minutes of the meeting; and manage any conflicts appropriately and in line with this policy. This equally applies where a contract is held jointly with another organisation or with other ICBs under lead commissioner arrangements.
- 6.27.2. The individuals involved in the monitoring of a contract should not have any direct or indirect financial, professional, or personal interest in the incumbent provider or in any other provider that could prevent them, or be perceived to prevent them, from carrying out their role in an impartial, fair and transparent manner.
- 6.27.3. The ICB will consider any potential conflicts of interest when circulating any contract or performance information/reports on providers and manage the risks appropriately.

6.28. Joint working with the pharmaceutical industry

- 6.28.1. This section should be read in conjunction with section 6.20, Commercial sponsorship.
- 6.28.2. The Department of Health (DH) and the Association for British Pharmaceutical Industry (ABPI) seek to encourage collaborative working for the benefit of the local healthcare economy and ultimately the patient.
- 6.28.3. Pharmaceutical companies that are members of the ABPI are required to comply with the ABPI Code of Practice for the Pharmaceutical Industry 2016 which regulates the promotion of prescription medicines and certain other non-promotional activities.
- 6.28.4. The ABPI guidance seeks to provide a framework and greater clarity for pharmaceutical companies about various aspects of Joint Working and Sponsorship.
- 6.28.5. This section of the policy is intended to:

- 6.28.6. Ensure transparency for all our stakeholders on our approach to joint working with the pharmaceutical industry.
- 6.28.7. Promote ethical working relationships between the pharmaceutical industry and the NHS and should be used in conjunction with the DH/ABPI document “Moving beyond sponsorship: Interactive toolkit for joint working between the NHS and the pharmaceutical industry”
- 6.28.8. Joint working can be defined as “situations where, for the benefit of patients, one or more pharmaceutical companies and the NHS pool skills, experience and/or resources for the joint development and implementation of patient centred projects and share a commitment to successful delivery”. The key requirements from this definition are:
- Any joint working project must be focused on benefits to patients
 - There must be a “pooling” of resources between the pharmaceutical company or companies and the NHS organisation(s) involved. Each party must, therefore, make a significant contribution to the Joint Working project to avoid the arrangement being construed as merely a gift, benefit in kind, donation or some other non-promotional/commercial practice. Resources may come in various forms, including people, expertise, equipment, communication channels, information technology and finance.
- 6.28.9. Other principles to be applied to any instances of joint working and sponsorship are:
- All joint working and sponsorship will support projects that address local and national priorities and will maintain the freedom of clinicians to prescribe the most clinically appropriate and effective treatment for individual patients.
 - Joint working and sponsorship will be conducted in an ethical, open and transparent manner.
 - Joint working will take place at a corporate (organisational) level, and not with individual healthcare professionals or NHS administrative staff.
 - Joint working contracts will be negotiated on fair and reasonable terms, in line with NHS values.
 - Confidentiality of information received in the course of the joint working arrangement will be respected and never used outside the scope of the project. All patient identifiers will be removed from data to preserve and respect patient confidentiality in line with the Data Protection Act 2018.
 - In the interests of transparency, the overall arrangements for joint working and sponsorship must be made public via the ICB website.
 - Joint working and sponsorship is based on mutual trust and respect. Pharmaceutical companies must comply with the ABPI Code at all times. All NHS employed staff should comply with NHS, the ICB and relevant professional body codes of conduct at all times.
 - Clinical and prescribing policies or guidelines must be based upon principles of evidence-based medicine and cost effectiveness. They will be consistent with national recommendations including the National

Institute for Health and Clinical Excellence (NICE), expert bodies such as the Royal College of General Practitioners (RCGP) and local guidance.

- The Pharmaceutical industry should not have undue influence.
- Sponsorship must not provide personal benefit.

6.28.10. Any Joint Working/Sponsorship must ensure that all arrangements are neutral, free from preference regarding the use of the company's product over other more clinically appropriate or cost-effective products or services. In addition, arrangements must be in keeping with local guidelines and formularies.

6.28.11. The ICB will act in a transparent, objective manner, never endorsing any individual company or product through such agreements.

6.28.12. Where joint working is being contemplated, full consideration of the proposal must be given before any agreement is made. Advice should be sought from the Pharmacy and Medicines Optimisation Team and the Head of Governance. Legal advice may also be necessary.

6.28.13. There must be a specific agreement for each joint working project which contains information on:

- The name of the joint working project, the parties to the agreement, the date and the term of the agreement.
- The expected benefits for patients, the NHS and the pharmaceutical company.
- How the success of the project will be measured, when and by whom. A set of baseline measurements must be established at the outset of the project to track and measure the success of the project aims, particularly patient outcomes. For longer term projects (>1 year) patient outcomes should be analysed at least every six months as a minimum to ensure that anticipated patient benefits are being delivered.
- An outline of the financial arrangements.
- The roles and responsibilities of the ICB and the pharmaceutical company. All aspects of input from the company should be included such as training, support for service redesign, business planning, data analysis etc.
- The agreement should specify criteria that result in high certainty that both parties can meet their commitments. For example, both parties should be able to demonstrate that they have the capability, resource or track record to deliver on the commitments they are making.
- The planned publication of any data or outcomes.
- Procedures for dealing with Freedom of Information Act requests.
- If a pharmaceutical company enters into a joint working agreement on the basis that its product is already included in an appropriate place on the local formulary, a clear reference to this should be included in the joint working agreement so that all the parties are clear as to what has been agreed.

- The agreement should include contingency arrangements to cover possible unforeseen circumstances such as changes to summaries of product characteristics and updated clinical guidance. Agreements should include a dispute resolution clause and disengagement/exit criteria including an acknowledgement by the parties that the project might need to be amended or stopped if a breach of the ABPI Code is ruled.

6.28.14. Approval must be obtained from the Commissioning Committee or relevant sub-group before the project proceeds. This will allow a full evaluation of the joint working agreement including governance issues and the overall impact of the joint working to be assessed in relation to healthcare priorities.

6.28.15. Joint Working offers of any kind from pharmaceutical companies must be declared and registered whether refused or accepted and be available for public scrutiny on request.

6.28.16. The ICB will encourage competitor companies to collaborate on any such ventures. If several companies are able to provide the same arrangements they should all – or at least a selection – be approached to ascertain their willingness to undertake joint working. If willing to do so, they could then share a joint working arrangement.

6.28.17. Any joint working arrangements will be reported to the Audit, Risk and Compliance Committee.

6.28.18. A primary care rebate scheme (PCRS) is an agreement between an ICB and a pharmaceutical company that provides an economic benefit to the commissioner and, in theory, may increase the volume sales of a company's product. These are different to national patient access schemes which are negotiated nationally by the Department of Health to enable patient access for very high-cost drugs that have clear clinical benefits. PCRS could be seen to undermine national pricing agreements between the Department of Health and Industry.

- The ICB believes that the pharmaceutical industry should supply medicines to the NHS using transparent pricing mechanisms, wherever possible.
- The ICB does accept rebates from pharmaceutical companies. The decision as to whether to accept a rebate is made by the Pharmacy & Medicines Optimisation Team based on the [PrescQIPP operating model](#).

6.29. Prevention of Fraud and Bribery

6.29.1. 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 Director of Finance and Commercial, or to the ICB Chair or ICB Chief Executive Officer where it would not be appropriate to report to the Executive Director of Finance and Commercial.

- 6.29.2. 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>.

6.30. Identifying and Reporting Breaches

- 6.30.1. 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'.

- 6.30.2. 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'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**).
- National Fraud and Corruption Line 0300 123 2040
 - The Executive Director of Corporate Services
 - The ICB Governance Lead.
 - The Conflicts of Interest Guardian.
 - The Executive Director of Finance and Commercial.

- 6.30.3. 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 (Whistleblowing) Policy.

- 6.30.4. 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.

- 6.30.5. 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.

6.31. Taking Action in Response to Breaches

- 6.31.1. 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.
- 6.31.2. Any potential breach of the conflicts of interest elements of this policy will be investigated and actual breaches published on the ICB website. This includes the treatment of service contracts where a breach of conflicts of interest was identified.
- 6.31.3. Potential breaches highlighted during the course of ICB business, reported to the Conflicts of Interest Guardian or identified in any other way, will be documented by the Director of Corporate Services and investigated.
- 6.31.4. Each breach needs to be investigated and judged on its own merits, and this should start with those involved having the opportunity to explain and clarify any relevant circumstances.
- 6.31.5. A conflict of interest panel will be assembled by the Director of Corporate Services. The panel will be chaired by a non-executive board member and a minimum of two other non-executive board members will be members of the panel.
- 6.31.6. All documented evidence will be compiled by the Director of Corporate Services or their representative and circulated to panel members at least five working days prior to the panel meeting.
- 6.31.7. There is an expectation that the individual being investigated will respond to questions and provide evidence sought in a timely manner to reduce possible delay.
- 6.31.8. The ICB recognises that receiving requests as part of the investigative process could be distressing for the individuals, and therefore HR will be approached to provide or sign-post relevant support.
- 6.31.9. Witnesses and the individual being investigated may be invited to the meeting if appropriate.

- 6.31.10. The panel meeting will be minuted by the Director of Corporate Services, or their representative. and minutes will be kept on file for a minimum of six years.
- 6.31.11. The role of the panel is to assess whether an actual breach has occurred and to decide on a course of action to reflect the consequences of that breach.
- 6.31.12. Legal or other appropriate advice may be sought prior to imposing sanctions which could have serious consequences for those involved, Appendix 5 outlines the 'Potential Sanctions' (as per NHS England Managing Conflicts of Interest Guidance 2024).
- 6.31.13. 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, Care Quality Commission, Local Government Association, and/or health professional regulatory bodies.
- 6.31.14. 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**.
- 6.31.15. 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/regulators described above for them to consider what further investigations or sanctions might be.
 - Where the individual is not a direct employee, review of their appointment to the role that has given rise to the conflict.
 - Civil/contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach, e.g. a claim for misfeasance in public office.

- Criminal sanctions such as investigation and prosecution under fraud, bribery, and corruption legislation, i.e. the Fraud Act 2006 and Bribery Act 2010.

6.31.16. Statutorily regulated healthcare professionals who work for, or are engaged by, the ICB are under professional duties imposed by their relevant regulator to act appropriately with regard to conflicts of interest. The ICB will report statutorily regulated healthcare professionals to their regulator if they believe that they have acted improperly, so that these concerns can be investigated. Statutorily regulated healthcare professionals should be made aware that the consequences for inappropriate action could include fitness to practise proceedings being brought against them, and that they could, if appropriate, be struck off by their professional regulator as a result. and

6.32. Transparency Concerning Breaches

- 6.32.1. Anonymised reports on breaches, the impact of these, and actions taken will be considered by the Audit Committee and any other relevant committee/group.
- 6.32.2. To aid transparency the ICB will consider whether anonymised information on breaches and action taken in response should be prepared and published on its website.

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, which must be a minimum of 90% compliance as of 31 March each year.
 - Annual Audit of arrangements to manage conflicts of interest undertaken by the ICB's auditors, including an annual review by Counter Fraud as part of requirement 12 Government Functional Standards.
 - The Audit, Risk and Compliance Committee will monitor compliance with this policy and the declaration of interest process via reporting as identified in the committee's workplan.
 - Anonymised reporting on breaches and significant issues relating to the management of conflicts of interest to the Audit Committee or other relevant committee.
 - Identification and monitoring of any associated risks.
 - 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. Implementation and Staff Training

- 8.1. Induction training must be provided to all employees, Board members and members of ICB committees and sub-committees on the management of conflicts of interest. This is to ensure staff and others within the ICB understand what conflicts are and how to manage them effectively.
- 8.2. Induction training will cover the following:
- What is a conflict of interest?
 - Why is conflict of interest management important?
 - What are the responsibilities of the organisation you work for in relation to conflicts of interest?
 - What should you do if you have a conflict of interest relating to your role, the work you do or the organisation you work for (who to tell, where it should be recorded, what actions you may need to take and what implications it may have for your role).
 - How conflicts of interest can be managed.
 - What to do if you have concerns that a conflict of interest is not being declared or managed appropriately.
 - What are the potential implications of a breach of the ICB's rules and policies for managing conflicts of interest?
 - Other areas monitored: Gifts, Hospitality, Commercial Sponsorship, Pharmaceutical Industry, Joint Working.
- 8.3. 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). As a minimum, all staff will be required to complete Module 1, with Modules 2 and 3 to be completed by senior staff/Board members as identified on the ICB's mandatory training matrix.
- 8.4. 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.
- 8.5. 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.

- 8.6. 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.
- 8.7. 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. Views and input from relevant stakeholders will be sought when the policy is reviewed, including those of the ICB's Local Counter Fraud Specialist and procurement advisers.
- 9.3. If only minor changes are required, the sponsoring committee (Audit, Risk and Compliance Committee) has authority to make these changes without referral to the ICB Board. If 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 in the NHS, 17 September 2024](#)
- Managing Conflicts of Interest Mandatory Training Modules 1, 2 and 3, available via Electronic Staff Record.
- [Guidance on integrated care board constitutions and governance, 26 July 2024](#)
- 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)
- The Provider Selection Regime ([PSR](#)) Statutory Guidance
- Economic Crime and Corporate Transparency Act (ECCT).
- [NHS Fit and Proper Person Test](#)
- [General Medical Council: Identifying and Managing Conflicts of Interest](#)

- Transparency and doctors with competing interests – guidance from the British Medical Association February 2025

10.2. Associated ICB Policies

- MSEICB 003 Procurement and Contracting 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 primarily based on:

Managing Conflicts of Interest in the NHS, 17 September 2024

12. **Equality Impact Assessment (EIA)**

- 12.1. The EIA (**Appendix A**) identified no equality issues with this policy.

Appendix A - Equality Impact Assessment

INITIAL INFORMATION

Name of policy: Conflicts of Interest Policy	Directorate/Service: Corporate Services
Version number (if relevant): 0.2	
Assessor's Name and Job Title: Sara O'Connor, Senior Manager Corporate Services	Date: 6 February 2026

OUTCOMES
<i>Briefly describe the aim of the policy and state the intended outcomes for staff</i>
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
<i>What data / information have you used to assess how this policy might impact on protected groups?</i>
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.
<i>Who have you consulted with to assess possible impact on protected groups? If you have not consulted other people, please explain why?</i>
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
<i>How often will you review this policy / service?</i>
Annually
<i>If a review process is not in place, what plans do you have to establish one?</i>
N/A

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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 <u>and</u> nature of business)	Type of Interest (see guidance notes below – please mark 'X')			Is the interest direct or indirect? (see guidance notes below)	Nature of Interest	Date of Interest		Action taken to mitigate risk Action to be agreed with Head of Service (with support from ICB Governance Lead if required) who must sign p2 of this form
	Financial Interest	Financial Professional Interest	Professional Personal Interest			From	To (Insert end date if interest is time limited. Advise ICB Gov Lead when interest ceases)	

NB: The names of individuals who make a 'Nil' declaration will not be included in the publicly available register of interests (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 mseicb-thu.icbgovernanceteam@nhs.net](mailto:mseicb-thu.icbgovernanceteam@nhs.net)

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	<p>This is where an individual may get direct financial benefits from the consequences of a commissioning decision. This could, for example, include being:</p> <ul style="list-style-type: none"> • 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	<p>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:</p> <ul style="list-style-type: none"> • An advocate for a particular group of patients; • A GP or other clinician with special interests e.g., in dermatology, ophthalmology, acupuncture etc.

Interest	Description
	<ul style="list-style-type: none"> • 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 (including sponsored research). • 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	<p>This is where an individual may benefit (a benefit may arise from the making of gain or avoiding loss) 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:</p> <ul style="list-style-type: none"> • 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	<p>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 would include:</p> <p>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.</p> <p>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.</p>

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 Jane.King8@nhs.net

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 Conflicts of Interest Policy\(Including Gifts and Hospitality, Outside Employment, Commercial Sponsorship and other situations where conflicts might arise\) Policy Ref 018](#).

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

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?
6.8.3	Gifts offered from other sources (i.e. other than suppliers or contractors) and valued 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?
	<ul style="list-style-type: none"> • 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](#) or mseicb-thu.icbgovernanceteam@nhs.net

Audit Committee Chair: **TBC**

Conflicts of Interest Guardian: **TBC**

Executive Director Finance and Commercial – [Jennifer Kearton](#)

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

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