Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

INAUGURAL MEETING AGENDA

Friday 1st July 2022, 9.30am to 11.30am

MS Teams

Please notify us in advance of your intention to join the meeting by emailing ddccg.communications@nhs.net by close of play on 30th June 2022

This meeting will be recorded – please notify the Chair if you do not give consent

Time	Reference	Item	Presenter	Delivery
09:30	**Introductory Items**			
	ICB/2223/001	Introductory Welcome from the Chair	John MacDonald	Verbal
	ICB/2223/002	Confirmation of any apologies and quoracy Dr Avi Bhatia	John MacDonald	Verbal
	ICB/2223/003	Declarations of Interest • Register of Interests • Summary register for recording interests during the meeting • Glossary	John MacDonald	Paper
	ICB/2223/004	Introduction - Members of the Integrated Care Board	John MacDonald	Verbal
	ICB/2223/005	Outline of the roles of the Integrated Care Board Non-Executive Members	John MacDonald	Paper
	ICB/2223/006	Introductory Welcome and Update from the Integrated Care Board Chief Executive Officer	Dr Chris Clayton	Verbal
10:00	**Items for Decision**			
	ICB/2223/007	Adoption of key statutory documentation for the new Integrated Care Board: • Constitution • Governance Handbook • Health and Safety Policy • Appoint the ICB Founder Members of the Integrated Care Partnership	Helen Dillistone	Paper

Time	Reference	Item	Presenter	Delivery
	ICB/2223/008	Process for approving and developing the essential Policies of the Integrated Care Board	Helen Dillistone	Paper
	ICB/2223/009	Opening Integrated Care Board Assurance Framework and Strategic Risks	Helen Dillistone	Paper
	ICB/2223/010	Opening Integrated Care Board Risk Register	Helen Dillistone	Paper
	ICB/2223/011	Arrangements and process for the appointment of the External Auditors	Keith Griffiths	Paper
11.00	**Items for Information only**			
	ICB/2223/012	Closing Due Diligence Checklist for NHS Derby and Derbyshire CCG	Helen Dillistone	Paper
	ICB/2223/013	Delegation of Services from NHS England to Integrated Care Boards	Zara Jones	Paper
	ICB/2223/014	Transition Assurance Committee – Final Report and minutes, June 2022	Helen Dillistone	Paper
11.25	**Closing Items**			
	ICB/2223/015	Forward Planner – any items to note for July 21st meeting.	John MacDonald	Verbal
	ICB/2223/016	Any Other Business	John MacDonald	Verbal
	ICB/2223/017	Date and time of next meeting: Date: Thursday, 21st July 2022 Time: 9am to 10.45am Venue: MST	John MacDonald	Verbal

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Integrated Care Board

Surname	Forename	Job Title	Also a member of	Declared Interest (Including direct/ indirect Interest)	Type of Interest				Date of Interest		Action taken to mitigate risk
					Financial Interest	Non Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To	
Allen	Tracey	Partner Member - DCHS	Primary & Community Collaborative Delivery Board Integrated Place Executive Meeting	CEO of Derbyshire Community Healthcare Services NHS Foundation Trust Partner is a Director (not Board Member) for NHS Derby and Derbyshire ICB Trustee for NHS Providers Board	✓			 ✓ 	01/07/22 01/07/222 01/07/22	Ongoing Ongoing Ongoing	Declare interest when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Clayton	Chris	Chief Executive	N/A	Spouse is a partner in PWC				✓	01/07/22	Ongoing	Declare interest if relevant
Corner	Julian	Non-Executive Member	Finance & Estates Committee Public Partnerships Committee Population Health & Strategic Commissioning Committee Remuneration Committee	As the CEO of Lankelly Chase Foundation, I may have an interest in organisations being commissioned by the JUCD if that would support a grant funding relationship that Lankelly Chase has with them.		✓			01/03/22	30-Jun-25	Not aware of any grant relationships between Lankelly Chase and Derbyshire based organisations, or organisations that might stand to benefit from JUCD commissioning decisions. If that were to happen I would alert the JUCD chair and excuse myself from decisions both at Lankelly Chase and JUCD.
Dhadda	Bukhtawar	Non-Executive Member	Audit & Governance Committee People & Culture Committee Quality & Performance Committee Population Health & Strategic Commissioning Committee Remuneration Committee	GP Partner at Swadlincote Surgery Private GP work for Medical Solutions Online (Health Hero)	✓ ✓				01/07/22 01/07/22	Ongoing Ongoing	Withdraw from all discussion and voting if organisations are potential providers unless otherwise agreed by the meeting chair
Dillistone	Helen	Executive Director of Corporate Affairs	Audit & Governance Committee Public Partnerships Committee	Nil							No action required
Gildea	Margaret	Non-Executive Member	Audit and Governance Committee People and Culture Committee Quality and Performance Committee Remuneration Committee	Director of Organisation Change Solutions Limited Coaching and organisation development with First Steps Eating Disorders Director, Melbourne Assembly Rooms	✓ ✓	 ✓			01/07/22 01/07/22 01/07/22	Ongoing Ongoing Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Griffiths	Keith	Executive Director of Finance	Finance & Estates Committee Population Health & Strategic Commissioning Committee	TBC							
Jones	Zara	Executive Director of Strategy & Planning	Finance & Estates Committee Population Health & Strategic Commissioning Committee Quality & Performance Committee	Nil							No action required
MacDonald	John	ICB Chair	N/A	Interim Chair at University Hospitals of Leicester NHS Trust (with effect from 17.4.2021 on a secondment basis) Board Member at Nottinghamshire Integrated Care System	✓	 ✓			01/07/22 01/07/22	Ongoing Ongoing	Declare interest when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Majid	Ifti	Partner Member - DHcFT	People & Culture Committee	CEO of Derbyshire Healthcare NHS Foundation Trust Co-Chair of NHS Confederation BME leaders Network Chair of the NHS Confederation Mental Health Network Trustee of the NHS Confederation Spouse is Managing Director (North) Priory Healthcare	✓	 ✓ ✓ ✓ 		 ✓	01/07/22 01/07/22 01/07/22 01/07/22 01/07/22	Ongoing Ongoing Ongoing Ongoing Ongoing	Declare interest when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Rawlings	Amanda	Executive Director of People & Culture	People & Culture Committee Population Health & Strategic Commissioning Committee	Employed jointly between NHS Derby and Derbyshire Integrated Care Board and University Hospitals of Derby and Burton NHS Foundation Trust, as Chief People Officer	✓				01/07/22	Ongoing	This position was agreed by both the ICB and UHDB. Declare interest when relevant and withdraw from all discussion and voting if UHDB is potential provider, unless otherwise agreed by the meeting chair
Smith	Andy	Partner Member - Derby City Local Authority	N/A	Director of Adult Social Care and Director of Children's Services, Derby City Council Member of Regional ADASS and ADCS Groups	✓	 ✓			01/07/22 01/07/22	Ongoing Ongoing	Declare interest when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Stacey	Brigid	Chief Nurse Officer	Quality & Performance Committee System Quality Group CRHFT Contract Management Board CRHFT Clinical Quality Review Group UHDB Contract Management Board UHDB Clinical Quality Review Group EMAS Quality Assurance Group Maternity Transformation Board (Chair)	Nil							No action required
Sunderland	Sue	Non-Executive Member - Audit & Governance	Audit and Governance Committee Finance and Estates Committee Public Partnerships Committee Population Health & Strategic Commissioning Committee IFR Panels CFI Panels	Audit Chair NED, Nottinghamshire Healthcare Trust Audit Chair of Joint Audit Risk & Assurance Committee for the Office of the Police & Crime Commissioner and Chief Constable of Derbyshire Finance NED Inclusion Healthcare Social Enterprise CIC Husband is an independent person sitting on Derby City Audit Committee & Standards Committee.		✓ ✓ ✓ 		 ✓	01/07/22 01/07/22 01/07/22 01/07/22	Ongoing 01/04/23 30/08/22 Ongoing	The interest should be kept under review and specific actions determined as required Unlikely for there to be any conflicts to manage

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Surname	Forename	Job Title	Also a member of	Declared Interest (Including direct/ indirect Interest)	Type of Interest				Date of Interest		Action taken to mitigate risk
					Financial Interest	Non Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To	
Wallace	Dean	Partner Member - Derbyshire Local Authority	Integrated Place Executive Meeting	Director of Public Health, Derbyshire County Council Chief Operating Officer, Derbyshire Community Health Services NHS Foundation Trust	✓ ✓				01/07/22 01/09/22	31/08/22 Ongoing	Declare interest when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Weiner	Chris	Executive Medical Director	Quality & Performance Committee Population Health & Strategic Commissioning Committee	Nil							No action required
Wright	Richard	Non-Executive Member - Finance & Estates	Audit and Governance Committee Finance and Estates Committee Quality and Performance Committee Population Health & Strategic Commissioning Committee Remuneration Committee	Chair of Sheffield UT Multi Academy Educational Trust Member of National Centre for Sport and Exercise Medicine Sheffield Board	✓ ✓				01/07/22 01/07/22	31/08/2022 Ongoing	Declare interests if relevant

SUMMARY REGISTER FOR RECORDING ANY INTERESTS DURING MEETINGS

A conflict of interest is defined as “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” (NHS England, 2017).

Meeting	Date of Meeting	Chair (name)	Director of Corporate Delivery/ICB Meeting Lead	Name of person declaring interest	Agenda item	Details of interest declared	Action taken

Abbreviations & Glossary of Terms

A&E	Accident and Emergency
AfC	Agenda for Change
AGM	Annual General Meeting
AHP	Allied Health Professional
AQP	Any Qualified Provider
Arden & GEM CSU	Arden & Greater East Midlands Commissioning Support Unit
ARP	Ambulance Response Programme
ASD	Autistic Spectrum Disorder
BAF	Board Assurance Framework
BAME	Black Asian and Minority Ethnic
BCCTH	Better Care Closer to Home
BCF	Better Care Fund
BMI	Body Mass Index
bn	Billion
BPPC	Better Payment Practice Code
BSL	British Sign Language
CAMHS	Child and Adolescent Mental Health Services
CATS	Clinical Assessment and Treatment Service
CBT	Cognitive Behaviour Therapy
CCG	Clinical Commissioning Group
CDI	Clostridium Difficile
CEO (s)	Chief Executive Officer (s)

CfV	Commissioning for Value
CHC	Continuing Health Care
CHP	Community Health Partnership
CMHT	Community Mental Health Team
CMP	Capacity Management Plan
CNO	Chief Nursing Officer
COO	Chief Operating Officer (s)
COP	Court of Protection
COPD	Chronic Obstructive Pulmonary Disorder
CPD	Continuing Professional Development
CPN	Contract Performance Notice
CPRG	Clinical & Professional Reference Group
CQC	Care Quality Commission
CQN	Contract Query Notice
CQUIN	Commissioning for Quality and Innovation
CRG	Clinical Reference Group
CRHFT	Chesterfield Royal Hospital NHS Foundation Trust
CSE	Child Sexual Exploitation
CSF	Commissioner Sustainability Funding
CSU	Commissioning Support Unit
CTR	Care and Treatment Reviews

CVD	Chronic Vascular Disorder
CYP	Children and Young People
D2AM	Discharge to Assess and Manage
DAAT	Drug and Alcohol Action Teams
DCC	Derbyshire County Council or Derby City Council
DCHSFT	Derbyshire Community Health Services NHS Foundation Trust
DCO	Designated Clinical Officer
DHcFT	Derbyshire Healthcare NHS Foundation Trust
DHSC	Department of Health and Social Care
DHU	Derbyshire Health United
DNA	Did not attend
DoF(s)	Director(s) of Finance
DoH	Department of Health
DOI	Declaration of Interests
DoLS	Deprivation of Liberty Safeguards
DPH	Director of Public Health
DRRT	Dementia Rapid Response Team
DSN	Diabetic Specialist Nurse
DTOC	Delayed Transfers of Care
ED	Emergency Department
EDS2	Equality Delivery System 2
EDS3	Equality Delivery System 3

EIA	Equality Impact Assessment
EIHR	Equality, Inclusion and Human Rights
EIP	Early Intervention in Psychosis
EMASFT	East Midlands Ambulance Service NHS Foundation Trust
EMAS Red 1	The number of Red 1 Incidents (conditions that may be immediately life threatening and the most time critical) which resulted in an emergency response arriving at the scene of the incident within 8 minutes of the call being presented to the control room telephone switch.
EMAS Red 2	The number of Red 2 Incidents (conditions which may be life threatening but less time critical than Red 1) which resulted in an emergency response arriving at the scene of the incident within 8 minutes from the earliest of; the chief complaint information being obtained; a vehicle being assigned; or 60 seconds after the call is presented to the control room telephone switch.
EMAS A19	The number of Category A incidents (conditions which may be immediately life threatening) which resulted in a fully equipped ambulance vehicle able to transport the patient in a clinically safe manner, arriving at the scene within 19 minutes of the request being made.
EMLA	East Midlands Leadership Academy
EoL	End of Life
ENT	Ear Nose and Throat
EPRR	Emergency Preparedness Resilience and Response
FCP	First Contact Practitioner
FFT	Friends and Family Test
FGM	Female Genital Mutilation
FIRST	Falls Immediate Response Support Team
FRP	Financial Recovery Plan
GDPR	General Data Protection Regulation
GP	General Practitioner
GPFV	General Practice Forward View
GPSI	GP with Specialist Interest
HCAI	Healthcare Associated Infection
HDU	High Dependency Unit
HEE	Health Education England
HI	Health Inequalities
HLE	Healthy Life Expectancy
HNA	Health Needs Assessment
HSJ	Health Service Journal
HWB	Health & Wellbeing Board
H1	First half of the financial year
H2	Second half of the financial year
IAF	Improvement and Assessment Framework
IAPT	Improving Access to Psychological Therapies
ICB	Integrated Care Board
ICM	Institute of Credit Management
ICO	Information Commissioner's Office
ICP	Integrated Care Provider
ICS	Integrated Care System
ICU	Intensive Care Unit
IG	Information Governance
IGAF	Information Governance Assurance Forum
IGT	Information Governance Toolkit
IP&C	Infection Prevention & Control
IT	Information Technology
IWL	Improving Working Lives
JAPC	Joint Area Prescribing Committee
JSAF	Joint Safeguarding Assurance Framework

JSNA	Joint Strategic Needs Assessment
JUCD	Joined Up Care Derbyshire
k	Thousand
KPI	Key Performance Indicator
LA	Local Authority
LAC	Looked after Children
LCFS	Local Counter Fraud Specialist
LD	Learning Disabilities
LGBT+	Lesbian, Gay, Bisexual and Transgender
LHRP	Local Health Resilience Partnership
LMC	Local Medical Council
LMS	Local Maternity Service
LPF	Lead Provider Framework
LTP	NHS Long Term Plan
LWAB	Local Workforce Action Board
m	Million
MAPPA	Multi Agency Public Protection arrangements
MASH	Multi Agency Safeguarding Hub
MCA	Mental Capacity Act
MDT	Multi-disciplinary Team
MH	Mental Health
MHIS	Mental Health Investment Standard
MIG	Medical Interoperability Gateway
MIUs	Minor Injury Units

MMT	Medicines Management Team
MOL	Medicines Order Line
MoM	Map of Medicine
MoMO	Mind of My Own
MRSA	Methicillin-resistant Staphylococcus aureus
MSK	Musculoskeletal
MTD	Month to Date
NECS	North of England Commissioning Services
NEPTS	Non-emergency Patient Transport Services
NHSE/ I	NHS England and Improvement
NHS e-RS	NHS e-Referral Service
NICE	National Institute for Health and Care Excellence
NUHFT	Nottingham University Hospitals NHS Trust
OOH	Out of Hours
PALS	Patient Advice and Liaison Service
PAS	Patient Administration System
PCCC	Primary Care Co-Commissioning Committee
PCD	Patient Confidential Data
PCDG	Primary Care Development Group
PCN	Primary Care Network
PHB's	Personal Health Budgets
PHE	Public Health England

PHM	Population Health Management
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PIR	Post Infection Review
PLCV	Procedures of Limited Clinical Value
POA	Power of Attorney
POD	Project Outline Document
POD	Point of Delivery
PPG	Patient Participation Groups
PSED	Public Sector Equality Duty
PwC	Price, Waterhouse, Cooper
Q1	Quarter One reporting period: April – June
Q2	Quarter Two reporting period: July – September
Q3	Quarter Three reporting period: October – December
Q4	Quarter Four reporting period: January – March
QA	Quality Assurance
QAG	Quality Assurance Group
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity and Prevention
QUEST	Quality Uninterrupted Education and Study Time
QOF	Quality Outcome Framework
QP	Quality Premium

Q&PC	Quality and Performance Committee
RAP	Recovery Action Plan
RCA	Root Cause Analysis
REMCOM	Remuneration Committee
RTT	Referral to Treatment
RTT	The percentage of patients waiting 18 weeks or less for treatment of the Admitted patients on admitted pathways
RTT Non admitted	The percentage if patients waiting 18 weeks or less for the treatment of patients on non-admitted pathways
RTT Incomplete	The percentage of patients waiting 18 weeks or less of the patients on incomplete pathways at the end of the period
ROI	Register of Interests
SAAF	Safeguarding Adults Assurance Framework
SAR	Service Auditor Reports
SAT	Safeguarding Assurance Tool
SBS	Shared Business Services
SDMP	Sustainable Development Management Plan
SEND	Special Educational Needs and Disabilities
SIRO	Senior Information Risk Owner
SOC	Strategic Outline Case
SPA	Single Point of Access
SQI	Supporting Quality Improvement
SRO	Senior Responsible Officer
SRT	Self-Assessment Review Toolkit
STEIS	Strategic Executive Information System
STHFT	Sheffield Teaching Hospital NHS Foundation Trust
STP	Sustainability and Transformation Partnership
T&O	Trauma and Orthopaedics
TCP	Transforming Care Partnership
UEC	Urgent and Emergency Care
UHDBFT	University Hospitals of Derby and Burton NHS Foundation Trust
UTC	Urgent Treatment Centre
YTD	Year to Date
111	The out of hours service is delivered by Derbyshire Health United: a call centre where patients, their relatives or carers can speak to trained staff, doctors and nurses who will assess their needs and either provide advice over the telephone, or make an appointment to attend one of our local clinics. For patients who are house-bound or so unwell that they are unable to travel, staff will arrange for a doctor or nurse to visit them at home.
52WW	52 week wait

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NHS DERBY AND DERBYSHIRE ICB BOARD

INAUGURAL MEETING

1st July 2022

	Item No: 005

Report Title	Outline of the roles of the Integrated Care Board Non-Executive Members							
Author	Suzanne Pickering, Head of Governance Helen Dillistone, Executive Director of Corporate Affairs							
Sponsor (Executive Director)	John MacDonald, ICB Chair							
Presenter	John MacDonald, ICB Chair							
Paper purpose	Decision	☒	Discussion	☐	Assurance	☒	Information	☐
Appendices	None							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	Remuneration Committee							

Recommendations
The Board are recommended to **APPOINT** the Non-Executive Members to lead roles on the Board.
Purpose
The purpose of the paper is to formally appoint the Non-Executive Members to lead roles on the Board.
Background
NHSE has brought into effect the constitution with standing orders through the Establishment Order. As part of the NHSEI ICB establishment obligations, the Board is required at its inaugural Board meeting to transact specific elements of business which include the formal appointment of key roles.
Report Summary
The ICB Non-Executive Members have been appointed as Chairs of ICB Committees and have additional special lead roles for the ICB. The following details the Non-Executive Members Committee responsibility and leads roles.

Dr Buk Dhadda – Chair of the Quality and Performance Committee
- ICB Board Vice Chair
- Doctors Disciplinary Lead

Julian Corner – Chair of the Population Health and Strategic Commissioning Committee, and Public Partnerships Committee
- Chair of Individual Funding Requests Appeals Panel

Margaret Gildea – Chair of the Remuneration Committee, and People and Culture Committee
- Freedom to Speak up Guardian
- Health & Wellbeing Champion
- Equality and Diversity Champion

Sue Sunderland – Chair of the Audit and Governance Committee
- Conflicts of Interest Guardian
- Chair of Individual Funding Requests Panel

Richard Wright – Chair of the Finance and Estates Committee
- Security Management Champion
- Chair of Persistent Contacts Panel
- Panel Member of Individual Funding Requests Panel

Identification of Key Risks
Not applicable

Have any conflicts of interest been identified throughout the decision-making process?
None identified

Project Dependencies

Completion of Impact Assessments				
Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☒	Inclusive leadership	☒

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
Not applicable for this report.

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
Board members have a responsibility to support the Net Zero Carbon, NHS Greener agenda and Green Plan targets.

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NHS DERBY AND DERBYSHIRE ICB BOARD

INAUGURAL MEETING

1st July 2022

	Item No: 007

Report Title	Adoption of key statutory documentation for the new Integrated Care Board							
Author	Suzanne Pickering, Head of Governance Helen Dillistone, Executive Director of Corporate Affairs							
Sponsor (Executive Director)	Helen Dillistone, Executive Director of Corporate Affairs							
Presenter	Helen Dillistone, Executive Director of Corporate Affairs							
Paper purpose	Decision	☒	Discussion	☐	Assurance	☐	Information	☐
Appendices	Appendix 1 - ICB Constitution Appendix 2 - ICB Governance Handbook Appendix 3 - ICB Health and Safety Policy							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	Shadow ICB Board - 08.06.2022 System Transition Assurance Committee CCG Transition Working Group							

Recommendations
The Board is asked to **APPROVE** the Constitution, Governance Handbook and Health and Safety Policy. The Board is recommended to formally **APPOINT** the ICB founder members of the Integrated Care Partnership.
Purpose
The purpose of this report is to for the Board to formally receive and adopt the Constitution, Governance Handbook and Health and Safety Policy, as the new statutory organisation from the 1st July 2022.
Background
NHS Derby and Derbyshire Integrated Care Board (ICB) is the newly established health statutory body for the Derby City and Derbyshire population. The ICB is a new statutory organisation and takes over the duties and responsibilities of the NHS Derby and Derbyshire Clinical Commissioning Group which was disestablished on 30th June 2022. The ICB will also be responsible for a range of new statutory duties set out in the Act.

ICSs are partnerships of health and care organisations that come together to plan and deliver joined-up services and to improve the health of people who live and work in their area. Each ICS will comprise of an:

a) Integrated Care Board: bringing the NHS together locally to improve population health and care; and

b) Integrated Care Partnership (ICP): the broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS.

NHSEI 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.

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; and
- getting the best from collective resources so people get care as quickly as possible.

The Derbyshire ICS will have an NHS Body Integrated Care Board which has a distinct purpose, with governance and leadership arrangements designed to promote greater collaboration across the NHS and with other local partners. Adapting to this requires a significant change in the way commissioning activities are delivered and functions are carried out to understand population needs, plan services and allocate resources, which address the Derby City and Derbyshire population's health outcomes and secure the provision of services collaboratively with partners.

The ICB Constitution describes the governing principles, rules and procedures to ensure accountability and probity in the day to day running of the ICB Board and to ensure that it remains true to its vision.

Report Summary

NHS Derby and Derbyshire ICB Constitution

The development and approach to the NHS Derby and Derbyshire ICB Constitution

Since August 2021, work has been in progress to develop and agree the Constitution for the new Derbyshire ICB. The work has progressed in line with the guidance and Model Constitutions produced and issued by NHSEI, various updated versions have been issued over recent months. A number of submissions of the Derbyshire draft Constitution have been made in accordance with the timeline established by NHSEI, with feedback incorporated into subsequent drafts.

On 26th May NHSEI issued the final draft Model Constitution; on 6th June, the NHSE Midlands Regional Director approved the final draft ICB Constitution and it was published on the NHSE website,https://www.england.nhs.uk/publication/the-constitutions-of-integrated-care-boards/.

Appendix 1 attached to this report provides the final Constitution for the Derby and Derbyshire ICB.

Engagement and Consultation with the ICS Partners

As with all previous Constitutions, the ICB was required to consult and engage with its system partners. Engagement with the system partners took place between October and November 2021 with an engagement workshop in November attended by representatives from across both the health and care systems. Feedback was reflected in an Engagement Report which was submitted to NHSEI and reflected in the final draft ICB Constitution.

Since then, various iterations have been shared and discussed with the System Transition and Assurance Committee, CCG Transition Working group, and the shadow ICB Board.

Feedback was reflected in an Engagement Report which was submitted to NHSEI and reflected in the final draft ICB Constitution.

NHS Derby and Derbyshire ICB Governance Handbook

The ICB Constitution is supported by a number of documents which provide further details on how governance arrangements in the ICB will operate. The Governance Handbook has been developed in parallel with the Constitution and the emerging work on the committees to the ICB Board.

The Standing Orders which set out the arrangements and procedures to be used for meetings and the process to appoint the ICB Committees. These are appended to the Constitution and form part of it for the purpose of clause 1.6 of the Constitution and the ICB's legal duty to have a Constitution.

The purpose of the ICB Governance Handbook is to bring together a range of corporate statutory documents in one place and is described as the NHS Derby and Derbyshire Integrated Care Board Governance Handbook. The ICB Governance Handbook is not a legal requirement; however it is an approach that will assist NHS Derby and Derbyshire Integrated Care Board to build a consistent corporate approach and form part of the corporate memory.

The Governance Handbook includes:

- Committee Terms of Reference
- Eligible Providers of Primary Medical Services
- Functions and Decisions Map
- ICB Governance Structure
- Scheme of Reservations and Delegation
- Standing Financial Instructions
- Corporate Governance Framework
- Standards of Business Conduct Policy
- Managing Conflicts of Interest Policy

The Functions and Decisions Map sets out the functions and decision making and component parts of the Joined Up Care Derbyshire Integrated Care System, which includes the ICP.

The ICB founder members of the ICP are:

- Statutory Local Authority Officers, Derbyshire County Council and Derby City Council;
- Political Leadership, Chairs of Health and Wellbeing Boards, Council Cabinet members for Adult Social Care and Health, Children and Young People and Public Health;
- Statutory District Council Chief Officers, Chesterfield, North East Derbyshire and Bolsover;
- Political District Council Leadership, Elected members Chesterfield and Bolsover;
- NHS Partner Chief Executive Officers:
    - NHS Derby and Derbyshire ICB, including the ICB Chair
    - Derbyshire Community Healthcare Services NHS Foundation Trust
    - Derbyshire Healthcare NHS Foundation Trust
    - United Hospitals Derby & Burton NHS Foundation Trust
    - Chesterfield Royal Hospital NHS Foundation Trust
    - East Midlands Ambulance Service NHS Trust
    - Derbyshire Health United Health Care
    - Primary Care Network Clinical Director
    - Place Partnership Chair
    - Provider GP Leadership Board Chair
    - Clinical Professional Leadership Board Chair
- Healthwatch; and
- Voluntary, Community and Social Enterprise Sector.

<u>NHS Derby and Derbyshire ICB Committees</u>

NHS Derby and Derbyshire ICB Board has a total of eight formal Committees, including three statutory Committees. These are:

- Audit and Governance Committee
- Remuneration Committee
- System Quality Group

There are five non-statutory Committees listed below, and these committees have a membership of ICB colleagues as well as other system colleagues. These are:

- Finance and Estates Committee
- People and Culture Committee
- Population Health and Strategic Commissioning Committee
- Public Partnerships Committee
- Quality and Performance Committee

<u>NHS Derby and Derbyshire ICB Terms of References</u>

The Terms of References membership, roles and responsibilities, chairing and quoracy arrangements and reporting arrangements have been developed and reviewed through an engagement process with the ICB Committee Chair and the lead Committee Executive Officer.

The Terms of References are incorporated into an ICB Governance Handbook have been submitted to NHSE as part of the Readiness to Operate Statement requirements.

The Committees of NHS Derby and Derbyshire ICB will be established from 1st July 2022. A review period of 6 months has been set to enable the Committees to develop and become established and any changes to the terms of references made accordingly.

Appendix 2 attached to this report provides the final draft Governance Handbook for the Derby and Derbyshire ICB.

ICB Health and Safety Policy

As part of the Readiness to Operate Statement requirements, the ICB is required to approve the ICB's Health and Safety Policy as it is a legal requirement for the new statutory organisation from 1st July 2022.

Page 6 of the Health and Safety Policy includes the Health and Safety Policy Statement which is required to be signed by the ICB Chief Executive Officer.

Appendix 3 attached to this report provides the Health and Safety Policy for the Derby and Derbyshire ICB.

Identification of Key Risks
Not applicable

Have any conflicts of interest been identified throughout the decision-making process?
None identified

Project Dependencies
Not applicable

Completion of Impact Assessments				
Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☒	Inclusive leadership	☒

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?

Not applicable for this paper.					
When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Details/Findings The Constitution and ICB core purpose support the Net Zero Carbon ambition, NHS Greener agenda and Green Plan targets.					

Derby and Derbyshire
Integrated Care Board

NHS Derby and Derbyshire Integrated Care Board

Constitution

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

CONTENTS

1. INTRODUCTION

1.1 Background/Foreword

1.1.1 NHS Derby and Derbyshire Integrated Care Board (ICB) is the health statutory body for the Derby City and Derbyshire population. The ICB is a new statutory organisation and will take over the duties and responsibilities of the NHS Derby and Derbyshire Clinical Commissioning Group which will be disestablished on 30th June 2022. The ICB will also be responsible for a range of new statutory duties set out in the Act.

1.1.2 ICSs are partnerships of health and care organisations that come together to plan and deliver joined-up services and to improve the health of people who live and work in their area. Each ICS will comprise of an:

(a) Integrated Care Board bringing the NHS together locally to improve population health and care; and an

(b) Integrated Care Partnership (ICP): the broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS.

1.1.3 NHSE 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.

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.

1.1.4 The Derbyshire ICS will have an NHS Body Integrated Care Board which has a distinct purpose, with governance and leadership arrangements designed to promote greater collaboration across the NHS and with other local partners. Adapting to this requires a significant change in the way commissioning activities are delivered and functions are carried out to understand population needs, plan services and allocate resources, which address the Derby City and Derbyshire population's health outcomes and secure the provision of services collaboratively with partners.

1.1.5 The Derbyshire ICS will also have an ICP at system level, established as equal partner members. The ICP will operate as the forum to bring partners e.g. local government, NHS and others, together across the Derbyshire ICS area to align purpose and ambitions with plans to integrate care and improve health and wellbeing outcomes for the population of Derby City and Derbyshire. For a number of years there have been local collaborative arrangements at the 'neighbourhood' level. These have involved a coalition of commissioners, NHS Trust providers, local authorities, primary care, the voluntary and community sector, and the public working together to better meet the needs of local people. Two Place Partnerships on the local authority footprints have been formed, which retain and further strengthen local place alliances. The Place Partnerships will have an ethos of equality between partners and be established to deliver a range of functions on behalf of the ICB and ICP. These will include:

(a) co-ordinating and integrating local services built on a mutual understanding of the population and a shared vision;

(b) taking accountability for the delivery of coordinated, high quality care and improved outcomes for their populations; and

(c) the planning, management of resources, delivery, and performance of a range of community-based health and care services, in line with the strategic requirements of the ICB and ICP.

The overall approach will be a social model that is outcome driven and strength based; focussing on the assets of individuals and communities and developed with them through local leadership. There is a collective ambition for delegated responsibility and accountability to enable maximum impact from existing and enhanced structures.

1.1.6 Provider collaboratives are partnership arrangements involving two or more trusts (foundation trusts or NHS trusts and could also include community interest companies providing NHS care), that collectively work across multiple places to realise the benefits of mutual aid and working at scale. The purpose of provider collaboratives is to better enable their members to work together to continuously improve quality, efficiency, and outcomes, including proactively addressing unwarranted variation and inequalities in access and experience across different providers.

[1] It is a proposed common duty for NHS bodies that plan and commission services (NHS England and ICBs) and that provide services (Trusts and Foundation Trusts). It will oblige these bodies to consider the effects of their decisions on:

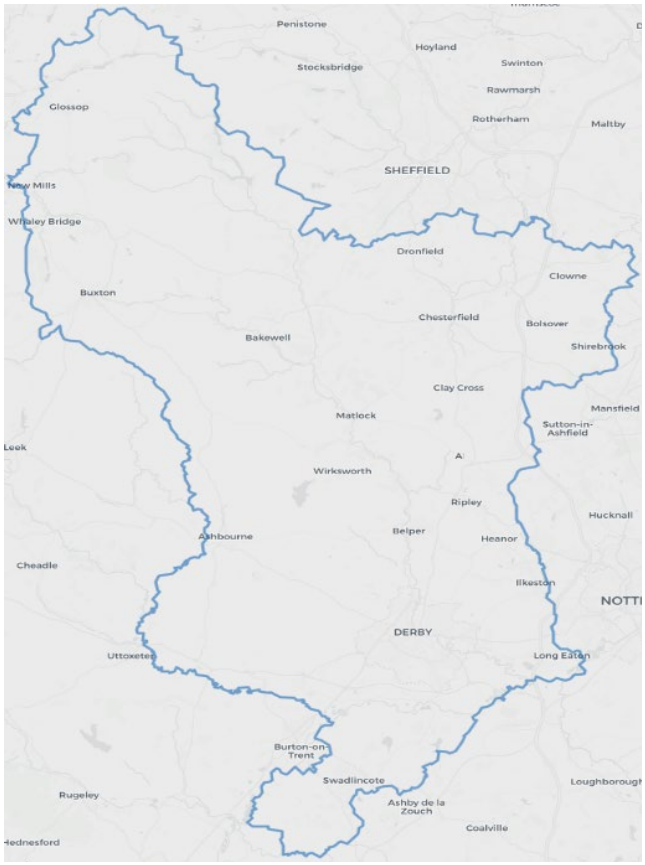
- the health and wellbeing of the people of England
- the quality of services provided or arranged by both themselves and other relevant bodies
- the sustainable and efficient use of resources by both themselves and other relevant bodies

1.2 **Name**

The name of this Integrated Care Board is NHS Derby and Derbyshire ICB ("the ICB").

1.3 **Area Covered by the Integrated Care Board**

1.3.1 The area covered by the ICB is approximately 2,495 km^2 within Derbyshire and Derby City.



1.3.2 As the ICB is fully coterminous with the areas covered by Local Authorities, the area covered by the ICB is defined by the Lower Layer Super Output Areas (LSOAs) as listed below.

1.3.3 The following are the District and Borough Councils and the Upper Tier Local Authority which the ICB covers, the:

(a) County Council of Derbyshire

(b) City Council of Derby

(c) Borough of Chesterfield

(d) Borough of High Peak (including Glossop)

(e) Borough of Amber Valley

(f) Borough of Erewash

(g) District of Bolsover

(h) District of North East Derbyshire

(i) District of Derbyshire Dales

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.ddicb.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); and

(g) provisions of the Civil Contingencies Act 2004.

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

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

(a) section 14Z34 (improvement in quality of services);

(b) section 14Z35 (reducing inequalities);

(c) section 14Z38 (obtaining appropriate advice),

(d) section 14Z40 (duty in respect of research),

(e) section 14Z43 (duty to have regard to effect of decisions);

(f) section 14Z44 (public involvement and consultation);

(g) sections 223GB to 223N (financial duties); and

(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 the 1st of July 2022 by The Integrated Care Boards (Establishment) Order 2022' which made provision for its Constitution by reference to this document.

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

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

1.6 Variation of this Constitution

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

(a) where the ICB applies to NHS England in accordance with NHS England's published procedure and that application is approved; and

(b) where NHS England varies the Constitution of its own initiative, (other than on application by the ICB).

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

The Chief Executive Officer may periodically propose amendments to the Constitution which shall be considered and approved by the ICB Board members where:

(a) changes are thought to have a material impact;

(b) changes are proposed to the reserved powers of the members;

(c) at least half (50%) of all the ICB board Members formally request that the amendments be put before the full ICB board members for approval.

Proposed amendments to this Constitution will not be implemented until an application to NHS England for variation has been approved. This is set out in Appendix One, Standing Orders Section 4.9 Decision Making.

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) **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:

(i) The above documents (a) – (c);

(ii) terms of reference for all committees and sub-committees of the board that exercise ICB functions;

(iii) 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 of those organisations in accordance with section 65Z6 of the 2006 Act; and

(iv) 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 or those organisations in accordance with section 65Z6 of the 2006 Act.

(v) The up-to-date list of eligible providers of primary medical services under clause 3.6.2.

(e) **Corporate Governance Framework** – brings together a range of corporate statutory documents in one place to assist in building a consistent corporate approach and forms part of the corporate memory.

(f) **Governance Structure**

(g) **Key policy documents** which should also be included in the Governance Handbook or linked to it – including:

(i) Standards of Business Conduct Policy;

(ii) Conflicts of Interest Policy and Procedures; and

(iii) Policy for Public Involvement and Engagement.

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 www.ddicb.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:

(i) Executive Director of Finance

(ii) Executive Medical Director; and

(iii) Executive Director of Nursing and Quality.

And in addition to the two mandated Non-Executive Members for Audit and Remuneration there will be:

(b) an additional three 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:

(a) NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description;

(b) the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description;

(c) the local authorities which are responsible for social care and whose area coincides with or includes the whole or any part of the ICB's area.

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.

2.2 Board Membership

2.2.1 The ICB has five Partner Members.

(a) Two NHS Trust and Foundation Trust Partner Members;

(b) One Primary Medical Services Partner Member; and

(c) Two Local Authority Partner Members.

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

(a) Executive Director of People and Culture (Chief People Officer);

2.2.3 The board is therefore composed of the following sixteen members:

(a) Chair;

(b) Chief Executive;

(c) Two Partner members NHS and Foundation Trusts;

(d) One Partner member Primary Medical Services;

(e) Two Partner members Local Authorities;

(f) Five Non-Executive Members;

(g) Executive Director of Finance;

(h) Executive Medical Director;

(i) Executive Director of Nursing and Quality; and

(j) Executive Director of People and Culture (Chief People Officer).

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

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

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 in order to inform its decision-making and the discharge of its functions as it sees fit. Participants will be affiliated to the ICB Executive Team but will not be a member of the ICB.

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. Regular participants will include the following:

(a) Executive Director of Corporate Affairs (Board Secretary);

(b) Chair of the Clinical and Professional Advisory Committee;

(c) Chief Digital Information Officer;

(d) Other Executives.

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 willing to uphold the Seven Principles of Public Life (known as the Nolan Principles); and

(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, sections 56A to 56K of the Bankruptcy (Scotland) Act 1985 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).

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

3.2.6 A person whose term of appointment as the chair, a member, a director or a governor of a health service body, has been terminated on the grounds:

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

(b) that the person failed, without reasonable cause, to attend any meeting of that health service body for three successive meetings;

(c) that the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest; or

(d) of misbehaviour, misconduct or failure to carry out the person's duties.

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

(a) the person's suspension from a register held by the regulatory body, where that suspension has not been terminated;

(b) the person's erasure from such a register, where the person has not been restored to the register;

(c) a decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded; 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.

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

(a) the Chair will be independent; and

(b) must meet the core competencies identified for the role of Chair and be subject to performance appraisal.

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 clause 3.2 apply;

(c) any other exclusion criteria set out in the applicable NHS England guidance applies.

3.3.4 The term of office for the Chair will be up to 2 years for the initial terms and up to 3 years for subsequent terms and the maximum number of terms a Chair may serve is 3 terms.

3.4 **Chief Executive**

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

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

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

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

(b) meets the requirements as set out in the Chief Executive role description and person specification.

3.4.4 Individuals will not be eligible if:

(a) any of the disqualification criteria set out in clause 3.2 apply;

(b) subject to clause 3.4.3(a), they hold any other employment or executive role;

(c) the process of disqualification is to be overseen by NHS England and Improvement and the Independent Non-Executive Member for Audit.

3.5 **Partner Members – NHS Trusts and Foundation Trusts within the ICB area**

3.5.1 These Partner Members are jointly nominated by the NHS Trusts and/or FTs which provide services for the purpose 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. Those Trusts and Foundation Trusts are:

(a) Chesterfield Royal Hospital NHS Foundation Trust;

(b) Derbyshire Healthcare NHS Foundation Trust;

(c) East Midlands Ambulance Services NHS Trust;

(d) University Hospitals of Derby and Burton NHS Foundation Trust; and

(e) Derbyshire Community Health Services NHS Foundation Trust.

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

(a) be an Executive Director of one of the NHS Trusts or Foundation Trusts within the ICB's area (from those listed at 3.5.1 above);

(b) one of these members must have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

3.5.3 Individuals will not be eligible if:

(a) any of the disqualification criteria set out in clause 3.2 apply;

(b) any other exclusion criteria set out in the applicable NHS England guidance applies;

(c) a conflict of interest is evident, as determined by the Chair, which results in the individual being unable to fulfil the role.

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

3.5.5 The appointment process will be as follows:

a) Joint Nomination:

- When a vacancy arises, each eligible organisation listed at 3.5.1.a will be invited to make one nomination per vacancy.
- 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 five working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they do not, 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)

- The full list of nominees will be considered by a panel convened by the Chief Executive
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.5.2 and 3.5.3
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Chair's approval

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

3.5.6 The term of office for these Partner Members will be 3 years but individual terms may change subject to that individual fulfilling their substantive position and the total number of terms they may serve is 3 as a maximum. However, after the sixth year it may be permissible to extend by a single year at a time up to a total of 9 years by exception.

3.6 **Partner Member – Providers of Primary Medical Services**

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

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

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

(a) be a health care professional from the Primary Medical Services;

(b) meet the requirements as set out in the Partner Member – Primary Medical Services role description and person specification.

3.6.4 Individuals will not be eligible if:

(a) any of the disqualification criteria set out in clause 3.2 apply;

(b) any other exclusion criteria set out in the applicable NHS England guidance applies;

(c) a conflict of interest is evident, as determined by the Chair, which results in the individual being unable to fulfil the role.

3.6.5 This member will be appointed by a panel and approved by the Chair and the Chief Executive.

3.6.6 The appointment process will be as follows:

a) Joint Nomination:

- When a vacancy arises, each eligible organisation described at 3.6.1 and listed in the Governance Handbook will be invited to make one nomination per vacancy.
- The nomination of an individual must be seconded by 2 other eligible organisations. [seconding is most suitable when there are large numbers of nominating organisations]
- 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 five working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they do not, 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)

- The full list of nominees will be considered by a panel convened by the Chief Executive
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.6.3 and 3.6.4
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Chair's approval

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

3.6.7 The term of office for this Partner Member will be 3 years and the total number of terms they may serve is 3 terms.

3.7 **Partner Members – Local Authorities**

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

(a) Derby City Council;

(b) Derbyshire County Council.

3.7.2 This member will fulfil the eligibility criteria set out at clause 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 clause 3.7.1;

(b) meet the requirements as set out in the Partner Member – Local Authority role description and person specification.

(c) one of these members must have knowledge and experience in public health

(d) one of these members must have knowledge and experience in child and adult social care

3.7.3 Individuals will not be eligible if:

(a) any of the disqualification criteria set out in clause 3.2 apply;

(b) any other exclusion criteria set out in the applicable NHS England guidance applies.

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

3.7.5 The appointment process will be as follows:

a) Joint Nomination:

- When a vacancy arises, each eligible organisation listed at 3.7.1.a will be invited to make one nomination per vacancy.
- 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 five working days being deemed to

constitute agreement. If they do agree, the list will be put forward to step b) below. If they do not, 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)

- The full list of nominees will be considered by a panel convened by the Chief Executive
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.7.2 and 3.7.3
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Chair's approval

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

d) To support the appointment process for the above, the process for selection for the Local Authority Partner Members will be that the ICB will set out the requirements of the roles, namely and the upper tier local authorities will consider how best to serve the Board of the ICB with senior Officers from adults and children's social care and public health. The two Local Authority Members must therefore balance membership for each of those functions;

3.7.6 The term of office for this Partner Member will be 2 years, and the total number of terms they may serve is 3 terms.

3.8 **Executive Medical Director**

3.8.1 This member will fulfil the eligibility criteria set out at clause 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) meets the requirements as set out in the Executive Medical Director role description and person specification.

3.8.2 Individuals will not be eligible if:

(a) any of the disqualification criteria set out in clause 3.2 apply;

(b) any other exclusion criteria set out in the applicable NHS England guidance applies.

3.8.3 This member will be appointed by the Chief Executive, following a competitive process, subject to the approval of the Chair.

3.9 **Executive Director of Nursing and Quality**

3.9.1 This member will fulfil the eligibility criteria set out at clause 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) hold current valid registration with the Nursing and Midwifery Council;

(d) meet the requirements as set out in the Executive Director of Nursing role description person specification.

3.9.2 Individuals will not be eligible if:

(a) any of the disqualification criteria set out in clause 3.2 apply;

(b) any other exclusion criteria set out in the applicable NHS England guidance applies.

3.9.3 This member will be appointed by the Chief Executive, following a competitive process, subject to the approval of the Chair.

3.10 **Executive Director of Finance**

3.10.1 This member will fulfil the eligibility criteria set out at clause 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 qualified Accountant with full membership and evidence of up-to-date continuing professional development;

(c) Meets the requirements as set out in the Executive Director of Finance role description and person specification.

3.10.2 Individuals will not be eligible if:

(a) any of the disqualification criteria set out in clause 3.2 apply;

(b) any other exclusion criteria set out in the applicable NHS England guidance applies.

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

3.11 **Five Non-Executive Members**

3.11.1 The ICB will appoint five Non-Executive Members.

3.11.2 These members will be appointed by the Chair subject to the recruitment and selection process, one of which will be appointed as the Vice Chair. The Vice Chair will be nominated and selected by the Chair.

3.11.3 These members will fulfil the eligibility criteria set out at clause 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 ICS area;

(c) one shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit Committee;

(d) another should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration Committee;

(e) one member should have specific knowledge, skills and experience that makes them suitable to take the role of a senior independent member and take a lead role in the appraisal of the ICB Chair. This may not be the Chair of the Audit Committee.

3.11.4 Individuals will not be eligible if:

(a) any of the disqualification criteria set out in clause 3.2 apply;

(b) they hold a role in another health and care organisation within the ICB area;

(c) any other exclusion criteria set out in the applicable NHS England guidance applies;

(d) a conflict of interest is evident, as determined by the Chair, which results in the individual being unable to fulfil the role.

3.11.5 The usual term of office for a Non-Executive Member will be 3 years and the total number of terms an individual may serve is 2 terms with the potential to renew annually up to a maximum of 3 full terms (9 years).

3.11.6 In order to avoid a majority of the Non-Executive Member terms ending simultaneously, the Chair and Chief Executive will set the length of the initial term of office at between 2 and 3 years on a staggered basis across the roles.

3.11.7 Subject to satisfactory performance assessed through appraisal the ICB Chair may approve the re-appointment of a Non-Executive Member up to the maximum number of terms permitted for their role.

3.12 **Other Board Members**

3.12.1 Executive Director of People and Culture (Chief People Officer)

(a) This member will fulfil the eligibility criteria set out at clause 3.1 and also the following additional eligibility criteria:

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

(ii) meets the requirements as set out in the Executive Director of People and Culture (Chief People Officer) role description and person specification

(b) Individuals will not be eligible if:

(i) any of the disqualification criteria set out in clause 3.2 apply;

(ii) any other exclusion criteria set out in the applicable NHS England guidance applies;

(c) This member will be appointed by the Chief Executive subject to the approval of the Chair.

3.12.2 Regular Participants

(a) These participants will fulfil the eligibility criteria set out at clause 3.1 and also the following additional eligibility criteria:

(i) Executive Director of Corporate Affairs (Board Secretary);

(ii) Chair of Clinical and Professional Advisory Group (who will be a clinician); and

(iii) Other Executive Directors.

(b) Individuals will not be eligible if:

(i) any of the disqualification criteria set out in clause 3.2 apply; any other exclusion criteria set out in the applicable NHS England guidance applies;

(c) The above participants will be appointed by the Chief Executive subject to the approval of the Chair.

3.13 Board Members: Removal from Office

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

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

(a) if they no longer fulfil the requirements of their role or become ineligible for their role as set out in this Constitution, regulations or guidance;

(b) if they fail to attend a minimum of 50% of the meetings to which they are invited unless agreed with the Chair in extenuating circumstances;

(c) if they are deemed to not meet the expected standards of performance at their annual appraisal;

(d) if they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the ICB and is likely to bring the ICB into disrepute. This includes but it is not limited to dishonesty; misrepresentation (either knowingly or fraudulently); defamation of any member of the ICB (being slander or libel); abuse of position; non-declaration of a known conflict of interest; seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise;

(e) 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;

(g) if the role is no longer required (e.g. restructuring).

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

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

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

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

(a) terminate the appointment of the ICB's Chief Executive; and

(b) direct the chair of the ICB as to which individual to appoint as a replacement and on what terms.

3.14 Terms of Appointment of Board Members

3.14.1 With the exception of the Chair and Non-Executive Members, arrangements for remuneration and any allowances will be agreed by the Remuneration Committee

in line with the ICB remuneration policy and any other relevant policies published www.ddicb.nhs.uk 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 the Chief Executive.

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

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

3.15 Specific arrangements for appointment of Ordinary Members made at establishment

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

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

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

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

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

4. ARRANGEMENTS FOR THE EXERCISE OF OUR FUNCTIONS.

4.1 Good Governance

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

4.1.2 The ICB will agree a code of conduct and behaviours which sets out the expected behaviours that members of the board and its committees will uphold whilst undertaking ICB business. It also includes a set of principles that will guide decision making in the ICB. The ICB code of conduct and behaviours will be published in the Governance Handbook.

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; and

(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 clause 4.2.1(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 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 Scheme of Reservation and Delegation.

4.4 Scheme of Reservation and Delegation

4.4.1 The ICB has agreed a scheme of reservation and delegation (SoRD) which is published in full www.ddicb.nhs.uk.

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 www.ddicb.nhs.uk.

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; and

(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 subcommittees 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) operate under terms of reference and membership agreed by the ICB as relevant. Appropriate reporting and assurance mechanisms must be developed as part of agreeing terms of reference for Committees and Sub-Committees and reported to the board;

(b) ensure that committee terms of reference are approved by the board and aligned with the SoRD;

(c) ensure membership of the committees are specified by the board;

(d) provide reports to the board on their activities at agreed intervals;

(e) attend board Meetings at the invitation of the Chair;

(f) comply with the outputs of internal audit findings and committee effectiveness reviews;

(g) submit to the ICB board a decision and assurance report following each Committee meeting;

(h) submit their confirmed minutes to the ICB board for assurance;

(i) comply with agreed internal audit findings and committee effectiveness reviews;

(j) demonstrate consideration of the equality and diversity implications of decisions they make and consider whether any new resource allocation achieves positive change around inclusion, equality and diversity;

(k) ensure that members abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.

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

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

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

4.6.8 The following committees will be maintained:

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

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

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

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

4.6.9 The terms of reference for each of the above committees are published in the governance handbook.

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

4.7 Delegations made under section 65Z5 of the 2006 Act

4.7.1 As per clause 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:

(a) conducting the business of the ICB;

(b) the procedures to be followed during meetings; and

(c) 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 1 and form part of this Constitution.

5.2 Standing Financial Instructions (SFIs)

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

5.2.2 A copy of the SFIs published in the Governance Handbook available www.ddicb.nhs.uk.

6. ARRANGEMENTS FOR CONFLICT OF INTEREST MANAGEMENT AND STANDARDS OF BUSINESS CONDUCT

6.1 Conflicts of Interest

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

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

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 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**

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

6.2.1 decision-making will be open and transparent, will be inclusive and incorporate diverse views across the system. Decisions will be made in the interests of the health of the population and consistent with the statutory responsibilities of the ICB and ICS. Any individual involved in decisions relating to the ICB functions must be acting in the interests of the people of Derby and Derbyshire rather than furthering direct or indirect financial, personal, professional, or organisational interests. Decision making will be devolved to Place where appropriate.

6.2.2 the ICB has been created to give statutory NHS providers, local authority, and primary medical services (general practice) nominees a role in decision-making. These individuals will be expected to act in accordance with section 6.2.1(a), and it should not be assumed that they are personally or professionally conflicted by virtue of being an employee, director, partner or otherwise holding a position with one of these organisations;

6.2.3 the personal and professional interests of all ICB board members, ICB committee members and ICB staff who are involved in decision taking must 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;

6.2.4 actions to mitigate conflicts of interests 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 impact that the perception of an unsound decision might have, and the risks and benefits of having a particular individual involved in making the decision;

6.2.5 the ICB will clearly distinguish between those individuals who should be involved in formal decision taking, and those whose input informs decisions, including shaping the ICB's understanding of how best to meet patients' needs and deliver care for their populations. The way conflicts of interest are managed should reflect this distinction. For example, where independent providers (including the VCSE 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;

6.2.6 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 excuse themselves from the process; and

6.2.7 the way conflicts of interest are declared and managed will contribute to a culture of transparency about how decisions are made.

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; and

(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 www.ddicb.nhs.uk.

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

7.2 Principles

7.2.1 Subsidiarity: arrangements should be designed to facilitate decisions being taken as close to local communities as possible, and at a larger scale where there are clear benefits from collaborative approaches and economies of scale.

7.2.2 Population-focused vision: decisions should be consistent with a clear vision and strategy that reflects the four core purposes.

7.2.3 Shared understanding: partners should have a collective understanding of the opportunities available by working together and the impact of individual organisational decisions on other parts of the system.

7.2.4 Co-design and co-production: addressing system challenges and decision-making should involve working with people, communities, clinicians, and professionals in an equal way, sharing influence, skills and experience to design, deliver and monitor services and projects.

7.2.5 Timely access to information and data: system partners should share accurate and complete data (quantitative and qualitative) in an open and timely manner to enable effective decision-making.

7.2.6 Clear and transparent decision-making: system partners should work in an open way ensuring that decision-making processes stand up to independent scrutiny.

7.2.7 Accountability: arrangements should be in line with the accountability framework and to each other.

7.3 Meetings and publications

7.3.1 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.

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

7.3.3 Annual accounts will be externally audited and published.

7.3.4 A clear complaints process will be published.

7.3.5 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.

7.3.6 Information will be provided to NHS England as required.

7.3.7 The Constitution and governance handbook will be published as well as other key documents including but not limited to:

(a) Conflicts of Interest Policy and procedures;

(b) Registers of Interests;

(c) key policies.

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

(a) section 14Z34 to 14Z45 (general duties of integrated care boards); ;

(b) sections 223H and 223J (financial duties); and

(c) the proposed steps to implement the Derby City and Derbyshire County joint local health and wellbeing strategies.

7.4 Scrutiny and Decision Making

7.4.1 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 Nolan

Principles of Public Life and meet the criteria described in the Fit and Proper Person Test.

7.4.2 7.4.2 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.

7.4.3 The ICB will comply with the requirements of the NHS Provider Selection Regime, including: complying with existing procurement rules until the provider selection regime comes into effect.

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

7.5 **Annual Report**

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

(a) explain how the ICB has discharged its duties under section 14Z34 to 14Z45 and 14Z49 (general duties of integrated care boards)

(b) review the extent to which the ICB has exercised its functions in accordance with the plans published under section 14Z52 (forward plan) and section 14Z56 (capital resource use plan)

(c) review the extent to which the ICB has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised), and

(d) review any steps that the ICB has taken to implement any joint local health and wellbeing strategy to which it was required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.

8. ARRANGEMENTS FOR DETERMINING THE TERMS AND CONDITIONS OF EMPLOYEES.

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

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

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

a) permitting the Remuneration Committee to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions, provided that it follows any procedures put in place by the ICB for obtaining legal or professional advice;

b) the Human Resources Advisor may act as an attendee to the Remuneration Committee.

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

8.1.5 The main purpose of the Remuneration Committee is to exercise the functions of the ICB regarding remuneration included in relating to 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.

8.1.6 The duties of the Remuneration Committee include:

a) setting the ICB remuneration policy (or equivalent) and standard terms and conditions;

b) making arrangements to pay employees such remuneration and allowances as it may determine;

c) set remuneration and allowances for members of the board;

d) set any allowances for members of committees or sub-committees of the ICB who are not members of the board;

e) for the Chief Executive, Directors and other Very Senior Managers; determine all aspects of remuneration including but not limited to salary (including any performance-related elements), bonuses, pensions and cars;

f) determine arrangements for termination of employment and other contractual terms and non-contractual terms;

g) for all staff; determine the ICB remuneration policy (including the adoption of remuneration frameworks such as Agenda for Change);

h) oversee contractual arrangements;

i) determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate;

j) oversee the arrangements for the performance review for Directors/Senior Managers;

k) receive assurance in relation to ICB statutory duties relating to people such as compliance with employment legislation including such as Fit and Proper Person Regulation (FPPR);

l) setting the ICB remuneration policy (or equivalent) and standard terms and conditions;

m) set any allowances for members of committees or sub-committees of the ICB who are not members of the board; and

n) any other relevant duties.

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

9. ARRANGEMENTS FOR PUBLIC INVOLVEMENT

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

a) the planning of the commissioning arrangements by the Integrated Care Board;

b) the development and consideration of proposals by the ICB 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; and

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.

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

a) use our engagement model to put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS to ensure the voices of patients, service users, communities and staff are involved and that their insights are sought and utilised;

b) co-produce and redesign services and tackle system priorities in partnership with people and communities;

c) engender a culture of continuous engagement with people and communities and work with Healthwatch and community leaders as key partners;

d) build on the engagement assets of all partners in the ICS – networks, relationships, activity in local places;

e) start engagement at a formative stage when developing plans and feed back to people and communities how it has influenced activities and decisions;

f) understand our community's needs, experience and aspirations for health and care, using engagement to find out if change is working;

g) build relationships with excluded or harder to reach groups – especially those affected by inequalities – and create opportunities to engage where they do not currently exist;

h) provide clear and accessible public information about vision, plans and progress to build understanding and trust; and

i) govern our engagement strategy and activities through the relevant committee.

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

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 the 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; and

j) learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places.

9.1.4 In addition the ICB has agreed the following:

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

9.1.6 These arrangements, include:

a) a Communications and Engagement Strategy that is frequently reviewed by the ICB and where delivery is overseen by the relevant committee;

b) ensure arrangements are put in place that enable patient and public involvement at local Place level, and in the work of Provider Collaboratives;

c) appointment of a Non-Executive Member with a specific role to seek assurance on the ICB's arrangements for discharging its duties in relation to patient and public involvement;

d) deployment of our assets to support engagement, including:

i. our Citizen's Panel;
ii. our Online Engagement Platform;
iii. the System Insight Group and insight library;
iv. ensuring sufficient expertise, training and resources are available to support effective engagement;
v. arranging system-wide and place-based events and activities to speak to all stakeholders, including the ongoing deployment of our Derbyshire Dialogue model of online engagement.

Appendix 1 – Standing Orders

1. INTRODUCTION

These Standing Orders have been drawn up to regulate the proceedings of NHS Derby and Derbyshire 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 the 1st of July 2022.

2.2 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 section 5.1 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 2.

3.2 These standing orders apply to all meetings of the board, including its committees and sub-committees unless otherwise stated. All references to 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 Executive Director of Corporate Affairs will provide a settled view which shall be final.

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

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

4. MEETINGS OF THE INTEGRATED CARE BOARD

4.1 Calling Board Meetings

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

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

(a) the Chair may call a meeting at any time by giving not less than 14 calendar days' notice in writing;

(b) one third of the members of the board may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the board members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the board specifying the matters to be considered at the meeting; and

(c) in emergency situations the Chair may call a meeting with two 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 if part of a meeting 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, a member of the ICB, board, committee or sub-committee respectively shall be chosen by the members present, or by a majority of them, and shall preside.

4.2.3 The board 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.ddicb.nhs.uk.

4.4 **Petitions**

4.4.1 Where a valid petition has been received by the ICB it shall be included as an item for the agenda of the next meeting of the board in accordance with the ICB policy as 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 vote on their behalf. Partner Members and Executive Directors will ensure the attendance of a nominated deputy at all meetings where they are unable to attend.

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

4.6 **Virtual attendance at meetings**

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.

4.7 **Quorum**

4.7.1 The quorum for meetings of the Board will be at least 7 members, including:

(a) ICB Chair; plus

(b) either the Chief Executive or the Executive Director of Finance;

(c) either the Executive Medical Director or the Executive Director of Nursing and Quality;

(d) at least two Non-Executive Members; and

(e) at least two Partner Members.

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; and

(c) 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) a representative from the specific category where the vacancy or defect exists would attend.

4.9 Decision making

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

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

(a) all members of the board who are present at the meeting will be eligible to cast one vote each;

(b) in no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so;

(c) for the sake of clarity, any additional Participants and Observers (as detailed within paragraph 2.2 of the Constitution) 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; and

(f) should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

4.9.3 <u>Disputes</u>

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

4.9.4 Urgent decisions

(a) In the case of urgent decisions and extraordinary circumstances, every attempt will be made for the board to meet virtually. Where this is not possible the following will apply.

(b) The powers which are reserved or delegated to the board, may for an urgent decision be exercised by the Chair (or Vice Chair in the Chair's absence) and Chief Executive (or Deputy Chief Executive in the Chief Executive's absence) subject to every effort having been made to consult with as many board members as possible in the given circumstances.

(c) The exercise of such powers shall be reported to the next formal meeting of the board for formal ratification and the Audit Committee for oversight.

4.10 **Minutes**

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

4.10.2 The minutes of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be signed 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 Committee for review of the reasonableness of the decision to suspend Standing Orders.

6. USE OF SEAL AND AUTHORISATION OF DOCUMENTS.

6.1 **Integrated Care Board's seal**

The ICB may have a seal for executing documents where necessary. The following individuals or officers are authorised to authenticate its use by their signature:

6.1.1 the Chief Executive;

6.1.2 the Executive Director of Finance;

6.1.3 the Executive Director of Corporate Affairs (Board Secretary).

6.2 **Execution of a document by signature**

The following individuals are authorised to execute a document on behalf of the ICB by their signature.

6.2.1 the Chief Executive;

6.2.2 the Executive Director of Finance;

6.2.3 the Executive Director of Corporate Affairs (Board Secretary).

Appendix 2 – 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 paragraph 2 of this Constitution.
Committee	A committee created and appointed by the ICB board.
Sub-Committee	A committee created and appointed by and reporting to a committee.
Governance Handbook	The ICB Governance Handbook the contents which are described in section 1.7.3 (d)
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.
Provider Collaborative	NHS Trusts working together to achieve better outcomes for people and ensure sustainable services in the future.
Ordinary Member	The board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the board are referred to as Ordinary Members.
Partner Members	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are and appointed in accordance with the procedures set out in Section 3 having been nominated by the following**:** • NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description • the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description the local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.

Health Service Body	Health service body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.
	ICBs should add local definitions as required and should always include any local terms that refer to legally prescribed roles or functions.

NHS Derby and Derbyshire Integrated Care Board

Governance Handbook

KEY MESSAGES	
1.	Brings together a range of corporate statutory documents in one place
2.	Aims to assist the ICB in building a consistent corporate approach to its day to day operation
3.	Forms part of the ICB's corporate memory

VERSION CONTROL

Title:	NHS Derby and Derbyshire Integrated Care Board Governance Handbook
Supersedes:	Governance Handbook for NHS Derby and Derbyshire CCG.
Description of Amendment(s):	Versions 0.1, 0.2, 0.3, 0.4 and 0.5 – Initial drafts Version 0.6 – final draft following review by shadow ICB Board
Financial Implications:	See sections 8, 9 and 10.
Policy Area:	Corporate and Finance
Version No:	Version 0.6
Author:	Corporate Delivery and Finance
Approved by:	Audit and Governance Committee, TBC
Effective Date:	July 2022
Review Date:	June 2024
List of Referenced Policies	Continuing Healthcare Policy Corporate Governance Framework Disciplinary Policy Fraud, Bribery and Corruption Policy Individual Funding Requests Policy Policy Management Framework Procurement Policy Raising Concerns at Work (Whistleblowing) Policy Recruitment and Selection Policy Risk Management Strategy Standards of Business Conduct and Managing Conflicts of Interest Policy *See also section 1.4 of Standards of Business Conduct and Managing Conflicts of Interest Policy*
Key Words section (metadata for search facility online)	Governance Handbook Governance Structure Conflicts of Interest Standing Financial Instructions Prime Financial Policies Corporate Governance Framework Terms of Reference Member Practices Scheme of Reservations and Delegation
Reference Number	CD05

Target Audience	ICB approved policies apply to all employees, contractors, volunteers, and others working with the ICB in any capacity. Compliance with ICB policy is a formal contractual requirement. Compliance with ICB policy is a formal contractual requirement and failure to comply with the policy, including any arrangements which are put in place under it, will be investigated and may lead to disciplinary action being taken.

CONTENTS

1. PURPOSE

1.1 The purpose of this document is to bring together a range of corporate statutory documents in one place and is described as the NHS Derby and Derbyshire Integrated Care Board Governance Handbook (the "ICB Governance Handbook").

1.2 The ICB Governance Handbook is not a legal requirement; however it is an approach that will assist NHS Derby and Derbyshire Integrated Care Board (the "ICB") to build a consistent corporate approach and form part of the corporate memory.

1.3 The handbook includes:

1.3.1 Committee Terms of Reference;

1.3.2 Integrated Care System – Committee Terms of Reference;

1.3.3 Eligible Providers of Primary Medical Services

1.3.4 Scheme of Reservations and Delegation (SoRD);

1.3.5 Standing Financial Instructions;

1.3.6 Corporate Governance Framework;

1.3.7 Standards of Business Conduct Policy; and

1.3.8 Managing Conflicts of Interest Policy.

1.4 The ICB Governance Handbook will be published on the ICB's website for transparency and ease of access and updated regularly as a routine reference guide for member practices, staff and the public.

2. FUNCTIONS AND DECISION MAP

FUNCTIONS & DECISION MAKING: COMPONENT PARTS OF THE JUCD ICS

Integrated Care Board (ICB)

Integrated Care Boards (ICBs) will be new statutory organisations, to lead integration within the NHS. They will bring the NHS together locally to improve population health and establish shared strategic priorities within the NHS, connecting to partnership arrangements at system and place.

Health and Wellbeing Boards (HWBs)

Derby City Council

Derbyshire County Council

Integrated Care Partnership (ICP)

The Integrated Care Partnership (ICP) will align the ambitions, purpose and strategies of partners across each system. ICPs are:

- a forum for NHS and local authority leaders to come together with stakeholders from the system & community.
- responsible for generating an integrated care strategy to improve population health, address inequalities and the wider determinants of ill health

Relationships, networks, listening and shaped by communities, communications, information

Provider Collaborative

Partnership arrangements involving at least two trusts working at scale, with a shared purpose and effective decision-making arrangements

Place at Scale (City and County)

Population Health: Places should focus on improving the health and wellbeing for the population, preventing ill health and addressing health inequalities.

Integration: Improve the quality, co-ordination and accessibility of health and care services and build coalitions across a range of community partners.

Statutory organisations, primary and social care, voluntary sector, partners in addressing determinants of ill health

NHS DERBY AND DERBYSHIRE INTEGRATED CARE BOARD FUNCTIONS AND DECISIONS MAP

NHS Derby and Derbyshire Integrated Care Board

The Derby and Derbyshire Integrated Care Board (ICB) Functions and Decisions Map sets out the governance arrangements that support collective accountability between partner organisations for whole-system delivery and performance. The purpose of this Functions and Decisions Map is to facilitate transparent decision-making and foster the culture and behaviours that enable system working. This document should be read in conjunction with the ICB Constitution, ICB Statutory Functions and the Scheme of Reservations and Delegations documentation.

NHS England & Improvement, Department of Health & Social Care, and Local Government Association

Responsible for: Setting the direction and supporting the commissioning of high-quality services to deliver the NHS Long Term Plan balancing national direction with local autonomy to secure the best outcomes for patients. Making decisions about how best to support and assure performance, as well as supporting system transformation and the development of Integrated Care Systems. Acting as guardians of the health and care framework: by ensuring the legislative, financial, administrative and policy frameworks are fit for purpose and work together.

Derby and Derbyshire Integrated Care Partnership

Chair: Rotating City/County HWB and JUCD ICB Chairs
Lead Exec: Strategic Directors of LAs/ICB CEO

Accountabilities:

- Statutory forum where political, clinical, professional and community leaders from across the care and health system come together
- Provide leadership and advise to improve the health and wellbeing of their local population and reduce health inequalities
- Duty to prepare and publish a Joint Strategic Needs Assessment (JSNA) of current and future health and social care needs in relation to the population of the local authority.
- Prepare and publish a Pharmaceutical Needs Assessment (PNA) to assess the need for pharmaceutical services in Derby.
- Prepare and publish a Health and Wellbeing Strategy – a strategy for meeting the needs identified within the JSNA which sets the vision and high-level outcomes and priorities for their areas.
- Duty to encourage integrated working - to advance the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner.
- Provide such advice, assistance or other support as it thinks appropriate for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006
- Work collaboratively across local authority area to improve health and wider population outcomes inc. work with Place and Derby Partnership Board

Decisions:

- Support HWB outcomes & priorities and the co-ordination of plans for the integration of health and social care services to improve health and wellbeing of the population and reduce inequalities
- Agree content for contribution to the ICB's Annual Report.
- Drive greater use of resources in prevention (but financial decisions reserved to SFEC)

Derby and Derbyshire Integrated Care Board

Chair: ICB Chair
Lead Exec: ICB CEO

Accountabilities:

- Statutory organisation leading integration across the NHS. to improve population health and establish shared strategic priorities within the NHS, connecting to partnership arrangements at system and place.
- Ensure compliance with legal and statutory duties and obligations including quality, provider selection regime, the People Plan, public involvement and data and digital priorities, emergencies.
- Develop a plan and allocate resource to meet the health and healthcare needs of the population including provision, contracting etc.
- Establish joint working arrangements with partners that embed collaboration as the basis for delivery within the plan.
- Establish governance arrangements to support collective accountability for whole-system delivery and performance.
- Publish an Annual Report setting out how duties were discharged in the previous year.

Decisions:

- Agree and publish a constitution and annual report.
- Agree and publish a plan setting out how it will discharge its duties including the strategies of the HWBBs and strategic objectives and risks.
- Receive assurance from its committees as to the satisfactory discharge of statutory functions and duties or agree remedial actions as appropriate.
- Agree allocation of resources in line with financial regulations and strategic priorities.
- Agree process for assuming delegated responsibilities from NHSEI and for joint working on specialised services.

System Executive Senior Leadership Team

Chair: Rotating Chief Officers

Accountabilities:

- Executive level oversight of NHS delivery and performance and transformation.
- Managing the system's process of operational control and escalation
- Executive connection to inform the Integrated Care Partnership and enable focus on collective opportunities and actions to address health inequalities, improving life expectancy and healthy life expectancy, including anchor institution developments

Decisions:

- Agreeing and allocating the necessary resources (financial, knowledge, people and time) required to build the capacity and capability deliver the system objectives.
- Reviewing and endorsing recommendations from sub-groups to ensure successful delivery, where necessary unblocking obstacles preventing progress
- Individual members may make decisions on behalf of their organisations

Health & Wellbeing Boards

Derbyshire County H&W Board **Derby City H&W Board**

Accountabilities:

- Sets the vision and high-level outcomes and priorities for their areas.
- Conducts Joint Strategic Needs Assessments for their areas and for setting the high-level priorities and outcomes in the Joint Health and Wellbeing Strategies.
- Encourages integrated working between health, care, police and other public services in order to improve wellbeing outcomes for the local population.

Decisions:

- Agree priorities and the co-ordination of plans for the integration of health and social care services to improve health and wellbeing of the population and reduce inequalities
- Agree content for contribution to the ICB's Annual Report.

INTEGRATED PLACE EXECUTIVE

Chair: Dr Penny Blackwell
Lead Exec: Tracy Allen (NHS) and Helen Jones (LA)

Accountabilities:
One Integrated Place Executive (IPE) to co-ordinate and deliver the set of activities that are best done once. These include for example:

- Identifying Place priorities from system strategic plans (e.g., ICB NHS plan, ICP Integrated Care Strategy)
- Planning and overseeing the integration and co-ordination of integrated health and care services.
- Managing relevant whole system transformation programmes.
- Interface with provider collaborative and delivery board output to determine implications for place based provision.
- Hold delegated resources/accountability from ICB (via NHS Lead Provider in first instance).
- Identifying and addressing system / inter-agency barriers to integrated care.

Decisions:

- Agree the operating model for place based working
- Agree on deployment of local assets and resources to support health, social and economic development, including procurement
- Agree integrated and responsive services
- Agree transition plans and support for Glossop

System Providers

X2 Place Alliances (City and County) and PCNs

PROVIDER COLLABORATIVE AT SCALE

Provider Collaborative Leadership Board
Chair: TBC
Lead Exec: TBC

Accountabilities:

- Provide joint system leadership to transform and address provider quality and efficiency, working together at scale with a shared purpose and effective decision-making arrangements.
- Plan, deliver and transform services, address unwarranted variation and inequality in access, experience and outcomes across wider populations, improve resilience and ensuring that specialisation and consolidation occur where this will provide better outcomes and value.

Decisions:

- Identify and agree opportunities and priorities for collaboration in line with strategic objectives
- Agree on deployment of local assets and resources for service recovery, restoration and transformation
- Agree management of risks and mitigations of each provider partner
- Agree strategic plan collaboration for recommendation to ICB Board

Derby and Derbyshire
Integrated Care Board

STATUTORY ICB COMMITTEES

ICB COMMITTEES with SYSTEM MEMBERSHIP

NATIONAL QUALTIY BOARD MANDATED COMMITTEE

DERBY AND DERBYSHIRE INTEGRATED CARE BOARD
Chair: **ICB Chair**
Lead Exec: **ICB CEO**

- Statutory organisation leading integration across the NHS. to improve population health and establish shared strategic priorities within the NHS, connecting to partnership arrangements at system and place.
- Ensure compliance with legal and statutory duties and obligations including quality, provider selection regime, the People Plan, public involvement and data and digital priorities, emergencies.
- Develop a plan and allocate resource to meet the health and healthcare needs of the population including provision, contracting etc.
- Establish joint working arrangements with partners that embed collaboration as the basis for delivery within the plan.
- Establish governance arrangements to support collective accountability for whole-system delivery and performance.
- Publish an Annual Report setting out how duties were discharged in the previous year.

INTEGRATED CARE BOARD COMMITTEES

REMUNERATION COMMITTEE

Chair: **NEM for Remcom & People Strategy**
Lead Exec: **ICB CEO**

Accountabilities:
- Makes recommendations to the ICB about pay, terms of service and remuneration including fees and pensions.
- Reviews as required, the Chief Executive and individual senior officers' and managers' performance.
- Advises on and oversees contractual arrangements for staff

Decisions:
- Determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses, pensions and cars.
- Determine arrangements for termination of employment and other contractual terms and on-contractual terms.
  - Determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change);
  - Oversee contractual arrangements.
- Determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate

AUDIT AND GOVERNANCE COMMITTEE

Chair: **NEM for Audit and Governance**
Lead Exec: **Executive Director of Finance / Executive Director of Corporate Affairs (Board Secretary)**

Accountabilities:
- Tests the system and receives assurance on the robustness of an effective system of integrated governance, compliance with regulations and public law, risk management and internal control, across the whole of the ICB's activities, including emergency preparedness, IG and cyber security.
- Ensures compliance with regulations governing best practice in relation to procurement, protecting and promoting patient choice, and anti-competitive conduct; complying with public law requirements when entering into contracts concerning commissioning arrangements and use of public monies.
- Ensures that relevant conflicts of interests that affect the integrity of the ICB's decision making processes are declared and included in registers.
- Oversee policy development including ICB staff policy, estates and NHS Green agenda.

Decisions:
- Commission reports, legal advice or other professional support to help fulfil its obligations
- Create sub-groups to undertake specific pieces of work on behalf of the Committee
- Agree on assurances received, or remedial action required as to the adequacy of governance, risk management and internal control processes within the ICB
- Provides independent and objective recommendation of the external auditors to be appointed for the ICB and agrees external and internal audit plans.

QUALITY AND PERFORMANCE COMMIITTEE

Chair: **NEM for Quality and Performance**
Lead Exec: **Executive Director of Nursing & Quality**

Accountabilities:
- Provides quality and performance assurance and improvement across all providers of health and care in Derby and Derbyshire.
- Creates a culture of support, collective leadership, mutual holding to account and triangulates information and intelligence to safeguard the quality of care.
- Provides a mechanism of identifying risks to quality and performance and opportunities for improvement.
- Secures continuous improvements in quality and outcomes of clinical effectiveness, safety and patient experience
- Ensures assessment and provision of Safeguarding services, Continuing Health Care, Funded Nursing Care and Personalised Health Budgets and Individual Funding Requests

Decisions:
- Agree whether assurance is received or whether remedial actions required in relation to the quality, performance, safety, experience and outcomes of services, including metrics used to provide assurance.
- Implementation of investigatory processes where appropriate and agree any actions arising.
- Commission any reports, surveys or reviews of services it deems necessary to help it fulfil its obligations

POPULATION HEALTH & STRATEGIC COMMISSIONING COMMITTEE

Chair: **NEM for Strategy & Planning**
Lead Exec: **Executive Director of Strategy & Planning**
Accountabilities:
- Prepares and publishes a whole population health commissioning plan for physical and mental healthcare for patients in the geographical area, with the involvement of the Health and Wellbeing Boards and local community organisations and aligned to the strategy developed by the ICP.
- Develops and implements the commissioning strategy and policy of the ICB and helps to secure continuous improvement of the quality of services, retaining particular focus on health inequalities.
- Supports providers to lead major service transformation programmes, ensuring improved outcomes and quality to deliver and achieve the ICB's strategic and operational plans within financial allocations.
- Secures continuous improvement in the quality of primary medical care services.
- Promotes research and innovation.

Decisions:
- Agree priorities for prevention, early detection, reduction of health inequalities and continuous improvement, and programme of work to deliver.
- Agree allocation of resources to service strategy and plan including investments to be proposed.
- Clinically review business cases and approve or reject.
- Take decisions relating to the management of delegated functions.
- Receive assurance that commissioning decisions are underpinned and informed by communications and engagement with the membership and local population as appropriate.

FINANCE AND ESTATES COMMITTEE

Chair: **NEM for Finance**
Lead Exec: **Executive Director of Finance**

Accountabilities:
- Establishes a financial performance framework which enables the Establishes a financial performance framework which enables the ICB proactively to manage its financial, performance and savings agenda. Scrutinise and provide assurance to the Board in respect of the organisation's management of its financial performance and risk.
- Ensures the ICB operates within agreed budgets and proposes plans and necessary actions to maintain financial balance.
- Oversees development of the system estates strategy and plans to ensure it properly balances clinical, strategic and affordability drivers. Gain assurance that the estates plan is built into the system financial plans

Decisions:
- Agree the financial planning model to be adopted and relevant contractual frameworks, including the financial intelligence function
- Agree a system financial target, financial plans and priorities to be recommended to the Board
- Approve or reject business cases including investments or disinvestments
- Agree a 12-month operational and 5-year rolling strategic plan and any remedial actions required to deliver

PEOPLE AND CULTURE COMMITTEE

Chair: **NEM for Remcom & People Strategy**
Lead Exec: **Chief People Officer**

Accountabilities:
- Delivers the commitments of the NHS People Plan across the Derby and Derbyshire system.
- Oversees plans to develop, support and retain the health and care workforce, adopting a "one workforce" approach with all partners across the ICS, promoting the education and training of existing and future health care staff.
- Ensures workforce capacity and capability together with an organisational development plan; oversees the demonstration of equality, diversity and inclusion for all NHS staff.
- Supports the wellbeing of the workforce including health and safety, safeguarding and security management.

Decisions:
- Identify and agree actions to support ways of working at true system level including standardised systems
- Agree work programme for delivery of the People Plan
- Review workforce analysis and approve plans to address gaps
- Approve plans for organisational and staff development
- Agree collaborative recruitment and retention strategies

SYSTEM QUALITY GROUP

Chair: **Executive Director of Nursing & Quality**
Lead Exec: **Executive Director of Nursing & Quality**

Accountabilities:
- Enables system alignment on quality across the Integrated Care System across pathways, services and sectors
- Focuses on developing and reviewing shared quality priorities for the system; sharing knowledge, understanding risks Provides quality oversight in relation to public health outcomes and the wider determinants of health; and take appropriate action as required to reduce health inequalities.
- Receives quality and outcome information against key performance trajectories and identify quality issues
- Promotes the use of the Clinical Governance Matrix framework to provide one Quality Report that will assure the system and each statutory board of delivery against all Key Quality Indicators, aligned to the Quality Framework
- Ensures that the system organisations discharge their statutory duties in relation to the achievement of continuous quality improvement

Decisions:
- Agrees collective action necessary to achieve objectives or performance regimes.
- Agrees action required to address any quality issues
- Identify and agree processes to be established to deliver objectives.

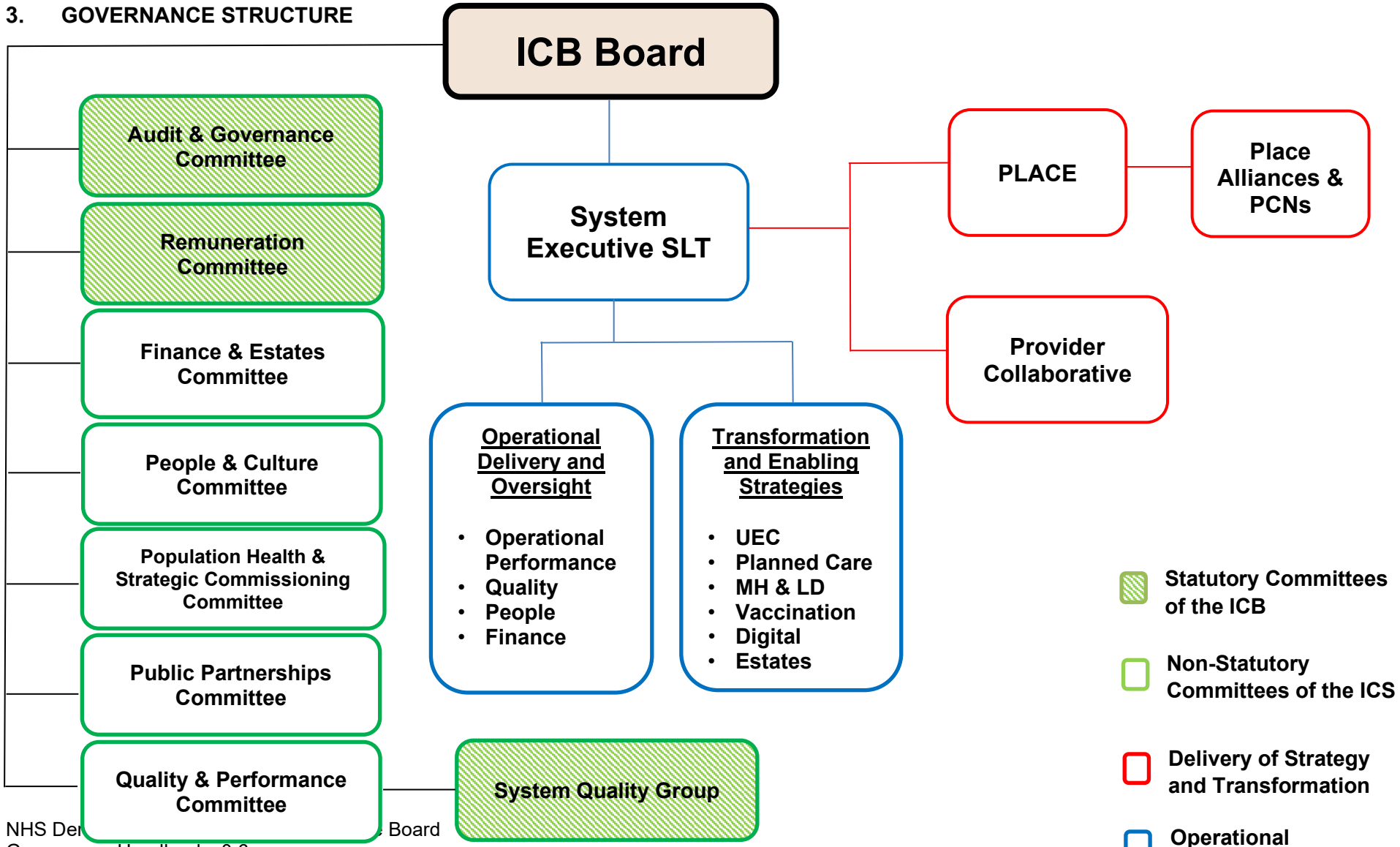
PUBLIC PARTNERSHIPS COMMITTEE

Chair: **NEM for Engagement**
Lead Exec: **Executive Director of Corporate Affairs (Board Secretary)**

Accountabilities:
- Ensures appropriate engagement and consultation with patients and the public for new or changing services and assesses the levels of assurance and risk.
- Ensures the local health system develops robust processes in the discharging of duties relating to involvement and consultation; seeks assurance that the Derbyshire system is following defined processes relating to due regard.
- Ensures published plans include patient views expressed and how they were addressed.
- Ensures involvement of traditionally underrepresented groups in shaping and influencing service development, with a particular focus of helping to reduce inequalities in health.

Decisions:
- Agree approach to formal consultation programme
- Receive and agree assurance that patients and the public are an integral part of designing, commissioning, transforming and monitoring services
- Agree assurance or risk that statutory duties relating to Patient and Public Engagement, as laid out in the Health & Social Care Act 2012, including those relating to Local Authority Scrutiny and that staff are appropriately trained
- Agree responses to external reviews and implementation of any learning.

3. GOVERNANCE STRUCTURE



4. INTEGRATED CARE BOARD COMMITTEES

4.1 Statutory Committees

4.1.1 Audit and Governance Committee

The Committee will incorporate the following duties:

(a) integrated governance, risk management and internal control;

(b) Internal Audit;

(c) External Audit;

(d) Corporate Governance;

(e) other assurance functions - reviews by Department of Health arm's length bodies or regulators/inspectors and professional bodies with responsibility for the performance of staff or functions;

(f) Counter Fraud;

(g) Freedom to Speak Up;

(h) Information Governance;

(i) financial reporting;

(j) Conflicts of Interest;

(k) management - request and review reports and positive assurances from directors and officers of the ICB on the overall arrangements for governance, risk management and internal control; and

(l) communication – coordinate and manage communications on governance, risk management and internal control with stakeholders internally and externally.

4.1.2 Remuneration Committee

The Committee will incorporate the following duties:

(a) with regard to the Accountable Officer, Directors and other Very Senior Managers – making recommendations relating to all aspects of salary (including any performance-related elements, bonuses);

(b) making recommendations to contractual arrangements for clinicians engaged to support the ICB Board;

(c) making recommendations on provisions for other benefits, including pensions and cars;

(d) making recommendations for arrangements for termination of employment and other contractual terms (decisions requiring dismissal shall be referred to the ICB Board);

(e) ensuring that officers are fairly rewarded for their individual contribution to the organisation having proper regard to the organisation's circumstances and performance and to the provisions of any national arrangements for such staff;

(f) ensuring proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate, advising on and overseeing appropriate contractual arrangements for such staff. This will apply to all ICB staff; and

(g) ensuring proper calculation and scrutiny of any special payments.

4.1.3 System Quality Group

The Committee will be responsible for:

(a) ensuring a collaborative approach to promote multi-professional leadership, a shared vision for Quality with the System and a culture of learning and improvement to ensure provision of high-quality sustainable services;

(b) seeking assurance on the performance of Health and Social Care organisations within the ICS in terms of the Care Quality Commission and any other relevant regulatory bodies;

(c) ensuring there are clear roles and accountabilities in relation to quality oversight, with effective improvement mechanisms and processes to effectively identify early warning signs that there is a quality issue;

(d) ensuring processes are established to manage risk emerging from poor quality, and providing assurance that local, national and regional policy requirements are embedded in services;

(e) having oversight of the Patient Safety Strategy, being informed of all Never Events and informing the key partners of any escalation or sensitive issues;

(f) ensuring considerations relating to safeguarding children and adults are integral to services and robust processes are in place to deliver statutory functions of all Health and Social Care Organisations within the ICS;

(g) having oversight in terms of variation and risk across clinical pathways and to provide a view on the quality aspects of clinical pathways, care journeys and Transformation Programmes;

(h) ensuring that processes are in place to provide assurance and oversight that services are high quality; meaning that they are safe, effective, caring, responsive and well-led and provide patients, service users and carers with positive experiences of care;

(i) using data and intelligence in order to identify and prioritise the most important quality issues, enabling corrective action to be taken; and

(j) taking action where required to investigate any quality, safety or patient experience concerns and to ensure that a clearly defined escalation process is in place, taking action to ensure that improvements in quality are implemented where necessary.

4.2 Non-Statutory Committees

4.2.1 Finance and Estates Committee

The Committee will be responsible for the:

(a) delivery of the single system-wide finance, digital and estates (including continuous improvement) plan built around a re-defined way of delivering care (as defined by the JUCD strategy, vision and objectives) regarding:

(i) deliverability and level of risk;

(ii) whether the plan delivers the best return on the resources available and can be delivered within the resources available;

(b) providing oversight of the framework and strategy for finance, digital and estates planning to ensure that each of the system partners have plans which are compatible with and compliment the system approach;

(c) oversight of the management of the system financial target, and overseeing development of a 5-year rolling system financial projection which demonstrates ongoing efficiency and value improvements/impacts of longer term investments;

(d) Overseeing development of the JUCD future financial regime and recovery to address our known financial pressures and to provide assurance to the ICB Board;

(e) ensuring effective oversight of future prioritisation and capital funding bids;

(f) oversight and monitoring of financial, digital, estates and continuous improvement performance and delivery in order to give the ICB Board confidence that JUCD is implementing its strategic outcomes;

(g) providing the ICB Board with an accurate understanding of the system's current and forecast financial position and the development and oversight of the system's medium term financial recovery plan to correct any underlying challenge;

(h) considering full business cases for material service change or efficiency schemes;

(i) managing associated risks by developing and monitoring a Finance, Digital and Estates Committee Risk Register;

(j) reviewing exception reports on any material:

(i) breaches of the delivery of agreed efficiency improvement plans including the adequacy of proposed remedial action plans; and

(ii) in-year overspends against delegated budgets, including the adequacy of proposed remedial action plans;

(k) having responsibility to the ICB Board for oversight and advice on the current risk exposures with regard to the short and long term financial plans and the associated recovery strategies;

(l) identifying and allocating resources where appropriate to improve performance of identified schemes or ad-hoc finance and performance related issues that may arise;

(m) considering significant investment or disinvestment decisions;

(n) reviewing the forward agenda for the Committee to ensure preparatory work to meet national planning timelines are appropriately scheduled;

(o) ensuring that suitable policies and procedures are in place to comply with relevant regulatory, legal and code of conduct requirements;

(p) reviewing the adequacy and effectiveness of relevant policies and procedures for ensuring compliance and related reporting; and

(q) having oversight of the system Recovery and Restoration work related to finance and efficiency and receive assurance regarding progress.

4.2.2 People and Culture Committee

The Committee will be responsible for:

(a) ensuring that the Derby and Derbyshire ICS has an ambitious People and Culture strategy;

(b) ensuring the People and Culture strategy supports the ICS and its partners to achieve the ambition to be an Anchor Institution;

(c) improving equality, diversity, and inclusion for our current and future workforce; maximising our potential as employers to reduce health and inequalities and to improve the health and wellbeing of our communities;

(d) promoting a positive culture to enable the system to be an agile, inclusive, and modern employer to attract, recruit and retain the people we need to deliver our plans;

(e) overseeing the development and delivery of the work programme to grow our system leadership capacity, capability, talent, and culture across our ICS;

(f) ensuring there is a robust package of support and focus on the wellbeing of the workforce including health and safety, safeguarding and security management across our ICS;

(g) ensuring plans are in place to develop, support and retain the health and care workforce, adopting a "one workforce" approach with all partners across the ICS, promoting collaborative recruitment, education and training of existing and future health and care staff where appropriate;

(h) ensuring analysis and intelligence is used to coordinate our ICS workforce plan that integrates workforce, activity and finance planning where appropriate across health and care to meet current and future population, service and workforce needs, across programmes, pathways and Place;

(i) overseeing the development and progress of a system wide approach to delivering People Services; ensuring the ten People Functions for the ICS are in place to make Derby and Derbyshire a better place to live and work for the ICS people; and

(j) promoting integrated system-working and to support collaborative working at scale.

4.2.3 Public Partnerships Committee

The Committee will be responsible for:

(a) making recommendations on the 'phase 2' responsibilities of the Committee, likely from autumn 2022, concurrent with the confirmation of the scope of the Integrated Care Partnership, specifically relating to the scope, reporting arrangements and membership of this committee;

(b) championing patient and public engagement across the Derbyshire health and care system, providing a watchful eye in scrutinising service developments;

(c) ensuring that the development and delivery of the Derby and Derbyshire Integrated Care Strategy is driven by the insight and opinions gathered from local people;

(d) championing the routine principles of continuous engagement and co-production when assessing all public engagement activity, challenging and escalating findings where standards and principles have not been met;

(e) seeking assurance of work to reach underserved groups and that this is being coordinated across partners and agencies, ensuring that all voices are being heard;

(f) seeking assurance, through reports, reviews and presentations that the public are an integral part of designing, commissioning, transforming and monitoring services;

(g) seeking assurance that the ICB and wider system are meeting statutory duties relating to Patient and Public Engagement, as laid out in the Health & Care Act 2022, including those relating to Local Authority Scrutiny;

(h) seeking assurance that the system has robust mechanisms for training relevant staff on statutory duties relating to Patient and Public Engagement, as laid out in the Health & Care Act 2022;

(i) overseeing the development and delivery of a robust infrastructure of engagement mechanisms including, but not limited to, place-level engagement, reference groups to provide insight on emerging issues, a citizen's panel from which can be drawn individuals across a matrix of geography/conditions/protected characteristics, project-specific lay representation and other mechanisms as required;

(j) ensuring due process and appropriate methodologies have been followed in terms of involving the public in system projects, including providing constructive advice and challenge on proposed methods;

(k) signing off the approach to all formal consultation programmes, either with delegated authority from the ICB Board or prior to their final sign off at those meetings;

(l) seeking assurance that the system has processes to ensure that adherence to the Equality Act duties of due regard is informing engagement programmes accordingly;

(m) reporting to the ICB Board with regard to key risk areas and monitoring actions;

(n) making recommendations for improvements and innovations in the way the system works with patients and the public;

(o) overseeing the development, completion and action planning of any internal or external audits relating to public engagement;

(p) responding to external reviews and National Lessons Learnt reviews and bulletins especially with regards to the way patients and the public are engaged;

(q) ensuring that all voices are heard at committee and programme meetings and that all groups are given appropriate opportunity to shape local services;

(r) acting as an advocate for the engagement work being carried out for the future of health and social care in Derbyshire through appropriate networks.

4.2.4 Quality and Performance Committee

The Committee will be responsible for:

(a) assuring that there are robust processes in place for the effective management of quality and performance;

(b) scrutinising structures in place to support quality, performance, planning, control and improvement, to be assured that the structures operate effectively and timely action is taken to address areas of concern;

(c) agreeing and put forward the key quality priorities that are included within the ICB strategy/annual plan, including priorities to address variation/inequalities in care;

(d) overseeing and monitor the delivery of the ICB key statutory requirements;

(e) reviewing and monitoring those risks on the Board Assurance Framework and the System Quality Group Risk Register which relate to quality and performance, and high-risk operational risks which could impact on care. the System Quality Group will need to escalate relevant risks to the Corporate Risk Register;

(f) ensuring the ICB is kept informed of significant risks and mitigation plans, in a timely manner;

(g) overseeing and scrutinising the ICB's response to all relevant Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the Department of Health and Social Care, NHSEI and other regulatory bodies/external agencies (e.g. CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained;

(h) maintaining an overview of changes in the methodology employed by regulators and changes in legislation/regulation and assure the ICB that these are disseminated and implemented across all sites;

(i) overseeing and seeking assurance on the effective and sustained delivery of the ICB Quality Improvement Programmes;

(j) ensuring that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place;

(k) receiving assurance that the ICB identifies lessons learned from all relevant sources, including, incidents, never events, complaints and claims and ensures that learning is disseminated and embedded;

(l) receiving assurance that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from death (including coronial inquests and PFD report);

(m) being assured that people drawing on services are systematically and effectively involved as equal partners in quality activities;

(n) scrutinising the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children;

(o) scrutinising the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for infection prevention and control;

(p) scrutinising the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for equality and diversity as it applies to people drawing on services;

(q) scrutinising the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety; and

(r) having oversight of and approve the Terms of Reference and work programmes for the groups reporting into the Committee (e.g. System Quality Groups, Infection Prevention and Control, Safeguarding Boards /Hubs etc.).

4.2.5 Population Health and Strategic Commissioning Committee

The Committee will be responsible for:

(a) ensuring strategic, long-term and outcome-based contracts and agreements are in place to secure the delivery of the ICB's commissioning strategy and associated operating plans;

(b) overseeing the preparation and publication of the ICB's commissioning strategy and associated operating plans, aligned to the Health and Wellbeing Boards and Integrated Care Partnership strategies;

(c) overseeing the implementation of ICB commissioning policies, within the financial envelope to help secure the continuous improvement of the quality of the services commissioning by the ICB;

(d) overseeing the development of savings plans and services as detailed in the ICB's Operational Plan, approving the appropriate business cases and mobilisation plans, subject to appropriate evidence being provided (with particular reference to statutory equality and engagement duties) to support the decisions made;

(e) prioritising service investments/disinvestments arising from strategic and operational plans, underpinned by value-based decisions and against available resources, and ensuring that appropriate evaluation is in place for new and existing investments;

(f) ensuring commissioning decisions are underpinned and informed by communications and engagement with the membership and local population as appropriate;

(g) supporting providers (working both within the Integrated Care System and Integrated Care Partnership) to lead major service transformation programmes to achieve agreed outcomes, including through joining-up health, care and wider support;

(h) working alongside councils to invest in local community organisations and infrastructure and, through joint working between health, social care and other partners including police, education, housing, safeguarding partnerships, employment and welfare services, ensuring that the NHS plays a full part in social and economic development and environmental sustainability;

(i) driving a focus on reducing health inequalities, improved outcomes and quality, and ensuring that the delivery of the ICB's strategic and operational plans are achieved within financial allocations.

4.3 ICB Board – Committee Terms of Reference

4.3.1 The following section details the terms of reference for the ICB committees.

4.3.2 The statutory committees' terms of reference include the Audit and Governance Committee; Remuneration Committee; and System Quality Group.

4.3.3 The non-statutory committees are as follows:

(a) Finance and Estates Committee;

(b) People and Culture Committee;

(c) Public Partnerships Committee;

(d) Quality and Performance Committee; and

(e) Population Health and Strategic Commissioning Committee.

Audit and Governance Committee

Terms of Reference

1. SCOPE

1.1 The Audit and Governance Committee (the "Committee") is established by NHS Derby and Derbyshire Integrated Care Board (the "ICB") as a Committee of the ICB Board in accordance with its Constitution.

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

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

2. PURPOSE

2.1 The purpose of the Committee is to ensure that the ICB complies with the principles of good governance whilst effectively delivering the statutory functions of the ICB.

2.2 To contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the ICB Board on the adequacy of governance, risk management and internal control processes within the ICB.

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

2.4 The Committee has no executive powers, other than those delegated in the SoRD and specified in the Prime Financial Policies, which includes:

2.4.1 complying with regulations governing best practice in relation to procurement, protecting and promoting patient choice, and anti-competitive conduct;

2.4.2 complying with public law requirements in relation to entering into contracts concerning commissioning arrangements and the use of public monies;

2.4.3 taking appropriate steps to ensure that the ICB is properly prepared to deal with emergencies that might affect it;

2.4.4 providing information, where required, to the Information Centre, e.g. to support publication of national data on healthcare services;

2.4.5 maintaining one or more publicly accessible registers of interests of members of the ICB, its employees, members of the ICB Board and members of committees or subcommittees of the ICB, and to make arrangements to ensure that relevant conflicts or potential conflicts of interest are declared and included in the registers;

2.4.6 making arrangements for managing conflicts and potential conflicts of interest in such a way as to ensure that they do not, and do not appear to, affect the integrity of the ICB's decision-making processes, and to have regard to guidance published by NHSEI on management of conflicts of interest;

2.4.7 meeting requirements of the Employment Rights Act 1996, the Equality Act 2010, the Data Protection and Freedom of Information Acts, the European Convention on Human Rights and Health and Safety; and

2.4.8 promoting innovation and research in the provision of health services.

3. RESPONSIBILITIES OF THE COMMITTEE

The Committee's duties can be categorised as follows:

3.1 Integrated governance, risk management and internal control

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

3.1.2 To ensure that financial systems and governance are established which facilitate compliance with DHSC's Group Accounting Manual.

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

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

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

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

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

3.2 **Internal Audit**

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

3.2.1 considering the provision of the internal audit service and the costs involved;

3.2.2 reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework;

3.2.3 considering the major findings of internal audit work, including the Head of Internal Audit Opinion, (and management's response), and ensure coordination between the internal and external auditors to optimise the use of audit resources;

3.2.4 ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation; and

3.2.5 monitoring the effectiveness of internal audit and carrying out an annual review.

3.3 **External Audit**

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

3.3.1 considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit;

3.3.2 discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan;

3.3.3 discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee; and

3.3.4 reviewing all external audit reports, including to those charged with governance (before its submission to the ICB Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

3.4 **Corporate Governance**

3.4.1 The Committee will discharge the ICB's responsibilities in respect of the following functions:

- Business Continuity;
- Complaints and PALS;
- Digital Development and ICT Assurance, including Cyber Security;
- Emergency Preparedness Resilience and Response;
- Estates;

- Health, Safety, Fire and Security;
- Information Governance;
- Organisational Development;
- Procurement; and
- Research Governance.

3.4.2 In order to discharges these duties, the Committee will:

- produce an annual work programme;
- ensure that suitable policies and procedures are in place to comply with relevant regulatory, legal and code of conduct requirements;
- review the adequacy and effectiveness of their responsible policies and procedures for ensuring compliance and related reporting;
- ensure that arrangements are in place to monitor compliance with statutory responsibilities;
- promote good risk management and ensure robust controls are in place in accordance with the ICB's Risk Management Framework;
- establish and approve the terms of reference of such reporting sub-groups or task and finish groups as the Committee believes are necessary to fulfil its terms of reference;
- review the risk register for its area of remit, considering the adequacy of the submissions and whether new risks need to be added or whether any risks require immediate escalation to the ICB Board;
- review the Committee forward planner to assist with the Committee in discharging its duties effectively;
- scrutinise the performance of the ICT service provider against national requirements, reported KPIs, cyber security, GP IT delivery assurance, business as usual requirements and project delivery, (as identified in the ICB digital strategy) ensuring risks are identified and managed appropriately.

3.5 **Other assurance functions**

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

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

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

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

(a) reviews and reports issued by arm's length bodies or regulators and inspectors: e.g. National Audit Office, Select Committees, NHS Resolution, CQC; and

(b) reviews and reports issued by professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges and accreditation bodies).

3.6 **Counter fraud**

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

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

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

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

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

3.7 **Freedom to Speak Up**

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

3.8 **Information Governance (IG)**

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

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

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

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

3.9 **Financial reporting**

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

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

3.9.3 To review and approve the annual report and financial statements (including accounting policies) as delegated to them by the ICB Board, focusing particularly on:

(a) the wording in the Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;

(b) changes in accounting policies, practices and estimation techniques;

(c) unadjusted mis-statements in the Financial Statements;

(d) significant judgements and estimates made in preparing of the Financial Statements;

(e) significant adjustments resulting from the audit;

(f) letter of representation; and

(g) qualitative aspects of financial reporting.

3.10 **Conflicts of Interest**

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

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

3.11 **Management**

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

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

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

3.12 **Communication**

3.12.1 To co-ordinate and manage communications on governance, risk management and internal control with stakeholders internally and externally.

3.12.2 To develop an approach with other committees, including the Integrated Care Partnership, to ensure the relationship between them is understood.

4. AUTHORITY

4.1 The Audit and Governance Committee is authorised by the ICB Board to:

4.1.1 investigate any activity within its terms of reference;

4.1.2 seek any information it requires within its remit, from any employee or member of the ICB Board (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these Terms of Reference;

4.1.3 commission any reports it deems necessary to help fulfil its obligations;

4.1.4 obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice; and

4.1.5 create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's Constitution, Standing Orders and Scheme of Reservations and Delegation (SoRD) but [may]/[not] delegate any decisions to such groups.

4.2 For the avoidance of doubt, the Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD, other than for the following exceptions:

4.2.1 [add any exceptions agreed by the ICB Board].

5. ACCOUNTABILITY AND REPORTING

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

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

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

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

(a) fitness for purpose of the assurance framework;

(b) completeness and 'embeddedness' of risk management in the organisation;

(c) integration of governance arrangements;

(d) appropriateness of the evidence that shows the organisation is fulfilling its regulatory requirements; and

(e) robustness of the processes behind the quality accounts.

6. MEMBERSHIP AND ATTENDANCE

6.1 Membership

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

6.1.2 The ICB Board will appoint no fewer than four members of the Committee including two who are Independent Non-Executive Members of the ICB Board. Other members of the Committee need not be members of the ICB Board, but they may be. The Non-Executive Members are:

(a) Non-Executive Member of Audit and Governance;

(b) Non-Executive Member of Finance and Estates;

(c) Non-Executive Member of People and Culture; and

(d) Non-Executive Member of Quality and Performance.

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

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

6.2 Chair and vice chair

6.2.1 In accordance with the constitution, the Committee will be chaired by the Non-Executive Member for Audit and Governance, appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.

6.2.2 Committee members may appoint a Vice Chair who will be another Non-Executive Member.

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

6.3 **Attendees**

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

(a) Executive Director of Finance or their nominated deputy;

(b) representatives of both internal and external audit;

(c) Executive Director of Corporate Affairs or their nominated deputy;

(d) Chief Executive Officer, as required; and

(e) individuals who lead on risk management and counter fraud matters.

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

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

6.3.4 All Executive Directors should be invited to discuss ICB objectives and risks in their area of responsibility at least annually.

6.3.5 The Chief Executive should be invited to attend the meeting at least annually.

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

6.4 **Attendance**

6.4.1 It is expected that members will prioritise these meeting and make themselves available; exceptionally where this is not possible a deputy may attend of sufficient seniority who will have delegated authority to make decisions on behalf of their organisation in accordance with the objectives set out in the Terms of Reference for this Committee. For Local Authority representatives this will be in accordance with the due political process.

6.4.2 Members are expected to attend at least 75% of meetings held each calendar year to ensure consistency.

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

6.5 **Access**

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

7. MEETING ARRANGEMENTS AND FREQUENCY

7.1 The Committee will meet [five] times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

7.2 The Chair of the Committee may arrange extraordinary meetings at their discretion and if required to consider matters in a timely manner.

7.3 Where necessary members will be required to respond to virtual electronic communications owing to timescales.

7.4 The Chair will be responsible for agreeing the agenda; ensuring matters discussed meet the objectives as set out in these Terms of Reference.

7.5 Additional items for the agenda will be taken by exception with the knowledge and agreement of the Chair in advance of the meeting commencing.

7.6 Ratified minutes of the meeting will be circulated to all sub-groups for dissemination to their members.

7.7 There will be a standing agenda item at the end of each meeting to check the objectives have been met and review effectiveness of the discussions.

8. QUORACY

8.1 For a meeting to be quorate a minimum of two Independent Non-Executive Members of the ICB Board are required, including the Chair or Vice Chair of the Committee.

8.2 A duly convened meeting of the Committee at which quorum is present at the meeting, or are contactable by video conference, is competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

8.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions requiring agreement by statutory bodies may be taken.

8.4 If any member of the Committee has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

9. BEHAVIOURS AND DECISION MAKING

9.1 Behaviours

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

9.2 Decision-Making

9.2.1 Members are expected to provide information as necessary to support the undertaking of accurate analysis to inform developments.

9.2.2 Voting

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

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

(c) Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be record in the minutes.

9.2.3 Urgent Decisions

(d) The Committee may be required to take urgent decisions. An urgent decision is one where the requirement for the decision to be made arises between the meetings of the Committee and in relation to which a decision must be made prior to the next scheduled meeting.

(e) Where an urgent decision is required a supporting paper will be circulated to all members. To reach a consensus view or make a decision the members may meet either in person, via video conference or communicate by email to take an urgent decision. The quorum, as described above, must be adhered to for urgent decisions.

(f) In such circumstances, a minute of the discussion and decision will be taken by the secretary and will be reported to the next meeting for formal ratification.

9.3 Equality and Diversity

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

10. IDENTIFYING AND MANAGING RISKS

10.1 The Committee will help to identify concerns and risks, diagnose and develop actions/improvement plans to mitigate and respond to risks, and oversee implementation.

10.2 The Committee will receive and review those risks delegated to it consisting of the Assurance Framework, corporate risks and any other significant risks. These risks will be a standing agenda item of the sub-committee meetings at least quarterly and at every meeting if risks are escalating or of concern.

11. INTERDEPENDENCIES WITH OTHER GROUPS

Consideration will be given at each meeting as to whether any items need to be escalated to the ICB Board or another ICB Committee.

12. MANAGING CONFLICTS OF INTEREST

Members of the Committee shall adopt the following approach:

12.1.1 ensure that they continue to comply with relevant organisational policies/governance framework for probity and decision-making;

12.1.2 a register of interests will be recorded and maintained. This will be reviewed annually to ensure accuracy, in the intervening periods members should declare any unregistered interests pertinent to the agenda on an on-going basis. Members will be responsible for notifying of any changes to their respective declarations as and when they occur;

12.1.3 in advance of any meeting, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals;

12.1.4 the Chair will take overall responsibility for managing conflicts of interest pertinent to agenda items as they arise; any such declarations will be formally recorded in the minutes of the meeting;

12.1.5 the Chair will determine how declared interests should be managed, which is likely to involve one the following actions:

(a) requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the discussions;

(b) allowing the individual to participate in the discussion, but not the decision-making process;

(c) allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the decision-making arrangements.

13. SECRETARIAT AND ADMINISTRATION

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

13.1 the agenda and papers are prepared in accordance with the ICB's Corporate Governance Framework and distributed within five working days of the meeting, in accordance with the Standing Orders, and having been agreed by the Chair with the support of the relevant executive lead;

13.2 attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;

13.3 records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;

13.4 good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept;

13.5 the Chair is supported to prepare and deliver reports to the Board;

13.6 the Committee is updated on pertinent issues/ areas of interest/ policy developments;

13.7 action points are taken forward between meetings and progress against those actions is monitored.

14. REVIEW

14.1 The Committee will review its effectiveness at least annually and complete an annual report submitted to the ICB Board.

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

Reviewed by Audit and Governance Committee:	TBC
Approved by the ICB Board:	TBC
Review Date:	TBC

Remuneration Committee

Terms of Reference

1. SCOPE

1.1 The Remuneration Committee (the "Committee") is established by NHS Derby and Derbyshire Integrated Care Board (the "ICB") as a Committee of the ICB Board in accordance with its Constitution.

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

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

2. PURPOSE

2.1 The Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006. In summary it will confirm the ICB Pay Policy including adoption of any pay frameworks for all employees including senior managers/directors (including board members) and non-executive directors.

2.2 The ICB Board has also delegated the following functions to the Committee:

2.2.1 elements of the nominations and appointments process for ICB Board members;

2.2.2 oversight of executive board member performance.

3. RESPONSIBILITIES OF THE COMMITTEE

The Committee's duties are as follows:

3.1 for the Chief Executive, Directors and other Very Senior Managers:

3.1.1 determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses, pensions and cars;

3.1.2 determine arrangements for termination of employment and other contractual terms and non-contractual terms;

3.2 for all staff:

3.2.1 determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change);

3.2.2 oversee contractual arrangements;

3.2.3 determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate; and

3.3 possible additional functions that ICBs might choose to include in the scope of the committee include:

3.3.1 functions in relation to nomination and appointment of (some or all) ICB Board members;

3.3.2 functions in relation to performance review/ oversight for directors/senior managers;

3.3.3 succession planning for the ICB Board;

3.3.4 assurance in relation to ICB statutory duties relating to people such as compliance with employment legislation including such as Fit and Proper Person Regulation (FPPR).

4. AUTHORITY

4.1 The Remuneration Committee is authorised by the ICB Board to:

4.1.1 investigate any activity within its terms of reference;

4.1.2 seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the committee) within its remit as outlined in these terms of reference;

4.1.3 obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by the ICB for obtaining legal or professional advice;

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

4.2 For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservations and Delegation will prevail over these terms of reference other than the committee being permitted to meet in private.

5. ACCOUNTABILITY AND REPORTING

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

5.2 The minutes of the meetings shall be formally recorded by the secretary and submitted to the ICB Board.

5.3 The Remuneration Committee will provide a verbal update to the Confidential ICB Board following each of its meetings. Where an individual's remuneration is discussed, the conflicts of interest must be managed appropriately.

5.4 The Committee will provide the ICB Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

6. MEMBERSHIP AND ATTENDANCE

6.1 Membership

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

6.1.2 The ICB Board will appoint no fewer than three members of the Committee including two Independent Non-Executive Members of the ICB Board. Other members of the Committee need not be members of the ICB Board, but they may be. The Non-Executive Members are:

(a) Non-Executive Member of Remuneration;

(b) Non-Executive Member of Finance and Estates;

(c) Non-Executive Member of Population Health and Strategic Commissioning; and

(d) Non-Executive Member of Quality and Performance.

6.1.3 The Chair of the Audit and Governance Committee may not be a member of the Remuneration Committee.

6.1.4 The Chair of the ICB Board may be a member of the Committee but may not be appointed as the Chair.

6.1.5 When determining the membership of the Committee, active consideration will be made to diversity and equality.

6.2 Chair and Vice Chair

6.2.1 In accordance with the constitution, the Committee will be chaired by the Non-Executive Member responsible for Remuneration, appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.

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

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

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

6.3 **Attendees**

6.3.1 Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

6.3.2 Meetings of the Committee may also be attended by the following individuals who are not members of the Committee for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote:

(a) the ICB's most senior HR Advisor or their nominated deputy;

(b) Executive Director of Finance or their nominated deputy; and

(c) Chief Executive or their nominated deputy.

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

6.3.4 No individual should be present during any discussion relating to:

(a) any aspect of their own pay; and

(b) any aspect of the pay of others when it has an impact on them.

7. MEETING ARRANGEMENTS AND FREQUENCY

7.1 The Committee will meet in private.

7.2 The Committee will meet at least twice each year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

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

7.4 The Chair of the Committee may arrange extraordinary meetings at their discretion and if required to consider matters in a timely manner.

7.5 Where necessary members will be required to respond to virtual electronic communications owing to timescales.

7.6 The Chair will be responsible for agreeing the agenda; ensuring matters discussed meet the objectives as set out in these Terms of Reference.

7.7 Additional items for the agenda will be taken by exception with the knowledge and agreement of the Chair in advance of the meeting commencing.

8. QUORACY

8.1 For a meeting to be quorate a minimum of two of the Non-Executive Members is required, including the Chair or Vice Chair.

8.2 A duly convened meeting of the Committee at which quorum is present at the meeting, or are contactable by video conference, is competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

8.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions requiring agreement by statutory bodies may be taken.

8.4 If any member of the Committee has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

9. BEHAVIOURS AND DECISION-MAKING

9.1 Behaviours

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

9.2 Decision-Making

9.2.1 Decisions will be guided by national NHS policy and best practice to ensure that staff are fairly motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency.

9.2.2 Members are expected to provide information as necessary to support the undertaking of accurate analysis to inform developments.

9.2.3 <u>Voting</u>

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

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

(c) Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be record in the minutes.

9.2.4 Urgent Decisions

(a) The Committee may be required to take urgent decisions. An urgent decision is one where the requirement for the decision to be made arises between the meetings of the Committee and in relation to which a decision must be made prior to the next scheduled meeting.

(b) Where an urgent decision is required a supporting paper will be circulated to all members. To reach a consensus view or make a decision the members may meet either in person, via video conference or communicate by email to take an urgent decision. The quorum, as described above, must be adhered to for urgent decisions.

(c) In such circumstances, a minute of the discussion and decision will be taken by the secretary and will be reported to the next meeting for formal ratification.

9.3 **Equality and Diversity**

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

9.4 **Benchmarking and guidance**

The Committee will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

10. IDENTIFYING AND MANAGING RISKS

10.1 The Committee will help to identify concerns and risks, diagnose and develop actions/improvement plans to mitigate and respond to risks, and oversee implementation.

10.2 The Committee will receive and review those risks delegated to it consisting of the Assurance Framework, corporate risks and any other significant risks. These risks will be a standing agenda item of the sub-committee meetings at least quarterly and at every meeting if risks are escalating or of concern.

11. MANAGING CONFLICTS OF INTEREST

Members of the Committee shall adopt the following approach:

11.1.1 ensure that they continue to comply with relevant organisational policies/governance framework for probity and decision-making;

11.1.2 a register of interests will be recorded and maintained. This will be reviewed annually to ensure accuracy, in the intervening periods members should declare any unregistered interests pertinent to the agenda on an on-going basis. Members will be responsible for notifying of any changes to their respective declarations as and when they occur;

11.1.3 in advance of any meeting, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals;

11.1.4 the Chair will take overall responsibility for managing conflicts of interest pertinent to agenda items as they arise; any such declarations will be formally recorded in the minutes of the meeting;

11.1.5 the Chair will determine how declared interests should be managed, which is likely to involve one the following actions:

(a) requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the discussions;

(b) allowing the individual to participate in the discussion, but not the decision-making process;

(c) allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the decision-making arrangements.

12. SECRETARIAT AND ADMINISTRATION

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

12.1 the agenda and papers are prepared in accordance with the ICB's Corporate Governance Framework and distributed within five working days of the meeting, in accordance with the Standing Orders, and having been agreed by the Chair with the support of the relevant executive lead;

12.2 attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;

12.3 records of members' appointments and renewal dates and the ICB Board is prompted to renew membership and identify new members where necessary;

12.4 good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept;

12.5 the Chair is supported to prepare and deliver reports to the ICB Board;

12.6 the Committee is updated on pertinent issues/ areas of interest/ policy developments;

12.7 action points are taken forward between meetings and progress against those actions is monitored.

13. REVIEW

13.1 The Committee will review its effectiveness at least annually and complete an annual report submitted to the ICB Board.

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

Reviewed by Remuneration Committee:	TBC
Approved by the ICB Board:	TBC
Review Date:	TBC

System Quality Group Committee

Terms of Reference

1. SCOPE

1.1 The System Quality Group is established by NHS Derby and Derbyshire Integrated Care Board (the "ICB") as a statutory group of the ICB in accordance with its Constitution.

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

1.3 The System Quality Group is chaired by the Executive Director of Nursing and Quality, as Senior Responsible Officer for Quality. Its members, including those who are not members of the ICB Board, are bound by the Standing Orders and other policies of the ICB.

2. PURPOSE

The purpose of the System Quality Group is to:

2.1 enable system alignment on quality across the Integrated Care System ("ICS");

2.2 be owned by the system and focused on:

2.2.1 developing and reviewing shared quality priorities for the system;

2.2.2 sharing knowledge, insights and learning to inform improvement;

2.2.3 understanding variation and risks to quality across the system, including early warning flags;

2.2.4 discussing collective action needed to address risks and issues, which the system is responsible for delivering with support from wider partners;

2.3 provide quality oversight in relation to public health outcomes and the wider determinants of health; and take appropriate action as required to reduce health inequalities;

2.4 focus on quality across pathways, care journeys, services, and sectors (e.g. planned care, urgent and emergency care, learning disabilities, mental health);

2.5 receive quality and outcome information against key performance trajectories and identify quality issues ensuring they are acted upon;

2.6 promote the use of the Clinical Governance Matrix framework to provide one Quality Report that will assure the system and each statutory board of delivery against all Key Quality Indicators, aligned to the Quality Framework;

2.7 ensure that the system organisations discharge their statutory duties in relation to the achievement of continuous quality improvement; and

2.8 pro-actively challenge and review delivery against the Constitution, NHS Long Term Plan, Public Health Outcomes Framework, and associated NHS performance regimes, agreeing any action plans or recommendations as appropriate.

3. ROLES AND RESPONSIBILITIES

The System Quality Group will have delegated responsibility to ensure:

3.1 Collaboration

3.1.1 Ensuring a collaborative approach to promote multi-professional leadership and a shared vision for Quality with the System.

3.1.2 Promoting a culture of learning and improvement to ensure provision of high-quality sustainable services.

3.1.3 Seeking assurance on the performance of Health and Social Care organisations within the ICS in terms of the Care Quality Commission (CQC) and any other relevant regulatory bodies.

3.2 Systems

3.2.1 Ensuring there are clear roles and accountabilities in relation to quality oversight.

3.2.2 Ensuring effective improvement mechanisms are in place, including peer review and external support.

3.2.3 Ensuring there are processes to effectively identify early warning signs that there is a quality issue.

3.2.4 Ensuring processes are established to identify, resolve, and escalate risk emerging from poor quality as a result of poor performance against performance indicators.

3.2.5 Having oversight of the Patient Safety Strategy, including process and compliance in relation to PSIRF being informed of all Never Events and informing the key partners of any escalation or sensitive issues.

3.2.6 Ensuring processes are in place to interpret and implement local, regional and national policy (e.g. quality accounts, safeguarding etc.) and provide assurance that policy requirements are embedded in services.

3.2.7 Ensuring considerations relating to safeguarding children and adults are integral to services and robust processes are in place to deliver statutory functions of all Health and Social Care Organisations within the ICS.

3.2.8 Ensuring that EQIAs are undertaken and reviewed for proposed service changes using the established mechanisms.

3.2.9 Ensuring that the System Oversight and Delivery Board are sighted on any impacts on quality as a result of any reduced performance; and where the opportunity for quality improvement and transformation may be impacted on.

3.3 **Learning and Insight**

3.3.1 Establishing systems to draw from intelligence in order to inform quality improvement, and to act on early warning signs.

3.3.2 Maintaining oversight in terms of variation and risk across clinical pathways and to provide a view on the quality aspects of clinical pathways, care journeys and Transformation Programmes.

3.3.3 Ensuring that quality assurance data is used to inform commissioning decisions and drive improvements in quality.

3.3.4 Ensuring that processes are in place to provide assurance and oversight that services are high quality; meaning that they are safe, effective, caring, responsive and well-led and provide patients, service users and carers with positive experiences of care.

3.4 **Improvement**

3.4.1 Ensuring that at every service level there is a consistent set of meaningful 'measures that matter' which can be used to inform improvement.

3.4.2 Using data and intelligence in order to identify and prioritise the most important quality issues, enabling corrective action to be taken.

3.4.3 Convening working groups to address system quality issues which are identified and to escalate to risk review processes as required.

3.4.4 Taking action where required to investigate any quality, safety or patient experience concerns and to ensure that a clearly defined escalation process is in place, taking action to ensure that improvements in quality are implemented where necessary.

3.4.5 Liaising with appropriate external bodies such as the CQC or professional regulatory bodies.

4. DELEGATED AUTHORITY

4.1 The System Quality Group is a formal committee of the ICB. The ICB Board has delegated authority to the System Quality Group, as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

4.2 The System Quality Group holds those powers as delegated in these Terms of Reference as determined by the ICB Board.

5. ACCOUNTABILITY

5.1 The System Quality Group is directly accountable to the ICB Quality and Performance Committee.

5.2 The minutes of the meetings shall be formally recorded by the secretary and submitted to the ICB Quality and Performance Committee, in accordance with the Standing Orders.

5.3 The Chair of the System Quality Group will report to the ICB Quality and Performance Committee following each meeting, confirming all decisions made, highlighting any concerns, actions taken, next steps and ongoing monitoring. The report will also include recommendations that are outside the delegated limits of the System Quality Group and matters which require escalation to, and approval from the ICB Board, if not already approved by them.

5.4 The System Quality Group will provide an annual report to the ICB Board on the effectiveness of the System Quality Group to discharge its duties.

5.5 The System Quality Group shall maintain an annual work programme, ensuring that all matters for which it is responsible are addressed in a planned manner, with appropriate frequency across the year.

5.6 The System Quality Group may investigate, monitor and review any activity within its terms of reference. It is authorised to seek any information it requires from any Group.

5.7 In order to ensure that the System Oversight and Delivery Board are sighted of potential quality issues in relation to performance and transformation, the Chair from the System Quality Group will be a member of the System Oversight and Delivery Board.

6. MEMBERSHIP AND ATTENDANCE

6.1 Membership

6.1.1 Members of the System Quality Group shall be appointed by the ICB Board in accordance with the ICB Constitution.

6.1.2 When determining the membership of the System Quality Group , active consideration will be made to equality, diversity and inclusion.

6.1.3 The membership of the System Quality Group will comprise of:

(a) ICB Executive Director of Nursing and Quality;

(b) System Chief Nursing Officers;

(c) System Medical Directors;

(d) Senior Healthwatch Representative (Derby City and Derbyshire County);

(e) Director of Public Health (Derby City and Derbyshire County);

(f) Local Authority Social Care Representatives (Derbyshire County Council and Derby City Council)

(g) Care Quality Commission (CQC) Representative;

(h) NHS England/Improvement Representative;

(i) ICS Quality Lead;

(j) Patient Safety Specialist;

(k) Primary Care Network representative

(l) Allied Health Professions Council Chair;

(m) Maternity Quality Surveillance Group Chair.

6.1.4 Subject experts will be attendees at each meeting.

6.1.5 The System Quality Group may also request attendance by appropriate individuals to present relevant reports and/or advise the System Quality Group.

6.1.6 System Quality Group members may nominate a suitable deputy when necessary and subject to the approval of the Chair of the System Quality Group. All deputies should be fully briefed and the System Quality Group secretariat informed of any agreement to deputise so that quoracy can be maintained.

6.2 **Chair and Vice Chair**

The Chair of the System Quality Group shall be ICB Executive Director of Nursing and Quality. In the event that the Chair is unavailable to attend, the Vice Chair will Chair the meeting, unless there is a conflict of interest. If the Chair has a conflict of interest then the Vice Chair or, if necessary, another member of the System Quality Group will be responsible for deciding the appropriate course of action.

6.3 **Attendance**

6.3.1 It is expected that members will prioritise these meeting and make themselves available; exceptionally where this is not possible a deputy may attend of sufficient seniority who will have delegated authority to make decisions on behalf of their organisation in accordance with the objectives set out in these Terms of Reference. For Local Authority representatives this will be in accordance with the due political process.

6.3.2 Members are expected to attend at least 75% of meetings held each calendar year to ensure consistency.

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

7. MEETING ARRANGEMENTS AND FREQUENCY

7.1 The System Quality Group will meet monthly to ensure all quality information submitted to the Quality and Performance Committee has been properly scrutinised and to develop an agreed view on any future issues arising.

7.2 The Chair of the System Quality Group may arrange extraordinary meetings at their discretion and if required to consider matters in a timely manner.

7.3 Where necessary members will be required to respond to virtual electronic communications owing to timescales.

7.4 The Chair will be responsible for agreeing the agenda; ensuring matters discussed meet the objectives as set out in these Terms of Reference.

7.5 Additional items for the agenda will be taken by exception with the knowledge and agreement of the Chair in advance of the meeting commencing.

7.6 Ratified minutes of the meeting will be circulated to all sub-groups for dissemination to their members.

7.7 There will be a standing agenda item at the end of each meeting to check the objectives have been met and review effectiveness of the discussions.

8. QUORACY

8.1 The quorum shall be one representative from each organisation, to include two clinical representatives. Nominated deputies are invited to attend in place of the regular member as required.

8.2 A duly convened meeting of the System Quality Group at which quorum is present at the meeting, or are contactable by video conference, is competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the System Quality Group.

8.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions requiring agreement by statutory bodies may be taken.

8.4 If any member of the System Quality Group has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

9. BEHAVIOURS AND DECISION-MAKING

9.1 Behaviours

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the System Quality Group shall behave

in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

9.2 **Decision-Making**

9.2.1 Members are expected to act as facilitators, providing effective communication for the programme to engage their respective organisations in the developments; modelling collective leadership.

9.2.2 Members are expected to provide information as necessary to support the undertaking of accurate analysis to inform developments.

9.2.3 Voting

(a) Decisions will be taken in accordance with the Standing Orders. The System Quality Group will reach conclusions by consensus. When this is not possible the Chair may call a vote.

(b) Only members of the System Quality Group may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

(c) Where there is a split vote, with no clear majority, the Chair of the System Quality Group will hold the casting vote. The result of the vote will be record in the minutes.

9.2.4 Urgent Decisions

(a) The System Quality Group may be required to take urgent decisions. An urgent decision is one where the requirement for the decision to be made arises between the meetings of the System Quality Group and in relation to which a decision must be made prior to the next scheduled meeting.

(b) Where an urgent decision is required a supporting paper will be circulated to all members. To reach a consensus view or make a decision the members may meet either in person, via video conference or communicate by email to take an urgent decision. The quorum, as described above, must be adhered to for urgent decisions.

(c) In such circumstances, a minute of the discussion and decision will be taken by the secretary and will be reported to the next meeting for formal ratification.

9.3 **Equality and Diversity**

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

10. INTERDEPENDENCIES WITH OTHER GROUPS

10.1 The System Quality Group may delegate responsibility for specific aspects of its duties to sub-committees or working groups. The Terms of Reference of each such

sub-committee or working group shall be approved by the System Quality Group and shall set out specific details of the areas of responsibility and authority.

10.2 Any sub-committees or working groups will report via their respective Chairs following each meeting or at an appropriate frequency as determined by the System Quality Group.

10.3 The System Quality Group will ensure any quality concerns are escalated from the following groups:

10.3.1 Planned Care;

10.3.2 Urgent and Emergency Care; and

10.3.3 Mental Health, Learning Disabilities and Autism.

11. IDENTIFYING AND MANAGING RISKS

11.1 The System Quality Group will help to identify concerns and risks, diagnose and develop actions/improvement plans to mitigate and respond to risks, and oversee implementation.

11.2 The System Quality Group will receive and review those risks delegated to it consisting of the Assurance Framework, corporate risks and any other significant risks. These risks will be a standing agenda item of the sub-committee meetings at least quarterly and at every meeting if risks are escalating or of concern.

12. MANAGING CONFLICTS OF INTEREST

Members of the System Quality Group shall adopt the following approach:

12.1.1 ensure that they continue to comply with relevant organisational policies/governance framework for probity and decision-making;

12.1.2 a register of interests will be recorded and maintained. This will be reviewed annually to ensure accuracy, in the intervening periods members should declare any unregistered interests pertinent to the agenda on an on-going basis. Members will be responsible for notifying of any changes to their respective declarations as and when they occur;

12.1.3 in advance of any meeting, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals;

12.1.4 the Chair will take overall responsibility for managing conflicts of interest pertinent to agenda items as they arise; any such declarations will be formally recorded in the minutes of the meeting;

12.1.5 the Chair will determine how declared interests should be managed, which is likely to involve one the following actions:

(a) requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the discussions;

(b) allowing the individual to participate in the discussion, but not the decision-making process;

(c) allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the decision-making arrangements.

13. SECRETARIAT AND ADMINISTRATION

The System Quality Group shall be supported with a secretariat function which will include ensuring that:

13.1 the agenda and papers are prepared in accordance with the ICB's Corporate Governance Framework and distributed within five working days of the meeting, in accordance with the Standing Orders, and having been agreed by the Chair with the support of the relevant executive lead;

13.2 attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;

13.3 records of members' appointments and renewal dates and the ICB Board is prompted to renew membership and identify new members where necessary;

13.4 good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept;

13.5 the Chair is supported to prepare and deliver reports to the ICB Board;

13.6 the System Quality Group is updated on pertinent issues/ areas of interest/ policy developments;

13.7 action points are taken forward between meetings and progress against those actions is monitored.

14. REVIEW

14.1 The System Quality Group will review its effectiveness at least annually and complete an annual report submitted to the ICB Board.

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

Reviewed by System Quality Group:	TBC
Approved by the ICB Board:	TBC
Review Date:	TBC

Finance and Estates Committee

Terms of Reference

1. SCOPE

1.1 The Finance and Estates Committee (the "Committee") is established by NHS Derby and Derbyshire the Integrated Care Board (the "ICB") as a Committee of the ICB Board in accordance with its Constitution.

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

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

2. PURPOSE

To provide oversight and assurance to the ICB Board in the development and delivery of a robust, viable and sustainable system financial and estates plan; and processes which meet the health and care needs of the citizens of Derby and Derbyshire and aid the implementation of the JUCD vision and strategy.

3. ROLES AND RESPONSIBILITIES

The Committee will gain assurance from the JUCD executive functions and provide assurance to the ICB Board on:

3.1 **Delivery**

3.1.1 Delivery of the single system wide finance, digital and estates (including continuous improvement) plan built around a re-defined way of delivering care (as defined by the JUCD strategy, vision and objectives) regarding:

(a) deliverability and level of risk;

(b) whether the plan delivers the best return on the resources available and can be delivered within the resources available.

3.1.2 Providing oversight of the framework and strategy for finance, digital and estates planning to ensure that each of the system partners have plans which are compatible with and compliment the system approach.

3.1.3 Oversight of the management of the system financial target.

3.1.4 Overseeing development of a 5-year rolling system financial projection which demonstrates ongoing efficiency and value improvements/impacts of longer term investments.

3.1.5 Overseeing development of the JUCD future financial regime and recovery to address our known financial pressures and to provide assurance to the ICB Board.

3.1.6 Ensuring effective oversight of future prioritisation and capital funding bids.

3.1.7 Oversight and monitoring of financial, digital, estates and continuous improvement performance and delivery in order to give the ICB Board confidence that JUCD is implementing its strategic outcomes.

3.2 **Statutory Oversight**

3.2.1 Providing the ICB Board with an accurate understanding of the system's current and forecast financial position and the development and oversight of the system's medium term financial recovery plan to correct any underlying challenge.

3.2.2 Considering full business cases for material service change or efficiency schemes.

3.2.3 Managing associated risks by developing and monitoring a Finance, Digital and Estates Committee Risk Register.

3.2.4 Reviewing exception reports on any material breaches of the delivery of agreed efficiency improvement plans including the adequacy of proposed remedial action plans.

3.2.5 Reviewing exception reports on any material in-year overspends against delegated budgets, including the adequacy of proposed remedial action plans.

3.2.6 Having responsibility to the ICB Board for oversight and advice on the current risk exposures with regard to the short and long term financial plans and the associated recovery strategies.

3.2.7 Identifying and allocating resources where appropriate to improve performance of identified schemes or ad-hoc finance and performance related issues that may arise.

3.2.8 Considering significant investment or disinvestment decisions.

3.2.9 Reviewing the forward agenda for the Committee to ensure preparatory work to meet national planning timelines are appropriately scheduled.

3.2.10 Ensuring that suitable policies and procedures are in place to comply with relevant regulatory, legal and code of conduct requirements.

3.2.11 Reviewing the adequacy and effectiveness of relevant policies and procedures for ensuring compliance and related reporting.

3.2.12 Having oversight of the system Recovery and Restoration work related to finance and efficiency and receive assurance regarding progress.

4. ACCOUNTABILITY

4.1 The Committee is directly accountable to the ICB Board.

4.2 The Committee is responsible for managing any risks associated with delivery of the Finance, Digital and Estates Strategy and more general strategic finance, digital and estates performance risks across the system; a register will be maintained to ensure effective tracking of mitigations and escalation as necessary.

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

4.4 The Chair of the Committee will report to the ICB Board following each meeting, confirming all decisions made, highlighting any concerns, actions taken, next steps and ongoing monitoring. The report will also include recommendations that are outside the delegated limits of the Committee and matters which require escalation to, and approval from the ICB Board, if not already approved by them.

4.5 The Committee will provide an annual report to the ICB Board on the effectiveness of the Committee to discharge its duties.

4.6 The Committee may investigate, monitor and review any activity within its terms of reference. It is authorised to seek any information it requires from any Group.

5. DELEGATED AUTHORITY

5.1 The Committee is a formal committee of the ICB. The ICB Board has delegated authority to the Committee as set out in the Scheme of Reservations and Delegation and may be amended from time to time.

5.2 The Committee has holds those powers as delegated in these Terms of Reference as determined by the ICB Board.

6. MEMBERSHIP AND ATTENDANCE

6.1 Membership

6.1.1 Members of the Committee shall be appointed by the ICB Board in accordance with the ICB Constitution.

6.1.2 When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

6.1.3 The membership of the Committee will comprise:

<u>Core NHS Members</u>

(a) 3 x Non-Executive Members

(b) ICB Executive Director of Finance

(c) ICB Associate Director of Finance

(d) ICB Head of Finance

(e) ICB Executive Director of Strategy and Planning

(f) Foundation Trust Non-Executive Director – Acute

(g) Foundation Trust Non-Executive Director – Community

(h) Foundation Trust Director of Finance – Acute

(i) Foundation Trust Director of Finance – Community

(j) East Midlands Ambulance Service NHS Trust Representative

(k) General Practice Representative

Transition Members

(a) System Estates Lead

(b) System Digital Lead

(c) System Transitional Lead

(d) Local Authority Representative Derby City

(e) Local Authority Representative Derby County

(f) Third Sector/Voluntary Sector Representative

6.2 **Chair and Vice Chair**

The Chair of the Committee shall be the Non-Executive Member for Finance and Estates. In the event that the Chair is unavailable to attend, a Non-Executive Member will act as the Vice Chair and Chair the meeting, unless there is a conflict of interest. If the Chair has a conflict of interest then the Vice Chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

6.3 **Attendance**

6.3.1 It is expected that members will prioritise these meeting and make themselves available; exceptionally where this is not possible a deputy may attend of sufficient seniority who will have delegated authority to make decisions on behalf of their organisation in accordance with the objectives set out in the Terms of Reference for this Committee. For Local Authority representatives this will be in accordance with the due political process.

6.3.2 Members are expected to attend at least 75% of meetings held each calendar year to ensure consistency.

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

7. MEETING ARRANGEMENTS AND FREQUENCY

7.1 The group will meet monthly before every ICB Board meeting to ensure all Finance, Digital and Estates information submitted to the ICB Board has been properly scrutinised and to develop an agreed view on any future issues arising.

7.2 The Chair of the Committee may arrange extraordinary meetings at their discretion and if required to consider matters in a timely manner.

7.3 Where necessary members will be required to respond to virtual electronic communications owing to timescales.

7.4 The Chair will be responsible for agreeing the agenda; ensuring matters discussed meet the objectives as set out in these Terms of Reference.

7.5 Additional items for the agenda will be taken by exception with the knowledge and agreement of the Chair in advance of the meeting commencing.

7.6 Ratified minutes of the meeting will be circulated to all sub-groups for dissemination to their members.

7.7 There will be a standing agenda item at the end of each meeting to check the objectives have been met and review effectiveness of the discussions.

8. QUORACY

8.1 The quorum shall be 2 Non-Executive Members, to include the Chair or Vice Chair, 3 Executive Directors, of which one should be a System Executive Director of Finance or their nominated deputy.

8.2 A duly convened meeting of the Committee at which quorum is present at the meeting, or are contactable by video conference, is competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

8.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions requiring agreement by statutory bodies may be taken.

8.4 If any member of the Committee has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

9. BEHAVIOURS AND DECISION-MAKING

9.1 Behaviours

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

9.2 Decision-Making

9.2.1 Members are expected to act as facilitators, providing effective communication for the programme to engage their respective organisations in the developments; modelling collective leadership.

9.2.2 Members are expected to provide information as necessary to support the undertaking of accurate analysis to inform developments.

9.2.3 Voting

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

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

(c) Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be record in the minutes.

9.2.4 Urgent Decisions

(a) The Committee may be required to take urgent decisions. An urgent decision is one where the requirement for the decision to be made arises between the meetings of the Committee and in relation to which a decision must be made prior to the next scheduled meeting.

(b) Where an urgent decision is required a supporting paper will be circulated to all members. To reach a consensus view or make a decision the members may meet either in person, via video conference or communicate by email to take an urgent decision. The quorum, as described above, must be adhered to for urgent decisions.

(c) In such circumstances, a minute of the discussion and decision will be taken by the secretary and will be reported to the next meeting for formal ratification.

9.3 Equality and Diversity

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

10. SUB-COMMITTEES

10.1 The Committee may delegate responsibility for specific aspects of its duties to sub committees or working groups. The Terms of Reference of each such sub-committee or working group shall be approved by the Committee and shall set out specific details of the areas of responsibility and authority.

10.2 Any sub-committees or working groups will report via their respective Chairs following each meeting or at an appropriate frequency as determined by the Committee.

11. IDENTIFYING AND MANAGING RISKS

11.1 The Committee will help to identify concerns and risks, diagnose and develop actions/improvement plans to mitigate and respond to risks, and oversee implementation.

11.2 The Committee will receive and review those risks delegated to it consisting of the Assurance Framework, corporate risks and any other significant risks. These risks will be a standing agenda item of the sub-committee meetings at least quarterly and at every meeting if risks are escalating or of concern.

12. MANAGING CONFLICTS OF INTEREST

Members of the Committee shall adopt the following approach:

12.1.1 ensure that they continue to comply with relevant organisational policies/governance framework for probity and decision making;

12.1.2 a register of interests will be recorded and maintained. This will be reviewed annually to ensure accuracy, in the intervening periods members should declare any unregistered interests pertinent to the agenda on an on-going basis. Members will be responsible for notifying of any changes to their respective declarations as and when they occur;

12.1.3 in advance of any meeting, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals;

12.1.4 the Chair will take overall responsibility for managing conflicts of interest pertinent to agenda items as they arise; any such declarations will be formally recorded in the minutes of the meeting;

12.1.5 the Chair will determine how declared interests should be managed, which is likely to involve one the following actions:

(a) requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the discussions;

(b) allowing the individual to participate in the discussion, but not the decision-making process;

(c) allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the decision-making arrangements.

13. SECRETARIAT AND ADMINISTRATION

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

13.1 the agenda and papers are prepared in accordance with the ICB's Corporate Governance Framework and distributed in accordance with the Standing Orders, having been agreed by the Chair with the support of the relevant executive lead;

13.2 attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;

13.3 records of members' appointments and renewal dates and the ICB Board is prompted to renew membership and identify new members where necessary;

13.4 good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept;

13.5 the Chair is supported to prepare and deliver reports to the ICB Board;

13.6 the Committee is updated on pertinent issues/ areas of interest/ policy developments;

13.7 action points are taken forward between meetings and progress against those actions is monitored.

14. REVIEW

14.1 The Committee will review its effectiveness at least annually and complete an annual report submitted to the ICB Board.

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

Reviewed by Finance and Estates Committee:	TBC
Approved by the ICB Board:	TBC
Review Date:	TBC

People and Culture Committee

Terms of Reference

1. SCOPE

1.1 The People and Culture Committee (the "Committee") is established by NHS Derby and Derbyshire Integrated Care Board (the "ICB") as a Committee of the ICB Board in accordance with its Constitution.

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

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

2. PURPOSE

The purpose of the Committee is to:

2.1 oversee the development and delivery of an Integrated Care System ("ICS") People and Culture Strategy which supports the ICB, Provider Leadership Collaborative and Integrated Place Partnership, City and County to achieve their objective of improving the health and well-being of the people in Derby and Derbyshire;

2.2 provide assurance to the ICB Board, the individual organisations in Joined Up Care Derbyshire, Provider Collaborative and Integrated Care Partnerships, City and County on the implementation of the strategy and the identification and mitigation of people, culture and workforce risks.

3. ROLES AND RESPONSIBILITIES

The Committee will be responsible for:

3.1 ensuring that the Derby and Derbyshire ICS has an ambitious People and Culture strategy;

3.2 ensuring the People and Culture strategy supports the ICS and its partners to achieve the ambition to be an Anchor Institution;

3.3 improving equality, diversity, and inclusion for our current and future workforce; maximising our potential as employers to reduce health and inequalities and to improve the health and wellbeing of our communities;

3.4 promoting a positive culture to enable the system to be an agile, inclusive, and modern employer to attract, recruit and retain the people we need to deliver our plans;

3.5 overseeing the development and delivery of the work programme to grow our system leadership capacity, capability, talent, and culture across our ICS;

3.6 ensuring there is a robust package of support and focus on the wellbeing of the workforce including health and safety, safeguarding and security management across our ICS;

3.7 ensuring plans are in place to develop, support and retain the health and care workforce, adopting a "one workforce" approach with all partners across the ICS, promoting collaborative recruitment, education and training of existing and future health and care staff where appropriate;

3.8 ensuring analysis and intelligence is used to coordinate our ICS workforce plan that integrates workforce, activity and finance planning where appropriate across health and care to meet current and future population, service and workforce needs, across programmes, pathways and Place;

3.9 overseeing the development and progress of a system wide approach to delivering People Services; ensuring the ten People Functions for the ICS are in place to make Derby and Derbyshire a better place to live and work for the ICS people; and

3.10 promoting integrated system-working and to support collaborative working at scale.

4. DELEGATED AUTHORITY

4.1 At this stage the group would not have any formally delegated authority from the Boards of statutory organisations. However, there may be specific areas where the ICB Board, Provider Leadership Collaborative Board and Integrated Place Partnership has come to a collective agreement which may be delegated to the Strategic People and Culture Committee to enact.

4.2 The seniority of individual members means that they are committing their respective organisations and making decisions within the scope of their own authority in tandem with other members of the group.

5. ACCOUNTABILITY

5.1 The Committee is directly accountable to the ICB Board.

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

5.3 The Chair of the Committee will report to the ICB Board following each meeting, confirming all decisions made. The report will include recommendations that are outside the delegated limits of the Committee and which require escalation to, and approval from the ICB Board, if not already approved by them.

5.4 The Committee will provide an annual report to the ICB Board, Provider Leadership Collaborative Board and Integrated Place Partnership including progress and a summary of key achievements in delivery of the People and Culture strategy.

5.5 The Committee shall maintain an annual work programme, ensuring that all matters for which it is responsible are addressed in a planned manner, with appropriate frequency across the year.

5.6 The Committee may investigate, monitor and review any activity within its terms of reference. It is authorised to seek any information it requires from any Group.

5.7 The Chair is responsible for proactively notifying the Chair of the ICB Board, of any matters pertinent to the business of the Strategic People and Culture Committee which need to be on the agenda of Board meetings.

6. MEMBERSHIP AND ATTENDANCE

6.1 Membership

6.1.1 Members of the Committee shall be appointed by the ICB Board in accordance with the ICB Constitution.

6.1.2 When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

6.1.3 The membership of the Committee will comprise of:

(a) Non-Executive Member for People and Culture;

(b) Non-Executive Member Quality and Performance;

(c) ICB Chief People Officer;

(d) Chairs of Trust People Committees;

(e) Chief People Officers/HRD's from Provider Trusts;

(f) Programme Director of the Provider Leadership Collaborative Board

(g) Chair of the Integrated Place Executive;

(h) Local Authorities HRD (or nominated Representative) and Service Lead;

(i) Primary Care leader.

6.1.4 Subject experts will be attendees at each meeting.

6.1.5 The Committee may also request attendance by appropriate individuals to present relevant reports and/or advise the Committee.

6.1.6 Committee members may nominate a suitable deputy when necessary and subject to the approval of the Chair of the Committee. All deputies should be fully briefed

and the Committee secretariat informed of any agreement to deputise so that quoracy can be maintained.

6.2 **Chair and Vice Chair**

The Chair of the Committee shall be the Non-Executive Member for People and Culture. In the event that the Chair is unavailable to attend, the Vice Chair will deputise and Chair the meeting.

6.3 **Attendance**

6.3.1 It is expected that members will prioritise these meeting and make themselves available; exceptionally where this is not possible a deputy may attend of sufficient seniority who will have delegated authority to make decisions on behalf of their organisation in accordance with the objectives set out in the Terms of Reference for this Committee.

6.3.2 Members are expected to attend at least 75% of meetings held each calendar year to ensure consistency.

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

7. MEETING ARRANGEMENTS AND FREQUENCY

7.1 The Committee will meet formally bimonthly and align to the reporting to timetable for the ICB Board meeting to ensure all people, culture and workforce information submitted to the Board has been properly scrutinised and to develop an agreed view on any future issues arising.

7.2 The Chair of the Committee may arrange extraordinary meetings at their discretion and if required to consider matters in a timely manner.

7.3 Where necessary members will be required to respond to virtual electronic communications owing to timescales.

7.4 The Chair will be responsible for agreeing the agenda; ensuring matters discussed meet the objectives as set out in these Terms of Reference.

7.5 Additional items for the agenda will be taken by exception with the knowledge and agreement of the Chair in advance of the meeting commencing.

7.6 Ratified minutes of the meeting will be circulated to all sub-groups for dissemination to their members.

7.7 There will be a standing agenda item at the end of each meeting to check the objectives have been met and review effectiveness of the discussions.

8. QUORACY

8.1 The quorum necessary for the transaction of business shall be 50% of members, to include the Chair or Vice Chair.

8.2 A duly convened meeting of the Committee at which quorum is present at the meeting, or are contactable by video conference, is competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

8.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions requiring agreement by statutory bodies may be taken.

8.4 If any member of the Committee has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

9. BEHAVIOURS AND DECISION-MAKING

9.1 Behaviours

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

9.2 Decision-Making

9.2.1 Members are expected to act as facilitators, providing effective communication for the programme to engage their respective organisations in the developments; modelling collective leadership.

9.2.2 Members are expected to provide information as necessary to support the undertaking of accurate analysis to inform developments.

9.2.3 <u>Voting</u>

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

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

(c) Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be record in the minutes.

9.2.4 <u>Urgent Decisions</u>

(a) The Committee may be required to take urgent decisions. An urgent decision is one where the requirement for the decision to be made arises between the

meetings of the Committee and in relation to which a decision must be made prior to the next scheduled meeting.

(b) Where an urgent decision is required a supporting paper will be circulated to all members. To reach a consensus view or make a decision the members may meet either in person, via video conference or communicate by email to take an urgent decision. The quorum, as described above, must be adhered to for urgent decisions.

(c) In such circumstances, a minute of the discussion and decision will be taken by the secretary and will be reported to the next meeting for formal ratification.

9.3 **Equality and Diversity**

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

10. SUB-COMMITTEES

10.1 The Committee may delegate responsibility for specific aspects of its duties to sub-committees or working groups. The Terms of Reference of each such sub-committee or working group shall be approved by the Committee and shall set out specific details of the areas of responsibility and authority.

10.2 Any sub-committees or working groups will report via their respective Chairs following each meeting or at an appropriate frequency as determined by the Committee.

11. IDENTIFYING AND MANAGING RISKS

11.1 The Committee will help to identify concerns and risks, diagnose and develop actions/improvement plans to mitigate and respond to risks, and oversee implementation.

11.2 The Committee will receive and review those risks delegated to it consisting of the Assurance Framework, corporate risks and any other significant risks. These risks will be a standing agenda item of the sub-committee meetings at least quarterly and at every meeting if risks are escalating or of concern.

12. MANAGING CONFLICTS OF INTEREST

Members of the Committee shall adopt the following approach:

12.1.1 ensure that they continue to comply with relevant organisational policies/governance framework for probity and decision-making;

12.1.2 a register of interests will be recorded and maintained. This will be reviewed annually to ensure accuracy, in the intervening periods members should declare any unregistered interests pertinent to the agenda on an on-going basis. Members

will be responsible for notifying of any changes to their respective declarations as and when they occur;

12.1.3 in advance of any meeting, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals;

12.1.4 the Chair will take overall responsibility for managing conflicts of interest pertinent to agenda items as they arise; any such declarations will be formally recorded in the minutes of the meeting;

12.1.5 the Chair will determine how declared interests should be managed, which is likely to involve one the following actions:

(a) requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the discussions;

(b) allowing the individual to participate in the discussion, but not the decision-making process;

(c) allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the decision-making arrangements.

13. SECRETARIAT AND ADMINISTRATION

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

13.1 the agenda and papers are prepared in accordance with the ICB's Corporate Governance Framework and distributed in accordance with the Standing Orders, having been agreed by the Chair with the support of the relevant executive lead;

13.2 attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;

13.3 records of members' appointments and renewal dates and the ICB Board is prompted to renew membership and identify new members where necessary;

13.4 good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept;

13.5 the Chair is supported to prepare and deliver reports to the ICB Board;

13.6 the Committee is updated on pertinent issues/ areas of interest/ policy developments;

13.7 action points are taken forward between meetings and progress against those actions is monitored.

14. REVIEW

14.1 The Committee will review its effectiveness at least annually and complete an annual report submitted to the ICB Board.

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

Reviewed by People and Culture Committee:	TBC
Approved by the ICB Board:	TBC
Review Date:	TBC

Public Partnerships Committee

Terms of Reference

1. SCOPE

1.1 The Public Partnerships Committee (the "Committee") is established by NHS Derby and Derbyshire Integrated Care Board (the "ICB") as a Committee of the ICB Board in accordance with its Constitution.

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

1.3 The committee is a non-executive chaired committee of the ICB board and its members, including those who are not members of the ICB board, are bound by the standing orders and other policies of the ICB.

2. PURPOSE

The purpose of the Committee is to:

2.1 monitor the continued development and delivery of the Joined Up Care Derbyshire (JUCD) Engagement Strategy to ensure alignment with the ten principles for working with people and communities outlined in national guidance;

2.2 ensure any service changes and plans are developed and delivered through effective engagement with those affected by change and that patients, carers and the public are at the centre of shaping the future of health and care in Derbyshire;

2.3 provide a lay forum within which discussions can take place to assess levels of assurance and risk in relation to the delivery of statutory duties in public and patient involvement and consultation, as defined within the Health & Care Act 2022;

2.4 retain a focus on the need for engagement in strategic priorities and programmes, to ensure the local health and care system is developing robust processes in the discharging of duties relating to involvement and consultation;

2.5 promote innovation and improvement in public and patient engagement;

2.6 provide update reports to the ICB Board on assurance and risk; and on the delivery of duties and activities relating to patient and public engagement and involvement;

2.7 champion Patient and Public Involvement in all processes relating to ICB and JUCD decisions;

2.8 seek assurance that the ICB is following defined processes to take due regard when considering and implementing service changes as defined by the Equality Act 2010 and delivered through targeted engagement.

3. ROLES AND RESPONSIBILITIES

The Committee is asked to:

3.1 make recommendations on the 'phase 2' responsibilities of the Committee, likely from autumn 2022, concurrent with the confirmation of the scope of the Integrated Care Partnership, specifically relating to the scope, reporting arrangements and membership of this committee;

3.2 champion patient and public engagement across the Derbyshire health and care system, providing a watchful eye in scrutinising service developments;

3.3 ensure that the development and delivery of the Derby and Derbyshire Integrated Care Strategy is driven by the insight and opinions gathered from local people;

3.4 champion the routine principles of continuous engagement and co-production when assessing all public engagement activity, challenging and escalating findings where standards and principles have not been met;

3.5 seek assurance of work to reach underserved groups and that this is being coordinated across partners and agencies, ensuring that all voices are being heard;

3.6 seek assurance, through reports, reviews and presentations that the public are an integral part of designing, commissioning, transforming and monitoring services;

3.7 seek assurance that the ICB and wider system are meeting statutory duties relating to Patient and Public Engagement, as laid out in the Health & Care Act 2022, including those relating to Local Authority Scrutiny;

3.8 seek assurance that the system has robust mechanisms for training relevant staff on statutory duties relating to Patient and Public Engagement, as laid out in the Health & Care Act 2022;

3.9 oversee the development and delivery of a robust infrastructure of engagement mechanisms including, but not limited to, place-level engagement, reference groups to provide insight on emerging issues, a citizen's panel from which can be drawn individuals across a matrix of geography/conditions/protected characteristics, project-specific lay representation and other mechanisms as required;

3.10 ensure due process and appropriate methodologies have been followed in terms of involving the public in system projects, including providing constructive advice and challenge on proposed methods;

3.11 sign off the approach to all formal consultation programmes, either with delegated authority from the ICB Board or prior to their final sign off at those meetings;

3.12 seek assurance that the system has processes to ensure that adherence to the Equality Act duties of due regard is informing engagement programmes accordingly;

3.13 report to the ICB Board with regard to key risk areas and monitoring actions;

3.14 make recommendations for improvements and innovations in the way the system works with patients and the public;

3.15 oversee the development, completion and action planning of any internal or external audits relating to public engagement;

3.16 respond to external reviews and National Lessons Learnt reviews and bulletins especially with regards to the way patients and the public are engaged;

3.17 ensure that all voices are heard at committee and programme meetings and that all groups are given appropriate opportunity to shape local services;

3.18 act as an advocate for the engagement work being carried out for the future of health and social care in Derbyshire through appropriate networks.

4. DELEGATED AUTHORITY

4.1 The Committee is a formal committee of the ICB. The ICB Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

4.2 The Committee holds those powers as delegated in these Terms of Reference as determined by the ICB Board.

5. ACCOUNTABILITY

5.1 The Committee is directly accountable to the ICB Board.

5.2 The Committee is authorised by the ICB Board to provide the ICB Board with appropriate assurances in respect of ensuring the voice of the public is heard throughout the ICB processes in the planning, commissioning, transformation and monitoring of services and to provide advice and support in the delivery of appropriate and effective methodologies.

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

5.4 The Chair of the Committee will report to the ICB Board following each meeting, confirming all decisions made. The report will include recommendations that are outside the delegated limits of the Committee and which require escalation to, and approval from the ICB Board, if not already approved by them.

5.5 The Committee will provide an annual report to the ICB Board on the effectiveness of the Committee to discharge its duties.

5.6 The Committee shall maintain an annual work programme, ensuring that all matters for which it is responsible are addressed in a planned manner, with appropriate frequency across the year.

5.7 The Committee may investigate, monitor and review any activity within its terms of reference. It is authorised to seek any information it requires from any Group.

6. MEMBERSHIP AND ATTENDANCE

6.1 Membership

6.1.1 Members of the Committee may be appointed from the ICB Board, Officers of the ICB or other external bodies as required to enable the Committee to fulfil its purpose.

6.1.2 When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

6.1.3 The membership of the Committee in Phase 1 will comprise of the following voting and non-voting members:

Voting Members

- Chair, ICB Non-Executive Member for Public Partnerships
- Vice-Chair, ICB Non-Executive Member for Audit and Governance
- Patient Lay Members
- NHS Foundation Trust Governor Members
  - Chesterfield Royal Hospital NHS FT
  - Derbyshire Community Health Services NHS FT
  - Derbyshire Healthcare NHS FT
  - University Hospitals of Derby and Burton NHS FT
- Voluntary Sector Representative
- ICB Diversity & Inclusion Network representative

Non-voting Members

- Chief Executive, Healthwatch Derby
- Chief Executive, Healthwatch Derbyshire
- ICB Executive Director of Corporate Affairs
- ICB Deputy Director of Communications and Engagement
- Community engagement representative, Derbyshire County Council
- Community engagement representative, Derby City Council
- ICB Head of Engagement

6.1.4 Phase 2 membership will be confirmed in due course. Subject experts will be attendees at each meeting.

6.1.5 The Committee may also request attendance by appropriate individuals to present relevant reports and/or advise the Committee.

6.1.6 Committee members may nominate a suitable deputy when necessary and subject to the approval of the Chair of the Committee. All deputies should be fully briefed and the Committee secretariat informed of any agreement to deputise so that quoracy can be maintained.

6.2 **Chair and Vice Chair**

The Chair of the Committee shall be a Non-Executive Member of the ICB Board. In the event that the Chair is unavailable to attend, a Non-Executive Member will act as the Vice Chair and Chair the meeting, unless there is a conflict of interest. If the Chair has a conflict of interest then the Vice Chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

6.3 **Attendance**

6.3.1 It is expected that members will prioritise these meeting and make themselves available; exceptionally where this is not possible a deputy may attend of sufficient seniority who will have delegated authority to make decisions on behalf of their organisation in accordance with the objectives set out in the Terms of Reference for this Committee. For Local Authority representatives this will be in accordance with the due political process.

6.3.2 Members are expected to attend at least 75% of meetings held each calendar year to ensure consistency.

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

7. MEETING ARRANGEMENTS AND FREQUENCY

7.1 The Committee will meet monthly before every ICB Board meeting to ensure all Quality and Performance information submitted to the ICB Board has been properly scrutinised and to develop an agreed view on any future issues arising.

7.2 The Chair of the Committee may arrange extraordinary meetings at their discretion and if required to consider matters in a timely manner.

7.3 Where necessary members will be required to respond to virtual electronic communications owing to timescales.

7.4 The Chair will be responsible for agreeing the agenda; ensuring matters discussed meet the objectives as set out in these Terms of Reference.

7.5 Additional items for the agenda will be taken by exception with the knowledge and agreement of the Chair in advance of the meeting commencing.

7.6 Ratified minutes of the meeting will be circulated to all sub-groups for dissemination to their members.

7.7 There will be a standing agenda item at the end of each meeting to check the objectives have been met and review effectiveness of the discussions.

8. QUORACY

8.1 The quorum shall be 2 Non-Executive Members, to include the Chair or Vice Chair, plus at least 2 representatives drawn from the lay members and FT Governors, and 1 Executive Director or Deputy.

8.2 A duly convened meeting of the Committee at which quorum is present at the meeting, or are contactable by video conference, is competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

8.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions requiring agreement by statutory bodies may be taken.

8.4 If any member of the Committee has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

9. BEHAVIOURS AND DECISION-MAKING

9.1 Behaviours

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

9.2 Decision-Making

9.2.1 Members are expected to act as facilitators, providing effective communication for the programme to engage their respective organisations in the developments; modelling collective leadership.

9.2.2 Members are expected to provide information as necessary to support the undertaking of accurate analysis to inform developments.

9.2.3 Voting

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

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

(c) Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be record in the minutes.

9.2.4 Urgent Decisions

(a) The Committee may be required to take urgent decisions. An urgent decision is one where the requirement for the decision to be made arises between the meetings of the Committee and in relation to which a decision must be made prior to the next scheduled meeting.

(b) Where an urgent decision is required a supporting paper will be circulated to all members. To reach a consensus view or make a decision the members may meet either in person, via video conference or communicate by email to take an urgent decision. The quorum, as described above, must be adhered to for urgent decisions.

(c) In such circumstances, a minute of the discussion and decision will be taken by the secretary and will be reported to the next meeting for formal ratification.

9.3 **Equality and Diversity**

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

10. SUB-COMMITTEES

10.1 The Committee may delegate responsibility for specific aspects of its duties to sub-committees or working groups. The Terms of Reference of each such sub-committee or working group shall be approved by the Committee and shall set out specific details of the areas of responsibility and authority.

10.2 Any sub-committees or working groups will report via their respective Chairs following each meeting or at an appropriate frequency as determined by the Committee.

11. IDENTIFYING AND MANAGING RISKS

11.1 The Committee will help to identify concerns and risks, diagnose and develop actions/improvement plans to mitigate and respond to risks, and oversee implementation.

11.2 The Committee will receive and review those risks delegated to it consisting of the Assurance Framework, corporate risks and any other significant risks. These risks will be a standing agenda item of the sub-committee meetings at least quarterly and at every meeting if risks are escalating or of concern.

12. CONFLICTS OF INTEREST

Members of the Committee shall adopt the following approach:

12.1.1 ensure that they continue to comply with relevant organisational policies/governance framework for probity and decision-making;

12.1.2 a register of interests will be recorded and maintained. This will be reviewed annually to ensure accuracy, in the intervening periods members should declare any unregistered interests pertinent to the agenda on an on-going basis. Members will be responsible for notifying of any changes to their respective declarations as and when they occur;

12.1.3 in advance of any meeting, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals;

12.1.4 the Chair will take overall responsibility for managing conflicts of interest pertinent to agenda items as they arise; any such declarations will be formally recorded in the minutes of the meeting;

12.1.5 the Chair will determine how declared interests should be managed, which is likely to involve one the following actions:

(a) requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the discussions;

(b) allowing the individual to participate in the discussion, but not the decision-making process;

(c) allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the decision-making arrangements.

13. SECRETARIAT AND ADMINISTRATION

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

13.1 the agenda and papers are prepared in accordance with the ICB's Corporate Governance Framework and distributed in accordance with the Standing Orders, having been agreed by the Chair with the support of the relevant executive lead;

13.2 attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;

13.3 records of members' appointments and renewal dates and the ICB Board is prompted to renew membership and identify new members where necessary;

13.4 good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept;

13.5 the Chair is supported to prepare and deliver reports to the ICB Board;

13.6 the Committee is updated on pertinent issues/ areas of interest/ policy developments;

13.7 action points are taken forward between meetings and progress against those actions is monitored.

14. REVIEW

14.1 The Committee will review its effectiveness at least annually and complete an annual report submitted to the ICB Board.

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

Reviewed by Public Partnerships Committee:	TBC
Approved by the ICB Board:	TBC
Review Date:	TBC

Quality and Performance Committee

Terms of Reference

1. SCOPE

1.1 The Quality and Performance Committee (the "Committee") is established by NHS Derby and Derbyshire Integrated Care Board (the "ICB") as a Committee of the ICB Board in accordance with its Constitution.

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

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

2. PURPOSE

2.1 The Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of service and performance, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Bill 2021. This includes reducing inequalities in the quality of care.

2.2 The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and performance. It needs to ensure internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high quality care.

2.3 The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

2.4 The purpose of the Committee is to:

2.4.1 maintain system oversight in relation to quality and performance across the ICB;

2.4.2 be assured that the system is focused on:

(a) developing and reviewing shared quality and performance priorities for the system;

(b) sharing knowledge, insights and learning to inform improvement;

(c) understanding variation and risks to quality across the system, including early warning flags; and

(d) discussing collective action needed to address risks and issues, which the system is responsible for delivering with support from wider partners;

2.4.3 be assured that focus is on quality and performance across pathways, care journeys, services and sectors (e.g. planned care, urgent and emergency care, mental health, learning disabilities and autism, children and young people, Primary Care and Social Care);

2.4.4 be sighted on quality, performance and outcome information against key performance trajectories and be assured that quality issues are appropriately acted upon;

2.4.5 be sighted on exceptions from the ICS Quality Report and gain assurance that the system and each statutory board deliver against all Key Quality Indicators, aligned to the Quality Framework;

2.4.6 receive matters of escalation in relation to exceptions from the ICS Quality Report, and other concerns raised by the System Quality Group and the System Oversight and Delivery Group;

2.4.7 maintain oversight that the system organisations discharge their statutory duties in relation to the achievement of continuous quality improvement;

2.4.8 be assured in terms of delivery against of the Constitution, NHS Long Term Plan, Public Health Outcomes Framework and associated NHS performance regimes, and the Local Authority Quality Assurance Strategy agreeing any action plans or recommendations as appropriate; and

2.4.9 manage any risks associated with the delivery of the System Quality Strategy and more general strategic quality risks across the system; a register will be maintained to ensure effective tracking of mitigations and escalation as necessary.

3. ROLES AND RESPONSIBILITIES

The responsibilities of the Committee will be authorised by the ICB Board. It is expected that the Committee will:

3.1 be assured that there are robust processes in place for the effective management of quality and performance;

3.2 scrutinise structures in place to support quality, performance, planning, control and improvement, to be assured that the structures operate effectively and timely action is taken to address areas of concern;

3.3 agree and put forward the key quality priorities that are included within the ICB strategy/annual plan, including priorities to address variation/inequalities in care;

3.4 oversee and monitor the delivery of the ICB key statutory requirements;

3.5 review and monitor those risks on the Board Assurance Framework and the System Quality Group Risk Register which relate to quality and performance, and high-risk operational risks which could impact on care. the System Quality Group will need to escalate relevant risks to the Corporate Risk Register;

3.6 ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner;

3.7 oversee and scrutinise the ICB's response to all relevant Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the Department of Health and Social Care, NHSEI and other regulatory bodies/external agencies (e.g. CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained;

3.8 maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation and assure the ICB that these are disseminated and implemented across all sites;

3.9 oversee and seek assurance on the effective and sustained delivery of the ICB Quality Improvement Programmes;

3.10 ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place;

3.11 receive assurance that the ICB identifies lessons learned from all relevant sources, including, incidents, never events, complaints and claims and ensures that learning is disseminated and embedded;

3.12 receive assurance that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from death (including coronial inquests and PFD report);

3.13 to be assured that people drawing on services are systematically and effectively involved as equal partners in quality activities;

3.14 scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children;

3.15 scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for infection prevention and control;

3.16 scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for equality and diversity as it applies to people drawing on services;

3.17 scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety; and

3.18 have oversight of and approve the Terms of Reference and work programmes for the groups reporting into the Committee (e.g. System Quality Groups, Infection Prevention and Control, Safeguarding Boards /Hubs etc.).

3.19 **Collaboration**

The Committee will maintain oversight and receive assurance in relation to ensuring:

3.19.1 there is a collaborative approach to promote multi-professional leadership and a shared vision for quality and performance within the System;

3.19.2 a culture of learning and improvement to ensure provision of high-quality sustainable services;

3.19.3 quality oversight is maintained in relation to public health outcomes and the wider determinants of health; and take appropriate action as required to support the reduction in health inequalities; and

3.19.4 quality and performance oversight is maintained in relation to the performance of Health and Social Care organisations within the ICS in terms of the Care Quality Commission (CQC) and any other relevant regulatory bodies.

3.20 **Systems**

The Committee will maintain oversight and receive assurance in relation to ensuring:

3.20.1 there are clear roles and accountabilities in relation to quality and performance oversight;

3.20.2 effective improvement mechanisms are in place, including peer review and external support;

3.20.3 ensuring there are processes to effectively identify early warning signs that there is a quality or performance issue;

3.20.4 processes are established to identify, resolve and escalate risk emerging from poor quality as a result of poor performance against performance indicators;

3.20.5 implementation of the Patient Safety Strategy, including process and compliance in relation to PSIRF; being informed of all Never Events and informing the key partners of any escalation or sensitive issues;

3.20.6 processes are in place to interpret and implement local, regional and national policy (e.g. quality accounts, safeguarding etc.) and provide assurance that policy requirements are embedded in services;

3.20.7 considerations relating to safeguarding children and adults are integral to services and robust processes are in place to deliver statutory functions of all Health and Social Care Organisations within the ICS; and

3.20.8 Equality Impact Assessments (EQIAs) are undertaken and reviewed by System Quality Group for proposed service changes using the established mechanisms with any matters of concern escalated.

The definition of the System and the scope is any quality and performance issues within the boundary of Derbyshire/Derby City. It covers health and social care providers, private providers of care, voluntary and charitable services.

3.21 **Learning and Insight**

The Committee will maintain oversight and receive assurance in relation to:

3.21.1 establishing systems to draw from intelligence in order to inform quality and performance improvement, and to act on early warning signs;

3.21.2 maintaining oversight in terms of variation and risk across clinical pathways and to provide a view on the quality aspects of clinical pathways, care journeys and Transformation Programmes;

3.21.3 ensuring that quality and performance assurance data is used to inform commissioning decisions and drive improvements;

3.21.4 ensuring that processes are in place to provide assurance and oversight that services are high quality; meaning that they are safe, effective, caring, responsive and well-led and provide patients, service users and carers with positive experiences of care, and

3.21.5 will liaise with appropriate external bodies such as the CQC or professional regulatory bodies.

3.22 **Improvement**

The Committee will maintain oversight and receive assurance in relation to ensuring:

3.22.1 that at every service level there is a consistent set of meaningful “measures that matter” which can be used to inform improvement;

3.22.2 data and intelligence are effectively utilised in order to identify and prioritise the most important quality and performance issues, enabling corrective action to be taken; and

3.22.3 action is taken where required to investigate any quality, safety or patient experience concerns, noting action is taken to ensure that improvements in quality are implemented where necessary.

4. DELEGATED AUTHORITY

4.1 The Committee is a formal committee of the ICB. The ICB Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

4.2 The Committee holds those powers as delegated in these Terms of Reference as determined by the ICB Board.

5. ACCOUNTABILITY

5.1 The Committee is directly accountable to the ICB Board.

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

5.3 The Chair of the Committee will report to the ICB Board following each meeting, confirming all decisions made, highlighting any concerns, actions taken, next steps and ongoing monitoring. The report will also include recommendations that are outside the delegated limits of the Committee and matters which require escalation to, and approval from the ICB Board, if not already approved by them.

5.4 The Committee will provide an annual report to the ICB Board on the effectiveness of the Committee to discharge its duties.

5.5 The Committee shall maintain an annual work programme, ensuring that all matters for which it is responsible are addressed in a planned manner, with appropriate frequency across the year.

5.6 The Committee may investigate, monitor and review any activity within its terms of reference. It is authorised to seek any information it requires from any Group.

5.7 The Committee will receive schedules assurance report from its delegated groups. Any delegated groups would need to be agreed by the ICB Board.

6. MEMBERSHIP AND ATTENDANCE

6.1 Membership

6.1.1 Members of the Committee shall be appointed by the ICB Board in accordance with the ICB Constitution.

6.1.2 The ICB Board will appoint no fewer than four members of the Committee including two who are Non-Executive Members of the ICB Board. Other attendees of the Committee need not be members of the ICB Board, but they may be.

6.1.3 When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

6.1.4 The membership of the Committee will comprise of:

(a) 3 x Non-Executive Members;

(b) ICB Executive Director of Nursing and Quality;

(c) ICB Medical Director;

(d) ICB Executive Lead for Performance;

(e) NHS Executive;

(f) Provider Representatives;

(g) Primary Care Representatives; and

(h) Local Authority Representatives.

6.1.5 Subject experts will be attendees at each meeting.

6.1.6 The Committee may also request attendance by appropriate individuals to present relevant reports and/or advise the Committee.

6.1.7 Committee members may nominate a suitable deputy when necessary and subject to the approval of the Chair of the Committee. All deputies should be fully briefed and the Committee secretariat informed of any agreement to deputise so that quoracy can be maintained.

6.2 **Chair and Vice Chair**

The Chair of the Committee shall be a Non-Executive Member of the ICB Board. In the event that the Chair is unavailable to attend, a Non-Executive Member will act as the Vice Chair and Chair the meeting, unless there is a conflict of interest. If the Chair has a conflict of interest then the Vice Chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

6.3 **Attendance**

6.3.1 It is expected that members will prioritise these meeting and make themselves available; exceptionally where this is not possible a deputy may attend of sufficient seniority who will have delegated authority to make decisions on behalf of their organisation in accordance with the objectives set out in the Terms of Reference for this Committee. For Local Authority representatives this will be in accordance with the due political process.

6.3.2 Members are expected to attend at least 75% of meetings held each calendar year to ensure consistency.

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

7. MEETING ARRANGEMENTS AND FREQUENCY

7.1 The Committee will meet monthly before every ICB Board meeting to ensure all quality and performance information submitted to the ICB Board has been properly scrutinised and to develop an agreed view on any future issues arising.

7.2 The Chair of the Committee may arrange extraordinary meetings at their discretion and if required to consider matters in a timely manner.

7.3 Where necessary members will be required to respond to virtual electronic communications owing to timescales.

7.4 The Chair will be responsible for agreeing the agenda; ensuring matters discussed meet the objectives as set out in these Terms of Reference.

7.5 Additional items for the agenda will be taken by exception with the knowledge and agreement of the Chair in advance of the meeting commencing.

7.6 Ratified minutes of the meeting will be circulated to all sub-groups for dissemination to their members.

7.7 There will be a standing agenda item at the end of each meeting to check the objectives have been met and review effectiveness of the discussions.

8. QUORACY

8.1 The quorum shall be 2 Non-Executive Members, to include the Chair or Vice Chair, plus at least the Executive Director of Nursing and Quality, or Medical Director from the ICB, one provider representative and one Local Authority representative. Nominated deputies are invited to attend in place of the regular member as required.

8.2 A duly convened meeting of the Committee at which quorum is present at the meeting, or are contactable by video conference, is competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

8.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions requiring agreement by statutory bodies may be taken.

8.4 If any member of the Committee has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

9. BEHAVIOURS AND DECISION-MAKING

9.1 Behaviours

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

9.2 Decision-Making

9.2.1 Members are expected to act as facilitators, providing effective communication for the programme to engage their respective organisations in the developments; modelling collective leadership.

9.2.2 Members are expected to provide information as necessary to support the undertaking of accurate analysis to inform developments.

9.2.3 Voting

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

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

(c) Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be record in the minutes.

9.2.4 Urgent Decisions

(a) The Committee may be required to take urgent decisions. An urgent decision is one where the requirement for the decision to be made arises between the meetings of the Committee and in relation to which a decision must be made prior to the next scheduled meeting.

(b) Where an urgent decision is required a supporting paper will be circulated to all members. To reach a consensus view or make a decision the members may meet either in person, via video conference or communicate by email to take an urgent decision. The quorum, as described above, must be adhered to for urgent decisions.

(c) In such circumstances, a minute of the discussion and decision will be taken by the secretary and will be reported to the next meeting for formal ratification.

9.3 **Equality and Diversity**

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

10. SUB-COMMITTEES

10.1 The Committee may delegate responsibility for specific aspects of its duties to sub-committees or working groups. The Terms of Reference of each such sub-committee or working group shall be approved by the Committee and shall set out specific details of the areas of responsibility and authority.

10.2 Any sub-committees or working groups will report via their respective Chairs following each meeting or at an appropriate frequency as determined by the Committee.

11. IDENTIFYING AND MANAGING RISKS

11.1 The Committee will help to identify concerns and risks, diagnose and develop actions/improvement plans to mitigate and respond to risks, and oversee implementation.

11.2 The Committee will receive and review those risks delegated to it consisting of the Assurance Framework, corporate risks and any other significant risks. These risks will be a standing agenda item of the sub-committee meetings at least quarterly and at every meeting if risks are escalating or of concern.

12. MANAGING CONFLICTS OF INTEREST

Members of the Committee shall adopt the following approach:

12.1.1 ensure that they continue to comply with relevant organisational policies/governance framework for probity and decision-making;

12.1.2 a register of interests will be recorded and maintained. This will be reviewed annually to ensure accuracy, in the intervening periods members should declare any unregistered interests pertinent to the agenda on an on-going basis. Members will be responsible for notifying of any changes to their respective declarations as and when they occur;

12.1.3 in advance of any meeting, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals;

12.1.4 the Chair will take overall responsibility for managing conflicts of interest pertinent to agenda items as they arise; any such declarations will be formally recorded in the minutes of the meeting;

12.1.5 the Chair will determine how declared interests should be managed, which is likely to involve one the following actions:

(a) requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the discussions;

(b) allowing the individual to participate in the discussion, but not the decision-making process;

(c) allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the decision-making arrangements.

13. SECRETARIAT AND ADMINISTRATION

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

13.1 the agenda and papers are prepared in accordance with the ICB's Corporate Governance Framework and distributed within five working days of the meeting, in accordance with the Standing Orders, and having been agreed by the Chair with the support of the relevant executive lead;

13.2 attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;

13.3 records of members' appointments and renewal dates and the ICB Board is prompted to renew membership and identify new members where necessary;

13.4 good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept;

13.5 the Chair is supported to prepare and deliver reports to the ICB Board;

13.6 the Committee is updated on pertinent issues/ areas of interest/ policy developments;

13.7 action points are taken forward between meetings and progress against those actions is monitored.

14. REVIEW

14.1 The Committee will review its effectiveness at least annually and complete an annual report submitted to the ICB Board.

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

14.3 The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Reviewed by Quality and Performance Committee:	TBC
Approved by the ICB Board:	TBC
Review Date:	TBC

Population Health and Strategic Commissioning Committee

Terms of Reference

1. SCOPE

1.1 The Population Health and Strategic Commissioning Committee (the "Committee") is established by NHS Derby and Derbyshire Integrated Care Board (the "ICB") as a Committee of the ICB Board in accordance with its Constitution.

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

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

2. PURPOSE

2.1 The purpose of the Committee is to ensure that the ICB complies with the principles of good governance whilst effectively delivering the statutory functions of the ICB.

2.2 The Committee has delegated authority to make decisions as set out in the ICB's Prime Financial Policies and the Scheme of Reservation and Delegation.

2.3 In accordance with its statutory powers under section 65Z5 of the NHS Act, NHS England has delegated the exercise of the following functions in the delegation agreement to the ICB relating to:

2.3.1 primary medical services;

2.3.2 primary dental services and prescribed dental services;

2.3.3 primary ophthalmic services;

2.3.4 pharmaceutical services and local pharmaceutical services.

Decisions of the ICB in respect of the Delegated Functions and made in accordance with the terms of this Agreement shall be binding on NHS England and the ICB. The ICB has established the Population Health and Commissioning Committee to function as a corporate decision-making body for the management of these delegated functions and the exercise of the delegated powers. This Committee will receive recommendations from the Primary Care Operational Group for decision on behalf of the ICB in line with the national delegation agreement.

3. ROLES AND RESPONSIBILITIES

The Committee will have delegated responsibility for overseeing the provision of health services in line with the allocated resources across the ICS through a range of activities including:

3.1 ensuring strategic, long-term and outcome-based contracts and agreements are in place to secure the delivery of the ICB's commissioning strategy and associated operating plans;

3.2 overseeing the preparation and publication of the ICB's commissioning strategy and associated operating plans, aligned to the Health and Wellbeing Boards and Integrated Care Partnership strategies;

3.3 overseeing the implementation of ICB commissioning policies, within the financial envelope to help secure the continuous improvement of the quality of the services commissioning by the ICB;

3.4 overseeing the development of savings plans and services as detailed in the ICB's Operational Plan, approving the appropriate business cases and mobilisation plans, subject to appropriate evidence being provided (with particular reference to statutory equality and engagement duties) to support the decisions made;

3.5 prioritising service investments/disinvestments arising from strategic and operational plans, underpinned by value-based decisions and against available resources, and ensuring that appropriate evaluation is in place for new and existing investments;

3.6 ensuring commissioning decisions are underpinned and informed by communications and engagement with the membership and local population as appropriate;

3.7 supporting providers (working both within the Integrated Care System and Integrated Care Partnership) to lead major service transformation programmes to achieve agreed outcomes, including through joining-up health, care and wider support;

3.8 working alongside councils to invest in local community organisations and infrastructure and, through joint working between health, social care and other partners including police, education, housing, safeguarding partnerships, employment and welfare services, ensuring that the NHS plays a full part in social and economic development and environmental sustainability;

3.9 driving a focus on reducing health inequalities, improved outcomes and quality, and ensuring that the delivery of the ICB's strategic and operational plans are achieved within financial allocations

4. DELEGATED AUTHORITY

4.1 The Committee is a formal committee of the ICB. The ICB Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

4.2 The Committee holds those powers as delegated in these Terms of Reference as determined by the ICB Board.

4.3 The Committee may further establish sub-groups and delegate decisions in accordance with guidance, for example to provider collaboratives at scale and at place.

5. ACCOUNTABILITY

5.1 The Committee is directly accountable to the ICB Board.

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

5.3 The Chair of the Committee will report to the ICB Board following each meeting, confirming all decisions made, highlighting any concerns, actions taken, next steps and ongoing monitoring. The report will also include recommendations that are outside the delegated limits of the Committee and matters which require escalation to, and approval from the ICB Board, if not already approved by them.

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

5.5 The Committee will provide an annual report to the ICB Board on the effectiveness of the Committee to discharge its duties.

5.6 The Committee shall maintain an annual work programme, ensuring that all matters for which it is responsible are addressed in a planned manner, with appropriate frequency across the year.

5.7 The Committee may investigate, monitor and review any activity within its terms of reference. It is authorised to seek any information it requires from any Group.

6. MEMBERSHIP AND ATTENDANCE

6.1 Membership

6.1.1 Members of the Committee shall be appointed by the ICB Board in accordance with the ICB Constitution.

6.1.2 The membership of the Committee will comprise of:

(a) Non-Executive Member for Population Health and Strategic Commissioning and Public Partnerships (Chair)

(b) Non-Executive Member for Quality and Performance

(c) Non-Executive Member for Audit and Governance

(d) Partner Member for Primary Medical Services – General Practitioner(s)

(e) Representative for Provider Collaborative at Scale

(f) Representative for Provider Collaborative at Place

(g) Representative for Clinical and Professional Leadership Group – Clinician(s)

(h) GP Clinical Lead

(i) Secondary Care Doctor

(j) Director of Public Health

(k) Executive Director of Strategy and Planning

(l) Executive Director of Nursing and Quality

(m) Executive Medical Director

(n) Executive Director of Finance

(o) Director of GP Development

(p) Chief People Officer

[NB: Vice Chair to be confirmed]

6.1.3 Subject experts will be attendees at each meeting.

6.1.4 The Committee may also request attendance by appropriate individuals to present relevant reports and/or advise the Committee.

6.1.5 Committee members may nominate a suitable deputy when necessary and subject to the approval of the Chair of the Committee. All deputies should be fully briefed and the Committee secretariat informed of any agreement to deputise so that quoracy can be maintained.

6.2 **Chair and Vice Chair**

The Chair of the Committee shall be a Non-Executive Member of the ICB Board. In the event that the Chair is unavailable to attend, a Non-Executive Member will act as the Vice Chair and Chair the meeting, unless there is a conflict of interest. If the Chair has a conflict of interest then the Vice Chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

6.3 **Attendance**

6.3.1 It is expected that members will prioritise these meeting and make themselves available; exceptionally where this is not possible a deputy may attend of sufficient seniority who will have delegated authority to make decisions on behalf of their organisation in accordance with the objectives set out in the Terms of Reference for this Committee. For Local Authority representatives this will be in accordance with the due political process.

6.3.2 Members are expected to attend at least 75% of meetings held each calendar year to ensure consistency.

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

7. MEETING ARRANGEMENTS AND FREQUENCY

7.1 The Committee will meet monthly before every ICB Board meeting to ensure all information submitted to the ICB Board has been properly scrutinised and to develop an agreed view on any future issues arising.

7.2 The Chair of the Committee may arrange extraordinary meetings at their discretion and if required to consider matters in a timely manner.

7.3 Where necessary members will be required to respond to virtual electronic communications owing to timescales.

7.4 The Chair will be responsible for agreeing the agenda; ensuring matters discussed meet the objectives as set out in these Terms of Reference.

7.5 Additional items for the agenda will be taken by exception with the knowledge and agreement of the Chair in advance of the meeting commencing.

7.6 Ratified minutes of the meeting will be circulated to all sub-groups for dissemination to their members.

7.7 There will be a standing agenda item at the end of each meeting to check the objectives have been met and review effectiveness of the discussions.

8. QUORACY

8.1 The quorum necessary for the transaction of business shall be 5 members, to include 2 Non-Executive Members, 1 Executive Director and 4 other members including two clinical.

8.2 A duly convened meeting of the Committee at which quorum is present at the meeting, or are contactable by telephone conference call, is competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

8.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions requiring agreement by statutory bodies may be taken.

8.4 If any member of the Committee has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

9. BEHAVIOURS, VALUES AND DECISION-MAKING

9.1 Behaviours

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

9.2 Values

In delivering their roles and responsibilities, the Committee shall undertake to contribute towards delivery of the following key purposes of an Integrated Care System:

9.2.1 strive to improve the outcomes in population health and healthcare;

9.2.2 tackle inequalities in outcomes, experience and access;

9.2.3 enhance productivity and value for money; and

9.2.4 assist the NHS in supporting broader social and economic development.

9.3 Decision-Making

9.3.1 Members are expected to act as facilitators, providing effective communication for the programme to engage their respective organisations in the developments; modelling collective leadership.

9.3.2 Members are expected to provide information as necessary to support the undertaking of accurate analysis to inform developments.

9.3.3 Voting

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

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

(c) Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be record in the minutes.

9.3.4 Urgent Decisions

(a) The Committee may be required to take urgent decisions. An urgent decision is one where the requirement for the decision to be made arises between the meetings of the Committee and in relation to which a decision must be made prior to the next scheduled meeting.

(b) Where an urgent decision is required a supporting paper will be circulated to all members. To reach a consensus view or make a decision the members may meet either in person, via telephone conference or communicate by email to take an urgent decision. The quorum, as described above, must be adhered to for urgent decisions.

(c) In such circumstances, a minute of the discussion and decision will be taken by the secretary and will be reported to the next meeting for formal ratification.

9.4 **Equality and Diversity**

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

10. IDENTIFYING AND MANAGING RISKS

10.1 The Committee will help to identify concerns and risks, diagnose and develop actions/improvement plans to mitigate and respond to risks, and oversee implementation.

10.2 The Committee will receive and review those risks delegated to it consisting of the Assurance Framework, corporate risks and any other significant risks. These risks will be a standing agenda item of the sub-committee meetings at least quarterly and at every meeting if risks are escalating or of concern.

11. SUB-COMMITTEES

11.1 The Committee may delegate responsibility for specific aspects of its duties to sub-committees or working groups. The Terms of Reference of each such sub-committee or working group shall be approved by the Committee and shall set out specific details of the areas of responsibility and authority.

11.2 Any sub-committees or working groups will report via their respective Chairs following each meeting or at an appropriate frequency as determined by the Committee.

12. INTERDEPENDENCIES WITH OTHER GROUPS

The Committee will ensure any quality concerns are escalated to the System Quality and Performance Committee. The Finance and Estates Committee and Integrated Care Partnership will also be dependent on this Committee.

13. CONFLICTS OF INTEREST

Members of the Committee shall adopt the following approach:

13.1.1 ensure that they continue to comply with relevant organisational policies/ governance framework for probity and decision-making;

13.1.2 a register of interests will be recorded and maintained. This will be reviewed annually to ensure accuracy, in the intervening periods members should declare any unregistered interests pertinent to the agenda on an on-going basis. Members will be responsible for notifying of any changes to their respective declarations as and when they occur;

13.1.3 in advance of any meeting, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals;

13.1.4 the Chair will take overall responsibility for managing conflicts of interest pertinent to agenda items as they arise; any such declarations will be formally recorded in the minutes of the meeting;

13.1.5 the Chair will determine how declared interests should be managed, which is likely to involve one the following actions:

(a) requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the discussions;

(b) allowing the individual to participate in the discussion, but not the decision-making process;

(c) allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the decision-making arrangements.

13.1.6 Conflicts of interest will apply to all providers of Primary Medical Care Services including GP partners, Primary Care Networks, Derbyshire Community Health Services NHS Foundation Trust, Chesterfield Royal Hospital NHS Foundation Trust and DHU Healthcare for decisions relating to Primary Medical Care Services.

14. SECRETARIAT AND ADMINISTRATION

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

14.1 the agenda and papers are prepared in accordance with the ICB's Corporate Governance Framework and distributed in accordance with the Standing Orders, having been agreed by the Chair with the support of the relevant executive lead;

14.2 attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;

14.3 records of members' appointments and renewal dates and the ICB Board is prompted to renew membership and identify new members where necessary;

14.4 good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept;

14.5 the Chair is supported to prepare and deliver reports to the ICB Board;

14.6 the Committee is updated on pertinent issues/ areas of interest/ policy developments;

14.7 action points are taken forward between meetings and progress against those actions is monitored.

15. REVIEW

15.1 The Committee will review its effectiveness at least annually and complete an annual report submitted to the ICB Board.

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

Reviewed by Population Health and Strategic Commissioning Committee:	TBC
Approved by the ICB Board:	TBC
Review Date:	TBC

5. INTEGRATED CARE SYSTEM COMMITTEES

The Derbyshire Integrated Care System (ICS) is a partnership of health and care organisations that come together to plan and deliver joined-up services and to improve the health of people who live and work in their area. NHS Derby and Derbyshire ICB Board will work collectively and collaborative with the following ICS committees:

- NHS Derby and Derbyshire Integrated Care Partnership;
- Place Partnership Board;
- Provider Collaborative Leadership Board;
- Health and Wellbeing Board; and
- System Executive Senior Leadership Team.

5.1 Integrated Care System – Committee Terms of Reference

[To be included]

6. ELIGIBLE PROVIDERS OF PRIMARY MEDICAL SERVICES

The following are eligible providers of primary medical services:

Practice Name	Address	Practice Code	Contract	Place	Primary Care Network
Adam House Medical Centre	85-91 Derby Road, Sandiacre, Nottingham, NG10 5HZ	C81026	PMS	Erewash	Erewash
Aitune Medical Practice	Midland Street, Long Eaton, Nottingham, NG10 1RY	C81023	PMS	Erewash	Erewash
Alvaston Medical Centre	14 Boulton Lane, Alvaston, Derby, DE24 0GE	C81047	GMS	Derby City	Derby City South
Appletree Medical Practice	47A Town Street, Duffield, Derby, DE56 4GG	C81048	GMS	Amber Valley	Belper
Arden House Medical Practice	Sett Close, New Mills, SK22 4AQ	C81634	PMS	High Peak	High Peak
Arthur Medical Centre	Main Street, Horsley Woodhouse, Derby, DE7 6AX	C81017	GMS	Amber Valley	Belper
Ashbourne Medical Practice	Clifton Road, Ashbourne, Derby, DE6 1DR	C81037	GMS	Derbyshire Dales	Derbyshire Dales
Ashbourne Surgery	Clifton Road, Ashbourne, Derby, DE6 1RR	C81086	GMS	Derbyshire Dales	Derbyshire Dales
Ashover Medical Centre	Milken Lane, Ashover, Chesterfield, S45 0BA	C81611	GMS	Derbyshire Dales	Derbyshire Dales
Bakewell Medical Centre (Peak and Dales Medical Partnership)	Butts Quarry, Bakewell, De45 1ED	C81016	GMS	Derbyshire Dales	Derbyshire Dales
Barlborough Medical Practice	7 Worksop Road, Barlborough, Chesterfield, S43 4TY	C81662	PMS	Bolsover and North Eastern Derbyshire	North East Derbyshire
Baslow Health Centre	Church Lane, Baslow, Bakewell, DE45 1SP	C81013	GMS	Derbyshire Dales	Derbyshire Dales

Practice Name	Address	Practice Code	Contract	Place	Primary Care Network
Blackwell Medical Centre	6 Gloves Lane, Blackwell, Alfreton, DE55 5JJ	C81661	PMS	Bolsover and North Eastern Derbyshire	South Hardwick
Blue Dykes Surgery (Royal Primary Care)	Eldon Street, Clay Cross, Chesterfield, S45 9NR	C18008	PMS	Bolsover and North Eastern Derbyshire	South Hardwick
Brailsford Medical Centre	The Green, Derby, DE6 3BX	C81075	GMS	Derbyshire Dales	Derbyshire Dales
Brimington Surgery	Church Street, Brimington, Chesterfield, S41 1JG	C81058	PMS	Chesterfield	Chesterfield and Dronfield
Brook Medical Centre	183 Kedleston Road, Derby, DE22 1FT	C81653	GMS	Derby City	Greater Derby
Brooklyn Medical Practice	65 Mansfield Road, Derby, DE75 7AL	C81052	GMS	Amber Valley	Alfreton, Ripley, Heanor and Crich
Buxton Medical Practice	Temple Road, Buxton, SK17 9BZ	C81065	GMS	High Peak	High Peak
Calow and Brimington Practice	Foljambe Road, Brimington, Chesterfield, S43 1DD	C81649	PMS	Chesterfield	Chesterfield and Dronfield
Castle Street Medical Centre	Castle Street, Bolsover, Chesterfield, S44 6PP	C81638	PMS	Bolsover and North Eastern Derbyshire	North Hardwick and Bolsover
Chapel Street Medical Centre	10 Chapel Street, Spondon, Derby, DE21 7RJ	C81068	GMS	Derby City	Greater Derby
Chatsworth Road Medical Centre	Chatsworth Road, Brampton, Chesterfield, S40 3PY	C81067	PMS	Chesterfield	Chesterfield and Dronfield
Chellaston and Melbourne Medical Practice	Rowallan Way, Chellaston, Derby, DE73 5GB	C81108	GMS	Derby City	Derby City South
Chesterfield Medical Partnership (Royal Primary Care Chesterfield West)	Ashgate Manor, Ashgate Road, Chesterfield, S40 4AA	C81045	PMS	Chesterfield	Chesterfield and Dronfield
Clay Cross Medical Centre	Bridge Street, Clay Cross, Chesterfield, S45 9NG	C81056	GMS	Bolsover and North Eastern Derbyshire	South Hardwick
College Street Medical Practice	86 College Street, Long Eaton, Nottingham, NG10 4NP	C81097	PMS	Erewash	Erewash

Practice Name	Address	Practice Code	Contract	Place	Primary Care Network
Cottage Lane Surgery	47 Cottage Lane, Gramesley, Glossop Derbyshire, SK13 6EQ	C81615	GMS	High Peak	Glossopdale
Crags Health Care	174 Elmton Road, Creswell, Worksop, S80 4DY	C81096	GMS	Bolsover and North Eastern Derbyshire	North Hardwick and Bolsover
Creswell Medical Centre	Welbeck Street, Creswell, Worksop, S80 4HA	Y04977	APMS	Bolsover and North Eastern Derbyshire	North Hardwick and Bolsover
Crich Medical Practice	Oakwell Drive, Crich, Derby, DE4 5PB	C81094	GMS	Amber Valley	Alfreton, Ripley, Heanor and Crich
Darley Dale Medical Centre (Credas Medical)	Two Dales, Matlock, DE4 2SA	C81030	PMS	Derbyshire Dales	Derbyshire Dales
Derby Family Medical Centre	1 Hastings Street, DE23 6QQ	C81118	GMS	Derby City	Greater Derby
Derwent Medical Centre	26 North Street, Derby, DE1 3AZ	C81652	GMS	Derby City	Derby City North
Derwent Valley Medical Practice	20 St Mark's Road, DE61 6AT	C81652	GMS	Derby City	Greater Derby
Dr Webb & Partners	Ilkeston Health Centre, South Street, Ilkeston, DE7 5PZ	C81022	GMS	Erewash	Erewash
Dronfield Medical Practice	High Street, Dronfield, S18 1PY	C81025	PMS	Bolsover and North Eastern Derbyshire	Chesterfield and Dronfield
Eden Surgery	Cavendish Road, Ilkeston, Derbyshire, DE7 5AN	C81604	PMS	Erewash	Erewash
Elmwood Medical Centre	Burlington Road, Buxton, SK17 9AY	C81074	PMS	High Peak	High Peak
Emmett Carr Surgery	Abbey Place, Renishaw, S21 3TY	C81095	PMS	Bolsover and North Eastern Derbyshire	North Hardwick and Bolsover
Evelyn Medical Centre	Marsh Avenue, Hope, S33 6RJ	C81092	GMS	Derbyshire Dales	Derbyshire Dales
Eyam Surgery	Church Street, Eyam, Hope Valley, S32 5QH	C81039	GMS	Derbyshire Dales	Derbyshire Dales
Friar Gate Surgery	Agard Street, Derby, DE1 1DZ	C81036	GMS	Derby City	Derby City North

Practice Name	Address	Practice Code	Contract	Place	Primary Care Network
Friendly Family Surgery	Welbeck Road, Bolsover, Chesterfield, S44 6DE	C81655	PMS	Bolsover and North Eastern Derbyshire	North Hardwick and Bolsover
Gladstone House Surgery	Gladstone Street West, Ilkeston, Derbyshire, DE7 5QS	C81115	PMS	Erewash	Erewash
Golden Brook Practice	Midland Street, Long Eaton, Nottingham, NG10 1RY	C81083	GMS	Erewash	Erewash
Goyt Valley Medical Practice	Chapel Road, Whaley Bridge, SK23 7SR	C81080	PMS	High Peak	High Peak
Gresleydale Healthcare Centre	Glamorgan Way, Church Gresley, Swadlincote, DE11 9JT	C81114	GMS	Derby City	Swadlincote
Hannage Brook Medical Centre	Hannage Way, Wirksworth, Derbyshire, DE4 4JG	C81062	GMS	Derbyshire Dales	Derbyshire Dales
Hartington Surgery	Dig Street, Hartington, SK17 0AQ	C81082	GMS	High Peak	High Peak
Haven Medical Centre	690 Osmaston Road, Derby, DE24 8GT	C81087	GMS	Derby City	Derby City South
Heartwood Medical Practice	Civic Way, Swadlincote, Derby, DE11 0AE	Y01812	GMS	Derby City	Swadlincote
Hollybrook Medical Centre	Hollybrook Way, Heatherton, Derby, DE23 3TX	C81054	PMS	Derby City	Derby City South
Horizon Healthcare	3-5 Burton Road, Derby, DE1 1TH	C81006	GMS	Derby City	Derby City North
Howard Medical Practice (Group Practice Centre)	Howard Street, Glossop, SK13 7DE	C81077	GMS	High Peak	Glossopdale
Imperial Road Surgery	8 Imperial Road, Matlock, DE4 3NL	C81028	GMS	Derbyshire Dales	Derbyshire Dales
Inspire Health	109 Saltergate, Chesterfield, S40 1LE	C81084	PMS	Chesterfield	Chesterfield and Dronfield
Ivy Grove Surgery	Steeple Drive, Ripley, Derbyshire, DE5 3TH	C81004	PMS	Amber Valley	Alfreton, Ripley, Heanor and Crich

Practice Name	Address	Practice Code	Contract	Place	Primary Care Network
Jessop Medical Practice	Greenhill Lane, Riddings, Alfreton, DE55 1LU	C81005	GMS	Amber Valley	Alfreton, Ripley, Heanor and Crich
Kelvingrove Medical Centre	28 Hands Road, Heanor, Derbyshire, DE75 7HA	C81049	GMS	Amber Valley	Alfreton, Ripley, Heanor and Crich
Killamarsh Medical Practice	209 Sheffield Road, Killamarsh, Sheffield, S21 1DX	C81091	PMS	Bolsover and North Eastern Derbyshire	North East Derbyshire
Lambgates Health Centre	Wesley Street, Hadfield, Glossop, SK13 1DJ	C81106	GMS	High Peak	Glossopdale
Lime Grove Medical Centre	Lime Grove Walk, Matlock, DE4 3FD	C81101	GMS	Derbyshire Dales	Derbyshire Dales
Limes Medical Centre	Limes Ave, Alfreton, DE55 7DW	C81099	PMS	Bolsover and North Eastern Derbyshire	South Hardwick
Lister House Chellaston Surgery	Fellow Lands Way, Derby, DE73 6SW	Y05286	APMS	Derby City	PCCO
Lister House Surgery	207 St Thomas Road, Derby, DE23 8RJ	C81072	GMS	Derby City	PCCO
Littlewick Medical Centre	42 Nottingham Road, Ilkeston, Derbyshire, DE7 5PR	C81061	GMS	Erewash	Erewash
Macklin Street Surgery	90 Macklin Street, Derby, DE1 1JX	C81073	GMS	Derby City	Derby City North
Manor House Surgery	Manor House, Glossop, SK13 8PS	C81081	PMS	High Peak	Glossopdale
Mickleover Medical Centre	Vicarage Road, Mickleover, Derby, DE3 0HA	C81042	GMS	Derby City	Greater Derby
Mickleover Surgery	10 Cavendish Way, Mickleover, Derby, DE3 9BJ	C81113	GMS	Derby City	Greater Derby
Moir Medical Centre	Regent Street, Long Eaton, Nottingham, NG10 QQ	C81010	PMS	Erewash	Erewash
Newbold Surgery	3 Windemere Road, Newbold, Chesterfield, S31 8DU	C81015	PMS	Chesterfield	Chesterfield and Dronfield

Practice Name	Address	Practice Code	Contract	Place	Primary Care Network
Newhall Surgery	46-48 High Street, Swadlincote, Derby, DE11 0HU	C81020	GMS	Derby City	Swadlincote
North Wingfield Medical Centre	Chesterfield Road, North Wingfield, S42 5ND	C81055	PMS	Bolsover and North Eastern Derbyshire	South Hardwick
Oakhill Medical Practice	Oakhill Road, Dronfield, S18 2EJ	C81070	GMS	Bolsover and North Eastern Derbyshire	Chesterfield and Dronfield
Old Station Surgery	Heanor Road, Ilkeston, Derbyshire, DE7 8ES	C81021	GMS	Erewash	Erewash
Osmaston Surgery	212 Osmaston Road, Derby, DE23 8JX	C81071	PMS	Derby City	Derby City North
Overdale Medical Practice	Breaston Surgery, 1 Bridgefield, Breaston, DE72 3DS	C81066	GMS	Derby City	Oakdale Park
Park Farm Medical Centre	3 Park Farm Centre, Allestree, Derby, DE22 2QN	C81064	GMS	Derby City	Greater Derby
Park Lane Surgery	2 Park Lane, Allestree, Derby, DE22 2DS	C81040	GMS	Derby City	Greater Derby
Park Medical Practice	Maine Drive, Chaddesden, Derby, DE21 6LA	C81051	GMS	Derby City	Oakdale Park
Park Surgery	60 Ilkeston Road, Heanor, Ilkeston, DE75 7DX	C81031	GMS	Amber Valley	Alfreton, Ripley, Heanor and Crich
Park View Medical Centre	Cranfleet Way, Long Eaton, Nottingham, NG10 3RJ	C81642	PMS	Erewash	Erewash
Parkfields Surgery	1217 London Road, Alvaston, Derby, DE24 8QJ	Y05733	APMS	Derby City	Derby City South
Parkside Surgery	Alfreton Primary Care Centre, Church Street, Alfreton, DE55 7AH	C81053	PMS	Amber Valley	Alfreton, Ripley, Heanor and Crich
Peartree Medical Centre	159 Peartree Road, Derby, DE23 8NQ	C81616	GMS	Derby City	Greater Derby
Ripley Medical Centre	Derby Road, Ripley, Derbyshire, DE5 3HR	C81059	PMS	Amber Valley	Alfreton, Ripley, Heanor and Crich

Practice Name	Address	Practice Code	Contract	Place	Primary Care Network
Riversdale	59 Bridge Street, Belper, Derbyshire, DE56 1AX	C81069	GMS	Amber Valley	Belper
Royal Primary Care	Stubbing Road, Grangewood, Chesterfield, S40 2HP	Y04995	APMS	Chesterfield	Chesterfield and Dronfield
St. Lawrence Road Surgery	17-19 St Lawrence Road, North Wingfield, Chesterfield, S42 5LH	C81647	PMS	Bolsover and North Eastern Derbyshire	South Hardwick
St. Thomas Road Surgery	207 St Thomas Road, Derby, DE23 8RJ	Y02442	APMS	Derby City	Greater Derby
Sett Valley Medical Centre	Hyde Bank Road, New Mills, SK22 4BP	C81003	PMS	High Peak	High Peak
Shires Healthcare	18 Main Street, Shirebrook, Mansfield, NG20 8DG	C81033	PMS	Bolsover and North Eastern Derbyshire	North Hardwick and Bolsover
Simmondley Medical Practice	15 Pennine Road, Glossop, SK13 6NN	C81640	GMS	High Peak	Glossopdale
Somercotes Medical Centre	22 Nottingham Road, Somercotes, Derbyshire, DE55 4JJ	C81027	GMS	Amber Valley	Alfreton, Ripley, Heanor and Crich
Springs Health Centre	Recreation Close, Clowne, Chesterfield, S43 3PL	C81001	PMS	Bolsover and North Eastern Derbyshire	North East Derbyshire
Staffa Health	3 Waverley Street, Tibshelf, Alfreton, DE55 5PS	C81029	PMS	Bolsover and North Eastern Derbyshire	South Hardwick
Stewart Medical Centre	Hartington Road, Buxton, SK17 6JP	C81034	PMS	High Peak	High Peak
Stubley Medical Centre	7 Stubley Drive, Dronfield Woodhouse, Dronfield, S18 8QU	C81089	PMS	Bolsover and North Eastern Derbyshire	Chesterfield and Dronfield
Surgery at Wheatbridge	30 Wheatbridge Road, Chesterfield, S40 1AB	C81012	PMS	Chesterfield	Chesterfield and Dronfield
Swadlincote Surgery	Darklands Road, Swadlincote, Derbyshire, DE11 0PP	C81032	GMS	Derby City	Swadlincote

Practice Name	Address	Practice Code	Contract	Place	Primary Care Network
Thornbrook Surgery	Thornbrook Road, Chapel en Le Frith, SK23 0RH	C81063	PMS	High Peak	High Peak
Valleys Medical Partnership	Gosber Road, Eckington, S21 4BZ	C81002	GMS	Bolsover and North Eastern Derbyshire	North East Derbyshire
Vernon Street Medical Centre	13 Vernon Street, Derby, DE1 1FW	C81007	GMS	Derby City	Greater Derby
Village Surgery	108 Victoria Road, Pinxton, NG16 6NH	C81050	PMS	Bolsover and North Eastern Derbyshire	South Hardwick
Village Surgery	Village Community Medical Centre, Derby, DE23 8AL	C81035	GMS	Derby City	Derby City South
Welbeck Road Surgery	1b Welbeck Road, Bolsover, Chesterfield, S44 6DF	C81041	PMS	Bolsover and North Eastern Derbyshire	North Hardwick and Bolsover
Wellbrook Medical Centre	Welland Road, Derby, DE65 5GZ	C81110	GMS	Derby City	Derby City South
West Hallam Medical Centre	The Village, West Hallam, Ilkeston, DE7 6GR	C81046	GMS	Amber Valley	Erewash
Whitemoor Medical Centre	Whitemoor Lane, Belper, Derbyshire, DE56 2JU	C81038	GMS	Amber Valley	Belper
Whittington Moor Surgery	Scarsdale Road, Whittington Moor, Chesterfield, S41 8NA	C81044	PMS	Chesterfield	Chesterfield and Dronfield
Willington Surgery	Kingfisher Lane, Willington, Derbyshire, DE65 6YB	C81057	GMS	Derby City	Derby City South
Wilson Street Surgery	11 Wilson Street, Derby, DE1 1PG	C81009	GMS	Derby City	Derby City North
Wingerworth Medical Centre	3 Allendale Road, Wingerworth, Chesterfield, S42 6PX	C81658	PMS	Bolsover and North Eastern Derbyshire	South Hardwick
Woodville Surgery	Burton Road, Woodville, Swadlincote, DE11 7JE	C81060	GMS	Derby City	Swadlincote

7. SCHEME OF RESERVATIONS AND DELEGATION

7.1 Decisions and functions reserved to the ICB Board

	Decisions and functions reserved to the ICB Board	Reference
ICB Board	A Unitary Board responsible for: • developing a plan and allocating resource to meet the health and healthcare needs of the population; • establishing joint working arrangements with partners that embed collaboration as the basis for delivery within the plan; • establishing governance arrangements to support collective accountability for whole-system delivery and performance; • arranging for the provision of health services including contracting arrangements, transformation, development of PCNs, working with local authority VCSE sector partners to put in place personalised care for people. Leading system implementation of people priorities including delivery of the People Plan and People Promise. Leading system-wide action on data and digital; and • leading integration within the NHS. They will bring the NHS together locally to improve population health and establish shared strategic priorities within the NHS, connecting to partnership arrangements at system and place.	
	The delegation arrangements and financial authority limits are as follows: • approval of capital business cases including granting, terminating or extending leases – all PFI schemes and other schemes greater than £250,000; • capital expenditure variations over the original business case figure – greater than £100,000; • approval of asset disposals – land and buildings, and other assets, where asset has a residual value greater than £100,000; • approval of budgets and their management – approval of budgets and resources;	SORD 1.1(a) SORD 1.2(a) SORD 1.4(a) and (b) SORD 2.1(a)

	Decisions and functions reserved to the ICB Board	Reference
ICB Board	• approval of Revenue Business Cases greater than £500,000 (with Finance and Estates Committee);	SORD 3.1(a)
	• tender ratification and award, including authorisation of any actions resulting from post tender negotiations for all types of tenders (on the lifetime value of the contract) for clinical spend above £1,500,000;	SORD 4.9(c)
	• income generation and research and development contracts – approval of income generation contracts and variations or extensions to income generation contracts, greater than £500,000;	SORD 8.1(a)
	• income generation and research and development contracts – approval of research and development contracts (including variations or extensions), greater than £500,000;	SORD 8.2(a)
	• losses and special payments – authorisation of losses and special payments, including ex-gratia payments, greater than £50,000 (following ratification by Audit and Governance Committee); and	SORD 10.1(a)
	• losses and special payments – authorisation of early retirement, redundancy and other termination payments to staff, greater than £100,000.	SORD 10.3(a)

7.2 **Decisions and functions delegated by the ICB Board to ICB committees**

ICB Committee	Decisions and functions delegated to the committee	Reference
Audit and Governance Committee	Delegated responsibility for: • the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the ICB's activities; • overseeing policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification; • overseeing policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service;	Audit and Governance Committee Terms of Reference

ICB Committee	Decisions and functions delegated to the committee	Reference
Audit and Governance Committee	• ensuring that there is an effective internal audit function and external audit plan that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance; • monitoring the integrity of the financial statements of the ICB and any formal announcements relating to financial performance; and • ensuring that the systems for financial reporting to the ICB, including those of budgetary control, are subject to review as to completeness and accuracy of the information. • complying with regulations governing best practice in relation to procurement, protecting and promoting patient choice, and anti-competitive conduct; • complying with public law requirements in relation to entering into contracts concerning commissioning arrangements and the use of public monies; • taking appropriate steps to ensure that the ICB is properly prepared to deal with emergencies that might affect it; and • providing information, where required, to the Information Centre, e.g. to support publication of national data on healthcare services; • maintaining one or more publicly accessible registers of interests of members of the ICB, its employees, members of the ICB Board and members of committees or subcommittees of the ICB, and to make arrangements to ensure that relevant conflicts or potential conflicts of interest are declared and included in the registers; • making arrangements for managing conflicts and potential conflicts of interest in such a way as to ensure that they do not, and do not appear to, affect the integrity of the ICB's decision-making processes, and to have regard to guidance published by NHSEI on management of conflicts of interest; • meeting requirements of the Employment Rights Act 1996, the Equality Act 2010, the Data Protection and Freedom of Information Acts, the European Convention on Human Rights and Health and Safety; and • promoting innovation and research in the provision of health services.	Audit and Governance Committee Terms of Reference

ICB Committee	Decisions and functions delegated to the committee	Reference
Audit and Governance Committee	The delegation arrangements and financial authority limits are as follows: • monitoring of the use of single tender/single quote action (on behalf of ICB Board); • income and debt write-off – monitoring of write-offs of debt or income (total debt per debtor) (following Executive Team approval); and • losses and special payments – monitoring of losses and special payments.	SORD 4.5 SORD 9.2 SORD 10.2
Remuneration Committee	The function of making recommendations to the ICB Board about the exercise of its functions in relation to: • determining the remuneration, fees and allowances payable to employees of the ICB and to other persons providing services to it; • determining allowances payable under pension schemes established by the ICB; and • the appropriate remuneration and terms of service for the Chief Executive Officer, Executive Directors, other Very Senior Managers, Clinicians and Independent Non-Executive Members.	Remuneration Committee Terms of Reference
Population Health and Strategic Commissioning Committee	Delegated responsibility for: • overseeing the preparation and publication of the commissioning plan with the involvement of the Health and Wellbeing Boards and aligned to the strategy developed by the ICP; • developing and implementing the commissioning strategy and policy of the ICB and to help secure the continuous improvement of the quality of services, including the specified duties under the Mental Health Act; • retaining a focus on health inequalities, improved outcomes and quality and ensure that the delivery of the ICB's strategic and operational plans are achieved within financial allocations; • commissioning consistently with the duties of the Secretary of State and NHSEI objectives, having regard to the Constitution; • making decisions within the limits as set out in the ICB's Scheme of Reservations and Delegation; and • further delegating to sub-committees relating specifically to primary care medical services but will retain oversight and accountability.	Population Health and Strategic Commissioning Committee Terms of Reference

ICB Committee	Decisions and functions delegated to the committee	Reference
Population Health and Strategic Commissioning Committee	The delegation arrangements and financial authority limits are as follows: • approval of capital business cases including granting, terminating or extending leases – up to £250,000; • capital expenditure variations over the original business case figure – greater than £25,000 and less than £100,000 or greater than 5% of the original business case whichever is the lower; • approval of budget virements – for other virements greater than £10,000; and • tender ratification and award, including authorisation of any actions resulting from post tender negotiations for all types of tenders (on the lifetime value of the contract) above £50,000 (clinical spend up to and including £1,500,000).	SORD 1.1(b) SORD 1.2(b) SORD 2.2(e) SORD 4.9(b(ii))
Finance and Estates Committee	Delegated responsibility to: • provide oversight and assurance to the ICB Board in the development and delivery of a robust, viable and sustainable system financial and estates plan; and processes which meet the health and care needs of the citizens of Derby and Derbyshire and aid the implementation of the ICS vision and strategy; • provide the ICB board with an accurate understanding of the system's current and forecast financial position and the development and oversight of the system's medium term financial recovery plan to correct any underlying challenge; • identify and allocate resources including consideration of significant investment or disinvestment decisions; and • ensure that suitable policies and procedures are in place to comply with relevant regulatory, legal and code of conduct requirements and review adequacy.	Finance and Estates Committee Terms of Reference

ICB Committee	Decisions and functions delegated to the committee	Reference
Finance and Estates Committee	The delegation arrangements and financial authority limits are as follows: • approval of capital business cases including granting, terminating or extending leases – up to £250,000; • capital expenditure variations over the original business case figure – greater than £25,000 and less than £100,000 or greater than 5% of the original business case whichever is the lower; • approval of Revenue Business Cases greater than £500,000 (with ICB Board); • approval of Revenue Business Cases greater up to £500,000; • non-Healthcare Expenditure (Limits include VAT) – approval of the signing of contracts including letters of intent (for lifetime value of contract) greater than £10million; • payroll Expenditure – off-payroll/agency workers with a Daily rate less than £600 ex VAT, less than 6 months and not categorised as a role of significant influence; and • opening of bank accounts or changes to banking arrangements.	 SORD 1.1(b) SORD 1.2(b) SORD 3.1(a) SORD 3.1(b) SORD 6.1(b) SORD 7.3(a) SORD 11.1
People and Culture Committee	Delegated responsibility to: • promote education and training of existing and future health care staff; • deliver the commitments of the NHS People Plan across the system; • oversee plans to develop, support and retain the health and care workforce, adopting a "one workforce" approach with all partners across the ICS; • ensure the appropriate workforce capacity and capability to deliver the ICS objectives together with an organisational development plan; and • oversee the demonstration of equality, diversity and inclusion in its plans and their implementation.	People and Culture Committee Terms of Reference

ICB Committee	Decisions and functions delegated to the committee	Reference
Quality and Performance Committee	Delegated responsibility to ensure: • the system organisations discharge their statutory duties in relation to the achievement of continuous quality improvement; • quality and outcome information against key performance trajectories is received and quality issues identified, ensuring they are acted upon; • delivery against of the Constitution, NHS Long Term Plan, Public Health Outcomes Framework, and associated NHS performance regimes, agreeing any action plans or recommendations as appropriate; • continuous improvements in quality and outcomes of clinical effectiveness, safety and patient experience are secured; • processes are in place to interpret and implement local, regional and national policy (e.g., Quality Accounts, Safeguarding etc.) and provide assurance that policy requirements are embedded in services; and • considerations relating to safeguarding children and adults are integral to services and robust processes are in place to deliver statutory functions of all Health and Social Care Organisations within the ICS.	Quality and Performance Committee Terms of Reference
Public Partnerships Committee	Delegated responsibility to: • ensure appropriate engagement and consultation with patients and the public for new or changing services; • assess levels of assurance and risk in relation to the delivery of statutory duties in public and patient involvement and consultation, as defined within the Health & Social Care Act 2012; • retain a focus on the need for engagement in strategic priorities and programmes, to ensure the local health system is developing robust processes in the discharging of duties relating to involvement and consultation; and • seek assurance that the Derbyshire system is following defined processes to take due regard when considering and implementing service changes as defined by the Equality Act 2010 and delivered through targeted engagement.	Public Partnerships Committee Terms of Reference

7.3 Decisions and functions delegated to be exercised jointly

Committee/entity that will exercise the function/decision	Decisions and functions delegated to the committee	Legal power	Governing arrangements
e.g. X local authority		e.g. section 75, section 65z5	Delegation agreement, MoU etc.
e.g. X NHS trust			
e.g. X ICB			

7.4 Decisions and functions delegated by the ICB Board to other statutory bodies

Body	Decisions and functions delegated to the body	Legal power	Governing arrangements
e.g. X local authority		e.g. section 75, section 65z5	Delegation agreement, MoU contract etc.
e.g. X NHS trust			
NHS England and NHS Improvement	Payroll Expenditure, off-payroll/agency workers with a daily rate more than £600 ex VAT, or more than 6 months or categorised as a role of significant influence (SORD 7.3(b))		

7.5 Decisions and functions delegated by the ICB Board to individual ICB Board members and employees

Individual ICB Board member of employee	Decisions and functions delegated to the individual	Reference
Chief Executive Officer	Approval of asset disposals – other Assets, where asset has a residual value of £50,000 and up to £100,000	SORD 1.4(b)
	Approval of budgets and their management – delegation of budgets	SORD 2.1(b)
	Approval of budget virements – if virement is a result of an authorised contract variation greater than £100,000 (with either Executive Director of Finance or Functional Director)	SORD 2.2(a)
	Procurement – authorisation of less than the requisite number of tenders/quotes for all contracts of £250,000 and above	SORD 4.2(a)
	Advertising of contracts/ publishing of contract awards over £25,000	SORD 4.6
	Permission to consider late tenders	SORD 4.8
	Sealing of documents	SORD 4.10 Standing Orders (Appendix 1, ICB Constitution)
	Commissioning Expenditure (Purchase of Healthcare) – contract signature for all contracts over £10 million (with Executive Director of Finance)	SORD 5.1(a)
	Commissioning Expenditure (Purchase of Healthcare) – contract signature for all contracts greater than £1 million and up to £10 million	SORD 5.1(b)
	Commissioning Expenditure (Purchase of Healthcare) – requisitions greater than £50 million	SORD 5.2(a)
	Commissioning Expenditure (Purchase of Healthcare) – invoice payment, where purchase orders have not been raised, greater than £50 million	SORD 5.3(a)
	Commissioning Expenditure (Purchase of Healthcare) – authorisation of monthly invoices in excess of agreed contract value	SORD 5.4
	Non-Healthcare Expenditure (Limits include VAT) – signing of contracts including letters of intent (for lifetime value of contract) greater than £500,000 (with Executive Director of Finance)	SORD 6.1(a)

Individual ICB Board member of employee	Decisions and functions delegated to the individual	Reference
	Non-Healthcare Expenditure (Limits include VAT) – authorisation of requisitions £500,000 and above (with Executive Director of Finance and with approval from the Finance and Estates Committee)	SORD 6.2(a)
Chief Executive Officer	Non-Healthcare Expenditure (Limits include VAT) – authorisation of requisitions for Procurement of Professional Services - additional controls are required due to the nature of expenditure for legal advice; specialist advice; and specific projects	SORD 6.2(e)
	Non-Healthcare Expenditure (Limits include VAT) – invoice payment, where purchase orders have not been raised, £500,000 and above (with Executive Director of Finance and with approval from Finance and Estates Committee)	SORD 6.3(a)
	Non-Healthcare Expenditure (Limits include VAT) – invoice payment for Procurement of Professional Services - additional controls are required due to the nature of expenditure for legal advice; specialist advice; and specific projects	SORD 6.3(e)
	Payroll Expenditure, substantive and within budgeted establishment for appointment of substantive staff of VSM contracts (with Executive Director of Finance and NHS England)	SORD 7.1(a)
	Payroll Expenditure, not within budgeted establishment, including authority to permanently amend the formal establishment	SORD 7.2(b)
	Payroll Expenditure – authorisation of other travel and expenses not covered by the ICB's Travel and Expenses Policy, over £300	SORD 7.5(a)
	Income Generation and Research and Development Contracts – approval of income generation contracts and variations or extensions to income generation contracts, £250,000 and up to £500,000	SORD 8.1(b)
	Income Generation and Research and Development Contracts – approval of research and development contracts (including variations or extensions), £250,000 and up to £500,000	SORD 8.2(b)
	Losses and special payments – authorisation of losses and special payments, including ex-gratia payments, £10,000 and up to £50,000 (following ratification by Audit and Governance Committee)	SORD 10.1(b)

Individual ICB Board member of employee	Decisions and functions delegated to the individual	Reference
	Losses and special payments – authorisation of early retirement, redundancy and other termination payments to staff, £50,000 and up to £100,000	SORD 10.3(b)
Executive Director of Finance	Capital expenditure variations over the original business case figure – less than £25,000 or less than 5% of the original business case whichever is the lower	SORD 1.2(c)
	Maintenance of the capital asset register	SORD 1.3
	Approval of asset disposals – other Assets, where asset has a residual value of £10,000 but less than £50,000	SORD 1.4(c)
	Approval of budgets and their management – delegation of budgets	SORD 2.1(b)
	Financial appraisal of potential suppliers	SORD 4.1
	Authorisation of less than the requisite number of tenders/quote for all contracts less than £250,000	SORD 4.2(b)
	Single tender/ single quote – a single tender waiver form must be completed and approved	SORD 4.3
	Single tender/single quote action for maintenance or other support contracts for existing goods or assets where the ICB is contractually tied to specific companies	SORD 4.4
	Tender ratification and award, including authorisation of any actions resulting from post tender negotiations for all types of tenders (on the lifetime value of the contract) above £50,000 (non-clinical spend)	SORD 4.9(b(i))
	Sealing of documents	SORD 4.10 Standing Orders (Appendix 1, ICB Constitution)
	Commissioning Expenditure (Purchase of Healthcare) – contract signature for contracts greater than £100,000 and up to £1 million	SORD 5.1(c)
	Commissioning Expenditure (Purchase of Healthcare) – authorisation of monthly invoices in excess of agreed contract value	SORD 5.4
	Non-Healthcare Expenditure (Limits include VAT) – signing of contracts including letters of intent (for lifetime value of contract) greater than £50,000 and up to £500,000 (with approval from the Finance and Estates Committee))	SORD 6.1(b)

Individual ICB Board member of employee	Decisions and functions delegated to the individual	Reference
	Non-Healthcare Expenditure (Limits include VAT) – authorisation of requisitions greater than £100,000 and up to and including £500,000 (with approval from the Finance and Estates Committee)	SORD 6.2(b)
Executive Director of Finance	Non-Healthcare Expenditure (Limits include VAT) – authorisation of requisitions for Procurement of Professional Services - additional controls are required due to the nature of expenditure for legal advice; specialist advice; and specific projects	SORD 6.2(e)
	Non-Healthcare Expenditure (Limits include VAT) – invoice payment, where purchase orders have not been raised, greater than £100,000 up to and including £500,000 (with approval from Finance and Estates Committee)	SORD 6.3(b)
	Non-Healthcare Expenditure (Limits include VAT) – invoice payment for Procurement of Professional Services - additional controls are required due to the nature of expenditure for legal advice; specialist advice; and specific projects	SORD 6.3(e)
	Payroll Expenditure – authorisation of other travel and expenses not covered by the ICB's Travel and Expenses Policy, over £300	SORD 7.5(a)
	Payroll Expenditure – approval to work overtime	SORD 7.6(a)
	Income Generation and Research and Development Contracts – approval of income generation contracts and variations or extensions to income generation contracts, less than £250,000	SORD 8.1(c)
	Income Generation and Research and Development Contracts – approval of research and development contracts (including variations or extensions), up to £250,000	SORD 8.2(c)
	Income and debt write-off – authorisation to refer debts to a debt collection agency	SORD 9.1
	Losses and special payments – authorisation of early retirement, redundancy and other termination payments to staff, up to £50,000	SORD 10.3(c)
	Signing of cheques for cash, signing of other cheques, and authorisation of electronic payments, cheque and BACs and CHAPs payment schedules	SORD 11.2 Bank Mandate
	Income from fees and charges – approval of the amounts to be charged for fees and charges	SORD 12.1

Individual ICB Board member of employee	Decisions and functions delegated to the individual	Reference
	Insurance (clinical and non-clinical) – Decision on level of insurance required, negotiated and agreement of premiums	SORD 14.1
Deputy Chief Executive Officer	Sealing of documents	SORD 4.10 Standing Orders (Appendix 1, ICB Constitution)
	Non-Healthcare Expenditure (Limits include VAT) – authorisation of requisitions for Procurement of Professional Services - additional controls are required due to the nature of expenditure for legal advice; specialist advice; and specific projects	SORD 6.2(e)
	Non-Healthcare Expenditure (Limits include VAT) – invoice payment for Procurement of Professional Services - additional controls are required due to the nature of expenditure for legal advice; specialist advice; and specific projects	SORD 6.3(e)
Executive Director of Corporate Affairs	Losses and special payments – authorisation of losses and special payments, including ex-gratia payments, up to £30,000 (following ratification by Audit and Governance Committee)	SORD 10.1(c)
	Standards of Business Conduct – maintenance of the ICB Register of Interests	SORD 13.1
	Standards of Business Conduct – maintenance of the ICB Gifts and Hospitality Register	SORD 13.2
Executive Director Strategy and Planning	Commissioning Expenditure (Purchase of Healthcare) – contract signature for contracts greater than £100,000 and up to £1 million	SORD 5.1(c)
	Commissioning Expenditure (Purchase of Healthcare) – authorisation of monthly invoices in excess of agreed contract value	SORD 5.4
All Executive Directors	Payroll Expenditure, not within budgeted establishment, including authority to appoint staff	SORD 7.2(a)
Other Executive Directors	Opening of tenders – where tender is above £25,000	SORD 4.7(a)
Budget Holders	Approval of asset disposals – other Assets, where asset has a residual value of less than £10,000	SORD 1.4(d)
	Approval of budgets and their management – approval to spend	SORD 2.1(c)

Individual ICB Board member of employee	Decisions and functions delegated to the individual	Reference
	Approval of budget virements – if virement is a result of an authorised contract variation greater than £25,000 up to £100,000 (with Executive Director of Finance or Functional Finance Director)	SORD 2.2(b)
Budget Holders	Approval of budget virements – if virement is a result of an authorised contract variation greater than £500 up to £25,000	SORD 2.2(c)
	Approval of budget virements – for other virements up to £10,000	SORD 2.2(f)
	Tender ratification and award, including authorisation of any actions resulting from post tender negotiations for all types of tenders (on the lifetime value of the contract) up to £50,000	SORD 4.9(a)
	Commissioning Expenditure (Purchase of Healthcare) – contract signature for contracts greater than £50,000 and up to £100,000	SORD 5.1(d)
	Commissioning Expenditure (Purchase of Healthcare) – requisitions greater than £1 million and up to £50 million	SORD 5.2(b)
	Commissioning Expenditure (Purchase of Healthcare) – invoice payment, where purchase orders have not been raised, greater than £1 million up to and including £50 million	SORD 5.3(b)
	Non-Healthcare Expenditure (Limits include VAT) – signing of contracts including letters of intent (for lifetime value of contract) up to £50,000	SORD 6.1(c)
	Non-Healthcare Expenditure (Limits include VAT) – authorisation of requisitions greater than £50,000 up to and including £100,000	SORD 6.2(c)
	Non-Healthcare Expenditure (Limits include VAT) – invoice payment, where purchase orders have not been raised, up to and including £50,000	SORD 6.3(d)
	Payroll Expenditure, substantive and within budgeted establishment for all other substantive appointments up to VSM contracts	SORD 7.1(b)
	Payroll Expenditure – authorisation of other travel and expenses not covered by the ICB's Travel and Expenses Policy, up to £300	SORD 7.5(b)
Budget Managers	Approval of budgets and their management – approval to spend	SORD 2.1(c)
	Approval of budget virements – if virement is a result of an authorised contract variation £500 and below	SORD 2.2(d)

Individual ICB Board member of employee	Decisions and functions delegated to the individual	Reference
	Commissioning Expenditure (Purchase of Healthcare) – requisitions greater than £50,000 and up to £1 million	SORD 5.2(c)
	Commissioning Expenditure (Purchase of Healthcare) – invoice payment, where purchase orders have not been raised, greater than £50,000 up to and including £1 million	SORD 5.3(c)
Budget Managers	Non-Healthcare Expenditure (Limits include VAT) – authorisation of requisitions up to and including £50,000	SORD 6.2(d)
	Non-Healthcare Expenditure (Limits include VAT) – invoice payment, where purchase orders have not been raised, greater than £50,000 up to and including £100,000	SORD 6.3(c)
	Payroll Expenditure – authorisation of other travel and expenses not covered by the ICB's Travel and Expenses Policy, up to £100	SORD 7.5(c)
Director responsible for GP Development	Approval of capital business cases including granting, terminating or extending leases – up to £10,000	SORD 1.1(c)
	Commissioning Expenditure (Purchase of Healthcare) – contract signature for contracts greater than £10,000 and up to £50,000	SORD 5.1(e)
Assistant Director responsible for GP Commissioning and Development	Approval of capital business cases including granting, terminating or extending leases – up to £5,000	SORD 1.1(d)
	Commissioning Expenditure (Purchase of Healthcare) – contract signature for contracts up to £10,000	SORD 5.1(f)
Deputy Director of Finance	Approval of asset disposals – other Assets, where asset has a residual value of 'other – where the asset has no residual value'	SORD 1.4(e)
Senior Manager Band 8a or above	Commissioning Expenditure (Purchase of Healthcare) – requisitions up to £50,000	SORD 5.2(d)
	Commissioning Expenditure (Purchase of Healthcare) – invoice payment, where purchase orders have not been raised, up to and including £50,000	SORD 5.3(d)
Band 7 or above	Commissioning Expenditure (Purchase of Healthcare) – Exceptional: Continuing Health Care under £10,000	SORD 5.5
	Commissioning Expenditure (Purchase of Healthcare) – Exceptional: Non-Contracted Activity under £1,000	SORD 5.6

Individual ICB Board member of employee	Decisions and functions delegated to the individual	Reference
Line Managers	Travel and Expenses – authorisation of travel and expense claims in line with the ICB's Travel and Expenses Policy. The maximum value of any single monthly claim is restricted to £2,500.	SORD 7.4
	Payroll Expenditure – ESR authorisation of overtime	SORD 7.6(b)
Nominated staff	Non-Healthcare Expenditure (Limits include VAT) – authorisation of requisitions for Procurement of Professional Services - additional controls are required due to the nature of expenditure for legal advice; specialist advice; and specific projects	SORD 6.2(e)
	Non-Healthcare Expenditure (Limits include VAT) – invoice payment for Procurement of Professional Services - additional controls are required due to the nature of expenditure for legal advice; specialist advice; and specific projects	SORD 6.3(e)

7.6 **Decisions and functions delegated to the ICB Board by other organisations**

Body making the delegation	Decisions and functions delegated to the individual	Reference
NHS England	Primary Medical Care Commissioning	Delegation agreement
NHS England	Pharmacy, Optometry and Dental Commissioning	Delegation agreement

Detailed schedule to operational/financial scheme of delegation

- Different terms are used by different organisations to describe the detailed financial limits that individuals are authorised to approve.
- Supporting documents containing further detail regarding who has what authority to commit resources in the delivery of ICB objectives.
- Usually make reference to the delivery of the SoRD, standing financial instructions and standing orders.

Decisions, Authorities and Duties Delegated to Officers of the ICB Board

1. The arrangements made by the NHS Derby and Derbyshire Integrated Care Board (ICB) as set out in the Overarching Scheme of Reservations and Delegation of decisions shall have effect as if incorporated in the ICB's Constitution.
2. The ICB remains accountable for all of its functions, including those that it has delegated.
3. The Overarching Scheme of Reservations & Delegation (Schedule of Matters Reserved to the ICB and Scheme of Delegation) and details the arrangements made by the ICB for discharging its functions.
4. The Schedule below details the Operational Scheme of Delegation (and financial authority limits). These should be read in conjunction with the Standing Financial Instructions (See ICB Governance Handbook).
5. This is prepared by the Chief Executive Officer and sets out those key operational decisions delegated to individual employees of the ICB.
6. The approval of the ICB's Operational Scheme of Delegation that underpins the ICB's “Overarching Scheme of Reservations and Delegation” is reserved to the ICB Board.

1	Capital Projects and Assets
2	Budgetary Control
3	Approval of Revenue Business Cases
4	Procurement
5	Commissioning Expenditure – Purchase of Healthcare
6	Non-Healthcare Expenditure (Limits include VAT) Contracts
7	Payroll Expenditure
8	Income Generation and Research and Development
9	Income and debt write-off
10	Losses and Special Payments
11	Bank accounts and payment methods
12	Income from fees and charges
13	Standards of Business Conduct
14	Insurance – clinical and non-clinical
15	Borrowing, lending and grants

	Responsibility	Delegation Arrangements	Further Information
1.	**Capital Projects and Assets**	***This includes any expenditure that meets IFRS 16 – Leases criteria***	
1.1	Approval of capital business cases including granting, terminating or extending leases: (a) All PFI schemes and other schemes greater than £250,000 (b) Up to £250,000 (c) Up to £10,000 (d) Up to £5,000	(a) ICB Board (b) Population Health and Strategic Commissioning Committee, and Finance and Estates Committee (c) Director responsible for GP Development (d) Assistant Director responsible for GP Commissioning and Development	This includes cases any capital business cases that may receive external funding. These powers may not be further delegated from the ICB Board. In the absence of the appropriate officer, authorisation must be obtained from the level above. In urgent cases joint approval by the Chief Executive Officer and Executive Director of Finance is required (up to the approval limits of approval of the Population Health and Strategic Commissioning Committee and Finance and Estates Committees). The Director responsible for GP Development and Assistant Director responsible for GP Commissioning and Development can approve the funding of essential capital works in primary care to address the COVID-19 crisis without the need for a capital business case. Approval required from NHSEI to confirm availability of capital funding before commencement of the works.

	Responsibility	Delegation Arrangements	Further Information
1.2	Capital expenditure variations over the original business case figure (a) Greater than £100,000 (b) Greater than £25,000 and less than £100,000 or greater than 5% of the original business case whichever is the lower (c) Less than £25,000 or less than 5% of the original business case whichever is the lower	 (a) ICB Board (b) Population Health and Strategic Commissioning Committee' and the Finance and Estates Committee (c) Executive Director of Finance	In urgent cases up to £100,000 joint approval by the Chief Executive Officer and Executive Director of Finance is required (up to approval limits of the Population Health and Strategic Commissioning Committee, and Finance and Estates Committees)
1.3	Maintenance of the capital asset register	Executive Director of Finance	Operationally managed by Operationally managed by the Head of department responsible for Finance – Financial Control
1.4	Approval of asset disposals: (a) Land and buildings Other Assets, where asset has a residual value: (a) Greater than £100,000 (b) £50,000 and up to £100,000 (c) £10,000 but less than £50,000	 (a) ICB Board (a) ICB Board (b) Chief Executive Officer (c) Executive Director of Finance	Head of department responsible for Finance – Financial Control must always be informed to enable the asset register to be updated. Disposals include those items that are lost, obsolete, redundant, and irreparable or cannot be repaired cost effectively.

	Responsibility	Delegation Arrangements	Further Information
	(d) Less than £10,000 (e) Other – where the asset has no residual value	(d) Budget Holders i.e. Executive Directors (e) Deputy level Director responsible for Finance	
2.	**Budgetary Control**		
2.1	Approval of budgets and their management (a) Approval of budgets and resources (b) Delegation of Budgets (c) Approval to spend	 (a) ICB Board (b) Chief Executive Officer and Executive Director of Finance (c) Budget Holder/Budget Manager is permitted to incur costs in accordance with their budgets & authorisation limits	The approval of budgets and resources will usually take place during the March ICB Board meeting when the Annual Plan is approved.
2.2	Approval of budget virements If virement is the result of an authorised contract variation: (a) Greater than £100,000	 (a) Chief Executive Officer and either Executive Director of Finance or Functional Director	Staff should refer to the ICB's Financial Management Budget Book.

	Responsibility	Delegation Arrangements	Further Information
	(b) Greater than £25,000 up to £100,000	(b) Budget Holder and either Executive Director of Finance or Functional Finance Director	
	(c) Greater than £500 up to £25,000	(c) Budget Holder	
	(d) £500 and below	(d) Budget Manager	
	For other virements:		
	(e) Greater than £10,000	(a) Population Health and Strategic Commissioning Committee	
	(f) Up to £10,000	(b) Budget Holder	
3.	**Approval of Revenue Business Cases**		
3.1	Approval of Revenue Business Cases		For Capital see Section 1.
	(a) Greater than £500,000	(a) Finance and Estates Committee and ICB Board	In urgent cases, joint approval by the Chief Executive Officer and Executive Director of Finance is required (up to limits of approval by the Finance and Estates Committee).
	(b) Up to £500,000	(b) Finance and Estates Committee	
4.	**Procurement**	*The detailed procedures supporting these delegations can be found in the ICB Procurement Policy*	
4.1	Financial appraisal of potential suppliers	Executive Director of Finance	As required dependant on goods and services being procured. Managed operationally by the Head of department responsible for Finance – Financial Control

	Responsibility	Delegation Arrangements	Further Information
4.2	Authorisation of less than the requisite number of tenders/quotes: (a) For all contracts of £250,000 and above (b) For all contracts less than £250,000	(a) Chief Executive Officer (b) Executive Director of Finance	The requisite number of tenders / quotes: (a) Above £10,000 to £20,000, at least 3 written competitive quotations for goods/services obtained. (b) Above £20,000 to £50,000, at least 5 written competitive quotations for goods / services obtained. All procurement with a value exceeding £25,000 must be advertised on Contract Finder. (c) Above £50,000, a full tender is to be carried out in line with the PCR 15 Regulations. Quotes/ tenders as per (a), (b) and (c) will not be required for the duration of the COVID-19 emergency for primary care expenditure. Robust evidence will be required (e.g. receipts, order confirmation/ invoices from suppliers) in order for primary care to receive reimbursement for expenditure however.
4.3	Single tender/ single quote: A single tender waiver form must be completed and approved.	Executive Director of Finance	Where a single tender/single quote is received, the ICB shall as far as practical, determine that the price to be paid is fair and reasonable and that details of the investigation carried out are recorded. Single tender/single quote will be reported for information only, at the next Audit and Governance Committee. Controls varied for primary care as set out in 1.1 for the duration of the COVID-19 emergency.

	Responsibility	Delegation Arrangements	Further Information
4.4	Single tender/single quote action for maintenance or other support contracts for existing goods or assets where the ICB is contractually tied to specific companies	Executive Director of Finance	Delegated to the Head of Department responsible for Finance – Financial Control, who will ensure such contracts are maintained on the Register of Procurement Decisions.
4.5	Monitoring of the use of single tender/single quote action.	Audit and Governance Committee on behalf of ICB Board	A single tender waiver must be completed and forwarded to the Head of Department responsible for Finance – Financial Control. Single Tender Actions must be maintained on the Register of Procurement Decisions.
4.6	Advertising of contracts/ publishing of contract awards over £25,000	Chief Executive Officer	Managed by the ICB Procurement Lead. Such advertising and publishing must be made available on Contract Finder.
4.7	Opening of tenders (a) Where tender is below £25,000 (b) Where tender is above £25,000	 (a) Budget Holder (b) An Executive Director	In using the e-Tendering solution, the Procurement Lead will first open the tender before allocating to the correct subject matter expert as delegated across. This will be automatic on Contracts Finder.
4.8	Permission to consider late tenders	Chief Executive Officer	With advice from the ICB's Procurement Lead

	Responsibility	Delegation Arrangements	Further Information
4.9	Tender ratification and award, including authorisation of any actions resulting from post tender negotiations: All types of tenders (on the lifetime value of the contract): (a) Up to £50,000 (b) Above £50,000 (i) Non-clinical spend (ii) Clinical spend up to and including £1,500,000 (iii) Both Clinical and Non-Clinical spend above £10million (c) Clinical spend above £1,500,000	(a) Budget Holder i.e. Executive Director (b) (i) Chief Executive Officer (ii) Population Health and Strategic Commissioning Committee (iii) Finance and Estates Committee ahead of the procurement (c) ICB Board	
4.10	Sealing of documents	As per the Standing Orders, Appendix 1 of ICB Constitution	

	Responsibility	Delegation Arrangements	Further Information
5.	**Commissioning Expenditure – Purchase of Healthcare (Programme)**	*This includes NHS, independent care placements, private sector healthcare contracts.* *WHERE NO SIGNED CONTRACT OF THE BELOW DELEGATIONS EXISTS, EXPENDITURE MUST BE RAISED VIA A REQUISITION AND PURCHASE ORDER (unless there are exceptional circumstances)*	
5.1	Contract Signature for contracts: (a) Over £10 million (b) Greater than £1 million and up to £10 million (c) Greater than £100,000 and up to £1 million (d) Greater than £50,000 and up to £100,000 (e) Greater than £10,000 and up to £50,000 (f) Up to £10,000	(a) Finance and Estates Committee ahead of the procurement (b) Chief Executive Officer (c) Executive Director of Finance or Executive Director of Strategy and Planning or Executive Medical Director (d) Budget Holders i.e. Exec Directors (e) Budget Managers, i.e. Functional Directors (f) Director responsible for GP Development	The delegations for contract signature apply even where the value is within budget. All contracts above £10 million should be approved by Finance and Estates Committee before signing by the delegated officers. Signing of contracts including letters of intent. The amounts are the lifetime value of the contract. Also applies to contract extensions and variations. Controls varied for primary care for the duration of the COVID-19 emergency Budget Manager delegation only applies where clear governance routes have been followed and a contract award has been approved in accordance with the SoRD.

	Responsibility	Delegation Arrangements	Further Information
5.2	Requisitions: (a) Greater than £50 million (b) Greater than £1 million and up to £50 million (c) Greater than £50,000 and up to £1 million (d) Up to £50,000	 (a) Chief Executive Officer (b) Budget Holder i.e. Executive Director, or Chief Executive Officer/Executive Director of Finance (c) Budget Manager i.e. Functional Director (d) Senior Manager Band 8a or above	Where practical, requisitions should be raised following a contract being signed by both parties. When requisitions are raised and approved, purchase orders will be generated and sent directly to the provider / supplier. The provider must quote the purchase order number on all invoices raised against that purchase order.
5.3	Invoice Payment Where purchase orders have been raised	Invoices for goods and services provided following a requisition and purchase order being raised are automatically approved when the delivery/provision is receipted in Oracle, providing the invoice value matches the purchase order and receipt	An invoice should only be receipted after it has been confirmed as correct. <u>COVID-19 temporary measure</u> All invoices / payment files that are the responsibility of either the Executive Medical Director or Director responsible for GP Development should be redirected to Deputy level Director responsible for Finance's delegated limit is adjusted to match that of the Budget Holder. All invoices/payment files that are the responsibility of the Nursing & Quality Directorate should be redirected to an Assistant Director responsible for Finance and Deputy level Director responsible for Finance (up to £50 million).

	Responsibility	Delegation Arrangements	Further Information
	Where purchase orders have **NOT** been raised (a) Greater than £50 million (b) Greater than £ 1 million up to and including £50 million (c) Greater than £50,000 up to and including £1 million (d) Up to and including £50,000	 (a) Chief Executive Officer (b) Budget Holder i.e. Executive Director, or Chief Executive Officer / Executive Director of Finance (c) Budget Manager i.e. Functional Director (d) Senior Manager – Band 8a or above)	Where no signed contract exists, expenditure must be raised via a requisition and purchase order (unless there are exceptional circumstances). <u>COVID-19 temporary measures</u> All invoices / payment files that are the responsibility of either the Executive Medical Director or Director responsible for GP Development should be redirected to Deputy level Director responsible for Finance's delegated limit is adjusted to match that of the Budget Holder. All invoices/payment files that are the responsibility of the Nursing & Quality Directorate should be redirected to an Assistant Director responsible for Finance and Deputy level Director responsible for Finance (up to £50 million).
5.4	Authorisation of monthly invoices in excess of agreed contract value.	Either Chief Executive Officer, Executive Director of Strategy and Planning and or Executive Director of Finance	
5.5	Exceptional: Continuing Health Care under £10,000	Band 7 or above	
5.6	Exceptional: Non-Contracted Activity under £1,000	Band 7 or above	

	Responsibility	Delegation Arrangements	Further Information
6.	**Non-Healthcare (Running Cost) Expenditure (Limits include VAT)**	***ALL EXPENDITURE MUST BE RAISED VIA A REQUISITION AND PURCHASE ORDER (unless there are exceptional circumstances)***	
6.1	**Contract Signature** Signing of contracts including letters of intent. The amounts below are based on the lifetime value of the contract. (a) Greater than £500,000 (b) Greater than £50,000 and up to £500,000 (c) Up to £50,000	 (a) Chief Executive Officer and Executive Director of Finance (b) Executive Director of Finance following approval from the Finance and Estates Committee (c) Budget Holders i.e. Executive Directors	The delegations for contract signature apply even where the value is within budget. All contracts should be approved by Finance and Estates Committee before signing by the delegated officers. Contracts should be sealed if it is in the interests of the ICB. Also applies to contract extensions and variations. In all contracts the ICB should endeavour to obtain best value for money.
6.2	**Authorisation of requisitions:** (a) £500,000 and above (b) Greater than £ 100,000 and up to and including £500,000	 (a) Chief Executive Officer and Executive Director of Finance following Finance and Estates Committee approval (b) Executive Director of Finance following approval from the Finance and Estates Committee	Where practical, requisitions should be raised following a contract being signed by both parties. When requisitions are raised and approved, purchase orders will be generated and sent directly to the supplier. The supplier must quote the purchase order number on all invoices raised against that purchase order.

	Responsibility	Delegation Arrangements	Further Information
	(c) Greater than £50,000 up to and including £100,000	(c) Budget Holder i.e. Executive Director	In line with budget management responsibilities (i.e. delegated budgets) and subject to quoting & tendering as required (see Section 4 above) These limits are the maximum limits for each delegated group and at any time, as deemed necessary, the Executive Director of Finance can impose lower limits for each delegated group.
	(d) Up to and including £50,000	(d) Budget Manager i.e. Functional Directors	
	(e) Procurement of Professional Services - additional controls are required due to the nature of expenditure for: (i) Legal advice (ii) Specialist advice (iii) Specific projects	(e) Chief Executive Officer, Executive Director of Corporate Affairs, or Executive Director of Finance or nominated staff.	
6.3	**Invoice Payment** Where purchase orders have been raised	Invoices for goods and services provided following a requisition and purchase order being raised are automatically approved when the delivery/provision is receipted in Oracle, providing the invoice value matches the purchase order and receipt	An invoice should only be receipted after it has been confirmed as correct. All expenditure must be raised via a requisition and purchase order (unless there are exceptional circumstances)
	Where purchase orders have **NOT been raised** (a) £500,000 and above	(a) Chief Executive Officer and Executive Director of Finance following Finance and Estates Committee approval	COVID-19 temporary measure All invoices / payment files that are the responsibility of either the Executive Medical Director or Director responsible for GP Development should be redirected to Deputy level Director responsible for Finance's delegated limit is adjusted to match that of the Budget Holder.

	Responsibility	Delegation Arrangements	Further Information
	(b) Greater than £ 100,000 and up to and including £500,000	(b) Executive Director of Finance following approval from Finance and Estates Committee	
	(c) Greater than £50,000 up to and including £100,000 (d) Up to and including £50,000 (e) Procurement of Professional Services - additional controls are required due to the nature of expenditure for: (i) Legal advice (ii) Specialist advice (iii) Specific projects	(c) Budget Holders i.e. Executive Directors (d) Budget Manager i.e. Functional Director (e) Chief Executive Officer, Executive Director of Corporate Affairs, or Executive Director of Finance or nominated staff	Query (c) and (d) – should they be the other way round?
7.	**Payroll Expenditure**	*Prior to incurring any pay expenditure including agency, interim and temporary workers, the ICB's Establishment Vacancy Control Process must be followed.*	
7.1	Substantive and within budgeted establishment (a) Appointment of substantive staff of VSM contracts	All appointments must be passed through the Remuneration Committee (a) Chief Executive Officer, Executive Director of Finance and NHS England	All appointments require approval from finance to confirm that budget is available.

	Responsibility	Delegation Arrangements	Further Information
	(b) All other substantive appointments up to VSM contracts	(b) Budget Manager i.e. Functional Director or higher	
7.2	Not within budgeted establishment, including: (a) Authority to appoint staff (b) Authority to permanently amend the formal establishment	 All members of the Exec team To be signed off by both Chief Executive Officer and Executive Director of Finance	
7.3	Off-payroll / Agency workers; (a) Daily rate less than £600 ex VAT, less than 6 months and not categorised as a role of significant influence (b) Daily rate more than £600 ex VAT or more than 6 months or categorised as a role of significant influence	 (a) Finance and Estates Committee (b) Approval required from NHSEI	For all agency, interim and other temporary workers the ICB's "Temporary Agency Workers Procedure" incorporating escalation policies for rates outside either framework or NHSEI caps, must be followed.

	Responsibility	Delegation Arrangements	Further Information
7.4	Travel and Expenses Authorisation of travel and expense claims in line with the ICB's Travel and Expenses Policy The maximum value of any single monthly claim is restricted to £2,500.	Via submission on e-pay to the appropriate line manager within the allocated time period and accompanied by scanned copies of receipts (except for mileage)	Any claims made by the Chair shall be authorised by the Chief Executive Officer and any expenses claimed by the Chief Executive Officer shall be authorised by the Chair of Executive Director of Finance. *Any claims that relate to expenses incurred over 90 days ago will be approved at the discretion of the Departmental Managers/Heads of Department and could be rejected.*
7.5	Authorisation of other travel and expenses ***not covered by*** the ICB's Travel and Expenses Policy (a) Over £300 (b) Up to £300 (c) Up to £100	 (a) Chief Executive Officer or Executive Director of Finance (b) Budget Holder i.e. Executive Director (c) Budget Manager i.e. Functional Director. Can be delegated to the Deputy Executive Director of Finance	Any study leave and associated expenses should be agreed by the Executive Director of Finance, Budget Manager i.e. Functional Director and their Executive Director in advance.
7.6	Overtime (a) Approval to work overtime (b) ESR authorisation of overtime	 (a) Executive Director of Finance (b) Line Manager following receipt of approval from Executive Director of Finance	Overtime should be agreed in advance and will only be agreed in exceptional circumstances.

	Responsibility	Delegation Arrangements	Further Information
8.	**Income Generation and Research and Development Contracts**		
8.1	Approval of income generation contracts and variations or extensions to income generation contracts: (a) Greater than £500,000	 (a) ICB Board	These powers may not be further delegated. In the absence of the appropriate officer, authorisation must be obtained from the level above.
	(b) £250,000 and up to £500,000 (c) Up to £250,000	(b) Chief Executive Officer (c) Executive Director of Finance	
8.2	Approval of research and development contracts (including variations or extensions) (a) Greater than £500,000 (b) £250,000 and up to £500,000 (c) Up to £250,000	 (a) ICB Board (b) Chief Executive Officer (c) Executive Director of Finance	These powers may not be further delegated. In the absence of the appropriate officer authorisation must be obtained from the level above
9.	**Income and debt write-off**		
9.1	Authorisation to refer debts to a debt collection agency	Executive Director of Finance	Operationally managed by the Head of Department responsible for Finance – Financial Control/Assistant level Director of Finance

	Responsibility	Delegation Arrangements	Further Information
9.2	Authorisation to write-off debt or income (total debt per debtor)	Members of the Audit and Governance Committee, Executive Team following Executive Director of Finance recommendation	This includes non-recovery of any payroll overpayments. Debit or credit notes are only to be raised after approval by the Members of the Audit and Governance Committee and Executive Team. All write-offs should be reported to Audit and Governance Committee.
10.	**Losses and special payments**	***All losses and special payments must be reported at every meeting to the Audit and Governance Committee***	
10.1	Authorisation of losses and special payments, including ex-gratia payments: (a) Greater than £50,000 (b) £10,000 and up to £50,000 (c) Up to £30,000 (staff compromise agreements only) (d) Up to £10,000	Audit and Governance Committee (a) ICB Board (b) Chief Executive Officer (c) Executive Director of Corporate Affairs (d) Audit and Governance Committee, Executive Team or where urgent, Executive Director of Finance or Functional Finance Directors	All losses greater than £100,000 must be approved by HM Treasury – see Losses Procedure contained in the General Financial Procedures, after advice taken by lawyers. The Executive Director of Finance will report any cases they consider to be "novel, contentious or repercussive" to the Chair of the Audit and Governance Committee as soon as they become aware of the case. These should also be reported to NHS England in line with current guidance.

	Responsibility	Delegation Arrangements	Further Information
10.2	Monitoring of losses and special payments	Audit and Governance Committee	Liaison with the ICB's Local Counter Fraud Specialist & Police as required and in line with the ICB's Fraud, Corruption and Bribery Policy.
10.3	Authorisation of early retirement, redundancy and other termination payments to staff: (a) Greater than £100,000 (b) £50,000 and up to £100,000 (c) Up to £50,000	 (a) ICB Board (b) Chief Executive Officer (c) Executive Director of Finance	
11.	**Bank accounts and payment methods**		
11.1	Opening of bank accounts or changes to banking arrangements	Finance and Estates Committee	The ICB will use Government Banking Services only.
11.2	Signing of cheques for cash, signing of other cheques, and authorisation of electronic payments, cheque and BACs and CHAPs payment schedules	See Bank Mandate	Bank Mandate to be maintained by the Head of Finance – Financial Control
12.	**Income from fees and Charges**		
12.1	Approval of the amounts to be charged for fees and charges	Executive Director of Finance	Examples are course fees from running courses for non-ICB employees, use of equipment and facilities (such as photocopiers and rooms)

	Responsibility	Delegation Arrangements	Further Information
13.	**Standards of Business Conduct**		
13.1	Maintenance of the ICB Register of Interests	Executive Director of Corporate Affairs	Maintained by Board Secretary
13.2	Maintenance of ICB Gifts and Hospitality Register	Executive Director of Corporate Affairs	Maintained by Board Secretary
14.	**Insurance – Clinical and Non-Clinical**		
14.1	Decision on level of insurance required, negotiated and agreement of premiums	Executive Director of Finance	The risk should be managed by the Chief Executive Officer in conjunction with the ICB's Executive Director of Corporate Affairs
15.	**Borrowing, Lending and Grants**		
15.1	Approval of **all** Loans and Grants	ICB Board	

8. STANDING FINANCIAL INSTRUCTIONS

NHS Derby and Derbyshire Integrated Care Board

Standing Financial Instructions

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1. INTRODUCTION

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1.1 Purpose

1.1.1 These Standing Financial Instructions:

(a) are issued in accordance with the Directions issued by the Secretary of State for Health under the provisions of the NHS Act 2006 ("the 2006 Act") as amended by the Health and Social Care Act 2012, with responsibilities set out under that and subsequent secondary legislation for the regulation of the conduct of NHS Derby and Derbyshire Integrated Care Board (ICB) in relation to all financial matters and are applicable to the whole organisation;

(b) contain directions that the ICB must follow and also contains directions from NHS England regarding resources, capital allocation and funding to ICBs. 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. Each ICB is to be established by order made by NHS England for an area within England, the order establishing an ICB makes provision for the constitution of the ICB;

(c) detail the financial responsibilities, policies and procedures adopted by the ICB. They are designed to ensure that the ICB's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency, effectiveness and value for money;

(d) should be used in conjunction with the Scheme of Reservations and Delegation (Section 6 in the ICB's Governance Handbook) and shall have effect as if incorporated into the ICB's constitution;

(e) identify the financial responsibilities, that apply to everyone working for the ICB, without exception. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the ICB's Standing Orders and must also consider prevailing Department of Health and Social Care and/or HM Treasury instructions.

1.1.2 They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial policies must be approved by the Audit and Governance Committee following review and recommendation by the Finance and Estates Committee (FEC).

1.1.3 Any policy referred to in these Standing Financial Instructions is also deemed to be an integral part of the Standing Financial Instructions.

1.1.4 The Chief Executive Officer shall have responsibility for ensuring that members of the ICB Board, sub-committees, employees and others as required are aware of the existence of these documents, and where necessary, be familiar with their detailed provisions.

1.1.5 The Executive Director of Finance should also ensure that the direction and guidance in the framework is followed by the ICB. The Financial Framework is:

(a) Standing Orders (SO):

(i) Scheme of Reservations and Delegation

(b) ICB Governance Handbook:

(i) Section 7 – Standing Financial Instructions (SFIs)

(ii) Section 6 – Scheme of Reservations and Delegation of the ICB Board.

1.2 **Interpretation**

Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Executive Director of Finance must be sought before acting.

1.3 **Non-Compliance with Standing Financial Instructions**

1.3.1 The failure to comply with Standing Financial Instructions and Standing Orders may result in disciplinary action in accordance with the ICB Disciplinary Policy in operation at the time. Disciplinary sanction may include dismissal.

1.3.2 All members of the ICB and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Executive Director of Finance.

1.4 **Scope**

1.4.1 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.

1.4.2 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.

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

1.4.4 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.

1.5 Responsibilities and delegation

1.5.1 The ICB Board

The ICB Board exercises financial supervision and control by:

(a) formulating and approving the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

(d) defining and delegating specific responsibilities for the performance of its functions to members of the ICB Board, Chief Executive Officer and employees as indicated in the Scheme of Reservations and Delegation.

1.5.2 Chief Executive Officer and Executive Director of Finance

The Chief Executive Officer and Executive Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable and responsible for financial control.

1.5.3 Chief Executive Officer

Within the Standing Financial Instructions, it is acknowledged that the Chief Executive Officer:

(a) is ultimately accountable to the ICB Board, and to the Secretary of State for Health and Social Care for ensuring that the ICB Board meets its obligation to perform its functions within the available financial resources;

(b) has overall executive responsibility for the ICB's activities; and is responsible to the Chair and the ICB Board for ensuring that its financial obligations and targets are met; and has overall responsibility for the ICB's system of internal control;

(c) has a duty to ensure that Members of the ICB Board and Committees, employees, all new appointees and contractors and their employees are notified of, and put in a position to understand their responsibilities within these Instructions.

1.5.4 Executive Director of Finance

(a) The Executive Director of Finance reports directly to the ICB Chief Executive Officer and is responsible for:

(i) financial leadership and financial performance of the ICB;

(ii) implementing the ICB's financial policies and for coordinating any corrective action necessary to further these policies;

(iii) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(iv) ensuring that sufficient records are maintained to show and explain the ICB's transactions, in order to disclose, with reasonable accuracy, the financial position of the ICB at any time; and, without prejudice.

(b) The duties of the Executive Director of Finance include:

(i) the provision of financial advice to other members of the ICB Board, Committees and employees in relation to ICB activities;

(ii) the design, implementation and supervision of systems of internal financial control;

(iii) the preparation and maintenance of such certificates, estimates, records and reports as the ICB may require for the purpose of carrying out its statutory duties;

(iv) the preparation and audit of annual accounts;

(v) adherence to the directions from NHS England in relation to accounts preparation;

(vi) ensuring that the allocated annual revenue and capital resource limits are not exceeded;

(vii) meeting statutory requirements relating to taxation;

(viii) supporting the ICB Board in delivery of the financial targets for the ICB as set out by NHS England;

(ix) ensuring planned budgets are approved by the relevant board; and

(x) supporting a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and process are in place to minimise risk.

1.5.5 ICB Board Members, Committee Members and Employees

All members of the ICB Board and Committees and employees, severally and collectively, are responsible for:

(a) the security of the property of the ICB;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources; and

(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Reservations and Delegation.

1.5.6 Where financial functions are carried out by Committees, or employees, the form in which their financial records are kept and the manner in which they discharge their duties, must be to the satisfaction of the Executive Director of Finance.

1.5.7 Contractors and their employees

Any contractor or employee of a contractor who is empowered by the ICB to commit the ICB to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive Officer to ensure that such persons are made aware of this.

2. ROLES AND RESPONSIBILITIES

Covering	
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2.1 Audit and Governance Committee

The ICB Board and Chief Executive Officer should be supported by an audit and risk assurance committee, which should provide proactive support to the board in advising on:

2.1.1 the management of key risks

2.1.2 the strategic processes for risk;

2.1.3 the operation of internal controls;

2.1.4 control and governance and the governance statement;

2.1.5 the accounting policies, the accounts, and the annual report of the ICB;

2.1.6 the process for reviewing of the accounts prior to submission for audit, management's letter of representation to the external auditors; and the planned activity and results of both internal and external audit.

2.2 Executive Director of Finance

2.2.1 The Executive Director of Finance is responsible for:

(a) ensuring that there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) ensuring that the Internal Audit function meets the mandatory audit standards and provides sufficient independent and objective assurance to the Audit and Governance Committee and the Chief Executive Officer;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

(d) ensuring that an annual Internal Audit report is prepared for the consideration of the Audit and Governance Committee;

(e) ensuring that the delegated authority as noted in the Scheme of Reservations and Delegation to the Officers of the ICB Board adopted by the ICB is reviewed periodically.

2.2.2 The Executive Director of Finance, internal auditors and external auditors are entitled without necessarily giving prior notice to require and receive:

(a) access at all reasonable times to any land, premises or members of the ICB Board and Sub-Committee or employee of the ICB;

(b) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(c) the production of any cash, stores or other property of the ICB under a member of the ICB Board, Sub-Committee's or an employee's control; and

(d) explanations concerning any matter under investigation.

2.3 Internal Audit

2.3.1 Internal Audit services are provided under arrangements proposed by the Executive Director of Finance and approved by the Audit and Governance Committee, on behalf of the ICB Board.

2.3.2 Only the Executive Director of Finance may commission the procurement of internal audit services (including services akin to internal audit services), having sought the approval of the Audit and Governance Committee.

2.3.3 The appointment and termination of the Head of Internal Audit and/or the Internal Audit Service must be approved by the Audit and Governance Committee.

2.3.4 Internal Audit will be responsible for providing an independent and objective opinion on risk management, control and governance, arrangements by measuring and evaluating their effectiveness to support the achievement of the organisation's agreed strategic and operational objectives.

2.3.5 The Head of Internal Audit will be responsible for providing to the Audit and Governance Committee:

(a) a strategic audit plan covering the next three years;

(b) a risk-based detailed plan for the coming year of internal audit work as agreed with Executive Director of Finance, for approval by the Audit and Governance Committee. This will be based upon the ICB's Assurance Framework and will enable the auditors to collect sufficient evidence to give an opinion on the adequacy and effective operation of the ICB;

(c) regular updates on the progress against plan including written audit reports in a form agreed by the Audit and Governance Committee for each audit undertaken;

(d) reports of management's progress on the implementation of agreed action plans that are required as result of internal audit findings;

(e) an annual report containing the opinion on the effectiveness of the whole system of internal control. This opinion will be used by the ICB Board to inform the Annual Governance Statement in the Annual Report and by NHS England as part of its performance management role of the ICB. The opinion will be based on a systematic review and evaluation of risk management, control and governance that comprises the policies, procedures and operations in place and in accordance with current assurance framework guidance issued by the Department of Health and Social Care, in order to:

(i) deliver a clear opinion on the effectiveness of internal control in the ICB;

(ii) identify and assess any major internal financial control weaknesses discovered;

(iii) establish and monitor the achievement of the ICB's strategic and operational objectives;

(iv) identify, assess and manage strategic and operations risks to achieving the organisation's objectives;

(v) identify the extent of economical, effective and efficient use of resources;

(vi) identify the extent of compliance with, and the financial effect of, the relevant established policies (including behavioural and ethical expectations), plans, procedures, laws and regulations;

(vii) identify the extent to which the ICB's assets and interests are accounted for and safeguarded from loss of any kinds, including those arising from:

- fraud, bribery, corruption and other offences;
- waste, extravagance or inefficient administration;
- poor value for money;
- other causes;

(viii) review the integrity and reliability of information, accounts and data, including internal and external reporting and accountability processes.

(ix) progress against plan in the current year;

(x) additional reports as requested by the Audit and Governance Committee.

2.3.6 Whenever any matter arises, which involves, or is thought to involve, irregularities concerning cash or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Executive Director of Finance must be notified immediately.

2.3.7 The Head of Internal Audit will normally attend Audit and Governance Committee meetings and has a right of access to all Audit and Governance Committee members, the Chair and Chief Executive Officer of the ICB.

2.3.8 The Head of Internal Audit is accountable to the Executive Director of Finance. The reporting system for Internal Audit shall be agreed between the Executive Director of Finance, the Audit and Governance Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in Public Sector Internal Audit Standards. The reporting system shall be reviewed at least every three years.

2.4 External Audit

2.4.1 The appointment (and where necessary the dismissal) of the External Auditor has been delegated by the ICB Board to the Audit and Governance Committee and will be as directed by the Department of Health and Social Care: Guidance on the Local Procurement of External Auditors for NHS Trusts and ICBs (2016).

2.4.2 The Code of Audit Practice published by the National Audit Office (the "Audit Code") contains the auditor's statutory responsibilities in relation to audit scope, reporting and additional duties. It also contains the responsibilities of the audited body in relation to the audit of financial statements and value for money arrangements.

2.4.3 The ICB shall comply with the Audit Code.

2.4.4 The External Auditor shall comply with the Audit Code.

2.4.5 The Head of External Audit will normally attend Audit and Governance Committee meetings and has a right of access to all Audit and Governance Committee members, the Chair and Chief Executive Officer of the ICB.

2.4.6 The Head of External Audit reports to the Audit and Governance Committee and is accountable to the Executive Director of Finance.

2.5 Security Management

2.5.1 The Audit and Governance Committee will be responsible for approving the ICB's security management arrangements.

2.5.2 In line with their responsibilities, the ICB's Chief Executive Officer will monitor and ensure compliance with Directions issued by the Secretary of State for Health and Social Care on NHS Security Management.

2.5.3 The ICB shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS Security Management.

2.5.4 The ICB shall nominate a Lay Member to oversee the NHS Security Management service who will report to the ICB Board.

2.5.5 The Chief Executive Officer has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Director of Corporate Delivery and the appointed LSMS.

2.6 **Whistleblowing**

The Audit and Governance Committee will be responsible for the review of the effectiveness of arrangements in place for allow staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

2.7 **Conflicts of Interest**

The Audit and Governance Committee shall receive reports in respect of any Conflicts of Interest breaches and will review the impact and actions taken.

3. FRAUD, BRIBERY AND CORRUPTION (ECONOMIC CRIME)

3.1 The Audit and Governance Committee will:

3.1.1 satisfy itself that the ICB has adequate arrangements in place for countering fraud as described in NHS Counter Fraud Authority (NHSCFA) - Standards for NHS Commissioners;

3.1.2 approve the ICB's counter fraud arrangements;

3.1.3 approve the annual counter fraud work programmes;

3.1.4 review the outcomes of such work;

3.1.5 ensure that the ICB has a Fraud, Bribery and Corruption Policy;

3.1.6 ensure that the ICB has arrangements in place to work effectively with the NHS Counter Fraud Authority;

3.1.7 review the NHSFA annual self-review tool (SRT) prior to its required annual submission to NHSCFA. The SRT:

(a) enables the ICB to produce a summary of the counter fraud, bribery and corruption work carried out over the previous twelve months.

(b) covers the key areas of activity outlined in the standards shown in NHSCFA – Standards for NHS Commissioners.

3.2 The Chief Executive Officer will ensure that the ICB Board, committee members and employees are aware of the Fraud, Bribery and Corruption Policy and comply with it.

3.3 Through a tender process, the ICB shall appoint a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by the NHSCFA – Standards for NHS Commissioners.

3.4 The LCFS will:

3.4.1 report to the ICB'S Executive Director of Finance;

3.4.2 work with staff in the NHSCFA and any other bodies in accordance with the NHSCFA – Standards for NHS Commissioners;

3.4.3 provide a written report, at least annually, on counter fraud work within the ICB.

3.5 In line with their responsibilities, the ICB Chief Executive Officer and Executive Director of Finance shall monitor and ensure compliance with Directions issued by the Secretary of State for Health and Social Care on fraud and corruption.

4. EXPENDITURE CONTROL, ALLOCATIONS, ANNUAL PLAN, BUDGETS, BUDGETARY CONTROL AND MONITORING

Covering	
Expenditure Control	4.1
Allocations	4.2
Preparation and approval of an Annual Plan and Budgets	4.3
Budgetary Delegation	4.4
Budgetary Control and Reporting	4.5
Quality, Innovation, Productivity and Prevention (QIPP)	4.6
Capital Expenditure	4.7
Monitoring Returns	4.8

4.1 Expenditure Control

4.1.1 The ICB is required by statutory provision not to exceed the allocations it receives from NHS England and any other sums it has received and is legally allowed to spend.

4.1.2 The Chief Executive Officer has overall executive responsibility for the ICB's activities and is responsible to the ICB Board for ensuring that it stays within its Resource Limit.

4.1.3 Any sums received on behalf of the Secretary of State excluding charges arising under Part II of the NHS Act 1977 are treated as sums received by the ICB.

4.1.4 The Executive Director of Finance will:

(a) provide monthly reports in the form required by the ICB Board, NHS England and the Secretary of State for Health and Social Care;

(b) ensure money drawn from the Department of Health and Social Care against the financing requirement arising from the Resource Limit is required for approved expenditure only, and is drawn down only at the time of need; following best practice as set out in 'HM Treasury Managing Public Money';

(c) be responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the ICB to fulfil its statutory responsibility not to exceed its Annual Revenue and Capital Resource Limits.

4.2 Allocations

The ICB's Executive Director of Finance will be responsible for:

4.2.1 the periodical review of the basis and assumptions used by NHS England for distributing allocations and ensure that these are reasonable and realistic in order to secure the ICB's entitlement to funds;

4.2.2 preparing an Annual Plan prior to the start of each financial year for submission to the ICB Board for approval showing the initial allocations received and their proposed uses including any sums to be held in reserve;

4.2.3 regularly updating the ICB SFEC and ICB Board on significant changes to the initial allocation and the uses of the new allocations; and

4.2.4 establishing a system for management of the Capital Resource Limit and the approval of investment proposals.

4.3 Preparation and Approval of Integrated Plan and Budgets

4.3.1 The Chief Executive Officer will be responsible for compiling a ICB Clinical Commissioning Strategy. The Strategy will take into account financial targets and forecast allocations along with any other available resources, and will be approved by the ICB Board and contain:

(a) a statement of the significant assumptions on which the strategy is based;

(b) details of major changes in workload, delivery of services or resources required to achieve the strategy.

4.3.2 Prior to the start of the financial year the Executive Director of Finance will be responsible for preparing an Annual Plan for the ICB, including budgets for review by the SFEC.

4.3.3 The SFEC will submit the Annual Plan to the ICB Board for approval.

4.3.4 The Annual Plan and associated budgets will:

(a) be in accordance with the aims and objectives set out in the Clinical Commissioning Strategy and Commissioning Intentions;

(b) accord with workload and manpower plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds;

(e) identify potential risks.

4.3.5 All budget holders must provide information as required by the Executive Director of Finance to enable budgets to be compiled.

4.3.6 The Executive Director of Finance:

(a) shall ensure that arrangements are in place to monitor and review financial performance against budget on a monthly basis, and report to the SFEC and ICB Board along with other committees as appropriate. This report should include explanations for significant variances from budget;

(b) has a responsibility to ensure that adequate training is delivered on an ongoing basis to budget holders to help them manage their budgets successfully.

4.4 Budgetary Delegation

4.4.1 The Chief Executive Officer may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;

(b) the purpose(s) of each budget heading;

(c) individual and group responsibilities;

(d) authority to exercise virement;

(e) achievement of planned levels of service;

(f) the provision of regular reports.

4.4.2 The Chief Executive Officer and delegated budget holders must not exceed the budgetary total or virement limits set by the ICB Board.

4.4.3 All budget holders will sign up to their allocated budgets at the start of the financial year.

4.4.4 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive Officer, subject to any authorised use of virement.

4.4.5 Non-recurring budgets should not be used to finance recurring expenditure without the authorisation in writing of the Chief Executive Officer, as advised by the Executive Director of Finance.

4.4.6 The Scheme of Reservations and Delegation to Officers of the ICB Board, summarises the matters delegated by the Chief Executive Officer, and to whom they are delegated.

4.5 **Budgetary Control and Reporting**

4.5.1 The Executive Director of Finance will ensure that systems to devise and maintain budgetary control are in place. These will include:

(a) monthly financial reports to the SFEC and ICB Board in a form approved by the ICB Board containing:

(i) income and expenditure to date showing trends and forecast year-end position;

(ii) movements in cash and allocations;

(iii) capital project spend and projected outturn against plan;

(iv) explanations of any material variances from plan;

(v) details of any corrective action where necessary and the Chief Executive Officer's and/or Executive Director of Finance's view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial activity and manpower budgets;

(d) monitoring of management action to correct variances;

(e) arrangements for the authorisation and processing of budget virements.

4.5.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the ICB Board;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement;

(c) all permanent employees are appointed in line with the Scheme of Reservations and Delegation to Officers of the ICB Board, of the ICB Constitution and in line with the ICB Recruitment and Selection Policy and Procedure;

(d) agency staff or temporary staff are procured in accordance with the ICB's Temporary Agency Workers Procedure and the delegated limits shown in Scheme of Reservations and Delegation to Officers of the ICB by the ICB Board.

4.6 Efficiencies

4.6.1 The ICB will have a risk adjusted Efficiencies Delivery Plan that delivers a balanced budget.

4.6.2 The Executive Director of Finance will be responsible for ensuring that:

(a) actual efficiency delivery is collated on a monthly basis;

(b) efficiency forecasts are collated.

4.6.3 The Population Health and Strategic Commissioning Committee will:

(a) have clinical oversight of the efficiency programme and the responsibility for the approval of new efficiency Schemes;

(b) act as the gateway of invest to save efficiency schemes to the ICB Board.

4.6.4 The Executive Director of Corporate Affairs will be responsible for ensuring that:

(a) the ICB efficiency programmes are managed;

(b) a review of the risks associated with delivering the efficiency programme is undertaken and reported to the SFEC;

(c) remedial action plans are developed for review by the SFEC;

(d) exception reports on any material breaches of delivery of agreed efficiency schemes are prepared for review by the SFEC.

4.6.5 The SFEC will:

(a) review efficiency programmes managed by the Executive Director of Corporate Affairs;

(b) review exception reports on any material breaches of the delivery of agreed efficiency schemes including the adequacy of proposed remedial action plans;

(c) provide a framework which proactively manages the ICB's efficiency programme and provides assurance in the delivery of efficiency to the ICB Board.

4.7 Capital Expenditure

The general rules applying to delegation and reporting shall also apply to capital expenditure (the particular applications relating to capital are contained in SFI section 16).

4.8 **Monitoring Returns**

The Chief Executive Officer is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation.

5. ANNUAL REPORT AND ACCOUNTS

The Executive Director of Finance, on behalf of the ICB, is responsible for ensuring:

5.1 the preparation of annual accounts in accordance with the accounting policies and guidance given by the Department of Health and Social Care, HM Treasury, NHS England, the ICB's accounting policies, International Financial Reporting Standards (IFRS) and generally accepted accounting practice;

5.2 the submission of annual accounts to NHS England for each financial year in accordance with the timetable prescribed by NHS England;

5.3 that the ICB will publish an annual report, in accordance with guidelines on local accountability. The document will comply with the Department of Health and Social Care Group Accounting Manual (issued annually);

5.4 that a ICB timetable is prepared for producing the annual report and accounts which must be agreed with external audit and the Audit and Governance Committee;

5.5 that the external auditor's management letter is published on the ICB's website, and all issues raised in the management letter are fully addressed within the agreed timescales;

5.6 that the ICB's annual report and accounts are audited by External Audit, presented to a public meeting and made available to the public in accordance with guidelines on local accountability.

6. COMPUTERISED FINANCIAL DATA

Covering	
Responsibilities and duties of the Executive Director of Finance	6.1
Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application	6.2
Contracts for computer services with other organisations	6.3
Requirements for computer systems which have an impact on corporate financial systems	6.4

6.1 **Responsibilities and duties of the Executive Director of Finance**

The Executive Director of Finance is responsible for:

6.1.1 ensuring that systems are in place to ensure the accuracy and security of the ICB's computerised financial data, and having due regard for the Data Protection Act 2018 will devise and implement any necessary procedures to ensure adequate (reasonable) protection of the ICB's data, programs and computer hardware from:

(a) accidental or intentional disclosure to unauthorised persons;

(b) deletion or modification;

(c) theft or damage;

6.1.2 ensuring that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure:

(a) security, privacy, accuracy, completeness, and timeliness of the data;

(b) the efficient and effective operation of the system;

6.1.3 ensuring that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

6.1.4 ensuring that an adequate management (audit) trail exists through all computerised finance system and that such computer audit reviews as the Executive Director of Finance may consider necessary are carried out;

6.1.5 ensuring that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation;

6.1.6 ensure, in relation to finance systems:

(a) awareness and understanding of financial systems, value for money and commercial issues;

(b) that transacting is carried out efficiently in line with current best practice e.g. e-invoicing;

(c) that the ICB meets the required financial and governance reporting requirements as a statutory body by the effective use of finance systems;

(d) the prevention and the detection of inaccuracies and fraud, and the reconstitution of any lost records;

(e) that the financial transactions of the authority are recorded as soon as, and as accurately as, reasonably practicable;

(f) 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;

(g) that risk is appropriately managed;

(h) identification of the duties of officers dealing with financial transactions and division of responsibilities of those officers;

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

(j) 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

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

6.2 **Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application**

In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of ICBs in the Region wish to sponsor jointly) all responsible directors and employees will send to the Executive Director of Finance:

6.2.1 details of the outline design of the system;

6.2.2 in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

6.3 **Contracts for computer services with other organisations**

6.3.1 The Executive Director of Finance shall ensure that contracts for computer services for financial applications with another organisation 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.

6.3.2 Where another organisation provides a computer service for financial applications, the Executive Director of Finance shall periodically seek assurances that adequate controls as outlined above are in operation.

6.4 **Requirements for computer systems which have an impact on corporate financial systems**

Where computer systems have an impact on corporate financial systems the Executive Director of Finance shall need to be satisfied that:

6.4.1 systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

6.4.2 data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

6.4.3 the Executive Director of Finance, finance staff and other relevant staff have access to such data;

6.4.4 such computer audit reviews as are considered necessary are carried out.

7. BANK AND GOVERNMENT BANKING SERVICE ACCOUNTS

Covering	
General	7.1
Governing Banking Service Account	7.2
Banking Procedures	7.3
Tendering and Review	7.4

7.1 General

7.1.1 The Executive Director of Finance is responsible for managing the ICB's banking arrangements and for advising the ICB Board on the provision of banking services and operation of accounts. This advice will take into account guidance/directions issued by the Department of Health and Social Care and Secretary of State.

7.1.2 In line with HM Treasury, "Managing Public Money", the ICB has no commercial bank accounts and uses the Government Banking Service (GBS) accounts, for all banking services.

7.1.3 Commercial bank accounts require the consent of HM Treasury in all instances.

7.1.4 The SFEC shall approve the opening of any new bank accounts.

7.1.5 The Executive Director of Finance is responsible for procedures relating to the proper use and security of credit cards. Staff who have responsibility for the use of credit cards will agree to abide by these procedures.

7.2 Governing Banking Services

The Executive Director of Finance is responsible for:

7.2.1 accounts operated through the Government Banking Service;

7.2.2 establishing separate bank accounts for the ICB's Funds held on Trust, including charitable funds, if any exist;

7.2.3 ensuring that arrangements are in place that ensure payments made from GBS accounts do not exceed the amount credited to the account except where arrangements have been made;

7.2.4 reporting to the ICB Board all arrangements made with the ICB's bankers for accounts to be overdrawn;

7.2.5 ensuring that there are arrangements in place for the monitoring of compliance with Department of Health and Social Care guidance on the level of cleared funds; and

7.2.6 ensuring that cash flows are prepared to record and forecast cash inflows and outflows in order to deliver the ICB's liquidity requirements.

7.3 Banking Procedures

7.3.1 The Executive Director of Finance will prepare detailed instructions on the operation of GBS accounts, which must include:

(a) the conditions under which each GBS account is to be operated;

(b) those authorised to sign cheques or other orders drawn on the ICB's accounts (the "Bank Mandate").

7.3.2 The Executive Director of Finance must advise the ICB's bankers in writing of the conditions under which each account will be operated.

7.4 Tendering and Review

7.4.1 Tendering and review is not required for GBS accounts.

7.4.2 If the ICB has commercial bank accounts, the Executive Director of Finance will review the banking arrangements of the ICB at intervals not exceeding five years, to ensure they reflect best practice and represent best value for money. This will include seeking competitive tenders for the ICB's commercial banking business.

7.4.3 The results of the tendering exercise should be reported to the ICB Board.

8. INCOME, FEES AND CHARGES/SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

Covering	
Income Systems	8.1
Fees and Charges	8.2
Debt Recovery	8.3
Security of cash, cheques and other negotiable instruments	8.4

8.1 Income Systems

8.1.1 An ICB has the 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.

8.1.2 The Executive Director of Finance is responsible for ensuring that:

(a) systems are in place for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due to the ICB;

(b) effective systems are in place for the prompt banking of all monies received by the ICB;

(c) arranging to register with HM Revenue and Customs, if required, under money laundering legislation.

8.2 **Fees and Charges**

8.2.1 The Executive Director of Finance is responsible for:

(a) approving and regularly reviewing the level of all fees and charges other than those determined by NHS England or by Statute. Independent professional advice on matters of valuation shall be taken as necessary;

(b) developing effective arrangements for making grants or loans.

8.2.2 All employees must inform the Finance Directorate, in accordance with notified procedures, promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases and other transactions.

8.3 **Debt Recovery**

8.3.1 The Executive Director of Finance is responsible for the appropriate recovery action on all outstanding debts.

8.3.2 Income not received should be dealt with in accordance with the ICB's losses procedures.

8.3.3 Overpayments should preferably be prevented, but if made they should be identified and full recovery made.

8.4 **Security of Cash, Cheques and other Negotiable Instruments**

8.4.1 The Executive Director of Finance is responsible for ensuring that systems and procedures are in place:

(a) to approve the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) to order and securely control any such stationery;

(c) to provide adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

(d) for the proper use and secure handling of cash and negotiable securities on behalf of the ICB.

8.4.2 Official money shall not, under any circumstances, be used for the encashment of private cheques or IOUs.

8.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Executive Director of Finance.

8.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the ICB is not to be held liable for any

loss, and written indemnities must be obtained from the organisation or individuals absolving the ICB from responsibility for any loss.

9. PROCUREMENT OF GOODS AND SERVICES

9.1 Duty to comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the ICB shall comply with the ICB Standing Orders and Standing Financial Instructions (except where Suspension of Standing Orders is applied) and comply with the Procurement Policy.

9.2 UK Procurement Thresholds Governing Public Procurement

UK Procurement Thresholds promulgated by the Department of Health and Social Care prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions, and will be detailed in the Procurement Policy.

9.3 Delegated Limits

Delegated Limits must be complied with and are prescribed in Scheme of Reservations and Delegation to Officers of the ICB Board.

9.4 Committing to Expenditure

9.4.1 Expenditure commitments must only be made if the budget holder i.e. Executive Director, has a budget for the expenditure.

9.4.2 Consideration must be given as to whether the expenditure will be accounted for as a lease. If it is, capital funding will be required.

9.4.3 All business cases and contract awards should be based on the whole life of the contract. This should include the cost of any extension periods and all VAT.

9.4.4 All employees and anyone able to commit to expenditure on its behalf must ensure that they:

(a) be aware of and comply with the Procurement Policy;

(b) do not commit either verbally or in writing to any expenditure, without ensuring compliance with the Procurement Policy and delegated limits. This includes variations and/or extensions to contracts which must consider the whole life cost of a contract;

(c) have the required delegated limit to commit the ICB's resources before undertaking procurement;

(d) obtain approval for a business case, from the Executive Team;

(e) seek quotes / tenders for the procurement of their goods, services or works in a legally compliant manner as set out in the Procurement Policy that ensures the best value for the ICB;

(f) ensure that a signed contract, has been put in place prior to the expenditure being incurred;

(g) adhere to the rule of aggregation, as detailed in the ICB Procurement Policy, when identifying the total value of the contracts. Budget holders must not split purchase orders and contracts to avoid procurement thresholds. Suspected disaggregation will be investigated and may lead to disciplinary action; and

(h) set the length of the proposed contract following a rigorous assessment of service need and value for money. Arbitrarily setting the length of a contract to avoid control processes will be subject to disciplinary action.

9.5 **Procurement**

The Chief Executive Officer is responsible for ensuring that:

9.5.1 the ICB has a legally compliant Procurement Policy;

9.5.2 the ICB has a Procurement Strategy;

9.5.3 the ICB has access to a specialist procurement service;

9.5.4 all ICB employees and anyone able to commit to expenditure on its behalf is aware of and complies with the Procurement Policy; and

9.5.5 all ICB procurement is in line with the Procurement Policy.

9.6 **Procurement Policy**

The Procurement Policy will include but not be limited to details regarding:

9.6.1 the full statutory and regulatory framework that the ICB must abide by;

9.6.2 procurement rules and UK law;

9.6.3 scope and applicability to ICB expenditure types;

9.6.4 procurement delegated authority limits as per the Scheme of Reservations and Delegation;

9.6.5 procurement options and routes, including threshold values;

9.6.6 awarding of contracts;

9.6.7 managing conflicts of interest.

9.7 **Agency or temporary staff contracts**

The ICB can only enter into contracts to procure agency staff or temporary staff is in accordance with the ICB's Temporary Agency Workers Procedure and the delegated limits shown in the Scheme of Reservations and Delegation.

9.8 **Financial standing and technical competence of suppliers of goods and services**

The Executive Director of Finance may make or institute any enquiries he/she/they deems appropriate concerning the financial standing and financial suitability of suppliers of goods and services. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical/clinical competency.

9.9 **Health Care Services**

Where the ICB must invite tenders for the supply of healthcare services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure and need to be read in conjunction with the ICB Procurement Policy Standing Financial Instruction No. 10 Tendering and No. 11 Commissioning secondary healthcare services and the NHS standard contract.

9.10 **Exceptions and instances where formal tendering need not be applied**

9.10.1 The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

9.10.2 Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate ICB record (see Appendix 1 – Single Tender Waiver Form) approved by the Executive Director of Finance and reported to the Audit and Governance Committee for information at each meeting. Legal advice must be sought to ensure the rationale for no competition is valid.

9.10.3 Formal tendering **must be applied** if the estimated expenditure is in excess of the current UK Procurement Thresholds limit as shown in the Procurement Policy.

9.10.4 Formal tendering procedures **may be waived** ONLY where the following circumstances are met if the estimated expenditure is below the UK Procurement Thresholds limit as shown in the Procurement Policy but above the ICB's limit for

a competitive process as shown in the ICB's Procurement Policy, as detailed in the Scheme of Reservations and Delegation and:

(a) in very exceptional circumstances where the Chief Executive Officer decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate ICB record (legal advice is recommended);

(b) where the requirement is covered by an existing contract and where it does not materially / modify the contract beyond the original specification or exceed 50% of the total contract value awarded;

(c) where Framework Agreements are in place as described in the ICB's Procurement Policy;

(d) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

(e) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

(f) where specialist expertise is required and is available from only one source;

(g) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate (experience, capacity, or intellectual property rights as an example) procurement advice should be sought to ensure this complies with regulation 32 and/or 72 under PCR2015;

(h) there is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering. Procurement advice should be sought to ensure this complies with regulation 32 and/or 72 under PCR2015;

(i) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the ICB is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned, the Executive Director of Finance will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

(j) the annual value of contract is below £10,000.

9.10.5 Formal tendering procedures **need not be applied** where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed the ICB's limit for a competitive process as shown in the ICB's Procurement Policy and as detailed in the Scheme of Reservations and Delegation; or

(b) where the supply is proposed under special arrangements negotiated by the Department of Health and Social Care, in which event the said special arrangements must be complied with;

(c) regarding disposals as set out in Standing Financial Instructions No. 19.

10. TENDERING

10.1 Formal competitive tendering

10.1.1 The ICB shall ensure that tenders are invited according to the Procurement Policy for the supply of goods and services having regard to the anticipated contract amount over the life of the contract.

10.1.2 Tenders may by either;

(a) a formal competitive tender process; or

(b) a fully compliant tender under UK regulations.

10.1.3 The ICB's procurement specialists should always manage the tender process:

10.2 Invitation to tender

When the ICB is required to tender for goods and services the following will apply:

10.2.1 all instructions for invitations to tender will be made using an e-tendering solution, including the latest date and time for the receipt of tenders;

10.2.2 every potential tenderer must have given, or give a written undertaking, not to engage in collusive tendering or other restrictive practice.

10.3 **Items which subsequently breach thresholds after original approval**

Items estimated to be below the limits set in the Procurement Policy for which formal tendering procedures are not required but subsequently prove to have a value above such limits shall be reported to the Chief Executive Officer, and be recorded in an appropriate ICB record.

10.4 **e-Tendering**

10.4.1 The e-Tendering solution will:

(a) provide electronic receipt and safe-keeping of tenders in accordance with the control system and approved by the Chief Executive Officer;

(b) access applications through an e-Procurement tool by the designated evaluation panel via a username and login;

(c) require the Procurement Lead for the opening of tenders estimated above £50,000. The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the ICB's Scheme of Reservations and Delegation; and

(d) provide the facility for opening and recording of tenders in accordance with the control system contained within the system and approved by the Chief Executive Officer.

10.4.2 The 'originating' Department will be taken to mean the Department commissioning the tender.

10.4.3 All Executive Directors/members will be authorised to be allocated with open tenders by the Procurement Lead regardless of whether they are from the originating department provided that a secondary authorised person also receives the allocation and is not from the originating department.

10.4.4 The ICB's Secretary will count as a Director for the purposes of opening tenders.

10.5 **Tender register**

10.5.1 A register shall be maintained by the Chief Executive Officer, or a person authorised by him, to show for each set of competitive tender invitations despatched:

(a) the name of all firms/individuals invited;

(b) the names of firms/individuals from which tenders have been received;

(c) the date the tenders were received and opened;

(d) the persons present at the opening;

(e) the price shown on each tender;

(f) a note where price alterations have been made on the tender and suitably initialled.

10.5.2 Each entry to this register shall be signed by those present.

10.5.3 Incomplete tenders (those from which information necessary for the adjudication of the tender is missing) and amended tenders (those amended by the tenderer upon his/her own initiative in writing after the due time for receipt, but prior to the opening of other tenders) should be dealt with in the same way as late tenders.

10.6 **Admissibility**

10.6.1 If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive or provide best value for money (for example, because the number of bids is insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive Officer.

10.6.2 Where only one tender is sought and/or received, the Chief Executive Officer and Executive Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the ICB through evaluation against the published criteria.

10.7 **Late tenders**

10.7.1 Late tenders cannot be received nor accepted when using the e-tendering solution.

10.7.2 Tenderers should communicate any difficulties to the ICB prior to the deadline to ensure bids are submitted timely before the closing date.

10.7.3 Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive Officer or his/her nominated officer(s) decides that there are exceptional circumstances i.e. dispatched in good time but delayed through no fault of the tenderer.

10.7.4 While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody (not released to the evaluation panel) by the Chief Executive Officer or his/her nominated officer(s).

10.7.5 Accepted late tenders will be reported to the ICB Board before the evaluation process is completed.

10.8 **Acceptance of formal tenders**

10.8.1 All Tenders should be treated as confidential and should be retained for inspection.

10.8.2 Any discussions with a tenderer, which are deemed necessary to clarify technical aspects of his/her tender before the award of a contract will not disqualify the tender. Clarification of responses is permitted as long as it not deemed as betterment (i.e. asking additional information or coaxing for a response).

10.8.3 The Chief Executive Officer should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that have submitted tenders. This should be detailed in the tender documentation.

10.8.4 No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the ICB and which is not in accordance with these Instructions, except with the authorisation of the Chief Executive Officer (e.g. where all tenders exceed the allocation).

10.8.5 The use of these procedures must demonstrate that the award of the contract was to the Most Economically Advantageous Tender (MEAT), which should be a criteria disclosed for evaluation.

10.8.6 Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented upfront in the tender documentation and in the contract file and the reason(s) for not accepting the lowest tender clearly stated.

10.8.7 It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach;

(d) ability to complete the project on time.

10.9 **In-house Services**

10.9.1 The Chief Executive Officer shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The ICB may also determine from time to time that in-house services should be market tested by competitive tendering.

10.9.2 In all cases where the ICB Board or its Sub-Committees determine that in-house services should be subject to competitive tendering, the following groups shall be set up:

(a) specification group, comprising the Chief Executive Officer or nominated officer/s and specialist provided to work on behalf of the ICB;

(b) in-house tender group, comprising a nominee of the Chief Executive Officer and procurement support;

(c) evaluation team, normally comprising of a specialist officer provided to work on behalf of the ICB, a Procurement Officer and a representative of the Executive Director of Finance. For services having a likely expenditure exceeding the UK Procurement Thresholds limit, a non-officer member should be a member of evaluation team.

10.10 **Tender reports to the ICB Board**

Reports to the ICB Board regarding ongoing tenders will be made on an exceptional circumstance basis only. All tender awards are reviewed for approval as per the Scheme of Reservations and Delegation to Officers of the ICB Board.

10.10.1 Quotations: competitive and non-competitive

(a) General Position on quotations

Quotations are required where formal tendering procedures are not adopted in line with the Procurement Policy and as per the Scheme of Reservations and Delegation to Officers of the ICB Board.

(b) Competitive Quotations

(i) Quotations must be in writing or via e-tendering.

(ii) All quotations should be treated as confidential and should be retained for inspection.

(iii) The Chief Executive Officer or his/her nominated officer(s) should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation, then the choice made and the reasons why should be recorded in a permanent record.

(c) Non-Competitive Quotations

Non-competitive quotations in writing may be obtained in the following circumstances and where approval has been gained by the Chief Executive Officer or Executive Director of Finance:

(i) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the delegated budget holder, possible or desirable to obtain competitive quotations. This would only apply under extreme circumstances and clear rationale would need to be provided to support why competition is absent;

(ii) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(iii) miscellaneous services, supplies and disposals;

(iv) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e. (i) and (ii)) apply.

10.10.2 Contract Award

(a) Providing all the conditions and circumstances set out in these Standing Financial Instructions and Procurement Policy have been fully complied with, formal authorisation and awarding of a contract may be decided by

designated managers to the value of the contract as determined in Scheme of Reservations and Delegation to Officers of the ICB Board.

(b) Formal authorisation must be put in writing. In the case of authorisation by the ICB Board this shall be recorded in their minutes.

10.10.3 Instances where formal competitive tendering or competitive quotation is not required

Where competitive tendering or a competitive quotation is not required, the ICB shall procure goods and services in accordance with procurement procedures approved by the Executive Director of Finance.

10.10.4 Compliance requirements for all contracts

The ICB Board may only enter into contracts on behalf of the ICB within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) the ICB's Standing Orders and Standing Financial Instructions;

(b) Government Directives and other statutory provisions;

(c) such of The NHS Standard Contract Conditions as are applicable;

(d) 'Standards for Better Health';

(e) appropriate NHS guidance (particularly with regards to contracts with Foundation Trusts);

(f) the terms and conditions of contract as was the basis on which tenders or quotations were invited, where appropriate.

In all contracts made by the ICB, the ICB Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive Officer shall nominate an officer who shall oversee and manage each contract on behalf of the ICB.

10.10.5 Disposals (See overlap with SFI No. 18)

(a) Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(i) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive Officer or his/her nominated officer;

(ii) obsolete or condemned articles, which may be disposed of in accordance with the supplies policy of the ICB;

(iii) items to be disposed of with an estimated sale value of less than £5,000, this figure is to be reviewed on a periodic basis;

(b) All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

(c) The evaluation team shall make recommendations to the ICB Board.

(d) The Chief Executive Officer shall nominate an officer to oversee and manage the contract on behalf of the ICB.

11. COMMISSIONING SECONDARY HEALTHCARE SERVICES AND THE NHS STANDARD CONTRACT

11.1 Role of the ICB in Commissioning Secondary Healthcare Services

11.1.1 The ICB has responsibility for commissioning healthcare services on behalf of its GP's resident patient population. This will require the ICB to work in partnership with local NHS Trusts, and Foundation Trusts, other ICBs, local authorities, patients, carers and the voluntary sector to develop robust commissioning plans.

11.1.2 Commissioning expenditure shall not exceed the budget approved by the ICB Board.

11.2 Role of the Chief Executive Officer

11.2.1 The Chief Executive Officer:

(a) is responsible for ensuring the ICB enters into contracts with service providers for the provision of NHS services and shall nominate officers to commission contracts with providers of healthcare in line with a Commissioning Plan approved by the ICB Board;

(b) shall nominate officers to commission services in line with the Clinical Commissioning Plan approved by the ICB Board; and

(c) is responsible, where the ICB makes arrangements for the provision of services by non-NHS providers, for ensuring that the agreements put in place have due regard to the quality and cost-effectiveness of services provided. Before making any agreement with non-NHS providers, the ICB should explore fully the scope to make maximum cost-effective use of NHS facilities.

11.3 Role of Executive Director of Finance

The Executive Director of Finance is responsible for ensuring that a system of financial monitoring is maintained in order to ensure the effective accounting of expenditure under legally binding contracts and Non Contracted Activity. This should

provide a suitable audit trail for all payments made under the agreements, maintain patient confidentiality and comply with Data Protection legislation.

11.4 NHS Standard Contract for the provision of services

11.4.1 Under the National Health Service Commissioning Board and Integrated Care Boards (Responsibilities and Standing Rules) Regulations 2012, the NHS Standard Contract (contract) must be used by ICBs and by NHS England where they wish to contract for NHS-funded healthcare services (including acute, ambulance, patient transport, continuing healthcare services, community-based, high-secure, mental health and learning disability services).

11.4.2 The Contract must be used regardless of the proposed duration or value of a contract (so it should be used for small-scale short-term pilots as well as for long-term or high-value services).

11.4.3 Where a single contract includes both healthcare and non-healthcare services, the NHS Standard Contract must be used.

11.4.4 The contract creates legally binding agreements between NHS commissioners and Foundation Trust, independent sector, voluntary sector and social enterprise providers.

11.4.5 Agreements between commissioners and NHS Trusts are 'NHS contracts' as defined in Section 9 of the National Health Service Act 2006. NHS Trusts will use exactly the same contract documentation, and their contracts will be treated by the ICB with the same degree of rigour and seriousness as if they were legally binding.

11.4.6 Agreements that involve a local authority as a commissioner and an NHS Trust will be legally binding between those parties.

11.4.7 The ICB will comply with all of the current technical guidance issued by NHS England.

11.4.8 All contracts should aim to implement the agreed priorities contained within the Integrated Care Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive Officer should take into account:

(a) the standards of service quality expected;

(b) the relevant national service framework (if any);

(c) the provision of reliable information on cost and volume of services;

(d) the NHS Oversight Framework and NHS Oversight Framework: ICB Metrics and Technical Annex;

(e) that contracts build where appropriate on existing Joint Investment Plans;

(f) that contracts are based on integrated care pathways.

11.5 Reports to ICB Board on Contracts

The Chief Executive Officer will need to ensure that regular reports are provided to the ICB Board detailing actual and forecast expenditure against contracts as appropriate.

12. TERMS OF SERVICE, AND RECRUITMENT OF MEMBERS OF THE ICB BOARD, COMMITTEES AND EMPLOYEES

Covering	
Remuneration Committee and Terms of Service	12.1
Funded Establishment	12.2
Staff Appointments	12.3
Contracts of Employment	12.4

12.1 Remuneration Committee and Terms of Service

12.1.1 In accordance with Standing Orders the ICB shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting and identifying which duties are delegated to any sub committees of the committee. (See NHS guidance contained in the Higgs report, 'Review of the Role and Effectiveness of Non-Executive Directors').

12.1.2 The Committee will:

(a) make written recommendations to the ICB Board on the appropriate remuneration and terms of service for the Chief Executive Officer, other officer members employed by the ICB and other senior employees including:

(b) all aspects of salary (including any performance-related elements/bonuses);

(c) provisions for other benefits, including pensions and cars;

(d) arrangements for termination of employment and other contractual terms;

(e) make such recommendations to the ICB Board on the remuneration and terms of service of officer members of the ICB Board and Committee members (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the ICB - having proper regard to the ICB's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(f) monitor and evaluate the performance of individual officer members Sub-Committee (and other senior employees);

(g) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

12.1.3 The Committee will report in writing to the ICB Board the basis for its recommendations. The ICB Board will use the report as the basis for their

decisions, but remain accountable for taking decisions on the remuneration and terms of service of Committee members. Minutes of the ICB Board's meetings should record such decisions.

12.1.4 For those employees not covered by the Committee, the ICB Board will consider and either approve or reject proposals presented by the Chief Executive Officer for the setting of remuneration and conditions of service.

12.1.5 The ICB will pay allowances to the Chairman and non-officer members of the ICB Board in accordance with instructions issued by the Secretary of State for Health and Social Care.

12.2 **Funded Establishment**

12.2.1 The manpower plans incorporated within the annual budget will form the funded establishment.

12.2.2 The funded establishment of any directorate may not be varied without the approval of the Chief Executive Officer and Executive Director of Finance.

12.3 **Staff Appointments**

12.3.1 A member of the ICB Board or any other employee may only engage, re-engage, or re-grade employees, or agree to changes in any aspect of remuneration:

(a) if authorised to do so by the Chief Executive Officer; and

(b) within the limit of their approved budget and funded establishment.

12.3.2 The ICB Board will approve procedures presented by the Chief Executive Officer for the determination of commencing pay rates, condition of service, etc., for employees.

12.4 **Contracts of Employment**

The ICB Board shall delegate responsibility to an officer to ensure that systems are in place for:

12.4.1 ensuring that all employees are issued with a Contract of Employment in a form approved by the ICB Board and which complies with employment legislation;

12.4.2 dealing with variations to, or termination of, contracts of employment;

12.4.3 ensuring that all lay members receive a contract for service that appropriately reflects their status and entitlements, or not, pay and/or expenses.

13. PROCESSING PAYROLL AND EXPENSES

Covering	
Chief People Officer	13.1
Payroll Service	13.2
Internal ICB requirements	13.3

13.1 Chief People Officer

13.1.1 The Chief People Officer (CPO) (or equivalent people role in the ICB) will lead the development and delivery of the long-term people strategy of the ICB ensuring this reflects and integrates the strategies of all relevant partner organisations within the ICS.

13.1.2 Operationally the CPO will be responsible for:

(a) defining and delivering the organisation's overall human resources strategy and objectives; and

(b) overseeing delivery of human resource services to ICB employees.

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

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

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

13.2 Payroll Service

13.2.1 The Executive Director of Finance is responsible for ensuring that:

(a) the ICB has arrangements in place for an effective payroll service and follow guidance from NHSE regarding the payroll service provider;

(b) if the payroll provider is contracted by the ICB and not NHSE, the chosen method of providing the ICBs Payroll Service is supported by appropriate, contracted terms and conditions, adequate internal controls and audit review procedures, and that suitable arrangement are made for the collection of payroll deductions and payment of these to appropriate bodies.

13.2.2 If the payroll provider is contracted by the ICB and not NHSE, the Executive Director of Finance is responsible for ensuring that the contract with the relevant outsources service provider covers:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) pay advances and their recovery;

(g) separation of duties of preparing records and inputs and verifying outputs and payments, including reconciliation of pay control accounts;

(h) the final determination of pay and allowances;

(i) ensuring that payment occurs on agreed dates;

(j) arrangements for ensuring compliance with the provisions of the Data Protection Act.

13.3 **Internal ICB requirements**

13.3.1 The Chief Executive Officer is responsible for ensuring that the ICB has:

(a) timetables for submission of properly authorised payroll documentation;

(b) suitable arrangements and comprehensive procedures in place for the effective and timely provision of information to the payroll provider to enable accurate, timely and effective processing of payroll by the payroll service provider enabling correct and timely payments to be made to employees;

(c) adequate internal controls and audit review processes to prevent incorrect payments being made.

13.3.2 The Executive Director of Finance is responsible for ensuring that there are systems and procedures in place to issue instruction regarding:

(a) maintenance of regular and independent reconciliation of balance sheet pay control accounts;

(b) the recovery from leavers of any sums of money, including overpayments and property due from them to the ICB, which have not been recovered from pay prior to leaving.

13.3.3 The Chief People Officer, alongside appropriately nominated managers and Committee members, has delegated responsibility for:

(a) submitting associated records (where applicable), and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the instructions and in the form prescribed by the Executive Director of Finance;

(c) notifying the Human Resources department of any changes to contracts using the Change of Circumstances form;

(d) notifying the Human Resources department of any new starters using the New Starter form, and ensure other relevant actions are completed;

(e) maintaining leave (annual carer's, parental etc.) and sickness records for all staff on the Electronic Staff Record (ESR)submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil sub-committee obligations in circumstances that suggest they have left without notice, the Executive Director of Finance must be informed immediately.

14. PAYMENT TO MEMBERS OF THE ICB BOARD, COMMITTEES AND EMPLOYEES

14.1 Pay Dates

Monthly pay is due to be paid on the last day of each month but payment will be made on the 20th day of each month directly into an employee's bank or building society account. If the 20th falls on a Saturday, Sunday or Bank Holiday, then payment will be made on the preceding working day. The Executive Director of Finance may vary this in exceptional circumstances.

14.2 Overtime/Enhancements

Any claim for non-contracted overtime or enhanced hours should be approved in advance by the budget holder i.e. Executive Director following approval from the Executive Director of Finance.

14.3 Advance Payments and Payments on Account

14.3.1 Advance payments will only be made where an employee is underpaid through no fault of their own, and the individual is suffering financial hardship as a result.

14.3.2 In such circumstances, the employee can request payment of the shortfall by completing the relevant form and submitting it to Human Resources following approval by both the budget holder i.e. Executive Director and Executive Director of Finance. The authorised form will then be sent to the payroll provider to estimate the net pay amount following the calculation of deductions including tax and national insurance. The actual amount will be corrected in the employee's next monthly salary payment.

14.3.3 Any urgent payroll payments raised by the payroll provider must be approved by a member of the Finance Department who has delegated responsibility within the Finance Ledger.

14.4 Recovery of Salary Overpayments

14.4.1 Where payments are made in error, the employee receiving the overpayment must immediately notify their manager / former manager and the payroll provider who will instigate recovery of the full overpayment from the individual concerned.

14.4.2 Their manager must inform the Head of Finance – Financial Control immediately.

14.4.3 Full recovery will always be sought, however a repayment plan may be agreed with the employee/former employee.

14.4.4 Repayments will be made through the payroll as a deduction against the individual's pay. In cases where the individual is no longer employed by the ICB, another form of payment will be agreed.

14.5 Travel and Other Expenses

14.5.1 Travel expense claims will be paid in accordance with the ICB Travel and Expenses Policy.

14.5.2 Reimbursement for expenses associated with travel and subsistence, relocation and removal expenses will be made by the e-Pay system.

14.5.3 Claims must be made through the e-Pay system and must be approved in line with the Scheme of Reservations and Delegation to Officers of the ICB Board before the 5th of the month. Budget holders i.e. Executive Directors are accountable for line managers checking and authorising only appropriate expenses incurred in line with the ICB Travel and Expenses Policy.

14.5.4 The e-Pay system will assist employees in calculating their claimable mileage and determination of the rate.

14.5.5 The e-Pay system should never be used to reimburse items that should have been and could have been purchased via the ICB's requisitioning and ordering systems.

15. NON-PAY EXPENDITURE, REQUISITIONING, OFFICIAN ORDERS AND PAYMENTS

15.1 System Requirements

15.1.1 The Executive Director of Finance is responsible for:

(a) advising the ICB Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained;

and, once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;

(b) ensuring that the ICB has a arrangements in place for an effective fully integrated requisitioning, ordering and payment system;

(c) following guidance from NHSE regarding the provider of the system;

(d) providing a timetable and system for submission of accounts for payment; including provision for the early settlement of accounts subject to settlement discounts or otherwise requiring early payment;

(e) issuing instructions to employees regarding the handling and payment of accounts.

15.1.2 The fully integrated requisitioning, ordering and payments system will:

(a) hold delegated authority limits and will have a list of ICB Board members and employees authorised to certify and approve requisitions, orders and invoices including their delegated limits;

(b) have a mechanism to convert authorised requisitions into official orders;

(c) have a receipt mechanism to confirm certification that goods or services have been duly received, examined and are in accordance with specification and order, and that the prices are correct;

(d) be able to record, code and provide payment details for all accounts payable by the ICB; and

(e) be integrated with the ICB's nominal ledger.

15.2 **Delegation of Authority**

15.2.1 The ICB Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive Officer will determine the level of delegation to budget managers.

15.2.2 The delegated limits for non-pay contract signing, requisitioning, ordering and payment are included in the Scheme of Reservations and Delegation.

15.2.3 The Chief Executive Officer will set out:

(a) the list of budget holders and managers who are authorised to place requisitions for the supply of goods and services;

(b) the maximum level of each requisition and the system for authorisation above that level.

(c) procedures on the seeking of professional advice regarding the supply of goods and services.

15.2.4 Changes to the list of members/employees and officers authorised to certify invoices are notified to the Executive Director of Finance.

15.3 **Official Orders**

15.3.1 Official Orders must be:

(a) generated by the accounting system following the approval of a requisition;

(b) be in numerical order;

(c) be in a form approved by the Executive Director of Finance;

(d) state the ICB's terms and conditions of trade;

(e) only be issued to, and used by, those duly authorised by the Chief Executive Officer.

15.3.2 Managers and Officers when raising official orders must ensure that;

(a) they comply fully with guidance issued on behalf of the Executive Director of Finance and delegated limits specified in Scheme of Reservations and Delegation;

(b) orders are not split or otherwise placed in a manner devised so as to avoid the delegated financial limits;

(c) all contracts (except as otherwise provided for in the Scheme of Reservations and Delegation), leases, tenancy agreements and other commitments are to be agreed by the Executive Director of Finance and Directors responsible for Contracting and Quality in advance of any commitment being made, and subsequently approved per the Scheme of Reservations Delegation;

(d) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and Social Care;

(e) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than in line with the ICB Standards of Interest and Managing Conflicts of Interest Policy;

(f) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Executive Director of Finance on behalf of the Chief Executive Officer;

(g) all goods and services are ordered on an official order except services executed in accordance with a contract and purchases from petty cash or where an order cannot be reasonably raised e.g. hotel bookings;

(h) verbal orders must only be issued very exceptionally – by an employee designated by the Chief Executive Officer and only in cases of emergency or:

(i) authorisations have been obtained;

(ii) the account is arithmetically correct;

(iii) VAT has been correctly charged;

(iv) the account is in order for payment; the verification;

(v) work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

(vi) for contracts based on the measurement of time, materials or expenses, will be made after confirming that:

- the time charged is in accordance with the time sheets;
- the rates of labour are in accordance with the agreed appropriate rates;
- the materials have been checked as regards quantity, quality, and price; and
- the charges for the use of vehicles, plant and machinery have been examined

15.4 **Prepayments**

15.4.1 Prepayments are only permitted for instances relating to payments for:

(a) rent;

(b) maintenance contracts;

(c) and in those instances, where, as normal business proactive, prepayments are required (e.g. training, publications).

15.4.2 Prepayments which fall outside of normal business practice (advance payments) are only permitted in exceptional circumstances and require HM Treasury approval. In such instances:

(a) the financial advantages must outweigh the disadvantages;

(b) the appropriate budget holder i.e. Executive Director, must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the ICB if the supplier, is at some time during the course of the advance payment agreement, unable to meet their commitments. The report must also include the prepayment timescale;

(c) the Executive Director of Finance will need to be satisfied with the proposed arrangements and the Executive Director of Finance should have received HM Treasury Approval before contractual arrangements proceed; and

(d) the budget holder i.e. Executive Director is responsible for ensuring that all items due under an advance payment contract are received and they must immediately inform the Chief Executive Officer if problems are encountered.

15.4.3 Petty Cash

(a) Authorisation for petty cash expenditure must comply with the delegated limits in the Scheme of Reservations and Delegation.

(b) Purchases from petty cash:

(i) should not circumvent normal procurement processes;

(ii) are restricted in value and by type of purchase in accordance with instructions issued by the Executive Director of Finance.

(c) Petty cash is for use in the following circumstances:

(i) low value purchase;

(ii) exceptional; or

(iii) urgent.

(d) Petty cash is for the reimbursement of staff members and visitors for small expenses such as:

(i) postage;

(ii) minor office supplies etc.

(e) Petty cash records are maintained in a form as determined by the Executive Director of Finance.

15.5 **Joint Finance Arrangements with Local Authorities and Voluntary Bodies**

Payments to local authorities and voluntary organisations made under the powers of sections 75, 256 and 257 of the NHS Act 2006 and section 28A of the NHS Act 1977 shall comply with procedures laid down by the Executive Director of Finance, which shall be in accordance with these Acts.

16. CAPITAL INVESTMENT, PRIVATE FINANCING AND FIXED ASSET REGISTER

16.1 Introduction

16.1.1 Capital investment typically covers land, buildings, equipment and IT, including and requires authority to:

(a) incur capital expenditure;

(b) make a capital grant;

(c) enter into a leasing arrangement.

16.1.2 No procurement should be undertaken or commitment given to purchase from a supplier prior to approval being received in accordance with delegated limits shown in the Scheme of Reservations and Delegation.

16.2 Capital Delegated Approval Limits

Capital Approval limits are shown in Scheme of Reservations and Delegation to Officers of the ICB Board.

16.3 Capital Investment

16.3.1 The approval of a capital programme does not constitute approval for expenditure on any scheme included within that programme.

16.3.2 The Chief Executive Officer is responsible for ensuring that:

(a) there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) there are processes in place for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

(c) capital investment is not authorised without evidence of the availability of resources to finance all revenue consequences; and

(d) for a capital investment where the contracts stipulate stage payments, there are processes in place to issue procedures for their management, incorporating the recommendations of Estate code as applicable.

16.3.3 For every capital expenditure proposal, there are processes in place to ensure that a business case (in line with the guidance contained within the (NHS England Business Case Approval Process Guidance) is produced setting out:

(a) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(b) confirmation that the Executive Director of Finance has examined and confirmed the appropriateness of the costs and revenue consequences detailed in the business case;

(c) appropriate project management and control arrangements; and

(d) the involvement of appropriate ICB personnel, NHSE personnel (if required) and external agencies.

16.3.4 The Chief Executive Officer Is responsible for:

(a) issuing a scheme of delegation for capital investment management in accordance with Estate code guidance and the ICB's Standing Orders; and

(b) issuing to the manager responsible for any scheme:

(i) specific authority to commit expenditure;

(ii) authority to proceed to tender (see overlap with SFI No.9 and 10);

(iii) approval to accept a successful tender (see overlap with SFI No 9 and 10).

16.3.5 The Executive Director of Finance is responsible for ensuring that there are processes in place:

(a) for the issue of procedures for the regular reporting of expenditure and commitment against authorised expenditure;

(b) to issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes issued by the Department of Health and Social Care and shown in the Scheme of Reservations and Delegation; and

(c) to ensure that arrangements are in place for the financial control and financial audit of capital investment.

16.4 Private Finance

16.4.1 The ICB should have due regard to current HM Treasury and Department of Health and Social Care guidance in relation to the requirement to test for Private Finance Initiative (PFI)/Public-private partnership (PPP) funding when considering capital

procurement. When it is proposed to use finance, which is to be provided other than through its allocations, the following procedures shall apply:

(a) the Executive Director of Finance shall be responsible for demonstrating that the use of private finance represents value for money and genuinely transfers significant risk to the private sector;

(b) where the sum involved exceeds delegated limits, the business case must be referred to the Department of Health and Social Care or in line with any current guidelines;

(c) the proposal must be specifically agreed by the ICB Board; and

(d) the procurement process will be in line with the ICB Procurement Policy and SFI's.

16.5 **Asset Registers**

16.5.1 The Chief Executive Officer is responsible for ensuring that there are processes in place for the maintenance of both the register of assets (asset register) and the register of inventory items (inventory register).

16.5.2 The Executive Director of Finance is responsible for ensuring there are processes in place to:

(a) define the items of equipment which will be recorded on either the capital asset register or the inventory register, taking account of the advice of the Executive Director of Finance concerning the form and the method of updating the registers;

(b) arranging for a physical verification of assets against the asset register to be conducted once a year; and

(c) regularly reconcile the registers to the ledger.

16.5.3 The minimum data set to be held in the asset register shall be sufficient to meet the requirements of capital accounting and reporting in line with Department of Health Group Accounting Manual(issued annually).

16.5.4 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads;

(c) lease agreements in respect of assets held under a lease capitalised as a "right of use asset".

16.5.5 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

16.5.6 The value of each asset shall be in accordance with methods specified in the Department of Health and Social Care Group Accounting Manual (issued annually) and:

(a) indexed to current values using methods and rates as specified in the ICBs accounting policies;

(b) depreciated using methods and rates as specified in the ICB's accounting policies.

16.6 **Property Solutions**

Any perceived requirement for a new property contract / additional office accommodation, should be discussed with the Chief Executive Officer in the first instance.

16.7 **NHS Local Improvement Finance Trust**

If the ICB is planning involvement with Local improvement Finance Trust (LIFT) projects, guidance from the joint Department of Health and Partnerships UK website at http://www.communityhealthpartnerships.co.uk should be accessed.

17. SECURITY OF ASSETS

17.1 The overall control of assets is the responsibility of the Chief Executive Officer.

17.2 Asset control procedures (including fixed assets, inventories, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Executive Director of Finance. This procedure shall make provision for:

17.2.1 recording managerial responsibility for each asset;

17.2.2 identification of additions and disposals;

17.2.3 identification of all repairs and maintenance expenses;

17.2.4 physical security of assets;

17.2.5 annual verification of the existence of, condition of, and title to, assets recorded;

17.2.6 identification and reporting of all costs associated with the retention of an asset;

17.2.7 reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

17.3 All discrepancies revealed by verification of physical assets to the fixed asset register or inventory register shall be notified to the Executive Director of Finance.

17.4 Every employee and officer has a responsibility for the security of property of the ICB. It is the responsibility of ICB Board, Committee members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the ICB Board. A substantial or persistent breach of agreed security practices must be reported in accordance with agreed procedures.

17.5 Any damage to the ICB's premises, vehicles and equipment, or any loss of equipment or supplies must be reported by ICB Board, sub-committee members and employees in accordance with the procedure for reporting losses.

17.6 Where practical, assets should be marked as ICB property.

18. DISPOSALS AND CONDEMNATIONS

18.1 Disposals

18.1.1 The Executive Director of Finance is responsible for ensuring that detailed procedures for the disposal of assets, including recording and accounting for the disposal, are prepared and notified to managers.

18.1.2 When it is decided to dispose of an ICB asset, the Budget Holder or authorised deputy will determine and advise the Executive Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

18.2 Condemnations

18.2.1 The Executive Director of Finance is responsible for ensuring that detailed procedures for the condemnation of assets, including recording and accounting for the disposal, are prepared and notified to managers.

18.2.2 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Executive Director of Finance;

(b) recorded by the Condemning Officer in a form approved by the Chief Finance Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Executive Director of Finance.

18.3 The Condemning Officer shall satisfy her/himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Executive Director of Finance who will take the appropriate action.

19. LOSSES AND SPECIAL PAYMENTS

Covering	
General	19.1
Employee/Officer Responsibilities	19.2
Theft, arson, neglect of duty or gross carelessness	19.3
Suspected fraud	19.4

19.1 General

19.1.1 The Executive Director of Finance is responsible for:

(a) ensuring that detailed procedural instructions for the recording of and accounting for losses and special payments are prepared and notified to employees;

(b) maintaining a Losses and Special Payments Register in which write-off action is recorded;

(c) taking any necessary steps to safeguard the ICB's interests in Creditor Voluntary Arrangements personal bankruptcies and company liquidations; and

(d) considering whether an insurance claim can be made.

19.1.2 All losses and special payments must be reported to the Audit and Governance Committee at every meeting.

19.1.3 Within limits delegated to it by the Department of Health and Social Care, approval for writing-off of losses shall be in accordance with the Scheme of Reservations and Delegation. No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health and Social Care.

19.1.4 For detailed operational guidance on losses and special payments, please refer to the ICB Losses and Special Payments policy.

19.2 Employee/Officer Responsibilities

19.2.1 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform:

(a) their Director, who must immediately inform the Chief Executive Officer and the Executive Director of Finance; or

(b) an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Executive Director of Finance and/or Chief Executive Officer.

19.3 Theft, Arson, Neglect or Duty or Gross Carelessness

19.3.1 Where a criminal offence is suspected that involves theft or arson, the Executive Director of Finance must immediately inform the police.

19.3.2 Additionally, for losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Executive Director of Finance must immediately notify:

(a) the ICB Board; and

(b) the External Auditor.

19.4 **Suspected fraud**

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

19.4.2 In cases of fraud and corruption or where anomalies may indicate fraud or corruption, the Executive Director of Finance must inform the relevant Local Counter Fraud Specialists in accordance with ICB Fraud, Bribery and Corruption Policy.

19.4.3 The Executive Director of Finance has responsibility for:

(a) ensuring appropriate arrangements are in place to provide adequate counter fraud provision which should include reporting requirements to the ICB Board and Audit and Governance 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; and

(b) notifying the NHS Counter Fraud Authority and the ICB External Auditor of all suspected frauds.

20. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT

20.1 The Chief Executive Officer shall ensure that all staff are made aware of the requirement for them to comply with the ICB's:

20.1.1 Standards of Business Conduct Policy;

20.1.2 Managing Conflicts of Interest Policy;

20.1.3 Gifts and Hospitality Policy.

20.2 These policies follow the guidance contained in the Managing Conflicts of Interest in the NHS Guidance for staff and organisations, which came into force on 1 June 2017.

21. PAYMENTS TO GPS WITH INDEPENDENT CONTRACTOR STATUS

21.1 **Role of the ICB**

The ICB will approve additions to, and deletions from, approved lists of GPs with independent contractor status ("contractors"), taking into account the health needs of

the local population, and the access to existing services. All applications and resignations received shall be dealt with equitably, within any time limits laid down in the contractors NHS terms and conditions of service.

21.2 **Duties of the Chief Executive Officer**

The Chief Executive Officer shall:

21.2.1 ensure that an up-to-date list of all contractors, that the ICB is responsible for is maintained;

21.2.2 ensure that systems are in place to deal with applications, resignations, inspection of premises, etc. within the appropriate contractor's terms and conditions of service.

21.3 **Duties of the Executive Director of Finance**

The Executive Director of Finance shall:

21.3.1 ensure that only contractors who are included on the ICB's approved list receive payments;

21.3.2 maintain a system of payments such that all valid contractors' claims are paid promptly and correctly, and are supported by the appropriate documentation and signatures;

21.3.3 ensure that regular independent verification of claims is undertaken, to confirm that:

(a) rules have been correctly and consistently applied;

(b) overpayments are preferably prevented but once detected full recovery made;

(c) suspicions of possible fraud are identified and subsequently dealt with in line with the ICB's Fraud, Bribery and Corruption Policy;

21.3.4 ensure that arrangements are in place to identify contractors receiving exceptionally high, low or no payments, and highlight these for further investigation; and

21.3.5 ensure that a prompt response is made to any query raised by NHS Business Services Authority via either the Prescription Service or the Dental Service, regarding claims from contractors submitted directly to them.

22. RETENTION OF RECORDS/FREEDOM OF INFORMATION

22.1 **Retention of Records**

15.2.1 The Chief Executive Officer shall be responsible for ensuring that systems are in place to maintain archives for all records required to be retained in accordance with the Records Management Code of Practice for Health and Social Care 2016 and other relevant notified guidance.

15.2.2 The records held in archives shall be capable of retrieval by authorised persons, and as such, arrangements are in place for effective responses to Freedom of Information requests.

15.2.3 Records held in accordance with the Records Management Code of Practice for Health and Social Care 2016, shall only be destroyed at the express instigation of the Chief Executive Officer in accordance with that guidance and the ICB policy. Details shall be maintained of records so destroyed.

22.2 Freedom of Information

22.2.1 The Chief Executive Officer shall be responsible for publishing and maintaining a Freedom of Information Publication Scheme or adopting a model Publication Scheme approved by the Information Commissioner.

22.2.2 A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about this ICB that it makes publicly available.

23. RISK MANAGEMENT AND INSURANCE

Covering	
Programme of Risk Management	23.1
Insurance: General	23.2
Insurance: Risk Pooling Schemes administered by NHS Resolution	23.3
Insurance arrangements with commercial insurers	23.4
Arrangements to be followed by the ICB Board in agreeing insurance cover	23.5

23.1 Programme of Risk Management

23.1.1 The Chief Executive Officer shall ensure that the ICB has a programme of risk management, in accordance with current Department of Health and Social Care assurance framework requirements, which must be approved by the ICB Board and monitored by the Audit and Governance Committee.

23.1.2 The programme of risk management shall include:

(a) a process for identifying and quantifying risks and potential liabilities;

(b) engendering among all levels of staff a positive attitude towards the control of risk;

(c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

(d) contingency plans to offset the impact of adverse events;

(e) audit arrangements including internal audit; clinical audit; and health and safety review;

(f) a clear indication of which risks shall be insured;

(g) arrangements to review the risk management programme.

23.1.3 The existence, integration and evaluation of the above elements will assist in providing a basis to complete the governance statement within the Annual Report and Accounts as required by current Department of Health and Social Care guidance.

23.2 **Insurance: General**

23.2.1 Insurance will be provided under arrangements proposed by the Executive Director of Finance to the ICB Board, and approved by HM Treasury where necessary.

23.2.2 Only the Executive Director of Finance may commission the procurement of insurance arrangements.

23.3 **Insurance: Risk Pooling Schemes administered by NHS Resolution**

23.3.1 The ICB Board shall decide if the ICB will insure through the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes.

23.3.2 Where it is possible to insure a risk via the risk pooling arrangement run by NHS Resolution, this will be the only acceptable form of insurance for that risk. These arrangements do not need the approval of HM Treasury.

23.3.3 If the ICB Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

23.4 **Insurance arrangements with commercial insurers**

HM Treasury approval is required for insurance arrangements with commercial insurers. There are, however, three exceptions when ICBs may enter into insurance arrangements with commercial insurers without seeking HM Treasury approval. The exceptions are:

23.4.1 for insuring motor vehicles, either owned or leased by the ICB including insuring third party liability arising from their use;

23.4.2 where the ICB is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into; and

23.4.3 where income generation activities take place these should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the ICB for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from NHS Resolution. In any case of doubt concerning a ICB's powers to enter into commercial insurance arrangements the Executive Director of Finance should consult the Department of Health and Social Care.

23.5 **Arrangements to be followed by the ICB Board in agreeing insurance cover**

23.5.1 Where the ICB Board decides to use the risk pooling schemes administered by NHS Resolution the Executive Director of Finance is responsible for ensuring that systems are in place to ensure that:

(a) the arrangements entered into are appropriate and complementary to the risk management programme; and

(b) documented procedures cover these arrangements.

23.5.2 Where the ICB Board decides not to use the risk pooling schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the Executive Director of Finance:

(a) shall ensure that the ICB Board is informed of the nature and extent of the risks that are self-insured as a result of this decision; and

(b) is responsible for ensuring systems are in place to draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

23.5.3 All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the "deductible"). The Executive Director of Finance is responsible for ensuring systems are in place to ensure documented procedures also cover the management of claims and payments below the deductible in each case (which should be accounted for in accordance with the process for losses).

24. CUSTODY OF SEAL, SEALING AND SIGNATURE OF DOCUMENTS

24.1 **Custody of Seal**

The common seal of the ICB shall be kept by the ICB's Corporate Secretary in a secure place.

24.2 **Sealing of Documents**

Where it is necessary for a document to be sealed, it should be sealed in accordance with Section 6 of the ICB's Standing Orders.

24.3 **Register of Sealing**

The Chief Executive Officer shall be responsible for keeping a register in which the Corporate Secretary shall enter a record of the sealing of every document.

24.4 **Use of Seal**

A seal would normally need to be applied on the following types of document:

24.4.1 the transfer deed for a purchase or sale of freehold land or lease;

24.4.2 a license or deed which is supplemental to a lease, for example: licenses to carry out works; licenses to assign; licenses to underlet; or a surrender of a lease;

24.4.3 other miscellaneous deeds including planning agreements such as Section 106 Agreements, Deeds of Guarantee and Deeds of Easements (rights);

24.4.4 where the Department of Health and Social Care or another statutory body insists on a document being sealed and following advice from the ICB's legal advisors that this is appropriate;

24.4.5 a construction contract and/or collateral warranty.

24.5 **Signature of Documents**

Where any document that will be a necessary step in legal proceedings on behalf of the ICB, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive Officer; the Executive Director of Finance; or the Corporate Secretary.

Appendix 1 – Single Tender Waiver Form

DFI Waiver Ref:

Application Form for the Waiving of Standing Orders and Standing Financial Instructions to Authorise Appointment of a Supplier following Receipt of Less than Requisite number of Quotes

To be approved by the Executive Director of Finance

Not to be approved exceeds the World Trade Organisation's (WTO) Government Procurement Agreement (GPA) limit without direct procurement team advice to the contrary.

The Scheme of Reservations and Delegation

In accordance with the ICB's Scheme of Reservations and Delegation (SoRD) – for procurement of goods and services:

- Under £10,000, no written quotations required, direct award permissible.
- From £10,000 to £20,000, at least 3 written competitive quotations should be sought
- From £20,000 to £50,000, at least 5 written competitive quotations should be sought
- Above £50,000, a full tender is to be carried out.

The SoD Waiver cannot be applied to the provision of goods or services where the value exceeds the UK Procurement Thresholds Government Procurement Agreement (GPA) limit (Value for Public Contracts 20/21 is £213,477 for goods and services, and is inclusive of VAT).

Where competition is not practicable then reliance has to be placed on professional advice and where this is the case the appropriate member of staff giving such advice must certify that there is no other acceptable source of supply.

SECTION 1 – REQUESTOR DETAILS

Requestor Name and Job Title: **ICB Executive / Functional Director Lead (if different to above):**

SECTION 2 – DETAILS OF GOODS AND SERVICES

Proposed Supplier:

Expected Contract Start Date:

Estimate of the Contract Value:
(please provide evidence of any quotes)

Detail the goods or services you require:

Have any Conflicts of Interest been identified?:

If Yes,
a) please provide details:

b) what actions have been taken to manage the conflict(s)?:

SECTION 3 - REASON FOR SINGLE SOURCE QUOTATION / TENDER

Please state under which Detailed Financial Instructions heading(s) you are claiming that competition is not appropriate by placing a cross in the relevant box below.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure. Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate ICB record and reported to the Audit and Governance Committee at each meeting.

Formal tendering procedures **may be waived** ONLY where the following circumstances are met if the estimated expenditure is below the OJEU limit but above the ICB's limit for a competitive process as shown in Section 1 above.

1. In very exceptional circumstances where the Chief Executive Officer decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate ICB record (legal advice is recommended) (SFI 9.10.4 (a)) ☐

2. Where the requirement is covered by an existing contract and where it does not materially / modify the contract beyond the original specification or exceed 50% of the total contract value awarded (SFI 9.10.4 (b)) ☐

3. Where Framework Agreements are in place as described in the ICB's Procurement Policy (SFI 9.10.4 (c)) ☐

4. Where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members (SFI 9.10.4 (d)) ☐

5. Where the timescale genuinely precludes competitive tendering but failure to plan the work properly is not a justification for waiving the requirement to tender (SFI 9.10.4 (e)) ☐

6. Where specialist expertise is required and is available from reduced number of source (SFI 9.10.4 (f)) ☐

7. When the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate (experience, capacity, or intellectual property rights as an example) procurement advice should be sought to ensure this complies with regulation 32 and/or 72 under PCR2015 (SFI 9.10.4 (g)) ☐

8. There is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering. Procurement ☐

advice should be sought to ensure this complies with regulation 32 and/or 72 under PCR2015 (SFI 9.10.4 (h)

9. For the provision of legal advice and services providing that any legal firm or partnership commissioned by the ICB is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned, the Executive Director of Finance will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.. (SFI 9.10.4 (i)) ☐

MANDATORY FIELD: Please make an appropriate statement to support your declaration answering the questions below;

1) Please provide information to explain the reasoning selected above

2) How did the ICB arrive at the situation where a Single Tender Waiver was required?

3) How will the ICB prevent this situation from arising in the future?

MANDATORY FIELD CONT:

4) How is the ICB assured we continue to receive Value for Money in contracting with a Single Provider?

5) Does the ICB continue to be legally compliant (if unsure, procurement advice should be sought by the requestor)?

6) What Governance Route has this contract/purchase been challenged to? E.g. Has this been through a Committee, or budget holder approval?

Declaration

The above information is true and complete and to the best of my knowledge represents best value for money. Neither I, nor anyone involved in the award of business have any direct or indirect financial interest in the recommended supplier and I confirm that I have not accepted any inducement or reward as a consequence of this recommendation. (To be completed in black ink)

Executive Director of Finance Signature

Print Name:

Job Title & Department:

Date reported to Audit and Governance Committee:

9. CORPORATE GOVERNANCE FRAMEWORK

NHS Derby and Derbyshire Integrated Care Board

Corporate Governance Framework

KEY POLICY MESSAGES	
1.	Aims to provide guidance to assist with the management of various ICB meetings
2.	Includes useful templates for use at ICB meetings
3.	Ensures a consistent approach and added value to the overall governance of the ICB

VERSION CONTROL

Policy Title:	NHS Derby and Derbyshire Integrated Care Board Corporate Governance Framework
Supersedes:	NHS Derby and Derbyshire CCG Corporate Governance Framework
Description of Amendment(s):	Version 0.1 – initial Draft
Financial Implications:	No change
Policy Area:	TBC
Version No:	Versions 0.1 and 0.2 – Initial draft
Author:	Corporate Governance Manager
Approved by:	Audit and Governance Committee, TBC
Effective Date:	July 2022
Review Date:	June 2024
List of Referenced Policies	N/A
Key Words section (metadata for search facility online)	Corporate Governance Framework Meeting Agenda Cover Sheet Minutes Matters Arising Terms of Reference Template Voice Recording Etiquette
Reference Number	CD08
Target Audience	ICB approved policies apply to all employees, contractors, volunteers, and others working with the ICB in any capacity. Compliance with ICB policy is a formal contractual requirement and failure to comply with the policy, including any arrangements which are put in place under it, will be investigated and may lead to disciplinary action being taken. This framework is applicable, in particular, to Administrators, Executive Assistants, meeting organisers and Chairs of meetings.

CONTENTS

1. PURPOSE

1.1 This document aims to provide guidance to assist with the management of NHS Derby and Derbyshire Integrated Care Board ("ICB") Board and Committees, including the formulation of terms of reference; agendas and minutes; and the general management of the Committee process.

1.2 Whilst this guidance is aimed at formal Committees it is equally applicable to other Committee meetings including 'task and finish' groups etc. Wherever possible such Committees/Groups are expected to adhere to these guidelines.

1.3 The Framework should be read in conjunction with the following documents:

1.3.1 ICB Constitution;

1.3.2 ICB Governance Handbook;

1.3.3 Standards of Business Conduct Policy;

1.3.4 Managing Conflicts of Interest Policy;

1.3.5 Report Writing Guidance and Principles.

1.4 Further guidance regarding committee papers can be obtained from the Corporate Delivery Team.

2. SCOPE

The Framework is required to ensure a consistent approach to meetings and to ensure that all documentation presented at meetings add value to the overall governance of the ICB.

3. INTENDED USERS

Within this policy where it states "all employees", it relates to:

3.1 members of the ICB Board, Committees and Sub-Committees;

3.2 employees of the ICB;

3.3 third parties acting on behalf of the ICB.

4. DISCLAIMER STATEMENT

4.1 It is a requirement that the reader follows this policy and accepts professional accountability and maintains the standards of professional practice as set by the appropriate regulatory body applicable to their professional role and to act in accordance with the express and implied terms of their contract of employment, in accordance with the legal duties outlined in the NHS Staff Constitution (section 3b).

4.2 If there are any concerns with this document then the reader should initially discuss the specific issue with their line manager or raise it through appropriate 'raising concerns' channels. The line manager should agree a course of action that is appropriate and reflect this with the policy sponsor.

5. DEFINITIONS AND AN EXPLANATION OF TERMS USED

"Agenda"

means a list of items of business to be considered and discussed at a meeting;

"Committee"

within the ICB, a Committee is defined as a high-level meeting which reports directly into the ICB Board or relevant Committee, and has delegated authority from the ICB Board or the relevant Committee;

"Conflicts of Interest"

means *"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"* (NHS England, 2017);

"Governance"

means the systems and processes by which the ICB leads, directs and controls its functions, in order to achieve organisational objectives and by which they relate to their partners and wider community;

"Group"

means a group in any other meeting which is held within the ICB with a Governance remit and reports through the Committee structure to the Board. ***N.B.*** *Within the Corporate Governance Framework where it states "Committee" please read it to be applicable to Committees and Groups*;

"Matters Arising"

means a summary of actions agreed at the meeting, which are to be carried out before the next meeting;

"Minutes"

means the written record of a meeting;

"Quoracy"

means having the necessary number of people present for decisions to be made at a meeting;

"Terms of Reference"

describes the purpose, scope and authority of a committee.

6. FULL DETAILS OF THE FRAMEWORK

6.1 Good Governance

6.1.1 Good governance is important within the ICB as it is concerned with:

(a) how the organisation is led and structured;

(b) how the organisation is able to demonstrate that it is operating in line with the fundamental principles of openness, integrity and accountability;

(c) how the ICB are meeting the statutory objective of providing high quality healthcare; and

(d) ensuring that the organisation's objectives are delivered economically, efficiently and effectively.

6.1.2 Managers and other staff throughout the ICB spend a considerable amount of their time attending Committee meetings. It is essential that this resource is an effective use of time. Consideration should also be given to whether a face-to-face meeting needs to be held or whether the meeting could take place via video conference.

6.1.3 Each Committee should have clear Terms of Reference related to the organisation's objectives so that its role is unambiguous and to ensure that it makes a relevant contribution. Committees should function effectively i.e. meet with appropriate frequency, be well attended and produce minutes that reflect their Terms of Reference.

6.1.4 Committees should make decisions with clear actions and recommendations that are followed throughout subsequent meetings (with timescales for implementation where appropriate).

6.2 Terms of Reference

Each Committee's Terms of Reference (see Appendix 1 for an example) should include the following:

6.2.1 **Scope:** an introduction to the Committee's constitutional responsibilities;

6.2.2 **Purpose:** a summary of the Committee's purpose;

6.2.3 **Roles and Responsibilities:** a summary of its main duties;

6.2.4 **Delegated Authority:** a summary of what the Committee's delegated responsibilities are;

6.2.5 **Accountability:** a description of who the Committee is accountable to and its direct reporting relationship;

6.2.6 **Membership and Attendance:** a list of the membership including details of who the Chair and Vice Chair are, their titles, voting rights and deputies (if applicable). This section also includes details for the membership on attendance expectations;

6.2.7 **Meeting Arrangements and Frequency:** how often the Committee will meet and the format of meeting preparation;

6.2.8 **Quoracy:** details of the number and type of members that make up the quorum, i.e. 'four members, one of whom should have a clinical background';

6.2.9 **Behaviours, Values and Decision Making:** details of the decision making and voting process;

6.2.10 **Identifying and Managing Risks:** a summary of how the Committee will receive and review risks;

6.2.11 **Sub-Committees:** a list of any sub-committee that reports into the Committee and the method by which they report in;

6.2.12 **Interdependencies with other groups:** details any groups which the committee reports into;

6.2.13 **Managing Conflicts of Interest:** a description of individuals' compliance with the ICB Constitution, Standards of Business Conduct Policy and Managing Conflicts of Interest Policy. This section also includes how the Committee will manage any conflicts of interest that arise in respect of the meeting;

6.2.14 **Secretariat and Administration:** details of the individual or team responsible for providing administrative support to the meeting; and

6.2.15 **Review:** it is recommended the Terms of Reference are reviewed at least annually.

6.3 Agendas

All meetings i.e. the ICB Board, Committees and internal meetings; should have an agenda (see Appendices 2–5 for examples) and should include the following:

6.3.1 Board Agendas (see Appendices 2 and 3)

(a) **Title:** the agenda should begin by stating the ICB Board's title, the date, time and location of the meeting;

(b) **Content of the Agenda:** the agenda should normally follow the order below:

(i) Welcome, introductions and apologies

(ii) Confirmation of quoracy

(iii) Declarations of Interest (including an updated Register of Interests for members of the committee and summary register for recording any conflicts of interests during meetings)

(iv) Glossary (where a meeting includes members of the public/Non-Executive Members, so any acronyms contained in the papers are understandable)

(v) Items received from members of the public

(vi) Presentations and regular reports

(vii) Minutes from sub-committees, for information

(viii) Minutes of the previous meeting and Matters Arising Actions Log: any action points recorded in the previous minutes should be reported back to the Committee. The item title and the minute number should be listed as well as the individual responsible (see Appendix 12)

(ix) Forward Planner (an agenda planning tool which enables reports to be scheduled in advance throughout the year)

(x) Any Other Business: members should be reminded that the Chair is to be notified at the beginning of the meeting, or earlier, of Any Other Business items that are to be raised

(xi) Date and venue of next meeting

(c) The Substantive agenda items, including presentations/regular reports: all agenda items to be presented/received should have an agenda number which is included on the cover sheet. The numbers should be consecutive throughout the year to allow for ease of reference (i.e. ICB/2223/01, ICB/2223/02 etc.) and should be refreshed at the beginning of each financial year.

(d) Draft agendas are produced and discussed with the Executive Team 2-3 weeks before the meeting.

(e) Board agendas should be agreed by the ICB Chair and should consist of a reasonable amount of items to prevent the meeting lasting more than two hours.

6.3.2 Committee Agendas (see Appendix 4)

(a) **Title:** the agenda should begin by stating the Committee's title, the date, time and location of the meeting;

(b) **Content of the Agenda:** the agenda should normally follow the order below:

(i) Welcome, introductions and apologies

(ii) Confirmation of quoracy

(iii) Declarations of Interest (including an updated Register of Interests for members of the committee and summary register for recording any conflicts of interests during meetings)

(iv) Glossary (where a meeting includes member of the public, so any acronyms contained in the papers are understandable);

(v) Presentations/regular reports;

(vi) Minutes from sub-groups;

(vii) Minutes of the previous meeting and Matters Arising Actions Log: any action points recorded in the previous minutes should be reported back to the committee. The item title and the minute number should be listed as well as the individual responsible (see Appendix 12);

(viii) Forward Planner: an agenda planning tool which enables reports to be scheduled in advance throughout the year;

(ix) Assurance Questions: this is a final agenda item to review how effective the meeting was and to allow Committees to decide whether anything should be escalated to the Board. The following questions should be included:

- Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes?
- Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations?
- Were papers that have already been reported on at another committee presented to you in a summary form?
- Was the content of the papers suitable and appropriate for the public domain?
- Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes?
- Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting?
- What recommendations do the Committee want to make to the ICB Board following the assurance process at today's Committee meeting?

(x) Any Other Business: members should be reminded that the Chair is to be notified at the beginning of the meeting, or earlier, of Any Other Business items that are to be raised; and

(xi) Date and venue of next meeting along with the papers' deadline.

(c) The substantive agenda items, including presentations / regular reports: all agenda items to be presented/received should have an agenda number which is included on the cover sheet. The numbers should be consecutive throughout the year to allow for ease of reference (i.e., ICB/2223/01, ICB/2223/02 etc.) and should be refreshed at the beginning of each financial year.

(d) All agendas should be agreed by the Chair of the meeting and should consist of a reasonable amount of items to prevent the meeting lasting more than three hours.

6.3.3 Internal Meeting Agendas

The format of the agenda should follow the example provided at Appendix 5.

6.4 **Virtual Decision Making**

6.4.1 If a decision is needed which cannot wait for the next scheduled meeting, then a virtual decision may be taken via video conference, email, online communication platform or face to face, subject to adherence of the following process:

(a) Chair of the meeting agrees to use of a virtual decision;

(b) the items for decision should be sent out to all Committee members via email with a reasonable deadline to allow the item to be reviewed and commented upon;

(c) a positive response must be received back from committee members via email to allow for the item to be approved – it cannot be approved until, as a minimum, the quoracy for the meeting has responded;

(d) the responses should be kept electronically with the Committee papers so an audit trail can be produced if required;

(e) the Committee members may respond with comments – if this is the case and they are simple amendments, the item should be approved subject to the amendments being made;

(f) if the amendments are more complex or there is a conflict in the responses from the Committee members, the Chair of the committee should make a decision whether it is appropriate to have a conference call to resolve the issues or whether it needs to wait until the next committee meeting where a full discussion can be held; and

(g) a written note of the outcome of the virtually approved decision should be an agenda item on the next committee meeting's agenda so that the decision can be formally ratified and minuted.

6.5 **Committee Papers**

6.5.1 If individual reports are not received in good time for circulation of Committee papers, the Chair should advise if the item is to be removed from the agenda.

6.5.2 Reports should be received seven working days in advance of the meeting to ensure timely:

(a) distribution of the papers, in order for members to have sufficient time to review five working days prior to the meeting; and

(b) uploading to the ICB's website for the public to view, which is subject to auditor review and scrutiny.

6.5.3 Cover Sheets

(a) All papers received by a Committee must have a fully completed Cover Sheet (see Appendices 6, 7, 8 and 9 for examples).

(b) The Cover Sheet helps identify the key pieces of information the committee needs to be aware of and what action the committee is required to take.

(c) Authors of papers are required to:

(i) clearly identify the 'ask' of the Committee;

(ii) detail which of the ICB's objective the report supports;

(iii) briefly describe the purpose and background to the report;

(iv) summarise the main body of the report under 'Report Summary';

(v) clearly refer to any risks that have been identified within the report;

(vi) give details of any instances where staff have been conflicted, or where conflicts have been raised at meetings where the report has been discussed;

(vii) state whether there are any project dependencies, detail any findings from completed impact assessments;

(viii) include a risk rating and summary, if the project has been to the Quality and Equality Impact Assessment Panel;

(ix) include a summary following any involvement with Patients, Public or other key stakeholders;

(x) confirm which of the Equality Delivery System goals the report supports, and whether there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty; and

(xi) confirm that consideration has been given to the Derbyshire Integrated Care System Greener Plan targets, and detail any findings.

6.5.4 Committee Reports

(a) Most reports will be requested by the Committee Administrator or Executive/ Senior Manager Representative, because they appear on the annual

Forward Planner of Agenda Items or were requested at a previous meeting. Committees should normally have in place a Forward Planner of Agenda Items (regular reports) for the year. This is an agenda planning tool which enables reports to be scheduled in advance throughout the year.

(b) Members of Committees, as well as members of staff more generally, may also request that reports are submitted for consideration. Anyone wishing to make such a request is advised to consult with the relevant Committee Administrator, Chair or Executive Director/Senior Manager Representative well in advance of the deadline for receipt of reports.

(c) Regular report authors are advised to review the Forward Planner of Agenda Items and contact the Committee Administrator/Chair if they have any questions.

(d) In general terms, the reports received by Committees are:

(i) for assurance – e.g. reports to the Committee about the level of confidence and evidence that a particular course of action has been taken;

(ii) for information – e.g. reports which do not require any formal action or decision;

(iii) for decision – e.g. where a particular course of action is proposed and requires official sanction, or where policy, strategy, or regulation requires approval; or

(iv) a combination of the above.

(e) Each paper should clearly identify what action it requires the Committee to take.

(f) Reports should seek to add value to the ICB, by providing important information, prompting high-level discussion and seeking approval for a course of action. Reports should be aligned to and contribute to the achievement of the ICB's objectives.

(g) The use of acronyms should be minimised. Where acronyms are used, ensure they are displayed in full when first mentioned (e.g. Chesterfield Royal Hospital NHS Foundation Trust (CRHFT));

(h) Reports require, as a minimum, the following sections:

(i) Executive Summary – this is the most important section of the document; the reader will use the summary to decide how much of the report they need to read so make it clear and count;

(ii) Introduction – including the aims and objectives of the report;

(iii) Body – can be divided into sub-sections to help present the information to the reader. It may include research, data and other information relevant to the purpose of the report;

(iv) Conclusion – the author's assessment of the facts presented in the report;

(v) Recommendation – must clearly articulate what the meeting is being asked to do with the information in the report. Option may include:

- **AGREE**
- **APPROVE**
- **NOTE**
- **SUPPORT**
- **RATIFY**

(i) Timetables should be agreed for the submission of reports and the distribution of committee papers:

(i) agendas for Committees are agreed approximately 2–3 weeks prior to the meeting with the Executive Team, following which authors of scheduled reports are contacted and asked to submit their reports and provide an update on the actions log regarding outstanding actions in line with the agreed deadline;

(ii) the deadline for receipt of papers and actions update by the Committee Administrator is seven working days before the meeting;

(iii) the complete agenda with papers is distributed to the committee five working days prior to the meeting so that the members have the opportunity to fully read and consider all the papers.

(j) The most consistent difficulty faced in achieving the timely distribution of papers is the late submission of reports. Authors have a duty to ensure that papers are delivered by the deadline date. Late papers will not be included unless in exceptional circumstances that have been agreed by the Chair or Executive Directors/Senior Manager Representative in advance. Executive Directors/Senior Manager Representatives are responsible for the quality of the papers presented to the meetings.

For more information on writing reports, please refer to the ICB's Report Writing Guidance and Principles.

6.6 Minutes

The purpose of minutes is to provide a formal record of the decisions and substantive discussion occurring in a meeting and provide a record of the integrity of the meeting (see Appendix 11 for an example template). The Chair is responsible for summarising

each agenda item at the meeting to ensure the substantive discussion is recorded in a clear and concise manner:

6.6.1 Title

The name of the Committee and the time, date and venue or online communication platform of the meeting should be clearly stated at the beginning of the minutes. Start and finish times should also be recorded.

6.6.2 Attendance

(a) When listing those present, the name of the individual and the position they are representing on the committee should be given. Members should be listed in alphabetical order (by surname) with the Chair identified by (Chair) written after the name. If a person joins or leaves the meeting the times and/or agenda item should be noted against their names for auditing purposes (e.g. (Item ICB/2223/01 only)).

(b) Where individuals are present at the meeting but are not part of the formal membership of the Committee, they should be recorded under 'In Attendance'. This would include any co-opted members and those presenting a paper/item to the Committee – in this instance the item number they are present for should be recorded.

(c) Apologies should be recorded, in alphabetical order, below those who are in attendance.

(d) In some situations, an individual may not be in attendance for the whole meeting. The minutes should reflect the point in time when that individual joined or left the meeting.

6.6.3 Quoracy

The quorum of the relevant Committee can be found in its terms of reference and this quoracy should be functioning whenever any decisions need to be made. If the meeting is not fully quorate, members present will agree in principle to any decisions, with a caveat that agreement will be sought from the missing members outside of the meeting. Confirmation that these items were agreed with the missing members should be included as a post-meeting note within the minutes of the meeting and then ratified at the next meeting.

6.6.4 Declarations of Interest

(a) It is imperative that the ICB ensures complete transparency in their decision making processes through robust record-keeping. Any declaration of interest, and arrangements agreed, in any meeting of the ICB, its Committees or sub-committees and Board should be recorded in the Register of Interests and in the relevant minutes.

(b) To support Chairs in their role, they will be provided with a declarations of interest checklist prior to meetings. A copy of this can be found in Appendix 5 of the Managing Conflicts of Interest Policy.

(c) At the beginning of all Committee meetings the Register of Interests for that meeting will be highlighted and there will be an opportunity for individuals to identify potential conflicts of interests relating to specific items of business. Individuals should also raise such items at the beginning of each agenda item so the appropriate course of action can be taken.

(d) Where an interest does occur during a meeting, the Chair is to notify the Corporate Governance Manager so that the Committee and ICB registers of interests can be updated, as well as making the Audit and Governance Committee aware.

(e) If any Committee members' circumstances change and this is raised at a meeting, the Register for Recording Any Interests During Meetings should also be completed and signed by the Chair. The respective individual will be sent a new form to complete and the updated register will be circulated with the meeting papers by the Corporate Governance Manager.

(f) 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:

(i) who has the interest;

(ii) the nature of the interest and why it gives rise to a conflict, including the magnitude of any interest;

(iii) the items on the agenda to which the interest relates;

(iv) how the conflict was agreed to be managed; and

(v) evidence that the conflict was managed as intended (for example recording the points during the meeting when particular individuals left or returned to the meeting).

(g) An example of good minuting should include the following wording in the declarations of interest item:

Declarations of interest

[Chair] reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the ICB.

Declarations declared by members of the [name of committee] are listed in the ICB's Register of Interests and included with the meeting papers. The Register is also available either via the Executive Assistant to the ICB or the ICB website at the following link: [insert hyperlink]

Declarations of interest from sub-committees

No declarations of interest were made.

[If declared, a register will be included in the papers to show who declared an interest, at what meeting and for which item]

Declarations of interest from today's meeting

No declarations of interest were made. OR

The following update was received at the meeting:

- *With reference to business to be discussed at this meeting, [name of individual] declared that he/she is a [shareholder in XXX].*

[Chair] declared that the meeting is quorate and that [name of individual] would not be included in any discussions on agenda item [X] due to a direct conflict of interest.

[Chair] and [name of individual] discussed the conflict of interest, which is recorded on the register of interest, before the meeting and [name of individual] agreed to remove [himself/herself] from the table and not be involved in the discussion around agenda item [X].

6.6.5 Content

(a) Minutes must contain:

(i) what decisions were made, including the level of assurance agreed by the committee and any new risks identified;

(ii) who proposed and supported items for decision;

(iii) the result of any votes (the numbers in favour, against and any abstentions);

(iv) what action was agreed; and

(v) who was given responsibility to carry out the action and by when.

(b) It is also a good idea to include a short summary of the opinions or challenges raised during the discussion of each agenda item, along with the reason why a certain decision was reached. Wherever possible, the minutes should focus on points made for and against a proposal or idea and should state the level of assurance the committee took from an agenda item and its relevant paper.

(c) Good minutes are accurate, brief (not verbatim) and clear. The minutes should be written in the order that the items appeared on the agenda and the minute numbers must correspond with the agenda numbers. If items were discussed in a different order at the meeting, then that should be explained at the start of the minutes (for example, "the Committee noted that 'Counter Fraud' (Item ICB/2223/05) would be discussed at the start of the meeting").

(d) When referring to an individual for the first time, the person's name must be written in full followed by their initials in brackets (e.g. John Smith (JS)). Only the initials are then used whenever this person is referenced within the minutes.

(e) Minutes should be written in a consistent style, from one meeting to the next. This is usually the Committee Administrator's responsibility. During the meeting, if the person writing the minutes is unsure of a decision or action, they should ask the Chair for clarification so that their minutes are accurate.

(f) The draft minutes should be approved by the Chair and then circulated by the Committee Administrator to members as soon as possible after the meeting.

(g) If the Chair wishes, they may request to sign the ratified minutes. A copy of this should be kept on file for future reference.

6.6.6 Use of English

(a) It is important that minutes and reports are clear, concise grammatically correct and accurate. The following guidelines may be helpful:

(i) while it is necessary to use some specialist terms you should avoid using deliberately obscure words or jargon;

(ii) where acronyms are used, ensure they are displayed in full when first mentioned (i.e. Chesterfield Royal Hospital NHS Foundation Trust (CRHFT));

(iii) do not duplicate in the minutes information which is contained in the papers presented to the meeting. A brief summary is enough. Minutes are designed to be read alongside the papers they refer to;

(iv) use the past tense when writing minutes, even if the events you are writing about have not yet happened (e.g. "it was reported that a further meeting would be arranged towards the end of the year");

(v) use paragraphs appropriately to break up long chunks of text;

(vi) be impartial and do not use loaded terms (even if these were used in the meeting);

(vii) use some of the words below to add variety to your minutes; and

(viii) if in doubt, ask yourself: "Would these minutes make sense to a member of the public"?.

(b) You may find the Plain English website useful: http://www.plainenglish.co.uk

(c) Some useful words to introduce variety in minutes:

raised	mentioned	reported	stated
informed	proposed	discussed	suggested
indicated	contributed	explained	presented

pointing out	confirmed	supported	enquired
highlighted	focused on	targeted	understood
preferred	needed	hoped	opinion
emphasised	repeated	stressed	underlined
explored	investigated	pursued	questioned
responded	advised	clarified	accepted
expressed	considered	implemented	

6.6.7 Use of recording devices

(a) Purpose

(i) The ICB permit the use of Dictaphones for designated administrative staff for the purpose of supporting the effective provision of minutes.

(ii) The notification poster at Appendix 14 should be used at each face-to-face meeting where voice recording is to take place.

(iii) The agendas of meetings should all include a caveat (as detailed in Appendices 2, 3 and 4) that notifies the attendees that the meeting will be recorded.

(iv) All staff who undertake voice recordings should be aware of and agree the standard operating procedure with the Information Governance Manager. This procedure describes clearly the processes which are required in each instance of the voice recording being processed. Within the term 'process' we understand that this includes the way in which information is Held, Obtained, Recorded, Used and Shared.

(b) Roles and Responsibilities

(i) All administrative staff who use voice recording equipment are responsible for its safe use and storage.

(ii) Those who intend to use voice recording equipment in support of their minute taking role are responsible for seeking and obtaining agreement from the Chair of the meeting prior to commencing recording.

(c) Process

The process below shall be followed by each individual undertaking voice or video recording:

(i) *Prior to the meeting*

- There will be an understanding of the expected duration of the meeting and provision made for both tapes and sufficient battery of a device.
- Attendees of the meeting will be made aware of the intention to use voice or video recording by detailing this on the agenda – with any queries being raised with the Information Standards Lead in advance of the meeting, or to be flagged with the Chair at the commencement of the meeting. Should any objections to recording be made, recording will not be undertaken until concerns have been resolved.
- It will be ensured that for each meeting, alternative meeting recording methods – i.e., laptop for typed notes or sufficient pads/pens will be available.

(ii) *During the meeting*

- The poster at Appendix 14, confirming the reasons for voice or video recording, will be clearly displayed on the meeting table. For larger meetings, more than one poster may be necessary.
- For meetings held via an online communication platform it is the responsibility of the Committee Administrator to notify attendees if the meeting is being recorded. Further guidance and the etiquette standards for virtual online Microsoft Teams meetings are included at Appendix 16. If any objections are made within the meeting to the recording, this will not be undertaken.
- The voice recording equipment will be the responsibility of the individual Committee Administrator, both for its set up and collection at the end of the meeting.
- The Committee Administrator should have an agreement with the Chair where any change of tape is required, this will necessitate a pause in discussion where topics are complex.

(iii) *After the meeting*

- The equipment is taken with the administrative staff following the meeting.
- The recording is held securely, either in a locked drawer, or locked flight case as agreed.

- The recording is accessed in a private setting only – i.e. the recording is listened to using headphones for the transcription of formal minutes.
- During the transcription of minutes, the recording is locked away when not in use.
- Once minutes are completed, the tapes used are wiped using the dictation device. This is required as the draft is completed.
- Tapes which have been used and wiped are held securely, to minimise any risk of ineffective deletion of data held on them.

(d) *Incident Reporting*

(i) Those asked to undertake voice recording as part of their role understand that they are handling unencrypted data, and that if this were to be lost, stolen, or otherwise compromised this would be available to anyone finding that information. In that sense it is the same as printed confidential information.

(ii) If there is an actual or suspected Loss, Theft or otherwise compromise of the voice recording, the individual staff member is required to report this to their line manager, and to the Information Standards Lead via a call to 07825 063164 or email to ruth.lloyd6@nhs.net immediately, noting that the ICB are required to report Information Governance related incidents within 72 hours.

6.7 Matters Arising

6.7.1 It is good practice to ensure the actions agreed at the Committee are completed. It is recommended that the actions are summarised from the minutes into a Matters Arising Actions Log (see Appendix 12 for an example).

6.7.2 The Matters Arising Actions Log should be circulated along with the Minutes of the previous meeting. The responsible action owner should provide an update on the action log for distribution with papers

6.7.3 The Matters Arising Actions Log will ensure that if the person responsible for the action is not able to attend and feedback to the following meeting or if an action takes longer to implement than anticipated, the action is not 'lost' and the committee can receive assurance that it has been implemented.

6.8 Reporting to the Integrated Care Board

6.8.1 Each Committee of the ICB should provide minutes of the most recent meeting to the ICB.

6.8.2 At the end of each Committee meeting the relevant assurance questions (see paragraph 6.3.2(ix)) must be asked and any items that need escalating to ICB confirmed.

6.8.3 Assurance Reports (see Appendix 10) are presented to the ICB Board to inform them of any decisions that have been made at Committees or any ICB-specific items that were discussed or directly impact the ICB. These reports should be completed immediately following the meetings in preparation for the succeeding ICB meeting.

6.8.4 Committees should adhere to the arrangements set out in the Standing Financial Instructions – Financial Limits for Delegated Authority in the ICB Handbook.

6.8.5 On an annual basis, preferably at the end of the financial year, each Committee should provide a Committee Annual Report to the ICB which summaries the key discussions and decisions made throughout the year. It will also include attendance, membership, quoracy and a review of the committee's effectiveness.

6.8.6 The Annual Report is to be completed by the Executive Director/Senior Manager Representative responsible for the committee. It is then taken to the relevant committee for approval prior to being taken to the ICB Board.

6.9 The Role of the Committee Administrator

6.9.1 The role of the Committee Administrator varies depending on the Terms of Reference, size and composition of the Committee, and the chairing skills/style of the Chair. There are, however, certain basic roles which can be identified:

(a) to make all the domestic arrangements for the meeting;

(b) to prepare and distribute all documentation;

(c) to present material impartially;

(d) to record all decisions/recommendations of the Committee in a presentable manner; and

(e) to update the Forward Planner of Agenda Items, Matters Arising Actions Log (see Appendix 12) and a meeting log of all the decisions made and discussions held.

6.9.2 Good preparation for a meeting by the Committee Administrator helps to ensure that business runs smoothly and the following checklist will help the Committee Administrator to carry out their duties efficiently and effectively:

(a) *General duties*

(i) Ensure an up-to-date membership list giving the name, position and location of each member is available electronically.

(ii) Ensure that all members are aware of the dates and venues or the means of online access for the meetings for the year and book the rooms in advance for the whole year. Ensure that it is appropriate in terms of refreshments, size, furniture, ventilation, etc. and make any necessary arrangements for refreshments or IT equipment.

(iii) Establish a timetable of when papers are due to be submitted.

(iv) Establish and maintain a Forward Planner of Agenda Items.

(b) *Induction of new members*

The Committee Administrator should send the following documents to newly appointed members:

(i) dates and venues of future committee meetings;

(ii) Terms of Reference and membership of that Committee and its related (sub) committees;

(iii) minutes of the previous three meetings;

(iv) a Declarations of Interest form for completion if they are external to the organisation or their role has changed;

(v) contact details of the Chair and Director of Corporate Delivery.

(c) *Before the meeting*

Before the meeting, the Committee Administrator should:

(i) make any necessary arrangements for IT equipment;

(ii) if booking a meeting room, consider the individual needs of people attending the meeting, e.g. are there any individual needs with respect to access (such as car parking, ramps, wide doors), hearing loops, toilet facilities or dietary needs;

(iii) circulate to members in advance asking for any agenda items and giving a deadline for responses;

(iv) prepare a draft agenda, together with any supporting papers, and discuss with the responsible Executive Director/Senior Management Representative or the Chair at least two weeks before the meeting. In doing this, check to see if any items recur on a yearly or other periodic basis by using the Forward Planner of Agenda Items;

(v) ensure that any acronyms which appear in the papers are included in the Glossary;

(vi) prepare final documentation and circulate to members at least 5 working days before the meeting, ensuring that any individual (as directed by the Chair) who has a conflict of interest does not receive the relevant papers as per paragraph 6.10.3(c);

(vii) if relevant, ensure Committee papers are uploaded to the ICB's website; and

(viii) try to arrive early for the meeting to check the room, layout etc. Always take:

- tabled papers (by exception) for distribution at the meeting (however, this should be avoided where possible unless the paper is hard to read, which is when A3 copies should be provided);
- a list of apologies and confirmation of quoracy;
- attendance sheet;
- meeting in progress sign(s);
- stationery (pens and paper);
- recording device and Poster for Table Voice Recording, if applicable;
- procedural information (e.g. Terms of Reference);
- register for recording interests declared at meetings;
- name plates;
- any correspondence for the members; and
- presentations uploaded to a laptop, if applicable.

(d) *During the meeting*

During the meeting, the Committee Administrator should:

(i) notify the attendees as to whether the meeting will be recorded, if the meeting is being held in person or via an online communication platform;

(ii) ensure that a clear record of any recommendations is taken, including any conflicts of interest which arise;

(iii) record attendance and ensure the signing-in sheet is signed by each person at the meeting (see Appendix 13 for an example);

(iv) make sure the Chair follows the agenda and that no items have been omitted;

(v) ensure that levels of assurance and new risks identified are fully recorded and reported as well as making sure that agreed actions have an owner and a deadline for completion.

(e) *After the meeting*

After the meeting, the Committee Administrator should:

(i) write to those who need to know about the Committee's decisions, including any referrals made to other Committees for action;

(ii) draft and check minutes within three working days for approval by the Chair within two working days and make any amendments;

(iii) circulate minutes (remembering to attach tabled papers for members who were not present) and Matters Arising Actions Log to members and anyone responsible for an action;

(iv) if relevant, ensure the agreed minutes of the previous meeting are uploaded to the ICB's website;

(v) add requested papers to the Forward Planner of Agenda Items;

(vi) ensure information from the meeting is appropriately circulated to Committee Administrators/specified individuals;

(vii) remind members of any work to be done before the next meeting;

(viii) communicate to any non-members who have been delegated any actions or future papers and agree realistic deadlines with them, to be agreed with the Chair or Executive Director/Senior Management Representative;

(ix) file all papers and place electronic copies of all documents on the shared drive;

(x) update the Committee Meeting Log;

(xi) start preparations for the next meeting.

6.10 **Role of the Chair**

The role of the Chair varies depending on the Terms of Reference, size and composition of the Committee, but there are certain basic roles which can be identified:

6.10.1 review the draft agenda with the Committee Administrator, at least two weeks before the meeting;

6.10.2 ensure the meeting is quorate in advance and at the start of the meeting;

6.10.3 when a member of the meeting (including the Chair or Vice Chair) has a conflict of interest in relation to one or more items of business to be transacted at the meeting, the Chair (or Vice Chair or remaining non-conflicted members) must decide how to

manage the conflict. The appropriate course of action will depend on the particular circumstances, but could include one or more of the following:

(a) where the Chair has a conflict of interest, deciding that the Vice Chair (or another non-conflicted member of the meeting if the Vice Chair is also conflicted) should chair all or part of the meeting;

(b) requiring the individual who has a conflict of interest (including the Chair or Vice Chair if necessary) not to attend the meeting;

(c) 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;

(d) 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 area;

(e) 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;

(f) 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;

6.10.4 ensure introductions are made at meetings where there are new attendees or members of the public present;

6.10.5 at the beginning of all meetings the Register of Interests for that meeting should be highlighted and the Chair should give individuals the opportunity to identify potential conflicts of interests relating to specific items of business. Where an interest does occur during a meeting, the Chair is to complete and sign the Register for Recording Any Interests During Meetings (Appendix 6 of the ICB's Managing Conflicts of Interest Policy). This should then be passed to the Committee Administrator who will send this to the Corporate Governance Manager so that the Committee's register of interests and the ICB's register of interests can be updated. If any committee members' circumstances change and they raise this at the meeting, this register should also be completed and signed by the Chair (a declarations of interest checklist for Chairs can be found in Appendix 5 of the ICB's Managing Conflicts of Interest Policy);

6.10.6 ensure the meeting runs to time (no more than two hours);

6.10.7 ensure all members have the opportunity to speak during the meeting – keeping order as necessary, and discussion relevant and to the point;

6.10.8 ensure decisions are made and actions agreed – where there is a split vote, with no clear majority, the Chair will hold the casting vote;

6.10.9 close off each item on the agenda and assist the minute taker by summarising key points, decisions and actions at the end;

6.10.10 with the exception of the ICB, at the end of the meeting the Chair should ask the Committee's assurance questions (see paragraph 6.3.2(ix)) and confirm whether anything requires escalation to ICB;

6.10.11 review and agree the draft minutes with the minute taker; and

6.10.12 ensure all actions are followed up.

6.11 Role of the Corporate Secretary

The role of the Corporate Secretary varies depending on the Terms of Reference, size and composition of the committee, and the chairing skills/style of the Chair. There are, however, certain roles which can be identified:

6.11.1 to provide support to all Committee Administrators;

6.11.2 to check whether new members have any special needs to enable them to participate fully in meetings and, if so, make provision accordingly with the Committee Administrator;

6.11.3 to advise the meeting on procedural issues and matters, and past precedent;

6.11.4 to be familiar with the Terms of Reference of the Committee and ensure that the position of the Committee is understood;

6.11.5 read and be aware of the minutes of past meetings to ensure familiarity with the history of the committee and past major decisions which have been taken; and

6.11.6 arrange to see the Chair of the Committee on a regular basis if possible. This will help establish a good working relationship and will also ensure that information about items which affect the Committee are related.

6.12 Layout and Format of Committee Papers

Printed information, including all Committee papers, should be accessible to people with sight problems, the following is general guidance and further information is available from the Royal National Institute for the Blind website (snib.org.uk). The following should be used whenever documents are likely to be accessed by the public:

6.12.1 type size should be between 11 and 14 points;

6.12.2 there should be good contrast between background and text, black text on a white background provides best contrast;

6.12.3 Arial font should be used;

6.12.4 blocks of capital letters, underlined or italicised text are difficult to read and should be avoided;

6.12.5 numbers (including page numbers) should be printed in a typeface which is easy to read. Readers with sight problems can misread 3, 5, 8 & 0;

6.12.6 avoid glossy paper or paper that is very thin.

6.13 **Be Aware of Your Audience**

It is important to be aware that it is relatively easy for members of the public, including the press, to access Committee papers, either because the meetings are held in public i.e. the ICB, or as a result of a 'Freedom of Information' request. Authors of papers need to be mindful of this particularly when conveying sensitive information. Further advice can be obtained from the following departments in the ICB:

6.13.1 Corporate Governance;

6.13.2 Information Governance; and

6.13.3 Communications.

6.14 Version control is important when documents are being created, and for any records that undergo a lot of revision and redrafting. Ensure that consistent numbering is used when using version control i.e. v1.0, v1.1, v1.2.

7. MEETING ETIQUETTE

Meeting etiquette is important as it provides a basis of trust, respect and honesty for the ICB. Meeting etiquette should be adhered to by all ICB staff, Board and Committee members at all meetings, sub-committees and groups. Further detail on these expectations can be found at Appendix 15.

8. EQUALITY STATEMENT

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

8.2 In carrying out its function, the ICB must have due regard to the PSED. This applies to all activities for which the ICB is responsible, including policy development, review and implementation.

9. DUE REGARD

This policy has been reviewed in relation to having due regard to the PSED of the Equality Act 2010 to eliminate discrimination; harassment; victimisation; to advance equality of opportunity; and foster good relations between the protected groups.

10. MONITORING/AUDIT

The Corporate Governance Team is responsible for the monitoring and performance management of the Corporate Governance Framework and associated Committees. Where relevant Committees are failing to adhere to this framework and the Corporate Governance Handbook, it will be reported to the Audit and Governance Committee and the Committee Chair will be required to provide a report stating how they intend to rectify the situation, this includes when there are recurrent delays in the circulation of papers and inappropriate lengths of meetings.

APPENDIX 1 – TERMS OF REFERENCE TEMPLATE

[Committee Name]

Terms of Reference

1. SCOPE

1.1 The X Committee ("the Committee") is established by NHS Derby and Derbyshire Integrated Care Board (the "ICB") as a Committee of the ICB Board in accordance with its Constitution.

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

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

2. PURPOSE

The purpose of the Committee is to ensure that [insert].

3. ROLES AND RESPONSIBILITIES

The Committee will incorporate the following duties [insert].

4. DELEGATED AUTHORITY

4.1 The Committee is a formal committee of the ICB. The ICB Board has delegated authority to the Committee as set out in the Scheme of Reservations and Delegation and may be amended from time to time.

4.2 The Committee holds those powers as delegated in these Terms of Reference as determined by the ICB Board.

5. ACCOUNTABILITY

5.1 The Committee is directly accountable to the ICB Board.

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

5.3 The Chair of the Committee will report to the ICB Board following each meeting, confirming all decisions made, highlighting any concerns, actions taken, next steps and ongoing monitoring. The report will also include recommendations that are outside the delegated limits of the Committee and matters which require escalation to, and approval from the ICB Board, if not already approved by them.

5.4 The Committee will provide an annual report to the ICB Board on the effectiveness of the Committee to discharge its duties.

5.5 The Committee shall maintain an annual work programme, ensuring that all matters for which it is responsible are addressed in a planned manner, with appropriate frequency across the year.

5.6 The Committee may investigate, monitor and review any activity within its terms of reference. It is authorised to seek any information it requires from any Group.

6. MEMBERSHIP AND ATTENDANCE

6.1 Membership

6.1.1 Members of the Committee shall be appointed by the ICB Board in accordance with the ICB Constitution.

6.1.2 When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

6.1.3 The membership of the Committee will comprise of:

(a)

(b)

(c)

6.1.4 Subject experts will be attendees at each meeting.

6.1.5 The Committee may also request attendance by appropriate individuals to present relevant reports and/or advise the Committee.

6.1.6 Committee members may nominate a suitable deputy when necessary and subject to the approval of the Chair of the Committee. All deputies should be fully briefed and the Committee secretariat informed of any agreement to deputise so that quoracy can be maintained.

6.2 Chair and Vice Chair

The Chair of the Committee shall be a Non-Executive Member of the ICB Board. In the event that the Chair is unavailable to attend, a Non-Executive Member will act as the Vice Chair and Chair the meeting, unless there is a conflict of interest. If the Chair has a conflict of interest then the Vice Chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

6.3 **Attendance**

6.3.1 It is expected that members will prioritise these meeting and make themselves available; exceptionally where this is not possible a deputy may attend of sufficient seniority who will have delegated authority to make decisions on behalf of their organisation in accordance with the objectives set out in the Terms of Reference for this Committee. For Local Authority representatives this will be in accordance with the due political process.

6.3.2 Members are expected to attend at least 75% of meetings held each calendar year to ensure consistency.

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

7. MEETING ARRANGEMENTS AND FREQUENCY

7.1 The Committee will meet monthly before every ICB Board meeting to ensure all Quality and Performance information submitted to the ICB Board has been properly scrutinised and to develop an agreed view on any future issues arising.

7.2 The Chair of the Committee may arrange extraordinary meetings at their discretion and if required to consider matters in a timely manner.

7.3 Where necessary members will be required to respond to virtual electronic communications owing to timescales.

7.4 The Chair will be responsible for agreeing the agenda; ensuring matters discussed meet the objectives as set out in these Terms of Reference.

7.5 Additional items for the agenda will be taken by exception with the knowledge and agreement of the Chair in advance of the meeting commencing.

7.6 Ratified minutes of the meeting will be circulated to all sub-groups for dissemination to their members.

7.7 There will be a standing agenda item at the end of each meeting to check the objectives have been met and review effectiveness of the discussions.

8. QUORACY

8.1 The quorum necessary for the transaction of business shall be [XX] members, to include [TBC].

8.2 A duly convened meeting of the Committee at which quorum is present at the meeting, or are contactable by video conference, is competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

8.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions requiring agreement by statutory bodies may be taken.

8.4 If any member of the Committee has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

9. BEHAVIOURS AND DECISION-MAKING

9.1 Behaviours

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

9.2 Decision-Making

9.2.1 Members are expected to act as facilitators, providing effective communication for the programme to engage their respective organisations in the developments; modelling collective leadership.

9.2.2 Members are expected to provide information as necessary to support the undertaking of accurate analysis to inform developments.

9.2.3 Voting

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

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

(c) Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be record in the minutes.

9.2.4 Urgent Decisions

(a) The Committee may be required to take urgent decisions. An urgent decision is one where the requirement for the decision to be made arises between the meetings of the Committee and in relation to which a decision must be made prior to the next scheduled meeting.

(b) Where an urgent decision is required a supporting paper will be circulated to all members. To reach a consensus view or make a decision the members may meet either in person, via video conference or communicate by email to take an urgent decision. The quorum, as described above, must be adhered to for urgent decisions.

(c) In such circumstances, a minute of the discussion and decision will be taken by the secretary and will be reported to the next meeting for formal ratification.

9.3 **Equality and Diversity**

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

10. SUB-COMMITTEES

10.1 The Committee may delegate responsibility for specific aspects of its duties to sub-committees or working groups. The Terms of Reference of each such sub-committee or working group shall be approved by the Committee and shall set out specific details of the areas of responsibility and authority.

10.2 Any sub-committees or working groups will report via their respective Chairs following each meeting or at an appropriate frequency as determined by the Committee.

11. INTERDEPENDENCIES WITH OTHER GROUPS

[Insert]

12. IDENTIFYING AND MANAGING RISKS

12.1 The Committee will help to identify concerns and risks, diagnose and develop actions/improvement plans to mitigate and respond to risks, and oversee implementation.

12.2 The Committee will receive and review those risks delegated to it consisting of the Assurance Framework, corporate risks and any other significant risks. These risks will be a standing agenda item of the sub-committee meetings at least quarterly and at every meeting if risks are escalating or of concern.

13. MANAGING CONFLICTS OF INTEREST

Members of the Committee shall adopt the following approach:

13.1.1 ensure that they continue to comply with relevant organisational policies/governance framework for probity and decision-making;

13.1.2 a register of interests will be recorded and maintained. This will be reviewed annually to ensure accuracy, in the intervening periods members should declare any unregistered interests pertinent to the agenda on an on-going basis. Members will be responsible for notifying of any changes to their respective declarations as and when they occur;

13.1.3 in advance of any meeting, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals;

13.1.4 the Chair will take overall responsibility for managing conflicts of interest pertinent to agenda items as they arise; any such declarations will be formally recorded in the minutes of the meeting;

13.1.5 the Chair will determine how declared interests should be managed, which is likely to involve one the following actions:

(a) requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the discussions;

(b) allowing the individual to participate in the discussion, but not the decision-making process;

(c) allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the decision-making arrangements.

14. SECRETARIAT AND ADMINISTRATION

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

14.1 the agenda and papers are prepared in accordance with the ICB's Corporate Governance Framework and distributed in accordance with the Standing Orders, having been agreed by the Chair with the support of the relevant executive lead;

14.2 attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;

14.3 records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;

14.4 good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept;

14.5 the Chair is supported to prepare and deliver reports to the Board;

14.6 the Committee is updated on pertinent issues/ areas of interest/ policy developments;

14.7 action points are taken forward between meetings and progress against those actions is monitored.

15. REVIEW

15.1 The Committee will review its effectiveness at least annually and complete an annual report submitted to the ICB Board.

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

Reviewed by [Committee Name]:	[Date]
Approved by [insert committee accountable to]:	[Date]
Review Date:	[Date]

APPENDIX 2 – NHS DERBY AND DERBYSHIRE ICB BOARD AGENDA TEMPLATE

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC AGENDA

[Date], [Time]

[Venue]

Please notify us in advance of your intention to join the meeting by emailing [insert enquiries email] by close of play [insert date of day before meeting]

Questions from members of the public should be emailed to [insert enquiries email] and a response will be provided within seven working days

This meeting will be recorded – please notify the Chair if you do not give consent

Time	Reference	Item	Presenter	Delivery
[xx:xx]	**Introductory Items**			
	ICB/2223/XX	Welcome, introductions and apologies	[Chair's Name]	Verbal
	ICB/2223/XX	Confirmation of quoracy	[Chair's Name]	Verbal
	ICB/2223/XX	Declarations of Interest • Register of Interests • Summary register for recording interests during the meeting • Glossary	[Chair's Name]	Paper
	ICB/2223/XX	Items Received from members of the public	[Chair's Name]	Verbal
[xx:xx]	**Strategy and Leadership**			
	ICB/2223/XX	Chair's Report	[Chair's Name]	Paper
	ICB/2223/XX	Chief Executive Officer's Report	[CEO Name]	Paper
[xx:xx]	**Items for Decision**			
	ICB/2223/XX	[Name of Report]	[Name]	
[xx:xx]	**Items for Discussion**			
	ICB/2223/XX	[Name of Report]	[Name]	

[xx:xx]	**Corporate Assurance**			
	ICB/2223/XX	[Name of Report]	[Name]	
[xx:xx]	**Items for Information**			
	The following items are for information and will not be individually presented			
	ICB/2223/XX	Ratified minutes of ICB Committee Meetings: •		Paper
[xx:xx]	**Minutes and Matters Arising**			
	ICB/2223/XX	Minutes from the meeting held on [Date]	[Chair's Name]	Paper
	ICB/2223/XX	Action Log from the meeting held on [Date]	[Chair's Name]	Paper
[xx:xx]	**Closing Items**			
	ICB/2223/XX	Forward Planner	[Chair's Name]	Paper
	ICB/2223/XX	Any Other Business	[Chair's Name]	Verbal
	ICB/2223/XX	Date and time of next meeting: Date: Time: Venue:	[Chair's Name]	Verbal

APPENDIX 3 – NHS DERBY AND DERBYSHIRE CONFIDENTIAL ICB BOARD AGENDA TEMPLATE

NHS DERBY AND DERBYSHIRE ICB BOARD

CONFIDENTIAL AGENDA

[Date], [Time]

[Venue]

This meeting will be recorded – please notify the Chair if you do not give consent

Time	Reference	Item	Presenter	Delivery
[xx:xx]	**Introductory Items**			
	ICBC/2223/XX	Welcome, introductions and apologies	[Chair's Name]	Verbal
	ICBC/2223/XX	Confirmation of quoracy	[Chair's Name]	Verbal
	ICBC/2223/XX	Declarations of Interest • Register of Interests • Summary register for recording interests during the meeting	[Chair's Name]	Paper
[xx:xx]	**Strategy and Leadership**			
	ICBC/2223/XX	[Name of Report]	[Name]	
[xx:xx]	**Items for Decision**			
	ICBC/2223/XX	[Name of Report]	[Name]	
[xx:xx]	**Items for Discussion**			
	ICBC/2223/XX	[Name of Report]	[Name]	
[xx:xx]	**Corporate Assurance**			
	ICBC/2223/XX	[Name of Report]	[Name]	
[xx:xx]	**Items for Information**			
	The following items are for information and will not be individually presented			
	ICBC/2223/XX	Ratified minutes of Confidential ICB Committee Meetings:		Paper

		•		
[xx:xx]	**Minutes and Matters Arising**			
	ICBC/2223/XX	Minutes from the meeting held on [Date]	[Chair's Name]	Paper
	ICBC/2223/XX	Action Log from the meeting held on [Date]	[Chair's Name]	Paper
[xx:xx]	**Closing Items**			
	ICBC/2223/XX	Forward Planner	[Chair's Name]	Paper
	ICBC/2223/XX	Any Other Business	[Chair's Name]	Verbal
	ICBC/2223/XX	Date and time of next meeting: Date: Time: Venue:	[Chair's Name]	Verbal

APPENDIX 4 – ICB CORPORATE COMMITTEE AGENDA TEMPLATE

NHS DERBY AND DERBYSHIRE INTEGRATED CARE BOARD

[NAME OF COMMITTEE] AGENDA

[Date], [Time]

[Venue]

This meeting will be recorded – please notify the Chair if you do not give consent

Time	Reference	Item	Presenter	Delivery
[xx:xx]	**Introductory Items**			
	[Initials of meeting/2223/XX]	Welcome, introductions and apologies	[Chair's Name]	Verbal
	[Initials of meeting/2223/XX]	Confirmation of quoracy	[Chair's Name]	Verbal
	[Initials of meeting/2223/XX]	Declarations of Interest • Register of Interests • Summary register for recording interests during the meeting	[Chair's Name]	Paper
[xx:xx]	**Items for Decision**			
	[Initials of meeting/2223/XX]	[Name of Report]	[Name]	
[xx:xx]	**Items for Discussion**			
	[Initials of meeting/2223/XX]	[Name of Report]	[Name]	
[xx:xx]	**Corporate Assurance**			
	[Initials of meeting/2223/XX]	[Name of Report]	[Name]	
[xx:xx]	**Items for Information**			
	The following items are for information and will not be individually presented			
	[Initials of meeting/2223/XX]	Ratified minutes of: •	[Name]	Paper
[xx:xx]	**Minutes and Matters Arising**			
	[Initials of meeting/2223/XX]	Minutes from the meeting held on [Date]	[Chair's Name]	Paper
	[Initials of meeting/2223/XX]	Action Log from the meeting held on [Date]	[Chair's Name]	Paper

[xx:xx]	Closing Items			
	[Initials of meeting/2223/XX]	Forward Planner	[Chair's Name]	Paper
	[Initials of meeting/2223/XX]	• Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? • Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? • Were papers that have already been reported on at another committee presented to you in a summary form? • Was the content of the papers suitable and appropriate for the public domain? • Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? • Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? • What recommendations do the Committee want to make to the ICB Board following the assurance process at today's Committee meeting?		
	[Initials of meeting/2223/XX]	Any Other Business	[Chair's Name]	Verbal
	[Initials of meeting/2223/XX]	Date and time of next meeting: Date: Time: Venue:	[Chair's Name]	Verbal

APPENDIX 5 – INTERNAL MEETING AGENDA TEMPLATE

NHS DERBY AND DERBYSHIRE INTEGRATED CARE BOARD

[NAME OF INTERNAL MEETING] AGENDA

[Date], [Time]

[Venue]

Time	Reference	Item	Presenter	Delivery
[xx:xx]	**Introductory Items**			
	[Initials of meeting/2223/XX]	Welcome, introductions and apologies	[Chair's Name]	Verbal
	[Initials of meeting/2223/XX]	Confirmation of quoracy	[Chair's Name]	Verbal
	[Initials of meeting/2223/XX]	Declarations of Interest • Register of Interests (if not applicable, please use the following definition: *Members are asked to declare any conflicts they have in regards to the agenda items today. A conflict of interest is defined as "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" (NHS England, 2017).*) • Summary register for recording interests during the meeting	[Chair's Name]	Paper
[xx:xx]	**Items for Decision**			
	[Initials of meeting/2223/XX]	[Name of Report]	[Name]	
[xx:xx]	**Items for Discussion**			
	[Initials of meeting/2223/XX]	[Name of Report]	[Name]	

[xx:xx]	**Items for Information**			
	The following items are for information and will not be individually presented			
	[Initials of meeting/2223/XX]		[Name]	Paper
[xx:xx]	**Minutes and Matters Arising**			
	[Initials of meeting/2223/XX]	Minutes from the meeting held on [Date]	[Chair's Name]	Paper
	[Initials of meeting/2223/XX]	Action Log from the meeting held on [Date]	[Chair's Name]	Paper
[xx:xx]	**Closing Items**			
	[Initials of meeting/2223/XX]	Forward Planner	[Chair's Name]	Paper
	[Initials of meeting/2223/XX]	Any Other Business	[Chair's Name]	Verbal
	[Initials of meeting/2223/XX]	Date and time of next meeting: Date: Time: Venue:	[Chair's Name]	Verbal

APPENDIX 6 – ICB BOARD COVER SHEET TEMPLATE

NHS DERBY AND DERBYSHIRE ICB BOARD

[DATE]

Item: [XX]

Report Title	[Insert title of report]							
Author	[Name, Job Title]							
Sponsor (Executive Director)	[Name, Job Title]							
Presenter	[Name, Job Title]							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☐
Appendices	[Please list all appendices and attachments to the report]							
Assurance Report Signed off by Chair	[Name, Job Title]/[Not Applicable]							
Which committee has the subject matter been through?	[Name of committee, date of meeting]							

Recommendations
The ICB Board are recommended to **[APPROVE/DISCUSS/NOTE/RATIFY/AGREE]** the [insert title of report].
Purpose
Background
Report Summary
Identification of Key Risks
Cross reference to risks within Board Assurance Framework or Risk Registers
Have any conflicts of interest been identified throughout the decision-making process?
Give details of any instances where staff have been conflicted, or where conflicts have been raised at meetings where the report has been discussed

Project Dependencies				
Completion of Impact Assessments				
Data Protection Impact Assessment	Yes ☐	No☐	N/A☐	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☐	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☐	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☐	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☐	No☐	N/A☐	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☐
A representative and supported workforce	☐	Inclusive leadership	☐

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?

When the ICB delivers their functions, the ICB must have due regard in:

- *eliminating unlawful discrimination*
- *advancing equality of opportunity between people who share a protected characteristic*
- *encouraging good relations between those who share a protected characteristic and those who do not*

Please discuss any implications or risks that have been identified in regard to these duties.

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings

APPENDIX 7 – CONFIDENTIAL ICB BOARD COVER SHEET TEMPLATE

NHS DERBY AND DERBYSHIRE ICB BOARD

CONFIDENTIAL SESSION

[DATE]

Item: [XX]

Report Title	[Insert title of report]							
Author	[Name, Job Title]							
Sponsor (Executive Director)	[Name, Job Title]							
Presenter	[Name, Job Title]							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☐
Appendices	[Please list all appendices and attachments to the report]							
Assurance Report Signed off by Chair	[Name, Job Title]/[Not Applicable]							
Which committee has the subject matter been through?	[Name of committee, date of meeting]							

Recommendations
The ICB Board are recommended to **[APPROVE/DISCUSS/NOTE/RATIFY/AGREE]** the [insert title of report].
Reason for inclusion in the confidential session
Please explain why this paper cannot be considered in the public session
Purpose
Background
Report Summary
Identification of Key Risks
Cross reference to risks within Board Assurance Framework or Risk Registers

Have any conflicts of interest been identified throughout the decision-making process?				
Give details of any instances where staff have been conflicted, or where conflicts have been raised at meetings where the report has been discussed				
Project Dependencies				
Completion of Impact Assessments				
Data Protection Impact Assessment	Yes ☐	No☐	N/A☐	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☐	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☐	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☐	**Risk Rating:**	**Summary:**
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable				
Yes ☐	No☐	N/A☐	**Summary:**	

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☐	Improved patient access and experience	☐
A representative and supported workforce	☐	Inclusive leadership	☐

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?					
When the ICB delivers their functions, the ICB must have due regard in: • *eliminating unlawful discrimination* • *advancing equality of opportunity between people who share a protected characteristic* • *encouraging good relations between those who share a protected characteristic and those who do not* *Please discuss any implications or risks that have been identified in regard to these duties.*					
When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Details/Findings					

APPENDIX 8 – COMMITTEE COVER SHEET TEMPLATE

[COMMITTEE NAME]

[DATE]

Item: [XX]

Report Title	[Insert title of report]							
Author	[Name, Job Title]							
Sponsor (Executive Director)	[Name, Job Title]							
Presenter	[Name, Job Title]							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☐
Appendices	[Please list all appendices and attachments to the report]							
Which committee has the subject matter been through?	[Name of committee, date of meeting]							

Recommendations
The [Committee name] are recommended to **[APPROVE/DISCUSS/NOTE/RATIFY/AGREE]** the [insert title of report].
Purpose
Background
Report Summary
Identification of Key Risks
Cross reference to risks within Board Assurance Framework or Risk Registers
Have any conflicts of interest been identified throughout the decision-making process?
Give details of any instances where staff have been conflicted, or where conflicts have been raised at meetings where the report has been discussed

Project Dependencies				
Completion of Impact Assessments				
Data Protection Impact Assessment	Yes ☐	No☐	N/A☐	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☐	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☐	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☐	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☐	No☐	N/A☐	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☐	Improved patient access and experience	☐
A representative and supported workforce	☐	Inclusive leadership	☐

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?

When the ICB delivers their functions, the ICB must have due regard in:

- *eliminating unlawful discrimination*
- *advancing equality of opportunity between people who share a protected characteristic*
- *encouraging good relations between those who share a protected characteristic and those who do not*

Please discuss any implications or risks that have been identified in regard to these duties.

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings

APPENDIX 9 – CONFIDENTIAL COMMITTEE COVER SHEET TEMPLATE

[COMMITTEE NAME]

CONFIDENTIAL SESSION

[DATE]

Item: [XX]

Report Title	[Insert title of report]							
Author	[Name, Job Title]							
Sponsor (Executive Director)	[Name, Job Title]							
Presenter	[Name, Job Title]							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☐
Appendices	[Please list all appendices and attachments to the report]							
Which committee has the subject matter been through?	[Name of committee, date of meeting]							

Recommendations
The [Committee name] are recommended to **[APPROVE/DISCUSS/NOTE/RATIFY/AGREE]** the [insert title of report].
Reason for inclusion in the confidential session
Please explain why this paper cannot be considered in the public session
Purpose
Background
Report Summary
Identification of Key Risks
Cross reference to risks within Board Assurance Framework or Risk Registers

Have any conflicts of interest been identified throughout the decision-making process?				
Give details of any instances where staff have been conflicted, or where conflicts have been raised at meetings where the report has been discussed				
Project Dependencies				
Completion of Impact Assessments				
Data Protection Impact Assessment	Yes ☐	No☐	N/A☐	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☐	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☐	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☐	**Risk Rating:**	**Summary:**
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable				
Yes ☐	No☐	N/A☐	**Summary:**	

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☐	Improved patient access and experience	☐
A representative and supported workforce	☐	Inclusive leadership	☐

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?					
When the ICB delivers their functions, the ICB must have due regard in: • *eliminating unlawful discrimination* • *advancing equality of opportunity between people who share a protected characteristic* • *encouraging good relations between those who share a protected characteristic and those who do not* *Please discuss any implications or risks that have been identified in regard to these duties.*					
When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Details/Findings					

APPENDIX 10 – BOARD ASSURANCE REPORT TEMPLATE

[COMMITTEE NAME]

[DATE]

Item: [XX]

Report Title	[Insert title of report]							
Author	[Name, Job Title]							
Sponsor (Executive Director)	[Name, Job Title]							
Presenter	[Name, Job Title]							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☐
Appendices	[Please list all appendices and attachments to the report]							
Assurance Report agreed by:	[Name of Chair and role]							

Recommendations
The Committee is requested to NOTE the Board Assurance Report for the minutes of the [meeting name].
Purpose
The Board Assurance Report is presented to inform of any decisions that have been made at [meeting name] or any ICB-specific items that were discussed or directly impact the ICB.
Report Summary
The following items were approved by the [meeting name]: • The implications of th[is][ese] decision[s] for the ICB are [financial/quality/other]. [Please insert details.] The following items were discussed, and should be noted by the Board: • The implications of th[is][ese] discussion[s] for the ICB are [financial/quality/other]. [Please insert details.]
Identification of Key Risks
Cross reference to risks within Board Assurance Framework or Risk Registers

Have any conflicts of interest been identified throughout the decision-making process?				
Give details of any instances where staff have been conflicted, or where conflicts have been raised at meetings where the report has been discussed				
Project Dependencies				
Completion of Impact Assessments				
Data Protection Impact Assessment	Yes ☐	No☐	N/A☐	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☐	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☐	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☐	**Risk Rating:**	**Summary:**
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable				
Yes ☐	No☐	N/A☐	**Summary:**	

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☐	Improved patient access and experience	☐
A representative and supported workforce	☐	Inclusive leadership	☐

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?

When the ICB delivers their functions, the ICB must have due regard in:

- *eliminating unlawful discrimination*
- *advancing equality of opportunity between people who share a protected characteristic*
- *encouraging good relations between those who share a protected characteristic and those who do not*

Please discuss any implications or risks that have been identified in regard to these duties.

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings

APPENDIX 11 – MINUTES TEMPLATE

MINUTES OF THE [COMMITTEE NAME] HELD ON [DATE] [VENUE NAME] AT [TIME]

[All names should be presented alphabetically by surname after the Chair]

Present: *[Those who are in attendance and a part of the Committee's membership)*		
[Chair Name]	[Initials]	[Job Title] (Chair)
[Name]	[Initials]	[Job Title]
In Attendance: *[(Those who are in attendance and not a part of the Committee's membership]*		
[Name]	[Initials]	[Job Title]
Apologies:		
[Name]	[Initials]	[Job Title]

Item No.	Item	Action
[Initials of meeting/2122 /XX]	**Welcome, introductions and apologies**	
[Initials of meeting/2122 /XX]	**Confirmation of quoracy**	
[Initials of meeting/2122 /XX]	**Declarations of Interest** [Chair] reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the ICB. Declarations declared by members of the [name of committee] are listed in the ICB's Register of Interests and included with the meeting papers. The Register is also available either via the Executive Assistant to the Board or the ICB website at the following link: [TBC] <u>Declarations of interest from sub-committees</u> No declarations of interest were made. *[If declared, a register will be included in the papers to show who declared an interest, at what meeting and for which item]* <u>Declarations of interest from today's meeting</u> No declarations of interest were made. OR The following update was received at the meeting: With reference to business to be discussed at this meeting, [name of individual] declared that he/she has an interest in Item [XX]. This was due to [include details of why they are conflicted].	

	It was agreed that [name of individual] would not be included in any discussions on agenda item [X] due to a direct conflict of interest. OR [Chair] and [name of individual] discussed the conflict of interest, which is recorded on the register of interest, before the meeting and [name of individual] agreed to remove [himself/herself] from the table and not be involved in the discussion around agenda item [X]. OR It was agreed that this item was for information purposes only and therefore [name of individual] would remain in the meeting.	
FOR DECISION		
[Initials of meeting/2122 /XX]	**[Title of item]** Due to a conflict of interest, [name of individual] left the meeting, excluding [himself/herself] from the discussion regarding [X]. **The [COMMITTEE NAME] APPROVED the [AGENDA ITEM X].**	
	[Name of individual] was brought back into the meeting.	
FOR DISCUSSION		
[Initials of meeting/2122 /XX]		
FOR CORPORATE ASSURANCE		
[Initials of meeting/2122 /XX]		
FOR INFORMATION		
[Initials of meeting/2122 /XX]		
[Initials of meeting/2122 /XX]	**ANY OTHER BUSINESS** [No other business was raised].	
MINUTES AND MATTERS ARISING		
[Initials of meeting/2122 /XX]	**Minutes from the meeting held on [Date]** The minutes from the meeting held on [date] were agreed as a true and accurate record.	
[Initials of meeting/2122 /XX]	**Action Log from the meeting held on [Date]** The action log was reviewed.	
DATE AND TIME OF NEXT MEETING		
Date: [Date]		
Time: [Time]		
Venue: [Venue]		

APPENDIX 12 – [NAME OF COMMITTEE] MATTERS ARISING ACTIONS LOG TEMPLATE [FINANCIAL YEAR]

Item No.	Item Title	Lead	Action Required	Action Implemented	Due Date

APPENDIX 13 – SIGNING IN SHEET TEMPLATE

Meeting:
Time/Date:
Venue:

Name	Title	Organisation	Signature

APPENDIX 14 – POSTER FOR TABLE VOICE RECORDING

Voice Recording (Dictaphone) is used in this meeting

The ICB has authorised voice recording for this meeting.

If you object to this being undertaken please inform the Chair prior to the commencement of the meeting.

The ICB have authorised the use of dictaphone/cassette equipment in this meeting. The purpose of this recording is as an administrative tool in support of the provision of clear and accurate minute taking.

The voice recording is not encrypted. A Standard Operating Procedure (SOP) is in place for the secure management of these recordings. The recording is retained for the period of drafting the minutes (normally a few days) and then subsequently deleted.

If you have any queries regarding the processing of information in this way please contact:

Contact: Ruth Lloyd, Information Standards Lead
Tel: 07825 063164

Email: ruth.lloyd6@nhs.net or [include IG Team email]

APPENDIX 15 – MEETING ETIQUETTE

Meeting etiquette is important as it provides a basis of trust, respect and honesty for the ICB. The following should be adhered to by all ICB staff, Board and Committee members at all meetings, Sub-Committees, Committees and Boards:

SHOWING A COMMITMENT TO ATTEND

- Arrive at least 15 minutes before the scheduled start of the meeting and take the opportunity to talk informally to colleagues and visitors. If someone is unavoidably late, they will phone to let the Chair or Accountable Officer know their expected time of arrival
- Members of committees are expected to attend at least 80% of the meetings unless there are exceptional reasons why they cannot
- Phones will be kept on silent for the duration of the meeting
- Laptops and tablets will only be utilised to access papers and supplementary information relevant to the meeting

BEING WELL PREPARED

- Agendas will be agreed in reasonable time before the meeting by the relevant Executive(s)/Director(s) of that meeting. Once agendas are agreed, additional items should not be added
- Actions will be reviewed prior to meetings by the responsible action owner and an update should be provided on the action log for distribution with papers
- Cover sheets, reports and papers will be presented using the agreed templates found in the Corporate Governance Framework
- Reports will be approved in a timely manner (seven working days) by the relevant Executive Director or Senior Manager prior to inclusion within the papers
- Reports that miss the agreed deadline will be deferred until the next meeting, unless exceptional circumstances apply
- The use of acronyms will be avoided (if used, they will be spelt out in full on the first occasion)
- Papers will be read by all members of the committee prior to the meeting to ensure all items have been considered in their entirety to facilitate discussion and ample debate
- No reports will be tabled on the day of the meeting, as this does not allow for the members to review the item comprehensively
- Reports will be presented succinctly and taken as ‘read’ at the meeting – giving context and key points only. If other members of staff are presenting, the responsible Executive/Director/Senior Manager will brief them on the need for brevity

- Meetings should last for no more than three hours. The chair and members of the committee must be mindful of the need for the minute taker to take a break if required.

ENCOURAGING DEBATE

- Everyone has the right to:
    - contribute to meeting discussions, to ensure the best decisions can be taken. Contributions will be concise and only substantive issues will be raised;
    - challenge each other, respectfully and genuinely; and
    - have their views treated with equal value, and any questioning will not be attacking or dismissive.
- Authors of reports will be alerted if their paper poses particularly challenging questions or where more information is needed
- Any questions that arise in the meeting (but which cannot be answered immediately will be answered in full to members either by email after the meeting, or as a matter arising at the next meeting

MAINTAINING CONFIDENTIALITY AND CORPORATE RESPONSIBILITY

- Adhere to the NHS Code of Conduct and Accountability
- Comply with the ICB's Constitution and Standards of Business Conduct and Managing Conflicts of Interest Policy
- Accept the principle of corporate responsibility
- Treat all issues on confidential agendas sensitively, unless agreed otherwise

REVIEWING PERFORMANCE

- At the end of each meeting, members will review whether they feel assured by the information they received, and whether anything should be escalated to the ICB Board or another committee.
- Each year all committees should provide an Annual Report to the ICB Board which summaries the key discussions and decisions made throughout the year. It will also include attendance, membership, quoracy and a review of the committee's effectiveness.

APPENDIX 16 – VIRTUAL ONLINE MICROSOFT TEAMS MEETING ETIQUETTE

The ICB is recording and publishing each ICB Board meeting.

The recording will be for the Public session of the ICB Board only and will be published to the ICB website and to YouTube. There will be no editing, removal, suspension or amendment possible for these recordings, therefore the behaviour of all included in this meeting must be considered and our high standards maintained.

Below are some points to consider where the ICB have employed Microsoft Teams as the solution for online virtual meetings:

Before the meeting:	
Remember you are going to be recorded and that recordings are available to all attendees	It will not be possible to edit or otherwise change any statements made or actions taken within the recording. Recordings of the meeting are automatically linked to the chat function and available to all attendees. It is important to note that this un-edited version is available even where an individual may have left the meeting because of a conflict of interest and should not be privy to certain information.
Use a headset with mic if possible	This provides the optimal audio experience for both you and other meeting attendees. If a headset isn't available, use your device's built-in audio/mic.
Avoid sitting with your back to a window or bright light source	This causes a silhouette appearance where others cannot see you or determine your identity.
Think about the background	ICB Board members are to have cameras off and mic's muted unless they are speaking. When your camera is on, the use of the *blur my background* feature in MS Teams, or a photograph background is recommended.
Close doors to avoid unexpected visitors	As we are working at home, others may pass by or inadvertently interrupt, and should the content of the meeting be confidential, cause a possible breach.
Join a few minutes early if possible.	This allows you to make sure everything is working and gives time to make any adjustments / check the screen setting etc.

It you have any technical issues (broadband speed) choose audio participation only	Do turn off your video and only use audio if you have poor broadband coverage (audio only requires less broadband capacity but still allows you to participate in the video conference).
Mute other devices and apps	Make sure to mute all other devices and close any other apps on your computer/laptop that might sound notifications or calls.
During the meeting:	
Enter muted	Enter any meeting with your mic muted and camera off. Others might already be engaged in conversation.
Have a moderator or convener for large meetings	During the meeting, the Chair will be supported by a nominated individual to monitor the 'chat' function. For the ICB Board this is shared between the Chair and the Chief Officer. The requirement is to put an asterisk in the chat box, to enable the meeting members to provide a verbal update as required.
Support the Chair of the meeting	Ensure that when you want to speak, you ask within the chat box by including an asterisk.
Keep your mic muted	Most important: Keep your mic muted unless you need to speak or are leading the meeting. If your audio becomes distracting, anyone in the meeting can mute any attendee. You will need to un-mute yourself to begin speaking when needed.
Unmute when you wish to talk	If you have muted your mic and need to speak, you must unmute before you start speaking.
Avoid talking over others	Unlike an in-person meeting, it's sometimes difficult to distinguish between multiple conversations leading to confusion.
Be clear, concise	Speak in a concise and clear manner and tone so that everyone can hear what you are saying – remembering that this is a recorded session.

Pause	Remember to pause occasionally to ensure attendees have time to ask questions.
Camera use	Using (or not using) your camera is your choice. Within the call, windows will show for attendees of the meeting. These automatically show/hide based on participation. Be sure to pause/turn off your camera. Don't walk around with your camera on (mobile device).
Use chat window	Consider, especially for large meetings, asking your questions in the chat window. Any conversations held within the chat box are not to be recorded within the minutes of a meeting.
Use the 'Raise Your Hand' function	As an easy way to ensure that participants can contribute to discussions without talking over each other.
If you are not the meeting administrator, do not invite others into the meeting	Should any additional participants be required, ensure that all members of the meeting understand who is present.
Don't take other calls during the meeting.	Being 'muted' doesn't mean that you are not required to be present in the meeting.
The confidential session, remains the confidential session	Be mindful that the content of the confidential session must remain confidential – please consider your working environment and who may be able to overhear the conversations.
At the close of the meeting:	
Ensure you close the call by clicking the red 'end call' button.	This way you will ensure that you are not being subject to any further recording.

Further guidance on the practical use of 'teams' can be found here:

https://www.avepoint.com/ebook/microsoft-teams-best-practices

10. STANDARDS OF BUSINESS CONDUCT POLICY

NHS Derby and Derbyshire Integrated Care Board

Standards of Business Conduct Policy

KEY MESSAGES	
1.	Outlines the standards of business conduct to be followed by all employees of the ICB.
2.	Ensures that the interests of patients and public funds are put first.
3.	Everything done by those who work in the ICB must be able to stand the test of parliamentary scrutiny, public judgments on propriety and professional codes of conduct.

VERSION CONTROL

Title:	NHS Derby and Derbyshire Integrated Care Board Standards of Business Conduct Policy v0.1
Supersedes:	Standards of Business Conduct and Managing Conflicts of Interest Policy for NHS Derby and Derbyshire CCG
Description of Amendment(s):	Initial draft
Financial Implications:	Not applicable
Policy Area:	Corporate Delivery
Version No:	Version 0.1
Author:	Frances Palmer, Corporate Governance Manager
Approved by:	Audit and Governance Committee, TBC
Effective Date:	July 2022
Review Date:	June 2024
List of Referenced Policies	See section 14
Key Words section (metadata for search facility online)	Standards of Business Conduct Fraud, Bribery and Corruption Conflicts of Interest Gifts, Hospitality, Sponsorship and Events Private Transactions Private Use of Equipment and Materials; Contract Secondary Employment Favouritism Relatives of Directors or Officers Raising a concern
Reference Number	CD25
Target Audience	ICB approved policies apply to all employees, contractors, volunteers, and others working with the ICB in any capacity. Compliance with ICB policy is a formal contractual requirement and failure to comply with the policy, including any arrangements which are put in place under it, will be investigated and may lead to disciplinary action being taken.

CONTENTS

1. INTRODUCTION

1.1 It is a long established principle that all public sector bodies including the NHS must be impartial and honest in the conduct of their business and that their employees should remain beyond suspicion of fraud and corruption. All corrupt business activity is therefore contrary to the NHS Derby and Derbyshire Integrated Care Board (the "ICB") values and will not be tolerated. Moreover, since the NHS is publicly funded, the ICB must be accountable to NHS England and NHS Improvement (NHSEI) for the services it provides and for the effective and economical use of taxpayers' money.

1.2 This policy is based on the standards set out in the 'Nolan Principles on Conduct in Public Life'. It should be read in conjunction with the ICB's Constitution and Standing Orders, and must be regarded as an integral part of the ICB's Standing Financial Instructions. The provisions of these must be observed at all times.

2. PURPOSE

The purpose of this policy is to ensure that the overall business interests of the ICB, and thereby the best interests of patients, are not prejudiced by individual employees' personal interests. This policy outlines the standards of business conduct to be followed by all employees of the ICB and provides specific guidance in respect of those areas of activity where there might be particular concerns.

3. SCOPE

3.1 This policy is mandatory and applies to all employees (permanent, seconded, contractors, management and clinical trainees, apprentices, temporary staff and volunteers) of the ICB, including ICB Board and Committee members. It also applies to ICB employed staff who carry out work within another organisation's premises. These are collectively referred to as 'individuals' hereafter. Compliance with ICB policy is a formal contractual requirement.

3.2 The guiding principles within paragraph 8 of this policy comprise:

3.2.1 gifts, hospitality, sponsored events and sponsorship;

3.2.2 conflicts of interest;

3.2.3 procurement;

3.2.4 contracting;

3.2.5 secondary employment;

3.2.6 preferential treatment in private transactions;

3.2.7 private use of equipment and materials; and

3.2.8 relatives of directors or officers.

3.3 In all these areas the guiding principles are to ensure that the interests of patients and public funds are put first. Individuals should seek advice from their Line Manager if they are in any doubt about a particular situation.

3.4 In the event of an infection outbreak, pandemic or major incident, the ICB recognises that it may not be possible to adhere to all aspects of this document. In such circumstances, individuals should take advice from their Line Manager.

4. DEFINITIONS

"Bribery"

means giving or receiving a financial or other advantage in connection with the "improper performance" of a position of trust, or a function that is expected to be performed impartially or in good faith;

"Conflict of Interest"

is defined as “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” (NHS England, 2017).

"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;

“Procurement”

means the process of finding and agreeing to terms, and acquiring goods, services, or works from an external source, often via a tendering or competitive bidding process;

5. LEGISLATION

5.1 Bribery Act 2010

5.1.1 The Bribery Act 2010 replaced fragmented and complex offences at common law and in the Prevention and Corruption Acts 1889–1916. The Act creates five basic offences:

(a) bribing another person with the intention of inducing that person to perform a relevant function or activity improperly or to reward that person for doing so;

(b) accepting a bribe with the intention that a relevant function or activity should be performed improperly as a result;

(c) bribing a foreign public official;

(d) a director, manager or officer of a commercial organisation allowing or turning a blind eye to bribery within the organisation; and

(e) failing to prevent bribery – where a person (including employees, agents and external third parties) associated with a relevant commercial organisation bribes another person intending to obtain or retain a business advantage. This is a strict liability offence which can be committed by the organisation unless it can show in it its defence that it had adequate procedures in place to prevent bribery.

5.1.2 Anyone working within a healthcare organisation (including the private sector) can be prosecuted for taking or offering a bribe. There is no maximum level of fine that can be imposed and anyone convicted of an offence could be imprisoned for up to 10 years.

5.1.3 All individuals should be aware, therefore, that breaking the provisions of the Act renders them liable to prosecution and may also lead to termination of their employment and loss of NHS pension rights. Appendix 1 provides a summary of the key issues to be considered by all individuals.

5.1.4 Individuals may report any concerns or allegations in complete confidence in line with the provisions of the ICB's Raising Concerns at Work (Whistleblowing) Policy, through the ICB's Local Counter Fraud Specialist on [insert telephone number] or [insert email]. Alternatively individuals can report their suspicions to the Executive Director of Finance, Conflicts of Interest Guardian, Freedom to Speak Up Guardian and Ambassadors, or to the NHS Counter Fraud Authority on the Fraud and Corruption reporting line: 0800 028 40 60 or online at www.cfa.nhs.uk/reportfraud. All reports are treated with complete confidence and individuals are protected under the Public Interest Disclosure Act 1998.

6. PUBLIC SERVICE VALUES

The NHS Code of Conduct[1] defines three crucial public service values which must underpin the work of the Health Service, namely:

6.1 Accountability

Everything done by those who work in the NHS must be able to stand the test of parliamentary scrutiny, public judgments on propriety and professional codes of conduct.

[1] NHS Code of Conduct: Code of Accountability in the NHS: Appointments Commission/Department of Health – 2nd Rev: 2004 https://www.nhsbsa.nhs.uk/sites/default/files/2017-02/Sect_1_-_D_-_Codes_of_Conduct_Acc.pdf

6.2 **Probity**

Individuals should have an absolute standard of honesty in dealing with the assets of the NHS; integrity should be the hallmark of all personal and professional conduct in decisions affecting patients, colleagues and suppliers and in the use of information acquired in the course of NHS duties.

6.3 **Openness**

There should be sufficient transparency about NHS activities to promote confidence between individuals, patients and the public.

7. RESPONSIBILITIES/ACCOUNTABILITIES

7.1 **Chief Executive Officer**

The Chief Executive Officer:

7.1.1 is the ICB's designated 'Accountable Officer' and has overall responsibility for ensuring the ICB operates efficiently, economically and with probity;

7.1.2 has overall responsibility for ensuring that the ICB has effective Standing Orders and Standing Financial Instructions and that these are made available to all individuals that require them; and

7.1.3 has overall responsibility for the implementation and operation of this policy.

7.2 **Executive Director of Corporate Affairs**

The Executive Director of Corporate Affairs will ensure that the:

7.2.1 registers of interests, including declarations of interests; gifts, hospitality, sponsored events and sponsorship; and procurement are kept and maintained by the ICB. Information contained within these registers is also available to interested parties of the general public and to the ICB's auditors (both internal and external) and Counter Fraud function;

7.2.2 contracts of employment for all new employees contain the guidance given at Appendix 1 of the policy. In addition, the contract shall contain a clause stating that failure to declare an interest may result in disciplinary action or criminal prosecution; and

7.2.3 the ICB's Functions and Decisions map, found in the ICB Constitution, is maintained and kept up to date by the [Corporate Delivery Team] and finance colleagues.

7.3 **Executive Director of Finance**

The Executive Director of Finance will ensure that appropriate financial procedures are written and distributed to all individuals that require them to perform their financial duties.

7.4 **Audit and Governance Committee**

The Audit and Governance Committee will review key areas of risk and will investigate thoroughly when indications of fraud or corruption are found, with support from the Counter Fraud Specialist.

7.5 **Directors and Managers**

7.5.1 All ICB Directors and Managers are responsible for assisting individuals in complying with this policy by ensuring:

(a) a copy of this policy, Standing Financial Instructions and the ICB Functions and Decisions Map are available to all individuals;

(b) that where a conflict of interest is made known to the manager, or where the manager has a conflict of interest, precise details of such interests are recorded in writing on the Declaration of Interests Form and sent to the Corporate Governance Manager for entry in the ICB's register of interests;

(c) when gifts, hospitality, sponsored events and sponsorship is accepted or declined a gifts and hospitality form (including sponsorship and events) is completed and sent to the Corporate Governance Manager for entry in the ICB's relevant register;

(d) that where attempts to compromise individuals have been made by external agencies, the facts are reported to the Executive Director of Finance, who will arrange for appropriate action to be taken;

(e) compliance with the NHS Procurement, Patient Choice and Competition Regulations 2013 (No. 2) and the ICB's Procurement Policy; where they or any individual is in contact with suppliers and contractors, including external consultants. Areas of particular concern relate to those individuals who are authorised to sign purchase orders, place contracts for goods or services and key decision makers/stakeholders in procurements and tenders.

7.5.2 Work to counter fraud, bribery and corruption is a core management responsibility which is contracted to the ICB's Counter Fraud function overseen by the Executive Director of Finance and NHS Counter Fraud Authority, which will be reflected in job descriptions and through the appraisal process.

7.6 **All ICB Employees**

7.6.1 All ICB employees must read and comply with the Summary of Staff Responsibilities Relating to Standards of Business Conduct (Appendix 1). In particular, individuals are expected to:

(a) ensure that the interests of patients remain paramount at all times;

(b) be impartial and honest in the conduct of their official business;

(c) use public funds entrusted to them to the best advantage of the service, always ensuring efficiency, economy and effectiveness;

(d) declare interests on an annual basis or whenever their circumstances change.

7.6.2 Individuals must not:

(a) abuse their official position for personal gain or to benefit their family or friends; and

(b) seek to advantage or further private business or other interests in the course of their official duties.

7.6.3 Any employee who breaches this policy may face disciplinary action, which could result in dismissal for gross misconduct. The ICB reserves the right to terminate its contractual relationship with other workers not directly employed by the ICB but contracted to a third party, if they breach this policy. Any breach of this policy may also affect individual professional registration.

7.6.4 All ICB employees must also comply with the Seven Principles of Public Life promulgated by the Nolan Committee, which include:

(a) **Selflessness** – individuals should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends;

(b) **Integrity** – individuals should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties;

(c) **Objectivity** – in carrying out public business, including making public appointments, awarding contracts, or recommending Individuals for rewards and benefits, ICB employees should make choices on merit;

(d) **Accountability** – individuals are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office;

(e) **Openness** – individuals should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands;

(f) **Honesty** – individuals have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest; and

(g) **Leadership** – individuals should promote and support these principles by leadership and example.

8. IMPLEMENTING THE GUIDING PRINCIPLES

8.1 Gifts, hospitality, sponsored events and sponsorship

8.1.1 Gifts

(a) *Overarching Principles*

(i) Gifts should not be accepted that may affect, or be seen to affect their professional judgement. This overarching principle should apply in all circumstances; and

(ii) any monetary gift or cash equivalents (e.g. vouchers, tokens, offers of remuneration to attend meetings whilst in a capacity working for or representing the ICB) must always be declined, whatever their value and whatever their source, and the offer which has been declined must be declared to the Corporate Governance Manager, who has designated responsibility for maintaining the register of gifts and hospitality and recorded on the register.

(b) *Gifts from suppliers or contractors*

All gifts of any nature offered to individuals by suppliers or contractors doing business (or likely to do business) with the ICB or GP Practice should be declined, whatever their value (subject to this, low cost branded promotional aids may be accepted and not declared where they are under the value of a common industry standard of £6). The Individual to whom the gifts were offered should also declare the offer to the Corporate Governance Manager so the offer which has been declined can be recorded on the register.

(c) *Gifts from GP practices*

For teams within the ICB who work closely with GP practices, any gifts received of little financial value (i.e. less than £50) such as flowers, refreshments and small tokens of appreciation can be accepted, but must be declared.

(d) *Gifts from other sources*

(i) Gifts offered from other sources should also be declined if accepting them might give rise to perceptions of bias or favouritism, and a common sense approach should be adopted as to whether or not this is the case. The only exceptions to the presumption to decline gifts relates to items of little financial value (i.e. less than £50) such as diaries, calendars, stationery and other gifts acquired from meetings, events or conferences, and items such as flowers and small tokens of appreciation from members of the public to individuals for work well done. Gifts of this nature may be accepted and do not need to be declared, nor recorded on the register.

(ii) Gifts valued at over £50 should be treated with caution and only be accepted on behalf of the ICB, not in a personal capacity. These should be declared.

(iii) 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).

(iv) Multiple gifts from the same source over a 12 month period should be treated in the same way as single gifts over £50, where the cumulative value exceeds £50.

8.1.2 Hospitality

(a) *Overarching principles*

(i) Individuals should not ask for or accept hospitality that may affect, or be seen to affect, their personal judgement.

(ii) A blanket ban on accepting or providing hospitality is neither practical nor desirable from a business point of view. However, Individuals should be able to demonstrate that the acceptance or provision of hospitality would benefit the NHS or ICB.

(iii) Modest hospitality 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.

(iv) When hospitality is offered by actual or potential suppliers or contractors, these can be accepted if modest and reasonable, but Individuals should always obtain senior approval and declare these.

(b) *Meals and refreshments*

(i) Under a value of £25 may be accepted and need not be declared.

(ii) Of a value between £25 and £75 may be accepted and must be declared.

(iii) Over a value of £75 should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on the Gifts and Hospitality Register as to why it was permissible to accept.

A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).

(c) *Travel and accommodation*

(i) Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared.

(ii) Offers which go beyond modest, or are of a type that the ICB itself might not usually offer, need approval by senior members of the ICB, should only be accepted in exceptional circumstances and must be declared. A clear reason should be recorded on the Gifts and Hospitality Register as to why it was permissible to accept travel and accommodation of this type.

8.1.3 Sponsored events

(a) Sponsorship of NHS events by external parties is valued. Offers to meet some or part of the costs of running an event secures the ICB's ability to take place, benefiting individuals and patients. However, there is potential for conflicts of interest between the ICB and sponsor, particularly regarding the ability to market commercial products or services.

(b) When sponsorships are offered, the following principles must be adhered to:

(i) 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;

(ii) during dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation;

(iii) no information should be supplied to the sponsor from which they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied;

(iv) 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;

(v) the involvement of a sponsor in an event should always be clearly identified in the interest of transparency;

(vi) 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; and

(vii) Individuals should declare their involvement with arranging sponsored events for the ICB.

8.1.4 Other forms of sponsorship

Organisations external to the ICB may also sponsor posts or research. 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, or if sponsored posts cause a conflict of interest between the aims of the sponsor and the aims of the organisation, particularly in relation to procurement and competition.

8.1.5 Management of Gifts & Hospitality

Gifts, Hospitality, Events and Sponsorship will be declared using a Gifts and Hospitality Form, which can be found on the ICB's intranet. Upon receipt of these forms, the ICB will maintain a Gifts and Hospitality Register, which will be published on the ICB's website. Please see the ICB's Gifts and Hospitality Policy for more details.

8.2 Conflicts of Interest

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 and new care models, as individuals may here find themselves in a position of being both commissioner and provider of services. Conflicts of interest can arise throughout the whole commissioning cycle from needs assessment, to procurement exercises, to contract monitoring.

8.2.1 Types of interests

Interests can be captured in four different categories:

(a) financial interests;

(b) non-financial professional interests;

(c) non-financial personal interests;

(d) indirect interests.

Please see the ICB's Managing Conflicts of Interest Policy for more details on the types of interests above.

8.2.2 Managing a conflict of interest

(a) The ICB will make arrangements to ensure conflicts of interests are declared as soon as possible, and in any event within 28 days. The Declarations of Interest Form is available on the ICB's intranet. Upon receipt of these forms, the ICB will update and maintain a declarations of interests register, which will be published on the ICB's website.

(b) Other opportunities to make declarations include:

(i) on appointment, of which they must complete and return their form within 28 days of starting their new role;

(ii) six-monthly;

(iii) at meetings;

(iv) on changing role, responsibility or circumstances.

(c) Further, it should be noted that:

(i) the possibility of the perception of wrongdoing, impaired judgement or undue influence shall also be considered a conflict of interest for the purposes of this policy and should be declared and managed accordingly;

(ii) where there is doubt as to whether a conflict of interest exists, it should be assumed that there is a conflict of interest and declared and managed accordingly; and

(iii) for a conflict to exist, financial gain is not necessary.

(d) Where an Individual has any queries with respect to conflicts of interest they should seek advice from the [Head of Governance] or [Corporate Governance Manager].

8.3 **Procurement**

8.3.1 Fair and open competition between prospective contractors or suppliers for ICB contracts is a requirement of the ICB Standing Orders and ICB Procurement Policy. This means that:

(a) no private, public or voluntary organisation or company which may bid for ICB business should be given any advantage over its competitors, such as advance notice of ICB requirements. This applies to all potential contractors, whether or not there is a relationship between them and the ICB, such as a long-running series of previous contracts;

(b) each new contract should be awarded solely on merit, taking into account the requirements of the ICB and the ability of the contractors to fulfil them.

8.3.2 To ensure the ICB commissions services fairly and transparently it complies with all procurement and competition law. The duty to treat all potential providers equally. This could include engagement with providers on service design to ensure service specifications have not been designed to exclude certain providers and the deadline for tender submissions has not been set to favour certain providers.

8.3.3 the ICB will ensure that no special favour is shown to current or former employees or their close relatives or associates in awarding contracts to private or other

businesses run by them or employing them in a senior or relevant managerial capacity. Contracts may be awarded to such businesses where they are won in fair competition against other tenders, but scrupulous care must be taken to ensure that the selection process is conducted impartially, and that individuals who are known to have a relevant interest play no part in the selection.

8.4 Contracting

Individuals who are in contact with suppliers and contractors, especially those who are authorised to sign purchase orders or procure contracts for goods materials or services, must adhere to the ICB's Scheme of Reservations and Delegation, and Standing Financial Instructions.

8.5 Secondary Employment

8.5.1 Individuals should not engage in any secondary employment which could have a bearing on their ability to perform their normal contractual obligations or which may involve the use of any confidential or commercial information obtained in the course of their employment with the ICB.

8.5.2 This does not mean that individuals cannot work outside the ICB, but anyone who thinks that they are risking a conflict of interest in this area should inform their line manager in writing. Secondary employment should only ever be undertaken in line with the provisions of the ICB's Secondary Employment Policy.

8.5.3 Individuals must not engage in any secondary employment during periods of sickness absence from the ICB whether self-certified or covered by a Doctors fit note. Failure to comply with these requirements could lead to disciplinary action or criminal prosecution. Please see the ICB's Your Attendance Matters Policy for full details.

8.6 Preferential Treatment in Private Transactions

Individuals must not seek out or accept preferential rates, or benefits in kind, for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of the ICB.

8.7 Private Use of Equipment and Materials

Individuals must obtain prior permission from their line manager before making private use of the ICB's ICT equipment, telephones, photocopy facilities or any other ICB equipment and materials.

8.8 Relatives of Directors or Officers

8.8.1 Candidates for any appointment shall, when making application, disclose in writing whether they are related to any director or the holder of any office under the ICB. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him/her liable to instant dismissal. Similarly, recruiting managers shall disclose any relationship with a candidate to HR.

8.8.2 Senior Managers and Executive Directors shall disclose any relationship with a candidate and it shall be the duty of the Chief Executive Officer to report to the ICB Board any such disclosure.

8.8.3 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the ICB whether they are related to any other Director. Where the relationship of an officer or another Director to a Director of the ICB is disclosed, the ICB's Close Personal Relationships Policy shall apply.

9. CONFIDENTIALITY

9.1 As a public body, the ICB recognises the need for openness. However, this should not be confused with a breach of confidentiality and all ICB employees have a duty to maintain confidentiality of information at all times. A breach of confidentiality is a potentially serious disciplinary offence that could result in dismissal.

9.2 Individuals should be particularly careful of using, or making public, confidential internal information of a commercial nature, regardless of whether or not disclosure is prompted by the expectation of personal gain.

9.3 If there is in any doubt about any information that can be made publicly available advice should be sought from the employee's line manager.

10. RAISING CONCERNS

10.1 The ICB takes any wrongdoing in the workplace very seriously. If, at any time, employees know of, or suspect, any wrong-doing in the workplace they must report the matter immediately to the relevant individuals referenced in paragraph 5.1.4 so that the ICB can take steps to deal with it appropriately. If an employee has a genuine concern they should report it straight away.

10.2 The ICB is aware that employees may not want to come forward with their concerns because they feel that speaking out would be disloyal to their colleagues. They may also be worried that they will be victimised or harassed or penalised in some other way. They may be tempted to ignore their concerns rather than report something that may only be a suspicion. The ICB has therefore drawn up a Raising Concerns at Work (Whistleblowing) Policy, which can be found on the ICB's intranet.

10.3 Concerns may also be raised with the ICB's Freedom to Speak Up Ambassadors or the Freedom to Speak Up Guardian, the Non-Executive Member for Audit and Governance. The purpose of this important role is to act as an independent and impartial source of advice to staff at any stage of raising a concern. Freedom to Speak Up Ambassadors are ICB employees who support the Freedom to Speak Up Guardian in their role to listen to staff and signpost to appropriate support and advice at any stage of raising a concern.

10.4 Of course, the ICB also wants to make it clear that, while the ICB will provide safeguards for employees when they raise genuine concerns, any spurious or vexatious allegations, particularly where they cause difficulties for innocent

colleagues, may lead to disciplinary action being taken against them in line with the ICB's Disciplinary Policy.

11. POLICY MONITORING AND REVIEW

This policy will be monitored and subject to review no later than two years from the date of the last review or in the event of further legislation or national guidance issued.

12. EQUALITY STATEMENT

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

12.2 In carrying out its function, the ICB must have due regard to the PSED. This applies to all activities for which the ICB is responsible, including policy development, review and implementation.

13. DUE REGARD

This policy has been reviewed in relation to having due regard to the PSED of the Equality Act 2010 to eliminate discrimination; harassment; victimisation; to advance equality of opportunity; and foster good relations between the protected groups.

14. REFERENCES

This policy should be read in conjunction with the following ICB documentation:

- Constitution
- Standing Financial Instruction
- Standing Orders
- Fraud, Corruption and Bribery Policy
- Gifts and Hospitality Policy
- Procurement Policy
- Managing Conflicts of Interest Policy
- Raising Concerns at Work (Whistleblowing) Policy
- Secondary Employment Policy
- Your Attendance Matters Policy
- Close Personal Relationships Policy
- Disciplinary Policy, and

with the following national documentation:

- The Bribery Act 2010 (Ministry of Justice April 2010)
- Criminal Finances Act 2017
- The Fraud Act 2006
- NHS Code of Conduct (2004)
- Public Interest Disclosure Act 1998
- NHS Procurement, Patient Choice and Competition Regulations 2013 (No. 2)
- Equality Act 2010
- Human Rights Act 1998

Appendix 1 – Summary of Responsibilities relating to standards of Business Conduct

It is important that you read and understand your responsibilities as summarised below. If you are uncertain or require explanation of any point stated then you should seek advice from your line manager.

Individuals must:

- make sure you understand your responsibilities on standards of business conduct and consult your manager, professional body or trades union representative if you are uncertain;
- make sure you are not placed in a position which risks, or appears to risk, conflict between your private interests and your ICB employment;
- declare all interests to your line manager where you or a close relative or associate, has a controlling and/or significant financial interest in a business or any other activity or pursuit that may compete for a NHS contract to supply either goods or services to the ICB; and
- declare all hospitality, including hospitality offered as part of an education programme, unless it is considered as modest as described in paragraph 8 of this document.

If in doubt, ask yourself:

- Am I, or might I be, in a position where I (or my family/friends) could gain from the connection between my private interests and my employment?
- Do I have access to information that could influence purchasing decisions?
- Could my outside interests be in any way detrimental to the NHS or to patients' interests?
- Do I have any other reason to think I may be risking a conflict of interest?

If still unsure – declare it!

- Adhere to the ICB's Procurement Policy if you are involved in any way with the acquisition of goods and services (a copy of which is available from your line manager.)
- Seek permission before taking on outside work, if there is any question of this adversely affecting your ICB duties in any way.
- Obtain permission before accepting any commercial sponsorship.

You must not:

- accept any gifts, inducements or inappropriate hospitality;
- abuse your past or present official position to obtain preferential rates for private transactions/deals with companies with which you have had, or may have, official dealings on behalf of the ICB;

- unfairly advantage one competitor over another or show favouritism in awarding contracts;
- staff must not work for outside employers when on sickness absence from the ICB whether self-certified or under a fit note issued by your own GP.

11. MANAGING CONFLICTS OF INTEREST POLICY

NHS Derby and Derbyshire Integrated Care Board

Managing Conflicts of Interest Policy

KEY POLICY MESSAGES	
1.	Helps the ICB to demonstrate accountability to stakeholders on the probity and transparency in the decision-making process
2.	Supports ICB staff and relevant individuals when needing to declare an interest
3.	Conflicts of interest can arise in many situations, environments and forms of commissioning

VERSION CONTROL

Policy Title:	NHS Derby and Derbyshire Integrated Care Board Managing Conflicts of Interest Policy
Supersedes:	Standards of Business Conduct and Managing Conflicts of Interest Policy for NHS Derby and Derbyshire ICB
Description of Amendment(s):	Version 0.1 – initial draft
Financial Implications:	Not applicable.
Policy Area:	Corporate Delivery
Version No:	Version 0.1
Author:	Corporate Governance Manager
Approved by:	Audit and Governance Committee, TBC
Effective Date:	July 2022
Review Date:	June 2024
List of Referenced Policies	See section 1.4
Key Words section (metadata for search facility online)	Conflicts Declarations Gifts Hospitality Procurement Breach
Reference Number	CD15
Target Audience	ICB approved policies apply to all employees, contractors, volunteers, and others working with the ICB in any capacity. Compliance with ICB policy is a formal contractual requirement and failure to comply with the policy, including any arrangements which are put in place under it, will be investigated and may lead to disciplinary action being taken.

CONTENTS

1. BACKGROUND

1.1 This policy underpins the NHS Derby and Derbyshire Integrated Care Board (the "ICB") Constitution and sets out further details of the expected conduct of all those who work within it.

1.2 The ICB is responsible for the stewardship of significant public resources when making decisions about the commissioning of health and social care services. In order to ensure and be able to evidence that these decisions secure the best possible services for the population it serves, the ICB must demonstrate accountability to relevant stakeholders (particularly the public), probity and transparency in the decision-making process.

1.3 A key element of this assurance involves management of conflicts of interest with respect to any decisions made. Although such conflicts of interest are inevitable, having processes to appropriately identify and manage them is essential to maintain the integrity of the NHS commissioning system and to protect the ICB, its Board ("ICB Board"), its employees and associated GP practices from allegations and perceptions of wrong-doing.

1.4 The policy should be read in conjunction with the following documents:

- British Medical Association – Guidance on Conflicts of Interest for GPs in their role as commissioners and providers;
- General Medical Council – Good Medical Practice (2013);
- NHS Derby and Derbyshire ICB Commercial Sponsorship and Joint Working with the Pharmaceutical Industry Policy;
- The Public Contract Regulations 2015;
- The NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013;
- The Bribery Act 2010;
- NHS Derby and Derbyshire ICB Fraud, Bribery and Corruption Policy;
- National Health Service Act 2006 (as amended by the Health and Social Care Act 2012);
- Next steps towards primary care co-commissioning (NHS England November 2014);
- Appointments Commission's Code of Conduct and Code of Accountability, Code of Conduct for NHS Managers 2002;
- The Healthy NHS Board: Principles for Good Governance (NHS Leadership Academy, 2013);
- NHS Derby and Derbyshire ICB Recruitment and Selection Policy;
- NHS Derby and Derbyshire ICB Gifts, Hospitality and Sponsorship Policy; and
- NHS Derby and Derbyshire ICB Procurement Policy.

In addition, it should be noted that this policy updates and expands upon the provisions contained in the ICB's Constitution.

2. SCOPE

2.1 This policy will apply to:

2.1.1 ICB employees

All employees, including:

(a) full and part-time staff;

(b) any staff on sessional or short term contracts;

(c) any students and trainees (including apprentices);

(d) agency staff;

(e) seconded staff;

(f) any self-employed consultants or other individuals working for the ICB under a contract for services.

2.1.2 Members of the ICB Board, Committees and Sub-Committees

(a) Co-opted members.

(b) Appointed deputies.

(c) Any members of the committees from other organisations.

2.1.3 All member practices of the ICB

(a) GP Partners (or where the practice is a company, each director).

(b) Practice Managers.

(c) GP Leads.

(d) Any individual directly involved with the business or decision-making of the ICB.

2.1.4 Commissioning Arrangements

(a) Commissioning arrangements including the management of delegated functions and decisions of the ICB in respect of the delegated functions and made in accordance with the terms of the Delegation Agreement which shall be binding on NHS England and the ICB.

All those mentioned in paragraph 2.1 will hereafter be referred to as “Individuals”.

2.2 The ICB will ensure that Individuals are aware of the existence of this policy by:

2.2.1 an introduction to the policy being given during the induction process for new starters to the ICB;

2.2.2 at a minimum, an annual reminder of the existence and importance of the policy delivered via internal communication methods; and

2.2.3 at a minimum, a six-monthly reminder to update, if applicable, Declaration of Interests Forms, Gifts and Hospitality Forms, Procurement Decisions and Contracts Awarded Forms, and Breach Declaration Forms, will be sent to all Individuals.

2.3 Individuals to whom this policy applies will be personally responsible for ensuring that they:

2.3.1 are familiar with its provisions;

2.3.2 comply with the requirements of the ICB's constitution, the standards of conduct outlined in this policy and be aware of the responsibilities outlined within it;

2.3.3 do not knowingly place themselves in a position which creates a potential conflict between their individual and personal interests and their ICB duties;

2.3.4 comply with the procedures set out in the policy including making declarations of potential or actual conflicts of interest where necessary;

2.3.5 attend any conflicts of interest training made available to them including training offered by NHS England and NHS Improvement; and

2.3.6 if applicable, also refer to their respective professional codes of conduct relating to conflicts of interest.

2.4 References in this policy to "committee" and "sub-committee" shall include reference to "joint committees" where relevant.

2.5 The ICB will view instances where this policy is not followed as serious and may take disciplinary action against Individuals, which may result in removal from office in accordance with the provisions of the ICB's constitution and/or dismissal. A referral may also be made to the ICB's Counter Fraud Specialist for investigation and may lead to a criminal investigation as per the ICB's Fraud, Bribery and Corruption Policy. The following ICB policies (as amended) will apply to breaches of this policy where appropriate:

2.5.1 Raising Concerns at Work (Whistleblowing) Policy;

2.5.2 Disciplinary Policy; and

2.5.3 Fraud, Bribery and Corruption Policy.

2.6 Where appropriate the ICB will support its Non-Executive Members in participating in any governance training programmes offered by NHS England and NHS Improvement.

2.7 The ICB's Audit and Governance Committee and ICB Board are committed to review this policy every two years.

3. DEFINITION OF AN INTEREST

3.1 A conflict of interest is defined as "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" (NHS England, 2017).

3.2 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 and new care models, as Individuals may here find themselves in a position of being both commissioner and provider of services. Conflicts of interest can arise throughout the whole commissioning cycle from needs assessment, to procurement exercises, to contract monitoring.

3.3 Interests can be captured in four different categories:

3.3.1 financial interests;

3.3.2 non-financial professional interests;

3.3.3 non-financial personal interests;

3.3.4 indirect interests.

More details can be found on these categories in section 5 below.

4. PRINCIPLES

4.1 This policy reflects principles of good governance and follows the:

4.1.1 Good Governance Standards of Public Services (2004), Office for Public Management (OPM) and Chartered Institute of Public Finance and Accountancy (CIPFA);

4.1.2 Seven Key Principles of the NHS Constitution;

4.1.3 The UK Corporate Governance Code;

4.1.4 Seven Principles of Public Life promulgated by the Nolan Committee, which include:

- **Selflessness** – Individuals should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends;

- **Integrity** – Individuals should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties;
- **Objectivity** – in carrying out public business, including making public appointments, awarding contracts, or recommending Individuals for rewards and benefits, Individuals should make choices on merit;
- **Accountability** – Individuals are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office;
- **Openness** – Individuals should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands;
- **Honesty** – Individuals have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest; and
- **Leadership** – Individuals should promote and support these principles by leadership and example;

4.1.5 Equality Act 2010 where:

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

4.2 In addition to the above, the ICB will:

4.2.1 **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;

4.2.2 **be proactive, not reactive:** seek to identify and minimise the risk of conflicts of interest at the earliest possible opportunity;

4.2.3 **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;

4.2.4 **be transparent:** document clearly the approach and decisions taken at every stage in the commissioning cycle so that a clear audit trail is evident;

4.2.5 create an **environment** and **culture** where Individuals feel supported and confident in declaring relevant information and raising any concerns.

5. TRAINING

To ensure that all ICB employees (as referred to in paragraph 2.1.1), ICB Board members and Clinical Leads are trained and supported in matters related to conflicts of interest, the ICB provides training through its Electronic Staff Record or eLearning for Healthcare (supplied by Health Education England), in the form of three modules:

5.1 Module 1 – covers what conflicts of interest are; how to declare and manage conflicts of interest, including individuals' responsibilities; and how to report any concerns;

5.2 Module 2 – provides further information on managing conflicts of interest throughout the whole commissioning cycle and in recruitment processes; and

5.3 Module 3 – provides advice on how chairs should manage conflicts of interest; an overview of the safeguards that should be applied in Primary Care Commissioning Committees; and how to identify and manage breaches of conflicts of interest rules, through a series of practical scenarios.

Module 1 is mandatory to all ICB employees and the ICB's annual target is 90% achievement. Modules 2 and 3 are optional, but advisable depending on the individual's role.

6. DECLARING CONFLICTS OF INTEREST

6.1 The ICB must make arrangements to ensure Individuals declare any conflict or potential conflict in relation to a decision to be made by the ICB as soon as they become aware of it, and in any event within 28 days. The Declarations of Interest Form is available at Appendix 1.

6.2 Individuals are given other opportunities to make declarations, which include:

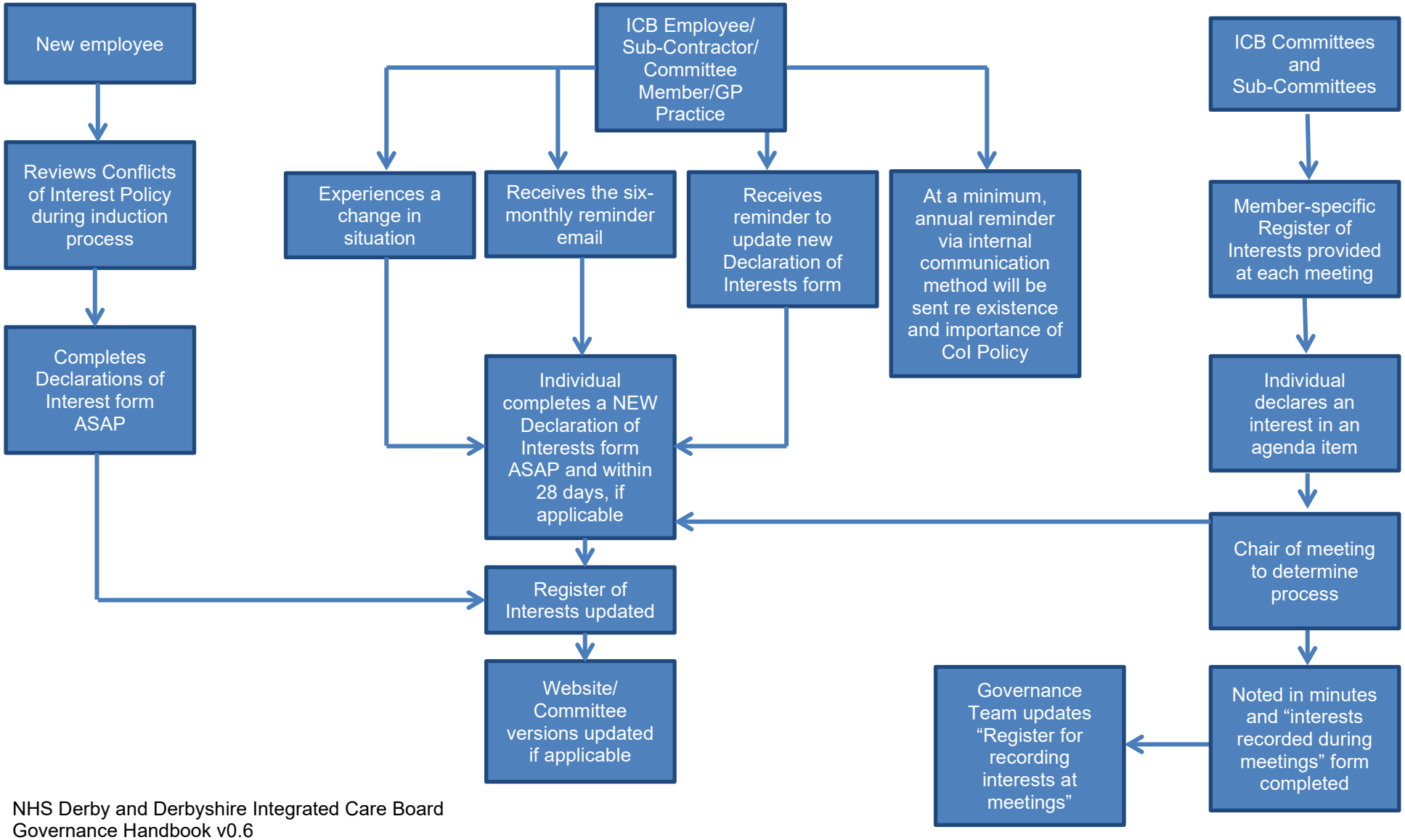
6.2.1 on appointment, of which they must complete and return their form within 28 days of starting their new role;

6.2.2 six-monthly;

6.2.3 at meetings;

6.2.4 on changing role, responsibility or circumstances.

See below for a flowchart detailing the process of declaring conflicts of interest in various settings:


New employee
Reviews Conflicts of Interest Policy during induction process
Completes Declarations of Interest form ASAP
ICB Employee/ Sub-Contractor/ Committee Member/GP Practice
Experiences a change in situation
Receives the six-monthly reminder email
Receives reminder to update new Declaration of Interests form
At a minimum, annual reminder via internal communication method will be sent re existence and importance of CoI Policy
Individual completes a NEW Declaration of Interests form ASAP and within 28 days, if applicable
Register of Interests updated
Website/ Committee versions updated if applicable
ICB Committees and Sub-Committees
Member-specific Register of Interests provided at each meeting
Individual declares an interest in an agenda item
Chair of meeting to determine process
Noted in minutes and "interests recorded during meetings" form completed
Governance Team updates "Register for recording interests at meetings"

6.3 The types of interest that should be declared are:

6.3.1 Financial interests

(a) This is where an Individual may get direct financial benefits from the consequences of a commissioning decision. This could, for example, include being:

(i) 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;

(ii) a shareholder (or similar ownership 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;

(iii) a management consultant for a provider;

(iv) a provider of clinical private practice.

(b) This could also include an Individual being:

(i) in secondary employment;

(ii) in receipt of secondary income;

(iii) in receipt of a grant from a provider;

(iv) in receipt of any payments (for example honoraria, one-off payments, day allowances or travel or subsistence) from a provider;

(v) 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

(vi) 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).

6.3.2 Non-financial professional interests

This is where an Individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career. This may, for example, include situations where the Individual is:

(a) an advocate for a particular group of patients;

(b) a GP with special interests e.g. in dermatology, acupuncture etc.;

(c) an active member of a particular specialist professional body (although routine GP membership of the Royal College of General Practitioners British Medical Association or a medical defence organisation would not usually by itself amount to an interest which needed to be declared);

(d) an advisor for the Care Quality Commission or the National Institute for Health and Care Excellence;

(e) engaged in a research role;

(f) the development and holding of patents and other intellectual property rights which allow Individuals to protect something that they create, preventing unauthorised use of products or the copying of protected ideas.

GPs and practice managers, who are members of the ICB Board or committees of the ICB, should declare details of their roles and responsibilities held within their GP practices.

6.3.3 Non-financial personal interests

This is where an Individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the Individual is:

(a) a voluntary sector champion for a provider;

(b) a volunteer for a provider;

(c) a member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation;

(d) suffering from a particular condition requiring individually funded treatment;

(e) a member of a lobby or pressure group with an interest in health.

6.3.4 Indirect interests

(a) This is where an Individual has a close association with a person 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, a:

(i) spouse/partner;

(ii) close family member or relative e.g. parent, grandparent, child, grandchild or sibling;

(iii) close friend or associate; or

(iv) business partner.

(b) A declaration of interest for a "business partner" in a GP partnership should include all relevant collective interests of the partnership, and all interests of their fellow GP partners.

(c) 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.

6.3.5 Potential conflicts of interest

(a) Where an Individual has an interest, or becomes aware of an interest, which could lead to a conflict of interest in the event of the ICB considering an action or decision in relation to that interest, this must be considered as a potential conflict.

(b) A potential conflict of interest will include, but is not limited to:

(i) a direct pecuniary interest: where an Individual may financially benefit from the consequences of a commissioning decision;

(ii) an indirect pecuniary interest: for example, where an Individual is a partner, member or shareholder in an organisation that will benefit financially from the consequences of a commissioning decision;

(iii) a non-pecuniary interest: where an Individual holds a non-remunerative or not-for-profit interest in an organisation, that could benefit from the consequences of a commissioning decision;

(iv) a non-pecuniary personal benefit: where an Individual may enjoy a qualitative benefit from the consequence of a commissioning decision which cannot be given a monetary value;

(v) where an Individual is closely related to, or in a relationship, including friendship, with an individual in the above categories.

(c) If in doubt the Individual concerned should assume that a potential conflict of interest exists.

(d) Concerns may also relate to financial or personal commitments, special interests, other non-financial objectives (status or kudos) or professional loyalties and duties. Potential conflicts can also arise from close family members' interests and obligations by association.

6.4 Further, it should be noted that:

6.4.1 the possibility of the perception of wrongdoing, impaired judgement or undue influence shall also be considered a conflict of interest for the purposes of this policy and should be declared and managed accordingly;

6.4.2 where there is doubt as to whether a conflict of interest exists, it should be assumed that there is a conflict of interest and declared and managed accordingly; and

6.4.3 for a conflict to exist, financial gain is not necessary.

6.5 Where an Individual has any queries with respect to conflicts of interest they should seek advice from the Head of Governance or Corporate Governance Manager.

7. REGISTER(S) OF CONFLICTS OF INTERESTS

7.1 Register of Interests

7.1.1 Process

(a) The ICB will maintain a register of interests (see Appendix 2) of all Individuals listed in paragraph 2.1.

(b) The register will be updated on the appointment of any Individual, when any person changes role or responsibility, and where there is any other material change in circumstances.

(c) At a minimum, a six-monthly reminder to update Declaration of Interest Forms will be sent to all Individuals.

(d) Conflicts of interests shall be reported to the Corporate Governance Manager who will update the register whenever a new or revised interest is declared. The Corporate Governance Manager must ensure that the register includes sufficient information about the nature of the interest and the details of those holding the interest.

(e) An interest will be recorded on the register within 28 days of receipt and should remain on the register for a minimum of six months.

(f) The register shall be formally reviewed and approved at the Audit and Governance Committee, and continually checked and updated throughout the year to ensure that the register is accurate and up to date.

(g) The ICB will retain a private record of historic interests for a minimum of six years after the date on which it expires.

7.1.2 Publication

(a) The register will be publicly available via the ICB's website or on request at the ICB's headquarters, and the ICB will include in the published register all individuals who meet the following criteria for 'decision making staff':

(i) all ICB Board members;

(ii) members of advisory groups which contribute to direct or delegated decision making on the commissioning or provision of taxpayer funded

services such as working groups involved in service redesign or stakeholder engagement that will affect future provision of services;

(iii) members of the Primary Care Co-Commissioning Committee;

(iv) members of other committees of the ICB;

(v) members of new care models joint provider/commissioner groups/ committees;

(vi) members of procurement (sub-)committees;

(vii) those at Agenda for Change Band 8d and above;

(viii) management, administrative and clinical staff who have the power to enter into contracts on behalf of the ICB; and

(ix) management, administrative and clinical staff involved in decision making concerning the commissioning of services; purchasing of goods, medicines, medical devices or equipment; and formulary decisions.

(b) The register will be reviewed regularly and updated as necessary and at least annually by the Corporate Governance Manager.

(c) The website will state that historic interests are retained by the ICB for six years, and to contact the Head of Governance to submit a request for this information.

(d) All Individuals who make a declaration of interest should be aware that the register(s) will be published in advance of publication.

(e) In exceptional circumstances, where the public disclosure of information could give rise to a real risk of harm or is prohibited by law, an Individual's name and/or other information may be redacted from the publicly available register(s). Where an Individual believes that substantial damage or distress may be caused, to him/herself or somebody else by the publication of information about them, they are entitled to request that the information is not published. Such requests must be made in writing to the Corporate Governance Manager. Decisions not to publish information must be made by the ICB's Conflicts of Interest Guardian. The ICB will retain a confidential unredacted version of the register(s), which will be confidentially presented at Audit and Governance Committee meetings.

(f) The register of interests will be published as part of the ICB's Annual Report and Annual Governance Statement.

7.2 Register of Gifts and Hospitality

7.2.1 Process

(a) The ICB will maintain a register of gifts and hospitality (see Appendix 3) of all Individuals listed in paragraph 2.1. The ICB will ensure robust processes are in place to ensure that Individuals do not accept gifts and hospitality or other benefits, which might reasonably be seen to compromise their professional judgement or integrity.

(b) All Individuals should consider the risks associated with accepting offers of gifts, hospitality, sponsorship and entertainment when undertaking activities for or on behalf of the ICB or their GP practice. This is especially important during procurement exercises, as the acceptance of gifts could give rise to real or perceived conflicts of interests, or accusations of unfair influence, collusion or canvassing.

(c) The Corporate Governance Manager shall update the Gifts and Hospitality Register whenever a new or revised interest is declared. The Corporate Governance Manager must ensure that the register includes sufficient information about the nature of the declaration and the details of those reporting it. The Declarations of Gifts and Hospitality Form is available at Appendix 4.

(d) Where an Individual has any queries with respect to gifts and hospitality they should seek advice from the Director of Corporate Delivery, Head of Governance or Corporate Governance Manager.

7.2.2 Publication

(a) The ICB will publish the gifts and hospitality register on the ICB's website to ensure that members of the public have access to this register on request. In exceptional circumstances, the same process as outlined in paragraph 6.1.2(e) shall be followed.

(b) All persons who are required to make a declaration of gifts or hospitality should be aware that the register will be published in advance of publication.

(c) The gifts and hospitality register will be published as part of the ICB's Annual Report and Annual Governance Statement.

7.2.3 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.

(a) Overarching principles

(i) Individuals should not accept gifts that may affect, or be seen to affect their professional judgement. This overarching principle should apply in all circumstances; and

(ii) any monetary gift or cash equivalents (e.g. vouchers, tokens, offers of remuneration to attend meetings whilst in a capacity working for or representing the ICB) must always be declined, whatever their value and whatever their source, and the offer which has been declined must be declared to the team or individual who has designated responsibility for maintaining the register of gifts and hospitality and recorded on the register.

(b) Gifts from suppliers or contractors

All gifts of any nature offered to Individuals by suppliers or contractors doing business (or likely to do business) with the ICB or GP Practice should be declined, whatever their value (subject to this, low cost branded promotional aids may be accepted and not declared where they are under the value of a common industry standard of £6). The Individual to whom the gifts were offered should also declare the offer to the Corporate Governance Manager so the offer which has been declined can be recorded on the register.

(c) Gifts from GP practices

For teams within the ICB who work closely with GP practices, any gifts received of little financial value (i.e. less than £50) such as flowers, refreshments and small tokens of appreciation can be accepted, but must be declared.

(d) Gifts from other sources

(i) Gifts offered from other sources should also be declined if accepting them might give rise to perceptions of bias or favouritism, and a common sense approach should be adopted as to whether or not this is the case. The only exceptions to the presumption to decline gifts relates to items of little financial value (i.e. less than £50) such as diaries, calendars, stationery and other gifts acquired from meetings, events or conferences, and items such as flowers and small tokens of appreciation from members of the public to staff for work well done. Gifts of this nature may be accepted and do not need to be declared, nor recorded on the register.

(ii) Gifts valued at over £50 should be treated with caution and only be accepted on behalf of the ICB, not in a personal capacity. These should be declared.

(iii) 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).

(iv) Multiple gifts from the same source over a 12 month period should be treated in the same way as single gifts over £50, where the cumulative value exceeds £50.

7.2.4 Hospitality

(a) Overarching principles

(i) Individuals should not ask for or accept hospitality that may affect, or be seen to affect, their personal judgement.

(ii) A blanket ban on accepting or providing hospitality is neither practical nor desirable from a business point of view. However, Individuals should be able to demonstrate that the acceptance or provision of hospitality would benefit the NHS or ICB.

(iii) Modest hospitality 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.

(iv) When hospitality is offered by actual or potential suppliers or contractors, these can be accepted if modest and reasonable, but Individuals should always obtain senior approval and declare these.

(b) Meals and refreshments

(i) Under a value of £25 may be accepted and need not be declared.

(ii) Of a value between £25 and £75 may be accepted and must be declared.

(iii) Over a value of £75 should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on the Gifts and Hospitality Register as to why it was permissible to accept.

A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).

(c) Travel and accommodation

(i) *Modest offers to pay some or all of the travel and accommodation costs* related to attendance at events may be accepted and must be declared.

(ii) Offers which go beyond modest, or are of a type that the ICB itself might not usually offer, need approval by senior staff (e.g. the ICB Governance Lead or equivalent), should only be accepted in exceptional circumstances and must be declared. A clear reason should be recorded on the Gifts and Hospitality Register as to why it was permissible to accept travel and accommodation of this type.

7.2.5 Sponsored events

(a) Sponsorship of NHS events by external parties is valued. Offers to meet some or part of the costs of running an event secures the ICB's ability to take place, benefiting staff and patients. However, there is potential for conflicts of interest between the ICB and sponsor, particularly regarding the ability to market commercial products or services.

(b) When sponsorships are offered, the following principles must be adhered to:

(i) 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;

(ii) during dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation;

(iii) no information should be supplied to the sponsor from which they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied;

(iv) 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;

(v) the involvement of a sponsor in an event should always be clearly identified in the interest of transparency;

(vi) 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; and

(vii) Individuals should declare their involvement with arranging sponsored events for the ICB.

(c) Other forms of sponsorship

Organisations external to the ICB may also sponsor posts or research. 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, or if sponsored posts cause a conflict of interest between the aims of the sponsor and the aims of the organisation, particularly in relation to procurement and competition.

8. ROLES AND RESPONSIBILITIES

All Individuals have the responsibility to appropriately manage conflicts of interest.

8.1 Appointing ICB Board or committee members and senior employees

The following should be considered when appointing ICB Board or committee members and senior employees:

8.1.1 whether conflicts of interest should exclude someone from being appointed to the relevant role. This will be considered on a case-by-case basis reflecting the ICB's general principles within the Constitution;

8.1.2 the materiality of the interest, in particular whether someone (or any person whom they have a close association with, as listed in 5.3.4(a)) could benefit (whether financially or otherwise) from any decision the ICB might make;

8.1.3 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 they would be unable to operate effectively and make a full and proper contribution in the proposed role, then that individual should not be appointed to the role;

8.1.4 a person who has a material interest in an organisation which provides, or is likely to provide, substantial services to the ICB (whether as a provider of healthcare or commissioning support services, or otherwise) should recognise the inherent conflict of interest risk that may arise and should not be a member of the ICB Board or of a committee or sub-committee of the ICB, in particular 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.

8.2 ICB Non-Executive Members

Non-Executive Members play a critical role in ICBs, providing scrutiny, challenge and an independent voice in support of robust and transparent decision-making and management of conflicts of interest.

8.3 Conflicts of Interest Guardian

8.3.1 To further strengthen scrutiny and transparency of the ICB's decision-making processes, the ICB has a Conflicts of Interest Guardian, undertaken by the ICB's Audit and Governance Committee Chair. They are supported by the ICB's Head of Governance.

8.3.2 The Conflicts of Interest Guardian in collaboration with the ICB's Director of Corporate Delivery and Head of Governance will:

(a) act as a conduit for GP practice staff, members of the public and healthcare professionals who have any concerns with regards to conflicts of interest;

(b) be a safe point of contact for employees or workers of the ICB to raise any concerns in relation to this policy;

(c) support the rigorous application of conflicts of interest principles and policies;

(d) provide independent advice and judgment where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation;

(e) give approval, if it is requested, that conflicts of interests are not published on the ICB's website and, if necessary, seek appropriate legal advice where required; and

(f) provide advice on minimising the risks of conflicts of interest.

8.4 Other Key Roles

8.4.1 Individuals should be aware that a breach of this policy could render them liable to prosecution under provisions such as the Bribery Act 2010, as well as leading to the termination of their employment or position within the ICB.

8.4.2 Individuals who fail to disclose relevant interests, outside employment or receipts of gifts, hospitality, sponsorship or entertainment as required by this policy or the ICB's Standing Orders and Prime Financial Policies may be subject to disciplinary action which could ultimately result in the termination of their employment or position within the ICB.

8.4.3 The Director of Corporate Delivery will be responsible for maintaining the Register of Interests, holding the Gifts and Hospitality Register and Register of Breaches, monitoring the Register of Procurement Decisions, publication of the aforementioned registers and reviewing the implementation of this policy.

8.4.4 The Accountable Officer of the ICB has ultimate accountability for the strategic and operational management of the organisation, including ensuring all policies are adhered to.

8.4.5 The ICB Board Members have an ongoing responsibility for ensuring the robust management of conflicts of interest.

8.4.6 The Audit and Governance Committee and ICB Board will ratify this policy for use throughout the ICB.

9. GOVERNANCE ARRANGEMENTS AND DECISION MAKING

9.1 Secondary Employment

9.1.1 The ICB will take all reasonable steps to ensure that employees, committee members, contractors and others engaged under contract with them are aware of the requirement to inform the ICB if they are employed or engaged in, or wish to be employed or engaged in, any employment or consultancy work in addition to their work with the ICB. The purpose of this is to ensure that the ICB is aware of any potential conflict of interest. Examples of work which might conflict with the business of the ICB, including part-time, temporary and fixed term contract work, include:

(a) employment with another NHS body;

(b) employment with another organisation which might be in a position to supply goods/services to the ICB, including paid advisory positions and paid honorariums which relate to bodies likely to do business with the ICB;

(c) directorship of a GP federation or non-executive roles; and

(d) self-employment, including private practice, charitable trustee roles, political roles and consultancy work, in a capacity which might conflict with the work of the ICB or which might be in a position to supply goods/services to the ICB.

9.1.2 The ICB requires Individuals to:

(a) obtain prior permission to engage in secondary employment, and reserve the right to refuse permission where it believes a conflict will arise which cannot be effectively managed;

(b) declare any existing outside employment on appointment and any new outside employment when it arises.

For more information, please see the ICB's Secondary Employment Policy.

9.2 Management of meetings and decision making

9.2.1 Chairing arrangements and decision-making processes

(a) Management of meetings

(i) 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 in order to manage the conflict of interest.

(ii) In making such decisions, the Chair (or Vice Chair or remaining non-conflicted members) may wish to consult with the Conflicts of Interest Guardian (see paragraph 7.3) or another member of the ICB Board.

(iii) The Register of Interests for each committee will be circulated with the meeting papers. The Chair and ICB Meeting Lead and, if required, the Conflicts of Interest Guardian, should proactively consider ahead of the meeting what conflicts are likely to arise and how they are to 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.

(iv) To support Chairs in their role, they will be provided with a declarations of interest checklist prior to meetings (see Appendix 5).

(v) At the beginning of all committee meetings the Register of Interests for that meeting will be highlighted and there will be an opportunity for Individuals to identify potential conflicts of interests relating to specific items of business. Individuals should also raise such items at the beginning of each agenda item so the appropriate course of action can be taken.

(vi) Similarly, 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.

(vii) 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.

(viii) When a member of the meeting (including the Chair or Vice Chair) has a conflict of interest in relation to one or more items of business to be

transacted at the meeting, the Chair (or Vice 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 particular circumstances, but could include one or more of the following:

- where the Chair has a conflict of interest, deciding that the Vice Chair (or another non-conflicted member of the meeting if the Vice Chair is also conflicted) should chair all or part of the meeting;
- requiring the Individual who has a conflict of interest (including the Chair or Vice Chair if necessary) not to attend the meeting;
- 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;
- 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 area;
- 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;
- 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.

(ix) Where the conflict of interest relates to outside employment and an Individual continues to participate in meetings pursuant to the preceding two bullet points, he or she are to ensure that the capacity in which they continue to participate in the discussions is made clear and correctly recorded in the minutes. Where it is appropriate for them

to participate in decisions they must only do so if they are acting in their ICB role.

(x) It is imperative that the ICB ensures complete transparency in decision-making processes through robust record-keeping. Any declaration of interest, and arrangements agreed, in any meeting of the ICB, its committees or sub-committees, or the ICB Board, should be recorded in the register at Appendix 6, and in the relevant minutes (see the ICB's Corporate Governance Framework, Appendix 7, for example wording). The Chair must therefore 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; and
- evidence that the conflict was managed as intended (for example recording the points during the meeting when particular Individuals left or returned to the meeting).

(xi) The Corporate Governance Manager will be responsible for updating the ICB's register of interests with this information and completing the Register for "Recording Interests During Meetings" (see Appendix 6), which will be presented at each Audit and Governance Committee along with "Interests Recorded During Meetings" form (see Appendix 7), which will be made available to Audit and Governance Committee upon request.

(b) Decision Making

(i) Where more than 50% of the members of a meeting are required to withdraw from a meeting or part of it, owing to the arrangements agreed for the management of conflicts of interests or potential conflicts of interests, the Chair (or acting Chair) will determine whether or not the discussion can proceed.

(ii) In making this decision the Chair (or acting Chair) will consider whether the meeting is quorate, in accordance with the number and balance of membership set out in the ICB's standing orders or elsewhere. Where the meeting is not quorate, owing to the absence (temporary or otherwise) of certain members, the discussion will be deferred until such time as a quorum can be convened. Where a quorum cannot be convened from the membership of the meeting, owing to the arrangements for managing conflicts of interest or potential conflicts of

interests, the Chair (or acting Chair) of the meeting shall consult with the Director of Corporate Delivery or Head of Governance on the action to be taken. This may include:

- requiring another of the ICB's committees or sub-committees, or the ICB's Board (as appropriate), which can be quorate, to progress the item of business; or if this is not possible
- inviting on a temporary basis one or more of the following to make up the quorum (where these are permitted members of the ICB Board or committee or sub-committee in question) so that the ICB can progress the item of business:
  - a member of the ICB who is an Individual;
  - a member of a relevant Health and Wellbeing Board;
  - a member of the ICB Board of another ICB;
  - a Non-Executive Member from any other ICB;
  - any other person.

These arrangements must be clearly recorded in the minutes of the meeting.

(iii) In any transaction undertaken in support of the ICB's exercise of its commissioning functions (including conversations between two or more Individuals, emails, correspondence and any other form of communication), Individuals must ensure, where they are aware of an interest, that they conform to the arrangements confirmed for the management of that interest. Where an Individual has not had confirmation of arrangements for managing the interest, they must declare their interest at the earliest possible opportunity in the course of that transaction, and declare that interest as soon as possible thereafter. The Individual must also inform either their line manager (in the case of staff), or the Director of Corporate Delivery or Head of Governance of the transaction.

(iv) The Director of Corporate Delivery or Head of Governance will take such steps as deemed appropriate, and request information deemed appropriate from Individuals, to ensure that all conflicts of interest and potential conflicts of interest are declared.

10. MANAGING CONFLICTS OF INTEREST THROUGH THE COMMISSIONING CYCLE

10.1 Principles

The ICB will manage conflicts of interest by applying a number of principles, processes and safeguards through:

10.1.1 statutory requirements;

10.1.2 doing business appropriately – ensuring commissioning decisions are in line with the ICB's constitution, standards of business and commissioning strategy;

10.1.3 being proactive not reactive by:

(a) considering potential conflicts of interests (e.g. when appointing Individuals to decision-making roles);

(b) ensuring all Individuals and decision-making staff (as referred to in paragraph 6.1.2(a)) are aware of their obligations to declare conflicts of interests;

(c) maintaining a register of interests; and

(d) agreeing in advance how to deal with scenarios where a conflict of interest occurs;

10.1.4 assuming Individuals will act ethically and professionally, but may not always appreciate the potential for conflicts of interest or relevant rules and procedures;

10.1.5 being balanced and proportionate – ensuring rules are clear and robust but not overly prescriptive or restrictive so as to hinder the decision-making process;

10.1.6 being open and ensuring early engagement with patients, the public, clinicians and other stakeholders, including local Healthwatch and Health and Wellbeing Boards in relation to proposed commissioning plans;

10.1.7 responsiveness and best practice – ensuring that commissioning intentions are based on local health needs and reflect evidence of best practice;

10.1.8 transparency – ensuring that the approach taken is clearly evidenced by an audit trail;

10.1.9 securing expert advice – ensuring that commissioning plans take into account advice from appropriate health and social care professionals and experts;

10.1.10 engaging with providers – ensuring early engagement with both incumbent and potential new providers over potential changes to commissioned services for the local population;

10.1.11 creating clear and transparent commissioning specifications;

10.1.12 following proper procurement processes and legal arrangements;

10.1.13 ensuring sound record-keeping;

10.1.14 having in place a clear, recognised and easily enacted system for dispute resolution.

10.2 **General Provisions**

In accordance with the ICB's constitution, the ICB shall manage conflicts of interest that are declared or arise through the commissioning cycle as stated in the following provisions:

10.2.1 the Accountable Officer has overall accountability for the ICB's management of conflicts of interest;

10.2.2 the Corporate Governance Manager will ensure that for every interest declared, either in writing or by oral declaration, arrangements are in place to manage the conflict of interest or potential conflict of interest, to ensure the integrity of the ICB's decision making processes;

10.2.3 arrangements for the management of conflicts of interest are to be determined by the ICB Meeting Lead or Chair of any relevant meeting and will include the requirement to put in writing to the relevant individual arrangements for managing the conflicts of interests or potential conflicts of interests, within a week of declaration. The arrangements will confirm the following:

(a) when an Individual should withdraw from a specified activity, on a temporary or permanent basis (this may include asking an Individual to be excluded from meetings, or relevant parts of meetings, during which relevant issues are discussed or to attend such discussions but not participate in any related vote); and

(b) monitoring of the specified activity undertaken by the Individual, either by a line manager, colleague or other designated Individual;

10.2.4 where an interest has been declared, either in writing or by oral declaration, the declarer will ensure that before participating in any activity connected with the ICB's exercise of its commissioning functions, they have received confirmation of the arrangements to manage the conflict of interest or potential conflict of interest from the Corporate Governance Manager;

10.2.5 where a member of staff might transfer to a provider (or their role may materially change) following the award of a contract, it will be treated as a relevant interest, and the potential conflict shall be managed appropriately.

10.3 **Designing Service Requirements**

The way in which services are designed can either increase or decrease the extent of perceived or actual conflicts of interest. Particular attention is to be given to public and patient involvement in the ICB's service development. Public involvement supports transparent and credible commissioning decisions. It should happen at every stage of

the commissioning cycle from needs assessment, planning and prioritisation to service design, procurement and monitoring. The ICB has a legal duty under the Health and Social Care Act 2012 to properly involve patients and the public in their respective commissioning processes and decisions.

10.3.1 Provider engagement

(a) The ICB aims to engage relevant providers, especially clinicians, in confirming that the design of service specifications will meet patient needs. This may include providers from the acute, primary, community, and mental health sectors, and may include NHS, third sector and private sector providers. However, conflicts of interest, as well as challenges to the fairness of the procurement process, can arise if the ICB engages selectively with only certain providers (be they incumbent or potential new providers) in developing a service specification for a contract for which they may later bid. This should also be considered when engaging with existing/ potential providers in relation to the development of new care models.

(b) Provider engagement should follow the three main principles of procurement law, namely equal treatment, non-discrimination and transparency. This includes ensuring that the same information is given to all at the same time and procedures are transparent. This mitigates the risk of potential legal challenge.

(c) As the service design develops, it is good practice to engage with a range of providers on an ongoing basis to seek comments on the proposed design.

(d) Engagement should help to shape the requirement to meet patient need, but it is important not to gear the requirement in favour of any particular provider(s). If appropriate, the advice of an independent clinical adviser on the design of the service should be secured.

(e) Any decisions in regards to obligations under the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 and the Public Contracts Regulations 2015 shall be documented.

10.3.2 Specifications

(a) The ICB will seek, as far as reasonably possible, to specify the outcomes that they wish to see delivered through a new service, rather than the process by which these outcomes are to be achieved. As well as supporting innovation, this helps prevent bias towards particular providers in the specification of services. However, careful consideration should be given to the appropriate degree of financial risk transfer in any new contractual model.

(b) Specifications should be clear and transparent, reflecting the depth of engagement, and set out the basis on which any contract will be awarded.

10.4 Transparency in Procurement and awarding grants

10.4.1 The ICB aims to recognise and manage any conflicts or potential conflicts of interest that may arise in relation to the procurement of any services or the administration of grants.

10.4.2 When awarding grants, the ICB will follow the same process as described in paragraphs 10.1 and 10.2.

10.4.3 The ICB must comply with two different regimes of procurement law and regulation when commissioning healthcare services: the NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 and the Public Contracts Regulations 2015. Whilst the two regimes overlap in terms of some of their requirements, they are not the same – so compliance with one regime does not automatically mean compliance with the other.

10.4.4 The National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 state:

> *"ICBs must not award a contract for the provision of NHS health care services where conflicts, or potential conflicts, between the interests involved in commissioning such services and the interests involved in providing them affect, or appear to affect, the integrity of the award of that contract; and*
>
> *ICBs must keep a record of how it managed any such conflict in relation to NHS commissioning contracts it has entered into."*

10.4.5 Paragraph 24 of PCR 2015 states: "Contracting authorities shall take appropriate measures to effectively prevent, identify and remedy conflicts of interest arising in the conduct of procurement procedures so as to avoid any distortion of competition and to ensure equal treatment of all economic operators". Conflicts of interest are described as "any situation where relevant staff members have, directly or indirectly, a financial, economic or other personal interest which might be perceived to compromise their impartiality and independence in the context of the procurement procedure".

10.4.6 The Procurement, Patient Choice and Competition Regulations (PPCCR) place requirements on the ICB to ensure that they adhere to good practice in relation to procurement, run a fair, transparent process that does not discriminate against any provider, do not engage in anti-competitive behaviour that is against the interest of patients, and protect the right of patients to make choices about their healthcare. Furthermore the PPCCR places requirements on the ICB to secure high quality, efficient NHS healthcare services that meet the needs of the people who use those services. The Public Contracts Regulations 2015 are focussed on ensuring a fair and open selection process for providers. The completion of a Procurement Decisions and Contracts Awarded Form (Appendix 8) and Procurement Register (Appendix 9) must therefore be updated whenever a procurement decision is taken.

10.4.7 A Procurement Checklist (Appendix 10) sets out factors that the ICB should address when devising plans to commission general practice services.

10.4.8 The ICB will make the evidence of their management of conflicts publicly available. Complete transparency around procurement will provide:

(a) evidence that the ICB is seeking and encouraging scrutiny of its decision-making process;

(b) a record of the public involvement throughout the commissioning of the service;

(c) a record of how the proposed service meets local needs and priorities for partners such as the Health and Wellbeing Boards, local Healthwatch and local communities;

(d) evidence to the Audit and Governance Committee, and internal and external auditors that a robust process has been followed in deciding to commission the service, in selecting the appropriate procurement route, and in addressing potential conflicts.

The ICB will publish the procurement register on the ICB's website to ensure that members of the public have access to this register on request. In exceptional circumstances, the same process as mentioned in paragraph 6.1.2(c) shall be followed.

10.4.9 Commissioning Support Units (CSU), are also expected to declare any conflicts of interest they may have in relation to the work commissioned by the ICB.

10.4.10 Register of procurement decisions

(a) The ICB will maintain a register of procurement decisions taken, either for the procurement of a new service, any extension or material variation of a current contract, awarding of grants or single tender waivers. This must include:

(i) the details of the decision;

(ii) who was involved in making the decision (including the name of the ICB clinical lead, the ICB contract manager, the name of the decision making committee and the name of any other individuals with decision-making responsibility);

(iii) a summary of any conflicts of interest in relation to the decision and how this was managed by the ICB (see paragraph 9.4.10(b) in relation to retaining the anonymity of bidders); and

(iv) the award decision taken.

(b) The register of procurement decisions must be updated whenever a procurement decision is taken. The Procurement, Patient Choice and Competition Regulations 9(1) place a requirement on commissioners to maintain and publish on their website a record of each contract it awards. The register of procurement decisions is therefore publicly available and easily accessible to patients and the public on the ICB's website and upon request for inspection at the ICB's headquarters:

https://www.derbyandderbyshireICB.nhs.uk/about-us/conflict-of-interest/

10.4.11 Declarations of interests for bidders/contractors and people who provide services to the ICB

(a) As part of a procurement process, it is good practice to ask bidders to declare any conflicts of interest. This allows the ICB to ensure that they comply with the principles of equal treatment and transparency. When a bidder declares a conflict, the ICB must decide how best to deal with it or ensure that no bidder is treated differently to any other. A Declaration of Interests Form for Bidders/Contractors must be completed (Appendix 11).

(b) It will not usually be appropriate to declare such a conflict on the register of procurement decisions, as it may compromise the anonymity of bidders during the procurement process. The ICB will therefore retain an internal audit trail of how the conflict or perceived conflict was dealt with to allow them to provide information at a later date if required. The ICB is required under regulation 84 of the Public Contract Regulations 2015 to make and retain records of contract award decisions and key decisions that are made during the procurement process, but are not expected to publish them. Such records must include 'communications with economic operators and internal deliberations' which should include decisions made in relation to actual or perceived conflicts of interest declared by bidders. These records should be retained for a period of at least three years from the date of award of the contract.

10.4.12 Single Tender Waivers

The decision to use a single tender waiver should still be classed as a procurement decision. If it results in the ICB entering into a new contract, extending a contract, or materially altering the term of an existing contract, then it is a decision and should be recorded. Therefore, the same process in this paragraph 9.4 should be followed for all single tender waivers.

10.4.13 Contract Monitoring

(a) The management of conflicts of interest applies to all aspects of the commissioning cycle, including contract management.

(b) Any contract monitoring meeting needs to consider conflicts of interest as part of the process i.e. the Chair of a contract management meeting should:

(i) invite declarations of interests;

(ii) record any declared interests in the minutes of the meeting; and

(iii) manage any conflicts appropriately and in line with this policy.

This equally applies where a contract is held jointly with another organisation such as the Local Authority or with other ICBs under lead commissioner arrangements.

(c) 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.

(d) All Individuals should guard against providing information on the operations of the ICB which might provide a commercial advantage to any organisation (private or NHS) in a position to supply goods or services to the ICB. For particularly sensitive procurement or contracts, Individuals may be asked to sign a non-disclosure agreement.

11. RAISING CONCERNS AND BREACHES

11.1 It is the duty of every Individual to speak up about genuine concerns in relation to the administration of the ICB's policy on conflicts of interest management, and to report these concerns. These Individuals should not ignore their suspicions or investigate themselves, but rather speak to the Head of Governance, Director of Corporate Delivery or Conflicts of Interest Guardian.

11.2 Breaches may occur in any of the following areas:

11.2.1 at any stage of the commissioning cycle (e.g. needs assessment, strategic planning, service planning and design, procurement or contract management);

11.2.2 Individuals declaring interests;

11.2.3 gifts, hospitality, sponsorship and events; or

11.2.4 Individuals and their outside employment.

11.3 Any non-compliance with the ICB's Standards of Business Conduct and Managing Conflicts of Interest Policy should be reported in accordance with the terms of that policy, and the ICB's Raising Concerns at Work (Whistleblowing) Policy (where the breach is being reported by an employee or worker of the ICB) or with the Raising Concerns at Work (Whistleblowing) Policy of the relevant employer organisation

(where the breach is being reported by an employee or worker of another organisation).

11.4 **Reporting breaches**

11.4.1 The ICB will maintain a Breach Declarations Register (see Appendix 12), which will record any notifications brought to the attention of the ICB. Notifications must be recorded on a Breach Declaration Form (see Appendix 13).

11.4.2 All such notifications should be treated with appropriate confidentiality at all times in accordance with the ICB's policies and applicable laws, and the person making such disclosures will receive an appropriate explanation of any decisions taken as a result of any investigation.

11.4.3 All Individuals should contact the ICB's designated Conflicts of Interest Guardian to raise any concerns. They are able to contact the Conflicts of Interest Guardian on a strictly confidential basis.

11.4.4 The breach will be jointly investigated by the Conflicts of Interest Guardian and Director of Corporate Delivery (providing the Director of Corporate Delivery is not conflicted – if they are conflicted, then the Head of Governance will support the investigation). The Conflicts of Interest Guardian will have access to other ICB policies on raising concerns, counter fraud or similar.

11.4.5 The Conflicts of Interest Guardian will make the final decision on whether a breach has occurred.

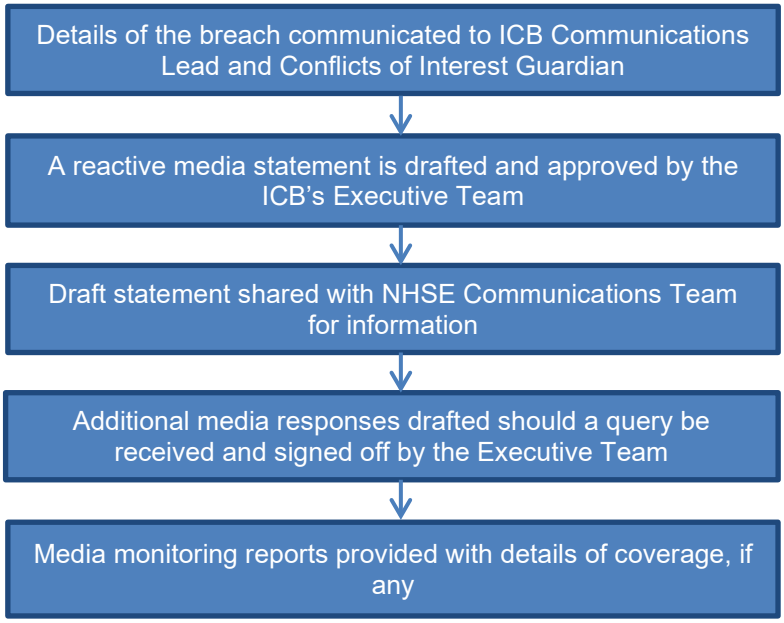
11.4.6 The Director of Corporate Delivery will inform the NHS England and NHS Improvement Locality Director of any breaches within seven days of the breach being identified.

11.4.7 Anonymised details of breaches will be published on the ICB's website for the purpose of learning and development.

11.4.8 Anyone who wishes to report a suspected or known breach of the policy, who is not an employee or worker of the ICB, should ensure that they comply with their own organisation's whistleblowing policy, since most such policies should provide protection against detriment or dismissal.

11.4.9 Providers, patients and other third parties can make a complaint to NHS Improvement in relation to a commissioner's conduct under the Procurement Patient Choice and Competition Regulations.

11.4.10 Should the ICB receive a media enquiry regarding a declared breach, the following process should be followed:



11.5 Prevention of Fraud, Bribery and Corruption

11.5.1 Fraud

(a) The Fraud Act 2006 came into force on the 15 January 2007 and introduced the general offence of fraud. This is broken into three key sections:

(i) fraud by false representation;

(ii) fraud by failing to disclose information;

(iii) fraud by abuse of position.

(b) The Fraud Act 2006 also created new offences of:

(i) possession and making or supplying articles for use in fraud;

(ii) fraudulent trading (sole traders);

(iii) obtaining services dishonestly.

11.6 Corruption/Bribery

(a) The Bribery Act 2010 replaced the previous Prevention of Corruption Acts 1889–1916 and created two general offences of bribery:

(i) offering or giving a bribe to induce someone to behave, or to reward someone for behaving, improperly; and

(ii) requesting or accepting a bribe either in exchange for acting improperly, or where the request or acceptance is itself improper.

(b) A new corporate offence was also introduced – negligent failing by a company or limited liability partnership to prevent bribery being given or offered by an employee or agent on behalf of that organisation.

(c) All Individuals are required to be aware of the Bribery Act 2010 and should also refer to the ICB's Fraud, Bribery and Corruption Policy for further details.

11.6.2 Reporting Suspicions

(a) All cases of suspected fraud, bribery or corruption must be investigated by an accredited NHS Counter Fraud Specialist appointed by the ICB. Any concerns or suspicions relating to fraud, bribery or corruption must therefore be reported to the ICB's appointed Counter Fraud Specialist; [TBC].

(b) Any suspicions or concerns of acts of fraud or bribery can also be reported online via https://www.reportnhsfraud.nhs.uk/ or via the NHS Fraud and Corruption Reporting Line on 0800 0284060. This provides an easily accessible and confidential route for the reporting of genuine suspicions of fraud within or affecting the NHS. All calls are dealt with by experienced trained staff and any caller who wishes to remain anonymous may do so.

12. CONSTITUTION, STANDING ORDERS, SCHEME OF RESERVATIONS AND DELEGATION AND PRIME FINANCIAL POLICIES

12.1 All Individuals must carry out their duties in accordance with the ICB's Constitution, Standing Orders, Scheme of Reservations and Delegation and Prime Financial Policies, and any applicable terms of reference. These set out the statutory and governance framework in which the ICB operates. Individuals must at all times refer to and act in accordance with the Constitution, Standing Orders, Scheme of Reservations and Delegation and Prime Financial Policies to ensure ICB processes are followed.

12.2 In the event of doubt Individuals should seek advice from the Governance Team. In the event of any conflict arising between the details of this policy and the Constitution, Standing Orders, Scheme of Reservations and Delegation and Prime Financial Policies, then the provisions of the Constitution, Standing Orders, Scheme of Reservations and Delegation and Prime Financial Policies shall prevail.

13. NEW CARE MODELS

13.1 When the ICB is commissioning a new care model (i.e. Multi-speciality Community Provider, Primary and Acute Care Systems or other arrangements of a similar scale or scope that (directly or indirectly) includes primary medical services) it is likely that there will be some Individuals with roles (whether clinical or non-clinical), that also have roles within a potential provider, or may be affected by decisions relating to new

care models. Any conflicts of interest must be identified and appropriately managed, in accordance with this policy.

13.2 Any Individual who has a material interest in an organisation which provides, or is likely to provide, substantial services to the ICB (whether as a provider of healthcare or provider of commissioning support services, or otherwise) is to recognise the inherent conflict of interest risk that may arise and should not be a member of the ICB Board or of a committee or sub-committee.

13.3 In the case of new care models, it is perhaps likely that there will be Individuals with roles in both the ICB and new care model provider/potential provider. These conflicts of interest should be identified as soon as possible, and appropriately managed locally. The position is to also be reviewed whenever an Individual's role, responsibility or circumstances change in a way that affects the Individual's interests.

13.4 Where an Individual participating in a meeting has dual roles, but it is not considered necessary to exclude them from the whole or any part of the meeting, he or she should ensure that the capacity in which they continue to participate in the discussions is made clear and correctly recorded in the meeting minutes, but where it is appropriate for them to participate in decisions they must only do so if they are acting in their ICB role.

13.5 Individuals under contract with the ICB are to inform the ICB if they are employed or engaged in, or wish to be employed or engaged in, any employment or consultancy work in addition to their work with the ICB.

13.6 The potential conflict should be managed where Individuals might be affected by the outcome of a procurement exercise. This is also true where Individuals are involved in both the contract management of existing contracts, and involved in procurement of related new contracts.

13.7 It is good practice to engage relevant providers, especially clinicians, in confirming that the design of service specifications will meet patient needs. This may include providers from the acute, primary, community, and mental health sectors, and may include NHS, third sector and private sector providers. Individuals should therefore be mindful of these issues when engaging with existing/potential providers in relation to the development of new care models, and must ensure they comply with their statutory obligations including, but not limited to, their obligations under the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 and the Public Contracts Regulations 2015.

14. EQUALITY STATEMENT

14.1 The ICB aims to design and implement policy documents that meet the diverse needs of our services, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account current UK legislative requirements, including the Equality Act 2010 and the Human Rights Act 1998, and promotes equal opportunities for all. This document has been designed to ensure that no one receives

less favourable treatment due to their protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity. Appropriate consideration has also been given to gender identity, socio-economic status, immigration status and the principles of the Human Rights Act.

14.2 In carrying out its function, the ICB must have due regard to the PSED. This applies to all activities for which the ICB is responsible, including policy development, review and implementation.

15. DUE REGARD

This policy has been reviewed in relation to having due regard to the PSED of the Equality Act 2010 to eliminate discrimination; harassment; victimisation; to advance equality of opportunity; and foster good relations between the protected groups.

Appendix 1 – Declaration of Interests: Financial and Other Interests

This form **must** be completed by **all** employees, sub-contractors, ICB Board members, and committee or sub-committee members on an annual basis.

This form must be completed in accordance with the ICB's Constitution and section 140 of *The National Health Service Act 2006, the NHS (Procurement, Patient Choice and Competition) Regulations 2013 and the Substantive guidance on the Procurement, Patient Choice and Competition Regulations.*

Note: Nil returns must be completed and returned.

If there is any doubt as to whether or not an interest is relevant, a declaration of the interest must be made.

Forename:.....

Surname: .....

Job Title: .....

Organisation (if not employed by ICB or Member Practice) .....

Position within or relationship with, the ICB (or NHS England and NHS Improvement in the event of joint committees):

ICB Employee ☐ Sub-Contractor ☐

Member Practice ☐ Name of Member Practice: .....

Position held: .....

ICB Board Member ☐

Committee Member ☐

Please check all that apply:

Audit & Governance	☐	Finance & Estates	☐	People & Culture	☐
Public Partnerships	☐	Quality & Performance	☐	Population Health & Strategic Commissioning	☐
Remuneration	☐	System Quality Group	☐		

Other ICB Meetings *(please list)* .....

.....

.....

DETAIL OF INTERESTS HELD (complete all that are applicable)				
Type of Interest (see reverse of form for details)	**Description of Interest (including for indirect interests, details of the relationship with the person who has the interest)**	**Date interest relates From & To (use DDMMYY date format)**		**Actions to be taken to mitigate risk (to be agreed with Line Manager or Senior ICB Manager)**

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 ICB publishes decision makers, ICB Board members, and public committee meeting registers on its website and also within public meeting papers.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to the ICB as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, or internal disciplinary action may result.

I do/do not *[delete as applicable]* give my consent for this information to be published on registers that the ICB holds. If consent is NOT given please give reasons:

Signed…….

Date……

Where interests change or new interests are identified this form must be updated and returned to Frances Palmer, Corporate Governance Manager. Email: frances.palmer1@nhs.net

If you require assistance in completing this form please contact Frances Palmer, Corporate Governance Manager. Email: frances.palmer1@nhs.net

TYPES OF INTEREST

Type of Interest	Description
Financial Interests	This is where an individual may get direct financial benefits from the consequences of a commissioning decision. This could, for example, include being: • a director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations. This includes involvement with a potential provider of a new care model • a shareholder (or similar owner interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations • a management consultant for a provider • a provider of clinical private practice • in secondary employment • in receipt of secondary income from a provider • 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 • 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)
Non-Financial Professional Interests	This is where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career. This may, for example, include situations where the individual is: • an advocate for a particular group of patients • a GP with special interests e.g. in dermatology, acupuncture etc. • an active member of a particular specialist professional body (although routine GP membership of the RCGP, BMA or a medical defence organisation would not usually by itself amount to an interest which needed to be declared) • an advisor for Care Quality Commission (CQC) or National Institute for Health and Care Excellence (NICE) • engaged in a research role • the development and holding of patents and other intellectual property rights which allow staff to protect something that they create, preventing unauthorised use of products or the copying of protected ideas • GPs and practice managers, who are members of the ICB Board or committees of the ICB, should declare details of their roles and responsibilities held with their GP practice
Non-Financial Personal Interests	This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is: • a voluntary sector champion for a provider • a volunteer for a provider

	• a member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation • suffering from a particular condition requiring individually funded treatment • a member of a lobby or pressure groups with an interest in healthcare
Indirect Interests	This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non- financial personal interest in a commissioning decision (as those categories are described above). For example, this should include: • spouse/partner • close relative e.g. parent, grandparent, child, grandchild or sibling • close friend or associate • business partner

Appendix 2 – Template Register of Interests

Name	Job Title	Committee Member/ Attendee	Declared interest (including direct/ indirect interest)	Type of Interest				Date of Interest		Action taken to mitigate risk
				Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To	

Appendix 3 – Declarations of Gifts and Hospitality Form

(including sponsorship and entertainment)

Name of recipient	
Job Title/Position	
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	
Action taken to mitigate conflict, details of any approvals and details of the officer reviewing and approving the declaration made and date	
Declined or Accepted?	

Reason for Accepting or Declining	
Other Comments	

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 Gifts and Hospitality Register is published on the ICB's website.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to the ICB as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, professional regulatory or internal disciplinary action may result.

I do/do not (delete as applicable) give my consent for this information to published on registers that the ICB holds. If consent is NOT given please give reasons:

Signed: ..... **Date:** .....

Signed: ..... **(Line Manager or Senior ICB Manager)**

Position: ..... **Date:** .....

Please return to Frances Palmer, Corporate Governance Manager. Email: frances.palmer1@nhs.net

If you require assistance in completing this form please contact Frances Palmer, Corporate Governance Manager. Email: frances.palmer1@nhs.net

Appendix 4 – Template Gifts and Hospitality Register

NHS DERBY AND DERBYSHIRE ICB GIFTS, HOSPITALITY & SPONSORSHIP REGISTER												
Name of Recipient	Job Title/ Position	Date of Offer	Date of Receipt	Details of Gift/ Hospitality/ Sponsorship	Estimated Value	Supplier/ Offeror Name and Nature of Business	Details of Previous Offers or Acceptance by this Offeror/ Supplier	Action taken to mitigate conflict, details of approvals and details of the officer reviewing and approving the declaration made and date	Accepted/ Declined	Reason for Accepting / Declining	Authorising Manager	Comments

Appendix 5 – Declarations of Interest Checklist

(including sponsorship and entertainment)

Under the Health and Social Care Act 2012, there is a legal obligation to manage conflicts of interest appropriately. It is essential that declarations of interest and actions arising from the declarations are recorded formally and consistently across all ICB Board, committee and sub-committee meetings. This checklist has been developed with the intention of providing support in conflicts of interest management to the Chair of the meeting

– prior to, during and following the meeting. It does not cover the requirements for declaring interests outside of the committee process.

Timing	Checklist for Chairs	Responsibility
In advance of the meeting	**1. The agenda** to include a standing item on declaration of interests to enable Individuals to raise any issues and/or make a declaration at the meeting.	Meeting Chair/ICB Meeting Lead/Administrator
	2. A **definition of conflicts of interest** should also be accompanied with each agenda to provide clarity for all recipients.	Meeting Chair/ICB Meeting Lead/Administrator
	3. Agenda to be circulated to enable attendees (including visitors) to identify any interests relating specifically to the agenda items being considered.	Meeting Chair/ICB Meeting Lead/Administrator
	4. Members should contact the Chair as soon as an actual or potential conflict is identified.	Meeting members
	5. If applicable, Chair to review a **summary report from preceding meetings** i.e. sub-committee, working group, etc. detailing any conflicts of interest declared and how this was managed.	Meeting Chair

Timing	Checklist for Chairs	Responsibility
	6. A **copy of the members' declared interests** is checked to establish any actual or potential conflicts of interest that may occur during the meeting.	Meeting Chair/ICB Meeting Lead
During the meeting	**7. Check and declare the meeting is quorate** and ensure that this is noted in the minutes of the meeting.	Meeting Chair/Administrator
	8. Chair requests **members to declare any interests in agenda items –** which have not already been declared, including the nature of the conflict.	Meeting Chair
	9. Chair makes a decision as to how to manage each interest which has been declared, including whether/ to what extent the Individual member should continue to participate in the meeting, on a case by case basis, and this decision is recorded.	Meeting Chair /ICB Meeting Lead/ Director of Corporate Delivery/ Head of Governance/ Corporate Governance Manager
	10. As a minimum requirement, the following should be **recorded in the minutes of the meeting**: • Individual declaring the interest (and why they are conflicted) • at what point the interest was declared • the nature of the interest • the Chair's decision and resulting action taken • the point during the meeting at which any individuals retired from and returned to the meeting – even if an interest has not been declared	Meeting Chair/ Administrator

Timing	Checklist for Chairs	Responsibility
	Visitors in attendance who participate in the meeting must also follow the meeting protocol and declare any interests in a timely manner.	
Following the meeting	**11.** All **new interests declared** at the meeting should be promptly updated onto the declaration of interest form.	Individual(s) declaring interest(s)
	12. All new completed declarations of interest should be **transferred onto the register of interests.**	Administrator/ Corporate Governance Manager

Appendix 6 – Summary Register for Recording any Interests during meetings

A conflict of interest is defined as “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” (NHS England, 2017).

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. Please let the Corporate Governance Team know if you have accepted or declined any gifts or hospitality.

Meeting	Date of Meeting	Chair (name)	ICB Meeting Lead	Name of person declaring interest	Agenda item	Details of interest declared	Action taken

Chair of meeting: .....

Signature .....

Date.....

Appendix 7 – Interests Recorded During Meetings

Report from [insert details of committee]	
Details of interest declared	[Insert who declared the interest and why]
Title of paper	[Insert full title of the paper]
Meeting details	[Insert date, time and location of the meeting]
Report author and job title	[Insert full name and job title/position of the person who has written this report]
Executive summary	[Include summary of discussions held, options developed, commissioning rationale, etc.]
Recommendations	[Include details of any recommendations made, including full rationale] [Include details of finance and resource implications]
Outcome of Impact Assessments completed (e.g. Quality/Equality) Impact Assessments	[Provide details of the QIA or EIA. If this section is not relevant to the paper state "not applicable"]
Outline engagement – clinical, stakeholder and public/patient	[Insert details of any patient, public or stakeholder engagement activity. If this section is not relevant to the paper state "not applicable"]
Management of Conflicts of Interest	[Include details of any conflicts of interest declared] [Where declarations are made, include details of conflicted Individual(s) name, position; the conflict(s) details, and how these have been managed in the meeting] [Confirm whether the interest is recorded on the register of interests – if not agreed course of action]
Assurance departments/organisations who will be affected have been consulted:	[Insert details of the people you have worked with or consulted during the process: • Finance (insert job title) • Commissioning (insert job title) • Contracting (insert job title) • Medicines Optimisation (insert job title) • Clinical leads (insert job title) • Quality (insert job title) • Safeguarding (insert job title) • Other (insert job title)]
Report previously presented at:	[Insert details (including the date) of any other meeting where this paper has been presented; or state "not applicable"]
Risk Assessments	[Insert details of how this paper mitigates risks – including conflicts of interest]

Appendix 8 – Procurement Decisions and Contracts Awarded Form

Ref No	
Contract/Service Title	
Reason for Procurement/Investment Description	
Existing contract or new procurement (if existing include details)	
Procurement type (e.g. ICB procurement, collaborative procurement with partners, competitive, restricted, AQP, contract extension)	
Collaborative Partners (e.g. none, other ICBs, local authority)	
ICB clinical lead (Name)	
ICB contract manager (Name)	
Decision making process, name of decision making committee, and date decision made	
Summary of conflicts of interest noted	
Actions to mitigate conflicts of interest	
Justification for actions to mitigate conflicts of interest	
Contract awarded (supplier name & registered address)	

Contract value (£) (Total) and value to ICB	
Contract Date	
Status of the process	
Comments to note	

To the best of my knowledge and belief, the above information is complete and correct. I undertake to update as necessary the information.

Signed: ..... **Date:** .....

On behalf of: .....

Please return to Frances Palmer, Corporate Governance Manager. Email: frances.palmer1@nhs.net

If you require assistance in completing this form please contact Frances Palmer, Corporate Governance Manager. Email: frances.palmer1@nhs.net

Appendix 9 – Template Procurement Register

NHS DERBY AND DERBYSHIRE ICB PROCUREMENT REGISTER														
Ref. No	**Service to be Procured**	**Reason for procurement**	**Reporting Governance** *Which sub-committees received the procurement updates?*	**Final decision taken and by whom at the ICB?**	**Comments**	**ICB Lead**	**ICB Clinical Lead**	**Summary of Conflicts of Interest Where was this identified?**	**If Yes - what actions were taken to manage the conflicts?**	**Successful Bidder**	**Value (£) excl VAT**	**Contract dates**	**Procurement Process i.e Competitive, Restricted Procedure, AQP**	**Collaborative Partners i.e None or other ICBs**

Appendix 10 – Procurement Checklist

Service:

Question	Comment/Evidence
1. How does the proposal deliver good or improved outcomes and value for money – what are the estimated costs and the estimated benefits? How does it reflect the ICB's proposed commissioning priorities? How does it comply with the ICB's commissioning obligations?	
2. How have you involved the public in the decision to commission this service?	
3. What range of health professionals have been involved in designing the proposed service?	
4. What range of potential providers have been involved in considering the proposals?	
5. How have you involved your Health and Wellbeing Board(s)? How does the proposal support the priorities in the relevant joint health and wellbeing strategy (or strategies)?	
6. What are the proposals for monitoring the quality of the service?	
7. What systems will there be to monitor and publish data on referral patterns?	
8. Have all conflicts and potential conflicts of interests been appropriately declared and entered in registers?	
9. In respect of every conflict or potential conflict, you must record how you have managed that conflict or potential conflict. Has the management of all conflicts been recorded with a brief explanation of how they have been managed?	
10. Why have you chosen this procurement route e.g., single action tender?	

Question	Comment/Evidence
11. What additional external involvement will there be in scrutinising the proposed decisions?	
12. How will the ICB make its final commissioning decision in ways that preserve the integrity of the decision-making process and award of any contract?	
Additional question when qualifying a provider on a list or framework or pre selection for tender (including but not limited to any qualified provider) or direct award (for services where national tariffs do not apply)	
13. How have you determined a fair price for the service?	
Additional questions when qualifying a provider on a list or framework or pre selection for tender (including but not limited to any qualified provider) where GP practices are likely to be qualified providers	
14. How will you ensure that patients are aware of the full range of qualified providers from whom they can choose?	
Additional questions for proposed direct awards to GP providers	
15. What steps have been taken to demonstrate that the services to which the contract relates are capable of being provided by only one provider?	
16. In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the GP contract?	
17. What assurances will there be that a GP practice is providing high-quality services under the GP contract before it has the opportunity to provide any new services?	

Please return to Frances Palmer, Corporate Governance Manager. Email: frances.palmer1@nhs.net

If you require assistance in completing this form please contact Frances Palmer, Corporate Governance Manager. Email: frances.palmer1@nhs.net

Appendix 11 – Template Declaration of Conflicts of Interests for Bidders/Contractors

Name of Organisation:	
Details of interests held:	
Type of Interest	**Details**
Provision of services or other work for the ICB or NHS England and NHS Improvement	
Provision of services or other work for any other potential bidder in respect of this project or procurement process	
Any other connection with the ICB or NHS England and NHS Improvement, whether personal or professional, which the public could perceive may impair or otherwise influence the ICB's or any of its members' or employees' judgements, decisions or actions	

Name of Relevant Person(s)		
Details of interests held:		
Type of Interest	**Details**	**Personal interest or that of a family member, close friend of other acquaintance?**
Provision of services or other work for the ICB or NHS England and NHS Improvement		
Provision of services or other work for any other potential bidder in respect of this project or procurement process		
Any other connection with the ICB or NHS England and NHS Improvement, whether personal or professional, which the public could perceive may impair or otherwise influence the ICB's or any of its members' or employees' judgements,		

decisions or actions		

To the best of my knowledge and belief, the above information is complete and correct. I undertake to update as necessary the information.

Signed:.....

On behalf of:.....

Date: .....

Please return to Frances Palmer, Corporate Governance Manager. Email: frances.palmer1@nhs.net

If you require assistance in completing this form please contact Frances Palmer, Corporate Governance Manager. Email: frances.palmer1@nhs.net

Appendix 12 – Breach Declarations Register

Ref No	Date of Breach	Person who reported the breach (including details of the organisation they belong to)	Description of the breach	How the person became aware of the breach	Action taken

Appendix 13 – Breach Declaration Form

Date of Breach	
Person who reported the breach (including details of the organisation they belong to)	
Description of the breach	
How the person became aware of the breach	
Action taken	

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. If information is disclosed it will be anonymised. The Breach Declarations Register is published on the ICB's website.

I confirm that the information provided above is complete and correct. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, professional regulatory or internal disciplinary action may result.

I do/do not (delete as applicable) give my consent for this information to published on registers that the ICB holds. If consent is NOT given please give reasons:

Signed: ..... **Date:** .....

Signed: ..... **(Line Manager or Senior ICB Manager)**

Position: ..... **Date:** .....

Please return to Frances Palmer, Corporate Governance Manager. Email: frances.palmer1@nhs.net

If you require assistance in completing this form please contact Frances Palmer, Corporate Governance Manager. Email: frances.palmer1@nhs.net

Derby and Derbyshire
Integrated Care Board

NHS Derby and Derbyshire Integrated Care Board

Health and Safety Policy and Procedures

KEY POLICY MESSAGES	
1.	It is essential that the ICB provides and maintains, so far as is reasonably practicable, a safe and healthy working environment.
2.	This policy sets out the health and safety responsibilities of key personnel within the organisation.
3.	This policy explains the systems and procedures that will be used to form the basis of our health and safety regime.

VERSION CONTROL

Title:	NHS Derby and Derbyshire Integrated Care Board Health and Safety Policy and Procedures
Supersedes:	NHS Derby and Derbyshire CCG Health and Safety Policy and Procedures
Description of Amendment(s):	Version 0.1
Financial Implications:	None
Policy Area:	Corporate Delivery
Version No:	Version 0.1
Author:	S. Walsh, Health & Safety Consultant. Richard Heaton, Business Resilience Manager.
Approved by:	ICB Board, 1st July 2022. Audit and Governance Committee, TBC
Effective Date:	1st July 2022
Review Date:	30th June 2024
List of referenced policies	Employee Safety Handbook
Key Words section (metadata for search facility online)	Health Safety Accidents Incidents First Aid Fire
Reference Number	CD11
Target Audience	ICB approved policies apply to all employees, contractors, volunteers, and others working with the ICB in any capacity. Compliance with ICB policy is a formal contractual requirement and failure to comply with the policy, including any arrangements which are put in place under it, will be investigated and may lead to disciplinary action being taken.

This record should be endorsed by all persons who carry out these periodic reviews (including Peninsula Health and Safety Consultants).

CONTENTS

1. CONTENTS

1.1 General Policy

A declaration of our intent to provide and maintain, so far as is reasonably practicable, a safe and healthy working environment and to enlist the support of our employees in achieving these goals.

1.2 Organisation and Responsibilities

This section sets out the health and safety responsibilities of key personnel within the organisation.

1.3 Safety Arrangements

This section explains the systems and procedures that will be used to form the basis of our health and safety regime.

1.4 Safety Records

This section (which may be in a separate folder) contains;

1.4.1 an Annual Review of our Health and Safety System and Procedures;

1.4.2 Periodic Checklists created specifically for individual roles and responsibilities;

1.4.3 a comprehensive source of records relating to statutory examination periodic inspection and testing of the work equipment and installations used by our organisation;

1.4.4 records for Fire Safety Management;

1.4.5 a system for keeping health and safety training records; and

1.4.6 a section for accident and incident reporting, and investigation.

2. HEALTH AND SAFETY POLICY

2.1 General Policy

This Health and Safety Policy contains a plan detailing how we manage our health and safety issues. The policy sets out our commitment to manage risks and provide good standards of health and safety and also to meet our legal duties. Health and safety is an integral part of how we do business as a responsible employer and we have put in place the necessary organisation and arrangements to achieve this. This policy has been prepared after a full appraisal of our health, safety and welfare requirements and will be reviewed periodically (at least annually).

2.2 Health and Safety General Policy Statement

This is a declaration of our intent to provide and maintain, so far as is reasonably practicable, a safe and healthy working environment and to enlist the support of

employees towards achieving these goals. The General Policy statement is brought to the attention of all employees by publication in the main policy manual and in the Employee Safety Handbook. It may also be included on notice boards in our premises.

2.3 **Organisation**

This part of the Policy details the health and safety responsibilities of key personnel within our organisation. These responsibilities are fulfilled by completion of various Safety Records, pro-formas and records in relation to on-going maintenance activities, training, accident reporting, and investigation, and actions that have taken place.

2.4 **Relevant legislation**

This page sets out details of the main statutes and regulations affecting health and safety at work that are currently in force.

2.5 **Safety Arrangements**

This part of the Policy explains the systems and procedures in place for managing individual topics or subjects for which our business is responsible.

3. EQUALITY STATEMENT

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

3.2 In carrying out its function, the ICB must have due regard to the PSED. This applies to all activities for which the ICB is responsible, including policy development, review and implementation.

4. DUE REGARD

This policy has been reviewed in relation to having due regard to the PSED of the Equality Act 2010 to eliminate discrimination; harassment; victimisation; to advance equality of opportunity; and foster good relations between the protected groups.

HEALTH AND SAFETY GENERAL POLICY STATEMENT

NHS Derby and Derbyshire Integrated Care Board (the "ICB") recognises that it has responsibilities for the health and safety of our workforce whilst at work and others who could be affected by our work activities. We will assess the hazards and risks faced by our workforce in the course of their work and take action to control those risks to an acceptable, tolerable level.

Our managers and supervisors are made aware of their responsibilities and required to take all reasonable precautions to ensure the safety, health and welfare of our workforce and anyone else likely to be affected by the operation of our business.

This business intends meeting its legal obligations by providing and maintaining a safe and healthy working environment so far as is reasonably practicable. This will be achieved by;

- providing leadership and adequate control of identified health and safety risks;
- consulting with our employees on matters affecting their health and safety;
- providing and maintaining safe plant and equipment;
- ensuring the safe handling and use of substances;
- providing information, instruction, training where necessary for our workforce, taking account of any who do not have English as a first language;
- ensuring that all workers are competent to do their work, and giving them appropriate training;
- preventing accidents and cases of work related ill health;
- actively managing and supervising health and safety at work;
- having access to competent advice;
- aiming for continuous improvement in our health and safety performance and management through regular (at least annual) review and revision of this policy; and
- the provision of the resource required to make this policy and our health and safety arrangements effective.

We also recognise:

- our duty to co-operate and work with other employers when we work at premises or sites under their control to ensure the continued health and safety of all those at work; and
- our duty to co-operate and work with other employers and their workers, when their workers come onto our premises or sites to do work for us, to ensure the health and safety of everyone at work.

To help achieve our objectives and ensure our employees recognise their duties under health and safety legislation whilst at work, we will also remind them of their duty to take reasonable care for themselves and for others who might be affected by their activities. These duties are explained on first employment at induction and also set out in an Employee Safety Handbook, given to each employee, which sets out their duties and includes our specific health and safety rules.

Signature:.....Date: .....

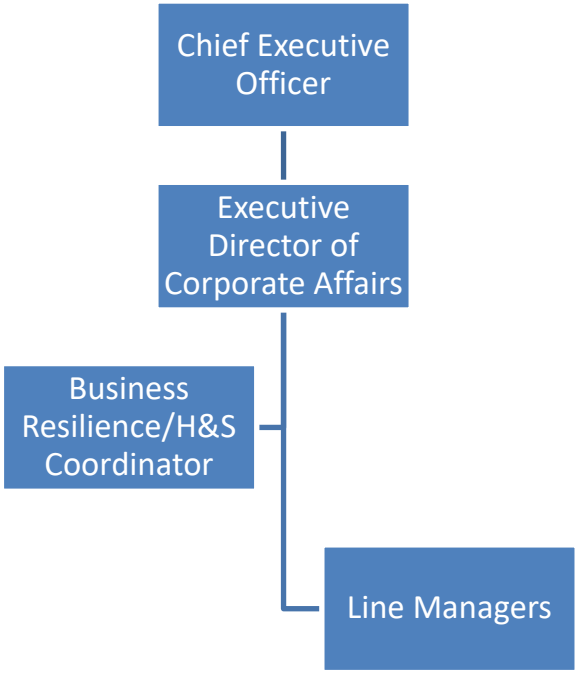
Position: .....

5. ORGANISATION

5.1 Health and Safety Management Structure

5.1.1 Although the Chief Executive Officer has overall responsibility for the implementation of this policy day to day responsibility for particular issues has been delegated to key personnel.

5.1.2 The management structure within our business is shown here and the allocation of day to day responsibility for particular health and safety issues is shown in the Responsibility Chart which appears later in this document.



5.2 Health and Safety Management Responsibilities

The Chief Executive Officer has recognised that they retain overall responsibility for health and safety matters. They also recognise that the business needs to take action in respect of the key points listed here. In managing these matters emphasis is placed on managers and supervisors for recognising hazards and potential risks and then taking steps to minimise their effects on employees and others.

5.2.1 <u>General</u>

(a) Provide and resource an effective health and safety management system.

(b) Make arrangements to consult with employees on health and safety matters.

(c) Arrange and maintain appropriate Employers' Liability Insurance cover.

(d) Ensure that health and safety implications are considered when acquiring new equipment and machinery.

(e) Ensure that contractors (when used) are competent and monitored during work.

(f) Ensure that a process is in place to identify and report hazards.

(g) Ensure that all employees receive appropriate health and safety training.

(h) Provide measures to protect the health and safety of employees working alone.

(i) Monitor the health and safety performance of the organisation.

5.2.2 Occupational Health

(a) Ensure that adequate procedures are in place to identify and address occupational health risks.

(b) Ensure that the measures required to reduce and control employees' exposure to occupational health risks are in place and used.

(c) Implement measures to reduce stress within the workplace.

5.2.3 Accidents, Incidents and First Aid

(a) Record accidents and incidents.

(b) Complete accident and incident investigations, identify causes and measures for prevention.

(c) Ensure that applicable injuries, diseases and dangerous occurrences are reported to the Enforcing Authority.

(d) Ensure that adequate first aid arrangements are in place.

5.2.4 Fire and Emergency Arrangements

(a) Ensure that;

(b) Adequate arrangements are in place to deal with fire safety at our premises or at our member's premises.

(c) Employees are aware of the fire and evacuation arrangements and other emergency procedures.

(d) Emergency equipment is provided, tested and maintained appropriately.

(e) Adequate Fire Risk Assessments are completed.

5.2.5 Risk Assessment

Ensure that:

(a) risk assessments are complete and Safe Systems of Work are produced for all activities that pose a significant risk of harm;

(b) risk assessments are documented; and

(c) the outcomes of risk assessments are carefully explained to the workforce.

5.2.6 Premises

(a) Provide a suitable and safe working environment for employees with adequate welfare facilities.

(b) Ensure that the fixed electrical installation is adequately installed and maintained.

(c) Introduce and maintain measures to control and manage the risks from asbestos.

(d) Ensure good housekeeping standards are instigated and maintained.

(e) Provide suitable and sufficient maintenance of the facilities provided within the workplace.

5.2.7 Equipment

Ensure that:

(a) all equipment provided by the organisation is suitable and properly used;

(b) all work equipment is adequately maintained and safe;

(c) portable electrical appliances are adequately maintained, inspected and tested;

(d) appropriate hand tools are provided and maintained; and

(e) any Personal Protective Equipment (PPE) provided gives suitable protection, is used and that employees are given information, instruction and training on its use.

5.2.8 Substances

Ensure that:

(a) all substances are used safely; and

(b) all substances are appropriately stored.

5.2.9 Managers and supervisors

In addition to their general responsibilities for health and safety the Responsibility Table, shown later, sets out specific delegated health and safety responsibilities and identifies the managers and supervisors they are allocated to. They should refer to the associated Safety Arrangements, set out later, for further detail about those responsibilities.

5.2.10 Employee and workers' responsibilities

Our policy takes account of the specific statutory duties placed on people to take care for their own health and safety whilst at work and for that of others. Specifically we expect employees to:

(a) ensure that company policies and procedures are read, understood and followed at all times;

(b) ensure that isolation and lockdown procedures are followed at all times;

(c) follow booking on and off site procedures at all sites (including head office);

(d) take reasonable care for their health and safety and the safety of others whilst at work;

(e) not intentionally or recklessly interfere with or misuse anything required by law or provided by the company in the interests of health and safety;

(f) visually inspect tools, PPE and equipment prior to use;

(g) ensure that PPE, tools and equipment are maintained, used and stored in accordance with manufacturer documentation;

(h) follow all safety instructions and guidance when using equipment;

(i) report any Good Catches, incidents, accidents and non-conformances to the Health and Safety manager;

(j) contribute to the promotion of health and safety in the workplace;

(k) follow all written safe systems of work (ssow) including method statements, risk assessments, COSHH data, permits to work etc. and their requirements;

(l) follow the safety instructions of senior management;

(m) ensure that they do not use tools and equipment unless they have been formally trained and are competent to do so;

(n) comply with legislation, Approved Codes of Practice and guidance notes;

(o) ensure all company vehicles are driven in a safe and suitable manner, and that the vehicle is left secure when not in use;

(p) consult on health and safety matters and investigations to ensure a safe working environment is established;

(q) seek advice from management on any issues relating to health and safety at work; and

(r) obey all site safety signs, general site rules and arrangements.

5.3 **Monitoring**

5.3.1 The operation of this policy and arrangements is actively monitored through the periodic review of our completed Safety Record Forms and also by using Periodic Workplace Checklists. The Chief Executive Officer has overall responsibility for this, but some of the routine tasks may be delegated. We also use an Annual Health and Safety Review form to determine whether our existing health and safety procedures and arrangements are adequate.

5.3.2 People who have delegated responsibilities under this policy will also complete Periodic Checklists of compliance with the policy and procedures arranging for remedial actions to be taken where necessary. The outcomes of these periodic reviews will also be taken into account during the annual review.

5.3.3 Monitoring and review help us to check the effectiveness of our Safety Management System.

5.4 **Responsibility Table**

This Responsibility Table shows the allocation of responsibility for particular health and safety issues to named people or management positions.

Key

CEO - Chief Executive Officer

EDC - Executive Director of Corporate Affairs

LMs - Line Managers

BRH/HC - Business Resilience/Health & Safety Coordinator

Safety Arrangements	**CEO**	**EDC**	**LMs**	**BRH/HC**
Managing Safety & Health at Work	✓			
Accident, Incident, Ill Health Reporting and Investigation		✓	✓	✓
Workplace H&S Consultation - Trade Union		✓	✓	✓
Workplace H&S Consultation - One-to-one		✓	✓	✓
Risk Assessment and Hazard Reporting			✓	✓
Occupational Health and Health Surveillance			✓	✓
Substance & Alcohol Abuse			✓	✓
Purchasing		✓	✓	✓
New and Expectant Mothers			✓	✓
Employing Children & Young Persons			✓	✓
Lone Working			✓	✓
Health & Safety Training			✓	✓
Health & Safety of Visitors			✓	✓
Personal Protective Equipment			✓	✓
Home Working		✓	✓	✓
Safe Systems of Work		✓	✓	✓

Safety Arrangements	CEO	EDC	LMs	BRH/HC
Action on Enforcing Authority Reports	✓	✓	✓	✓
Equality and Disability Discrimination Compliance		✓	✓	✓
H&S Information for Employees			✓	✓
Fire Safety - Arrangements and Procedures		✓	✓	✓
First Aid		✓	✓	✓
Welfare, Staff Amenities, Rest Rooms & the Working Environment		✓	✓	✓
Housekeeping and Cleaning		✓	✓	✓
Building Services		✓	✓	✓
The Control of Hazardous & Non Hazardous Waste		✓	✓	✓
Access, Egress, Stairs & Floors			✓	✓
Workplace Signs			✓	✓
Water Temperature Control			✓	✓
Premises			✓	✓
Electrical Safety			✓	✓
The Provision, Use & Maintenance of Work Equipment			✓	✓
Office Equipment			✓	✓
Storage of Chemical Substances & Agents			✓	✓
Slips, Trips & Falls			✓	✓
Access Equipment			✓	✓
Workplace Transport & Pedestrian Control			✓	✓
Occupational Road Safety			✓	✓
Infection Control			✓	✓
Manual Handling			✓	✓
Display Screen Equipment & DSE User Eye Tests & Spectacles			✓	✓
Legionella Control			✓	✓
Use of Chemical Agents & Substances			✓	✓
Asbestos at Work-ACMs Present & No Off Site Risk			✓	✓
Stress in the Workplace			✓	✓
Aggression & Violence in the Workplace			✓	✓
Contractor Control & Management			✓	✓

Note: People with delegated responsibilities for health and safety issues should ensure that the required risk assessments and safety records are completed, either by them or by others and that the required control measures are implemented when work activities take place.

Where more than one person has been assigned responsibility to a particular subject, each should ensure that they have fulfilled their responsibilities in the areas under their control and completed the relevant records. Together they need to check that collectively the organisation has covered all aspects of safety management for the subject.

6. RELEVANT LEGISLATION

6.1 In most cases Health and Safety legislation requires common sense, reasonably practicable precautions to avoid the risk of injury or ill-health at work. Our Health and

Safety Management System does not quote specific legal references; giving instead the information and detail of what is required in practice to secure compliance. If the guidance and requirements of our Health and Safety Management System are adopted compliance with the legal requirements will be achieved.

6.2 This page sets out, for the record, details of the main statutes and regulations affecting health and safety at work that were in force when this policy was prepared. The BusinessSafe Online Reference Library contains a similar list which will always be up to date. The document is titled 'Health and Safety Legislation (UK).

6.3 Not every piece of the legislation will apply to our operation on a day to day basis, but we need to be aware of them should circumstances change.

6.4 Further detail and access to the specific wording of each of these legal requirements is available from the BusinessSafe 24 Hour Advice Service on 0844 892 2785.

- Building Regulations 2010 (as amended)
- European Regulation (EC) No 2016/425/2016 on Personal Protective Equipment
- European Regulation (EC) No 2008/1272 on classification, labelling and packaging of substances and mixtures
- European Regulation (EC) No 2003/2003 concerning the export and import of dangerous chemicals, as amended
- Chemicals (Health and Safety) and Genetically Modified Organisms (Contained Use) (Amendment etc.) (EU Exit) Regulations 2019
- Classification, Labelling and Packaging of Chemicals (Amendments to Secondary Legislation) Regulations 2015
- Confined Spaces Regulations 1997
- Construction (Design and Management) Regulations 2015
- Control of Artificial Optical Radiation at Work Regulations 2010
- Control of Asbestos Regulations 2012
- Control of Electromagnetic Fields at Work Regulations 2016
- Control of Lead at Work Regulations 2002
- Control of Major Accident Hazard Regulations 2015
- Control of Noise at Work Regulations 2005
- Control of Substances Hazardous to Health Regulations 2002 (as amended)
- Control of Vibration at Work Regulations 2005
- Corporate Manslaughter and Homicide Act 2007
- Dangerous Substances and Explosive Atmospheres Regulations 2002
- Electricity at Work Regulations 1989
- Employers Liability (Compulsory Insurance) Regulations 1998 (as amended) Employment of Women, Young Persons and Children Act 1920.
- Equality Act 2010
- Furniture and Furnishings (Fire) (Safety) Regulations 1988 (as amended)
- Gas Appliances (Safety) Regulations 1995 (as amended)
- Gas Safety (Installation and Use) Regulations 1998 (as amended)
- Gas Safety (Management) Regulations 1996
- Hazardous Waste Regulations 2005 (as amended)
- Health and Safety (Amendment) (EU Exit) Regulations 2018

- Health and Safety Offences Act 2008
- Health and Safety at Work etc. Act 1974
- Health and Safety (Consultation with Employees) Regulations 1996
- Health and Safety (Display Screen Equipment) Regulations 1992
- Health and Safety (First Aid) Regulations 1981 (as amended)
- Health and Safety Information for Employees Regulations 1989 (as amended)
  Health and Safety (Safety Signs and Signals) Regulations 1996 (as amended)
  Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Health and Safety (Training for Employment) Regulations 1990
- Health and Safety at Work etc. Act 1974 (General Duties of Self-Employed Persons) (Prescribed Undertakings) Regulations 2015
- Ionising Radiations Regulations 2017
- Lifting Operations and Lifting Equipment Regulations 1998
- Lifts Regulations 2016
- Management of Health and Safety at Work Regulations 1999 (as amended)
- Manual Handling Operations Regulations 1992 (as amended)
- Notification of Cooling Towers and Evaporative Condensers Regulations 1992
- Personal Protective Equipment at Work Regulations 1992 (as amended)
- Personal Protective Equipment Regulations 2002
- Regulation (EU) 2016/425 on Personal Protection Equipment
- Pressure Systems Safety Regulations 2000
- Provision and Use of Work Equipment Regulations 1998
- Radiation (Emergency Preparedness and Public Information) Regulations 2001
- The Registration, Evaluation, Authorisation and Restriction of Chemicals Regulations 2007 (REACH)
- Regulatory Reform Fire Safety Order 2005
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013
- Safety Representatives and Safety Committees Regulations 1977
- Work at Height Regulations 2005 (as amended)
- Workplace (Health, Safety and Welfare) Regulations 1992
- Working Time Regulations 1998 (as amended)

7. SAFETY ARRANGEMENTS TABLE

Ref. Number	Title	Publication Date
SA1-1	Managing Safety & Health at Work	v1
SA1-3	Accident, Incident, Ill Health Reporting and Investigation	v2
SA1-5	Workplace H&S Consultation - Trade Union	v1
SA1-5	Workplace H&S Consultation - One-to-one	v1
SA1-6	Risk Assessment and Hazard Reporting	v2
SA1-7	Occupational Health and Health Surveillance	v2
SA1-8	Substance & Alcohol Abuse	v1
SA1-9	Purchasing	v1
SA1-11	New and Expectant Mothers	v2
SA1-12	Employing Children & Young Persons	v1
SA1-13	Lone Working	v3
SA1-14	Health & Safety Training	v1

Ref. Number	Title	Publication Date
SA1-15	Health & Safety of Visitors	v1
SA1-17	Personal Protective Equipment	v1
SA1-18	Home Working	v2
SA1-20	Safe Systems of Work	v1
SA1-21	Action on Enforcing Authority Reports	v1
SA1-22	Equality and Disability Discrimination Compliance	v2
SA1-23	H&S Information for Employees	v1
SA 2-1	Fire Safety - Arrangements and Procedures	v2
SA3-1	First Aid	v2
SA3-2	Welfare, Staff Amenities, Rest Rooms & the Working Environment	v2
SA3-3	Housekeeping and Cleaning	v2
SA3-5	Building Services	v3
SA3-6	The Control of Hazardous & Non Hazardous Waste	v3
SA3-9	Access, Egress, Stairs & Floors	v2
SA3-11	Workplace Signs	v1
SA3-14	Water Temperature Control	v1
SA3-15	Premises	v2
SA4-1	Electrical Safety	v2
SA4-2	The Provision, Use & Maintenance of Work Equipment	v1
SA4-4	Office Equipment	v1
SA4-5	Storage of Chemical Substances & Agents	v1
SA4-8	Slips, Trips & Falls	v1
SA4-21	Access Equipment	v2
SA4-28	Workplace Transport & Pedestrian Control	v3
SA4-31	Occupational Road Safety	v2
SA5-4	Infection Control	v1
SA5-9	Manual Handling	v3
SA5-11	Display Screen Equipment & DSE User Eye Tests & Spectacles	v2
SA5-12	Legionella Control	v1
SA5-14	Use of Chemical Agents & Substances	v2
SA5-16D	Asbestos at Work-ACMs Present & No Off Site Risk	v1
SA5-18	Stress in the Workplace	v1
SA5-19	Aggression & Violence in the Workplace	v1
SA7-2	Contractor Control & Management	v1

Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

INAUGURAL MEETING

1st July 2022

Item: 008

Report Title	Process for approving and developing the essential Policies of the Integrated Care Board							
Author	Chrissy Tucker, Director of Corporate Delivery Fran Palmer, Corporate Governance Manager							
Sponsor (Executive Director)	Helen Dillistone, Executive Director of Corporate Affairs							
Presenter	Helen Dillistone, Executive Director of Corporate Affairs							
Paper purpose	Decision	☒	Discussion	☐	Assurance	☐	Information	☐
Appendices	Appendix 1 – Policies Forward Planner							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	Transition Assurance Committee, 9th December 2021							

Recommendations
The Board are recommended to **AGREE** the plan for policy approvals.
Purpose
This report is prepared to provide a proposal to the Board for the process and plan to approve the required policies of the ICB.
Background
The Board has been provided with the mandatory policies for establishment within agenda item 007, namely: • Health and Safety Policy • Standards of Business Conduct Policy (within the Governance Handbook document) • Managing Conflicts of Interest Policy (within the Governance Handbook document) There are a number of other policies which the ICB will require. The plan attached at Appendix 1 demonstrates the proposals for updating and presenting these through the ICB committees for approval, split into quarterly periods. The dates for the policies to be presented will be confirmed with the Chair of each committee in line with the development of forward planners for the committees and with recognition of other agenda items that need to be brought forward at each meeting.

For HR and people related policies, the ambition is to unify these across the system wherever possible and this work is being led by Amanda Rawlings as Chief People Officer, however policy oversight for these areas will remain with the Audit and Governance Committee.

Pending establishment of the ICB Board, the Transition Assurance Committee, at its meeting on 9th December 2021, discussed the mandated and essential policies for the ICB. Assurance was received that the appropriate policies were in place and could be relied upon by the ICB until such time as the review cycle worked through.

The Board is asked to approve the plan.

Report Summary
As described above.

Identification of Key Risks
None identified.

Have any conflicts of interest been identified throughout the decision-making process?
None identified.

Project Dependencies
Not applicable.

Completion of Impact Assessments				
Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☒	Inclusive leadership	☒

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?					
All policies will include reference to the Equality Act 2010 and Due Regard.					
When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Details/Findings Not applicable.					

NHS DERBY AND DERBYSHIRE INTEGRATED CARE BOARD FORWARD PLAN FOR ALL POLICIES

POLICY AREA	POLICY TITLE	RATIONALE FOR BEING ESSENTIAL	APPROVING ICB COMMITTEE	DATE LAST APPROVED for CCG	CURRENT STATUS for ICB
Essential policies to be agreed July 2022–September 2022					
Business Resilience	Business Continuity Policy and Plan	Mandatory for NHSEI assurance assessment From the 1st July 2022, the ICB will become a Category 1 Responder and ICB-specific arrangements for business resilience are to be in place	Audit & Governance	January 2021	Drafted
	Emergency Preparedness, Resilience and Response Policy and Statement	Mandatory for NHSEI assurance assessment From the 1st July 2022, the ICB will become a Category 1 Responder and ICB-specific arrangements for business resilience are to be in place	Audit & Governance	January 2021	Drafted
	Violence Prevention and Reduction Policy and Strategy	Assurance needed for NHSE EPRR Core Standards during July-September 2022	Audit & Governance	November 2021	To be drafted
	Incident Reporting Policy	Assurance needed for NHSE EPRR Core Standards during July-September 2022	Audit & Governance	November 2021	To be drafted

POLICY AREA	POLICY TITLE	RATIONALE FOR BEING ESSENTIAL	APPROVING ICB COMMITTEE	DATE LAST APPROVED for CCG	CURRENT STATUS for ICB
Business Resilience	Incident Response Plan	Assurance needed for NHSE EPRR Core Standards during July-September 2022	Audit & Governance	November 2021	Drafted
	Cold Weather Plan	Assurance needed for NHSE EPRR Core Standards during July-September 2022	Audit & Governance	October 2021	Drafted
	Winter Preparedness and Action Plan Checklist	Assurance needed for NHSE EPRR Core Standards during July-September 2022	Audit & Governance	October 2021	Drafted
Corporate Strategy & Delivery	Risk Management Strategy	Essential for establishment of ICB and setting out the risk management arrangement for the organisation	Audit & Governance	November 2020	Drafted
	Public Involvement and Engagement Policy	Specified in Constitution as an essential policy	Engagement	New policy in development	TBC – Communications & Engagement Strategy in place (see below)
	Communications and Engagement Strategy	Already in place across the Derbyshire System	JUCD Board	May 2021	Approved

POLICY AREA	POLICY TITLE	RATIONALE FOR BEING ESSENTIAL	APPROVING ICB COMMITTEE	DATE LAST APPROVED for CCG	CURRENT STATUS for ICB
Corporate Strategy & Delivery	Complaints Policy	Essential for establishment of ICB	Audit & Governance	February 2020	Drafted
	Persistent Contacts Policy	Essential for establishment of ICB	Audit & Governance	October 2021	Drafted
	Policy Management Framework	Essential for establishment of ICB	Audit & Governance	May 2021	Drafted
	Standards of Business Conduct Policy	Mandatory for inclusion in ICB Governance Handbook from 1 July 2022	Audit & Governance	New policy	Drafted
	Managing Conflicts of Interest Policy	Mandatory for inclusion in ICB Governance Handbook from 1 July 2022	Audit & Governance	July 2021	Drafted
	Gifts and Hospitality Policy	Essential for managing conflicts of interest suite of documents, as per audit requirements	Audit & Governance	July 2021	Drafted
	Procurement Policy	Essential for managing conflicts of interest suite of documents, as per audit requirements	Audit & Governance	July 2021	Drafted – amendments from CSU to be incorporated

POLICY AREA	POLICY TITLE	RATIONALE FOR BEING ESSENTIAL	APPROVING ICB COMMITTEE	DATE LAST APPROVED for CCG	CURRENT STATUS for ICB
Corporate Strategy & Delivery	Health and Safety Policy	Mandatory by law (Health & Safety Act 1974) Essential for establishment of ICB to ensure ICB-specific arrangements for health and safety are in place	Audit & Governance	January 2021	Drafted
	Fraud, Corruption and Bribery Policy	Essential for ICB's financial security and the proper use of public funds	Audit & Governance	May 2021	Drafted
	Raising Concerns at Work (Whistleblowing) Policy	Essential for establishment of ICB in supporting staff	Audit & Governance	November 2021	Drafted
	Freedom of Information and Freedom of Information and Environmental Information Regulations Policy	Mandatory by law (Freedom of Information Act 2000)	Audit & Governance	July 2021	Drafted
	Commercial Sponsorship and Joint Working with the Pharmaceutical Industry Policy	Essential for establishment of ICB in supporting staff	Audit & Governance	November 2020	Drafted

POLICY AREA	POLICY TITLE	RATIONALE FOR BEING ESSENTIAL	APPROVING ICB COMMITTEE	DATE LAST APPROVED for CCG	CURRENT STATUS for ICB
Finance	Losses and Special Payments Policy	Essential for establishment of ICB	Finance & Estates	August 2021	To be drafted
Information Governance	Information Governance Policy	Mandatory for Information Governance Toolkit submission	Audit & Governance	November 2020	Drafted
	NHS Network, Internet and Electronic Mail Acceptable Use Policy	Mandatory for Information Governance Toolkit submission	Audit & Governance	January 2020	Drafted
	Records Management Policy	Mandatory for Information Governance Toolkit submission	Audit & Governance	January 2020	Drafted
Nursing & Quality	Serious Incidents Framework	Essential for establishment of ICB	Quality & Performance	June 2019	Drafted
	Adult Safeguarding Policy	Essential for establishment of ICB	Quality & Performance	March 2020	Drafted
	Safeguarding Children and Looked after Children Supervision Policy	Essential for establishment of ICB	Quality & Performance	May 2020	Drafted

POLICY AREA	POLICY TITLE	RATIONALE FOR BEING ESSENTIAL	APPROVING ICB COMMITTEE	DATE LAST APPROVED for CCG	CURRENT STATUS for ICB
	Safeguarding Children Strategy	Essential for establishment of ICB	Quality & Performance	October 2020	Drafted
Nursing & Quality	Safeguarding Children Training Strategy	Essential for establishment of ICB	Quality & Performance	June 2019	Drafted
	Safeguarding Children Training Programme	Essential for establishment of ICB	Quality & Performance	2021/22	Drafted
	Deprivation of Liberty Policy	Essential for establishment of ICB	Quality & Performance	March 2020	Drafted
	Prevent Policy	Essential for establishment of ICB	Quality & Performance	April 2020	Drafted
	Continuing Healthcare Policy	Essential for establishment of ICB	Quality & Performance	January 2021	Drafted
	Personal Health Budgets Policy	Essential for establishment of ICB	Quality & Performance	2017	Drafted
	Domestic Abuse Policy	Essential for establishment of ICB	Quality & Performance	March 2020	To be drafted
	Quality and Equality Impact Assessment Policy	Essential for establishment of ICB	Quality & Performance	June 2021	Drafted

POLICY AREA	POLICY TITLE	RATIONALE FOR BEING ESSENTIAL	APPROVING ICB COMMITTEE	DATE LAST APPROVED for CCG	CURRENT STATUS for ICB
	Supervision Policy	Essential for establishment of ICB	Quality & Performance	July 2020	Drafted

POLICY AREA	POLICY TITLE	DATE LAST APPROVED	APPROVING COMMITTEE
Policies to be drafted and agreed October 2022–December 2022			
Digital	Mobile Phone Policy	March 2020	Audit & Governance
	IT Security and Equipment Policy	November 2020	Audit & Governance
	Removable Media Policy	November 2020	Audit & Governance
Human Resources	Agile Working Policy	June 2019	Audit & Governance
	Annual Leave Policy	May 2019	Audit & Governance
	Dignity at Work Policy	May 2019	Audit & Governance
	Disclosure and Barring Policy	November 2019	Audit & Governance
	Flexitime Policy	July 2019	Audit & Governance
	Long Service Award Policy	November 2019	Audit & Governance

POLICY AREA	POLICY TITLE	DATE LAST APPROVED	APPROVING COMMITTEE
	Media and Social Media Policy	July 2019	Audit & Governance
	Organisation Change and Redundancy Policy	April 2019	Audit & Governance
	Professional Registration Policy	September 2019	Audit & Governance
	Recruitment and Selection Policy	April 2019	Audit & Governance
	Retirement Policy	September 2019	Audit & Governance
	Secondary Employment Policy	September 2019	Audit & Governance
	Travel and Expenses Policy	May 2019	Audit & Governance
	Working Time Directive Policy	November 2019	Audit & Governance
	Your Attendance Matters Policy	November 2019	Audit & Governance
	Your Performance Matters Policy	July 2019	Audit & Governance
Policies to be drafted and agreed January 2023–March 2023			
Digital	Digital Obsolescence Policy	January 2021	Audit & Governance
	Information Handling and Classification Policy	January 2021	Audit & Governance
	Communication and Information Security Policy	January 2021	Audit & Governance

POLICY AREA	POLICY TITLE	DATE LAST APPROVED	APPROVING COMMITTEE
Human Resources	Career Break Policy	September 2020	Audit & Governance
	Close Personal Relationships Policy	November 2020	Audit & Governance
	Disciplinary Policy	November 2020	Audit & Governance
	Flexible Working Policy	March 2021	Audit & Governance
	Grievance Policy	November 2020	Audit & Governance
	Maternity, Paternity, Adoption, Shared Parental and Parental Leave Policy	November 2020	Audit & Governance
	Pay Progression Policy	January 2020	Audit & Governance
	Pay Protection Policy	November 2020	Audit & Governance
	Probationary Policy	May 2020	Audit & Governance
	Special Leave Policy	January 2020	Audit & Governance
	Homeworking Policy (During Covid-19)	November 2020	Audit & Governance
	Learning and Development Policy	March 2021	Audit & Governance

Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

INAUGURAL MEETING

1st July 2022

Item: 009

Report Title	Opening Integrated Care Board Assurance Framework and Strategic Risks							
Author	Helen Dillistone Executive Director of Corporate Affairs Chrissy Tucker, Director of Corporate Delivery Rosalie Whitehead, Risk Management & Legal Assurance Manager							
Sponsor (Executive Director)	Helen Dillistone, Executive Director of Corporate Affairs							
Presenter	Helen Dillistone, Executive Director of Corporate Affairs							
Paper purpose	Decision	☒	Discussion	☐	Assurance	☐	Information	☐
Appendices	Appendix 1 - BAF and committee timeline Appendix 2 - BAF closing risks and opening position							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	CCG Governing Body (Public) 16th June 2022 ICB Shadow Board June CCG Committees Transition Assurance Committee Transition Working Group							

Recommendations
The Board are recommended to **AGREE** the opening position in relation to strategic risks and the proposals for Board Assurance Framework development within this report.
Purpose
The purpose of this report is to appraise the Board of the proposed process for developing the Board Assurance Framework and to note the suggested opening strategic risks for the ICB.
Background
The ICB Board Assurance Framework (BAF) will provide a structure and process that enables the organisation to focus on the strategic and principal risks that might compromise the ICB in achieving its corporate objectives. It will map out both the key controls that should be in place to manage those objectives and the associated strategic risks and confirms that the ICB has sufficient assurance about the effectiveness of the controls. This forms part of the development workshops from board development programme, and the timeline to develop the BAF is attached at Appendix 1.

Report Summary

1. Opening Position

The ICB is required to accept the residual strategic risks remaining following the closure of the Derby and Derbyshire CCG. These are listed in Appendix 2 at risks 1 through to 6 and reflect the articulation and scoring of those risks as agreed by the final meeting of the CCG Governing Body. At this inaugural meeting of the ICB Board, the Board is requested only to confirm acceptance of these risks on behalf of the ICB.

2. Developing the BAF

In developing the opening position for a new ICB BAF, the ICB must consider the closing strategic risk position of the CCG and consider their relevance to the future work of the ICB, including any re-scoring or amended articulation of the risks, together with any new strategic risks that may apply to the statutory organisation working as part of the Derbyshire Integrated Care System. This work will form part of the wider board development sessions and the suggested timeline for full completion is attached, detail in appendix 1.

The suggested opening strategic risks are attached at Appendix 2 and have come from several sources as follows:

a) CCG strategic risks – the CCG committees have undertaken a process of reviewing the strategic risks assigned to them and which of those may be closed or should be assigned to a future ICB committee. The CCG Governing Body has also reviewed these risks.
b) NHS system partner BAFs - Existing BAFS have been reviewed and common strategic risks identified and proposed as opening ICB risks, where not already included from other sources.
c) Emerging issues discussed at the Shadow ICB Board.
d) Residual risks from Transition Risk Registers.

Therefore, from the above sources there are initially 10 strategic risks that the ICB, in its opening BAF could adopt. 6 of these are strategic risks for transfer from the CCG, 2 are residual risks from transitional groups which should not be lost and the remaining 2 are emerging risks. Please see appendix 2 for the detail which describes the risk, the source of where this has been taken from or identified by, the ICB committee to which the risk could be assigned together, with relevant non-executive and executive leads identified.

The 2 emerging risks noted at Appendix 2 are by no means exhaustive. Others could include:

- Establishing effective governance, accountability and assurance arrangements
- Establishing effective clinical leadership arrangements
- Digital transformation
- Emergency preparedness, resilience and response
- Development of effective provider collaboratives (linked to the delivery groups)
- Clearly defining through the Operating Model, the role of Place and/or the maturity of Place arrangements linked to any delegations
- Equality & diversity requirements
- Safeguarding requirements
- Cyber security
- High risk reputational and operational areas such as Maternity services and EMAS/A&E

The discussions to take place in the workshops will need to consider which risks are strategic risks to be included in the BAF, which should be included on the ICB Corporate Risk Register, and any which might be better managed by Delivery Boards. The workshops will also give consideration to the risk relationship between the ICB, the Delivery Boards, the Provider Collaborative Leadership Board and the Integrated Place Executive.

The recommended next steps for BAF development are:

- ICB Board to consider the initial strategic risks outlined in appendix 2. Refinement and development will form part of the board development discussions taking place throughout July – September.

- The finalised and fully populated BAF will be presented to the Board at its September meeting, with full mitigations and scoring for each strategic risk, and to be refreshed and presented each quarter thereafter.

- The July and August ICB committees to accept opening strategic risks outlined in column G of appendix 2 at their inaugural meetings, to be developed and refined in line with the outcomes from the ICB Development Sessions.

- 360 Audit to facilitate a discussion on risk appetite at a future board development session.

3. Developing new ICB Strategic Objectives

Running parallel to this work, the ICB will need to develop and agree it's strategic aims/objectives. These would normally emanate from the broader strategy, but it is recognised that the strategy is yet to be fully formed and will form part of the ongoing transition and development work needed across the system.

- However - from the information presented in this report and from previous conversations, several important strategic areas and themes have been identified that the ICB may wish to give further thought to as part of the development sessions over the summer months as follows:

- Improve outcomes in population health and healthcare through transformational working.
- Reduce health inequalities in outcomes, experience and access.
- Maintain financial balance sustainably and enhance productivity and value for money.
- Develop and support system integration and collaboration to deliver the ambition and strategy of the system, which also supports broader social and economic development.
- Engage the public and our stakeholders to develop services to support health and independence across the whole of life.
- Develop the culture and ethos of the ICB as a great organisation to work for and with.
- Establish and embed the new ICB organisation.

The Board are therefore asked to note and provide comment on the above suggested areas and agree to the above forming part of the wider facilitated discussion at the next development session in July.

Identification of Key Risks
Not applicable
Have any conflicts of interest been identified throughout the decision-making process?
None identified.
Project Dependencies
Not applicable.
Completion of Impact Assessments

Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☒	Inclusive leadership	☒

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
Not applicable for this report

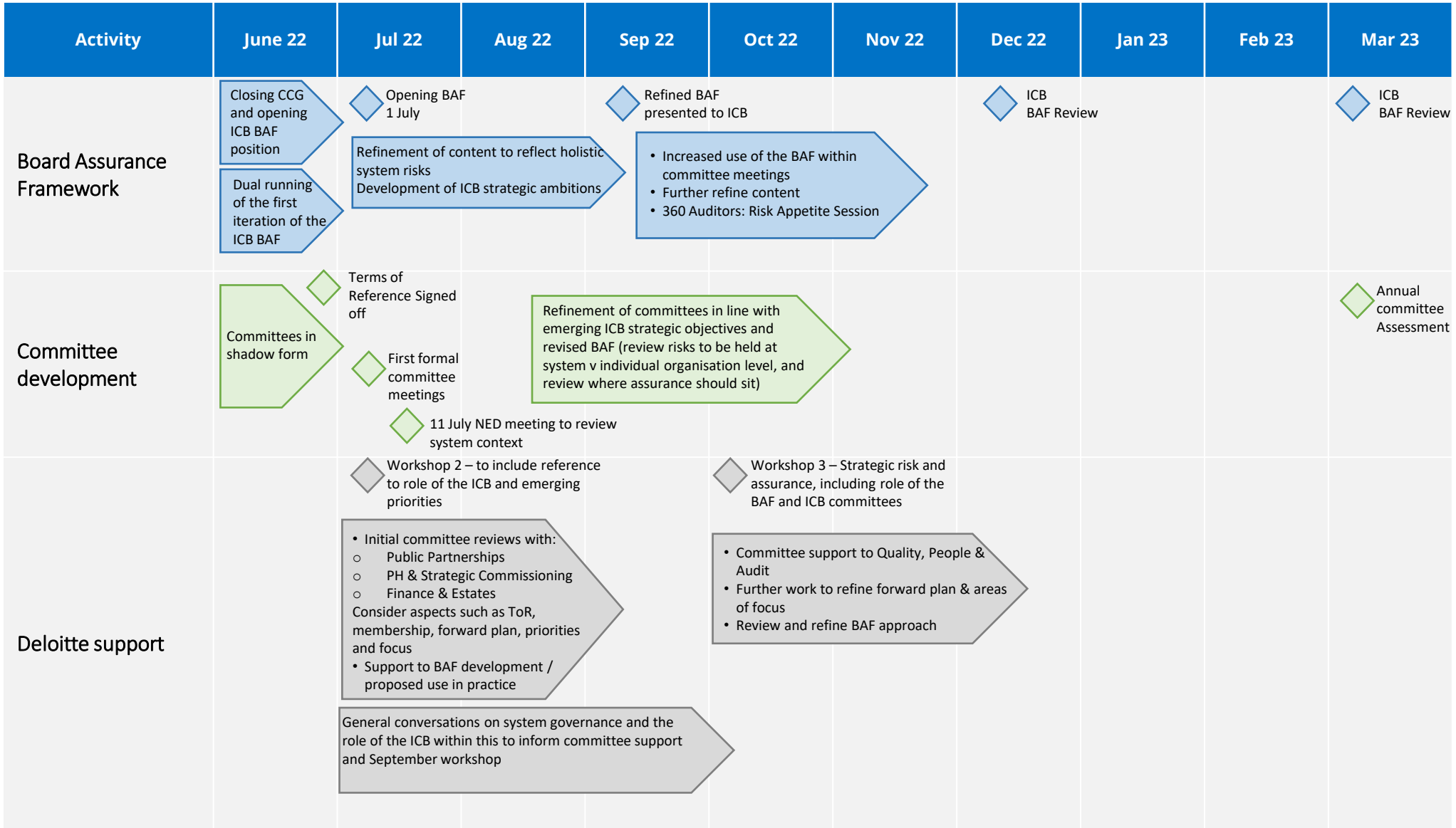
When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
A risk is currently proposed for the opening ICB Risk Register relating to the Greener Plan targets.

Governance workstream

Indicative programme of work

Derby and Derbyshire Integrated Care Board



CCG GBAF	CCG GBAF RISK DESCRIPTION	CLOSING CCG RISK SCORE	SOURCE OF RISK	ICB RESPONSIBLE COMMITTEE	COMMITTEE CHAIR	ICB BAF SUGGESTED RISK DESCRIPTION	ICB RISK SCORE			EXECUTIVE OWNER
							Probability	Impact	Rating	
CCG GBAF										
1	Lack of timely data, insufficient system ownership and ineffective commissioning may prevent the ability of the CCG to improve health and reduce health inequalities. This was of particular concern during the COVID pandemic where some people may not be able to access usual services or alternatives.	15	CCG Quality & Performance Committee	Quality & Performance	Dr Buk Dhadda	Lack of timely data, insufficient system ownership and ineffective commissioning may prevent the ability of the ICB to improve health and reduce health inequalities.	5	3	15	Brigid Stacey/Chris Weiner
2	The CCG is unable to identify priorities for variation reduction and reduce or eliminate them.	20	CCG Quality & Performance Committee	Quality & Performance	Dr Buk Dhadda	The ICB is unable to identify priorities for variation reduction and reduce or eliminate them.	5	4	20	Brigid Stacey
3	Ineffective system working may hinder the creation of a sustainable health and care srtagey by failing to deliver the scale of transformational change needed at the pace required.	12	CCG Clinical & Lay Commissioning Committee	Population Health & Strategic Commissioning Committee	Julian Corner	Ineffective system working may hinder the creation of a sustainable health and care strategy by failing to deliver the scale of transformational change needed at the pace required.	3	4	12	Zara Jones
4	The Derbyshire health system is unable to manage demand, reduce costs and deliver sufficient savings to enable the system to move to a sustainable financial position.	16	CCG Finance Committee	Finance & Estates Committee	Richard Wright	The Derbyshire health system is unable to manage demand, reduce costs and deliver sufficient savings to enable the ICB to move to a sustainable financial position.	4	4	16	Keith Griffiths
5	The Derbyshire population is not sufficiently engaged to identify and jointly deliver the services that patients need.	9	CCG Engagement Committee	Public Partnerships Committee	Julian Corner	The Derbyshire population is not sufficiently engaged to identify services and improvements that patients need.	3	3	9	Helen Dillistone
6	The CCG does not achieve the national requirements for the Covid-19 Vaccination Programme and have robust operational models in place for the continuous sustainable delivery of the Vaccination Programme.	20	CCG Quality & Performance Committee	Quality & Performance Committee	Dr Buk Dhadda	The ICB does not achieve the national requirements for the Vaccination Programme and have robust operational models in place for the continuous sustainable delivery of the Vaccination Programme.	4	5	20	Brigid Stacey

EMERGING RISKS AS IDENTIFIED BY SHADOW ICB BOARD										
7		N/A	Emerging risk as identified by Shadow ICB Board	Quality & Performance Committee	Dr Buk Dhadda	The System is unable to deliver the required elements of the Operational Plan including finance, elective and non-elective care and workforce.	4	4	16	Brigid Stacey/Zara Jones/Keith Griffiths
8		N/A	Emerging risk as identified by Shadow ICB Board	Quality & Performance Committee	Dr Buk Dhadda	The Derbyshire health system is adversely affected by infection control risks emerging from flu, Monkeypox or emerging COVID variants.	4	4	16	Brigid Stacey/Chris Weiner
EMERGING RISK FROM EXISTING SYSTEM PARTNER BAFs AND TRANSITION RISK REGISTERS										
9		N/A	Emerging risk from existing System partner BAFs and Transition Risk Registers	People & Culture Board	Margaret Gildea	Workforce capacity and stability may be adversely impacted due to changes in organisational structures as a result of ICB establishment together with functions being conferred to the ICB from NHSEI.	4	4	16	Amanda Rawlings
10		N/A	Emerging risk from existing System partner BAFs	Quality & Performance Committee	Dr Buk Dhadda	The ICB may be unable to commission a consistently safe service to meet appropriate standards for quality and safety if activity and acuity in health continue or increase.	3	4	12	Brigid Stacey

NHS DERBY AND DERBYSHIRE ICB BOARD

INAUGURAL MEETING

1st July 2022

Item: 010

Report Title	Opening Integrated Care Board Risk Register							
Author	Chrissy Tucker, Director of Corporate Delivery Rosalie Whitehead, Risk Management & Legal Assurance Manager							
Sponsor (Executive Director)	Helen Dillistone, Executive Director of Corporate Affairs							
Presenter	Helen Dillistone, Executive Director of Corporate Affairs							
Paper purpose	Decision	☒	Discussion	☐	Assurance	☐	Information	☐
Appendices	Appendix 1 – Opening ICB Risk Register							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	CCG Governing Body (Public) 16th June 2022 June CCG Committees							

Recommendations
The Board are recommended to **AGREE** the proposals for the Integrated Care Board Risk Register development within this report.
Purpose
The purpose of this report is to appraise the Board of the proposed process for developing the Risk Register and to note the opening risks for the ICB.
Background
The ICB Risk Register will be a live management document which enables the organisation to understand its comprehensive risk profile, and brings an awareness of the wider risk environment. All risks in the Risk Register will be allocated to a committee who will review new and existing risks each month and agree the latest position on the risk, advise on any further mitigating actions that might be required, or approve removal of fully mitigated risks. The committees of the Board are: • Remuneration Committee (a mandatory committee of the Board) • Audit and Governance Committee (Audit is a mandatory committee of the Board) • System Quality Group (a mandatory committee of the Board) • Quality and Performance Committee • Population Health and Strategic Commissioning Committee • Finance and Estates Committee

- People and Culture Committee
- Public Partnerships Committee

Report Summary

In developing the Risk Register, the ICB must consider the closing risks of the CCG and their relevance to the future work of the ICB, together with any new risks that may apply to the statutory organisation working as part of the Derbyshire Integrated Care System.

A proposed opening Risk Register is attached at Appendix 1. It brings together risks from a number of sources and suggests future allocation of those risks. The sources used are risk registers from the following:

- CCG Governing Body (covers all relevant risks from the previous CCG Committees as outlined in the Committee Annual Report and Close down of Committee Live Risks and Business, as presented at the Governing Body on 16th June 2022);
- System Operational Resilience Group (some risks from this group have become longer term risks more suitable for Delivery Board management);
- TWG/TAC ICB Transition;
- CCG Transition Project Group;
- Glossop Transition Steering Group.

The recommended next steps for Risk Register development are:

- the Board to note the opening risks transferred to the ICB;
- July and August ICB committees to accept opening risks at their inaugural meetings, to be developed and refined in line with the development of the BAF outcomes from the Board Development Sessions;
- Discussions need to take place as part of ongoing development of system governance in relation to risks held at Delivery Boards, Integrated Place Executive and the Provider Collaborative Leadership Board levels and how are they are managed within the system.

The Board development programme as part of its work will recognise the complexity of governance across the system and that sources of assurance for the ICB may evolve.

The Board at its meeting on 16th July will receive the Risk Register together with updated mitigating actions. The confidential session of that meeting will receive the Confidential Risk Register for transfer to the ICB.

Identification of Key Risks

N/A

Have any conflicts of interest been identified throughout the decision-making process?

None identified.

Project Dependencies				
Not applicable.				
Completion of Impact Assessments				
Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☒	Inclusive leadership	☒

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
Not applicable for this report

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Details/Findings A risk is currently proposed for the opening ICB Risk Register relating to the Greener Plan targets.					

Risk Reference	CCG Risk Description	CCG Committee	Residual/ Current Risk			ICB Risk Description	ICB Residual/ Current Risk			ICB Committee / Other notes	Committee Chair	Lead Executive
			Probability	Impact	Rating		Probability	Impact	Rating			
CCG COMMITTEES												
01	The Acute providers may breach thresholds in respect of the A&E operational standards of 95% to be seen, treated, admitted or discharged within 4 hours, resulting in the failure to meet the CCG constitutional standards and quality statutory duties.	Quality & Performance Committee	5	4	20	The Acute providers may breach thresholds in respect of the A&E operational standards of 95% to be seen, treated, admitted or discharged within 4 hours, resulting in the failure to meet the ICB constitutional standards and quality statutory duties.	5	4	20	Quality & Performance Committee	Dr Buk Dhadda	Brigid Stacey
02	Changes to the interpretation of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) safeguards, results in greater likelihood of challenge from third parties, which will have an effect on clinical, financial and reputational risks of the CCG	Quality & Performance Committee	3	4	12	Changes to the interpretation of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) safeguards, results in greater likelihood of challenge from third parties, which will have an effect on clinical, financial and reputational risks of the ICB.	4	3	12	Quality & Performance Committee	Dr Buk Dhadda	Brigid Stacey
03	TCP unable to maintain and sustain performance, pace and change required to meet national TCP requirements. The Adult TCP is on a recovery trajectory and rated amber with confidence, whilst CYP TCP is rated green. The main risks to delivery are within market resource and development with workforce provision as the most significant risk for delivery.	Quality & Performance Committee	4	4	16	RECOMMEND FOR CLOSURE				**Recommended for closure** at June Quality & Performance Committee and the risk is transferred to MH, LD&ASC System Delivery Board.	n/a	n/a
04	There is a risk to the sustainability of the individual GP practices across Derby and Derbyshire resulting in failure of individual GP Practices to deliver quality Primary Medical Care services resulting in negative impact on patient care.	Primary Care Commissioning Committee	4	4	16	There is a risk to the sustainability of the individual GP practices across Derby and Derbyshire resulting in failure of individual GP Practices to deliver quality Primary Medical Care services resulting in negative impact on patient care.	4	4	16	**Risk re-worded in May in preparation for ICB**. Population Health and Strategic Commissioning Committee.	Julian Corner	Chris Weiner
09	Sustainable digital performance for CCG and General Practice due to threat of cyber attack, network outages and the impact of migration of NHS Mail onto the national shared tenancy. The CCG is not receiving the required metrics to provide assurance regarding compliance with the national Cyber Security Agenda, and is not able to challenge any actual or perceived gaps in assurance as a result of this.	Governance Committee	2	4	8	Sustainable digital performance for ICB and General Practice due to threat of cyber attack, network outages and the impact of migration of NHS Mail onto the national shared tenancy. The ICB is not receiving the required metrics to provide assurance regarding compliance with the national Cyber Security Agenda, and is not able to challenge any actual or perceived gaps in assurance as a result of this.	2	4	8	Audit & Governance Committee	Sue Sunderland	Helen Dillistone

Risk Reference	CCG Risk Description	CCG Committee	Residual/ Current Risk			ICB Risk Description	ICB Residual/ Current Risk			ICB Committee / Other notes	Committee Chair	Lead Executive
			Probability	Impact	Rating		Probability	Impact	Rating			
10	If the CCG does not review and update existing business continuity contingency plans and processes, strengthen its emergency preparedness and engage with the wider health economy and other key stakeholders then this will impact on the known and unknown risks to the Derby and Derbyshire CCG, which may lead to an ineffective response to local and national pressures.	Governance Committee	2	4	**8**	If the ICB does not sufficiently resource EPRR and Business Continuity functions and strengthen emergency preparedness policies and processes it will be unable to effectively act as a Category 1 responder which may lead to an ineffective response to local and national pressures.	3	4	**12**	Audit & Governance Committee. Risk description re-worded to reflect Category 1 responder and score increased from 8 to 12.	Sue Sunderland	Helen Dillistone
11	Risk of the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the CCG to move to a sustainable financial position.	Finance Committee	4	4	**16**	Risk of the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the ICB to move to a sustainable financial position.	4	4	**16**	Finance & Estates Committee	Richard Wright	Keith Griffiths
12	Inability to deliver current service provision due to impact of service review. The CCG has initiated a review of NHS provided Short Breaks respite service for people with learning disabilities in the north of the county without recourse to eligibility criteria laid down in the Care Act. Depending on the subsequent actions taken by the CCG fewer people may have access to the same hours of respite, delivered in the same way as previously. There is a risk of significant distress that may be caused to individuals including carers, both during the process of engagement and afterwards depending on the subsequent commissioning decisions made in relation to this issue. There is a risk of organisational reputation damage and the process needs to be as thorough as possible. There is a risk of reduced service provision due to provider inability to retain and recruit staff. There is a an associated but yet unquantified risk of increased admissions – this picture will be informed by the review.	Quality & Performance Committee	3	3	**9**	RECOMMEND FOR CLOSURE				**Recommended for closure** at June Quality & Performance Committee and the risk is transferred to MH, LD&ASC System Delivery Board.	n/a	n/a
17	S117 package costs continue to be a source of high expenditure which could be positively influenced with resourced oversight, this growth across the system, if unchecked, will continue to outstrip available budget	Quality & Performance Committee	2	3	**6**	RECOMMEND FOR CLOSURE				**Recommended for closure** at June Quality & Performance Committee and the risk is transferred to MH, LD&ASC System Delivery Board.	n/a	n/a

Risk Reference	CCG Risk Description	CCG Committee	Residual/ Current Risk			ICB Risk Description	ICB Residual/ Current Risk			ICB Committee / Other notes	Committee Chair	Lead Executive
			Probability	Impact	Rating		Probability	Impact	Rating			
20	Failure to hold accurate staff files securely may result in Information Governance breaches and inaccurate personal details. Following the merger to Derby and Derbyshire CCG this data is not held consistently across the sites.	Governance Committee	3	3	**9**	Failure to hold accurate staff files securely may result in Information Governance breaches and inaccurate personal details. Following the merger to Derby and Derbyshire CCG this data is not held consistently across the sites.	3	3	**9**	Audit & Governance Committee	Sue Sunderland	Helen Dillistone
25	Patients diagnosed with COVID 19 could suffer a deterioration of existing health conditions which could have repercussions on medium and long term health.	Quality & Performance Committee	3	3	**9**	Patients diagnosed with COVID 19 could suffer a deterioration of existing health conditions which could have repercussions on medium and long term health.	3	3	**9**	Quality & Performance Committee	Dr Buk Dhadda	Brigid Stacey
33	There is a risk to patients on waiting lists as a result of their delays to treatment as a direct result of the COVID 19 pandemic. Provider waiting lists have increased in size and it is likely that it will take significant time to fully recover the position against these.	Quality & Performance Committee	4	4	**16**	There is a risk to patients on waiting lists as a result of their delays to treatment as a direct result of the COVID 19 pandemic. Provider waiting lists have increased in size and it is likely that it will take significant time to fully recover the position against these.	4	4	**16**	Quality & Performance Committee	Dr Buk Dhadda	Brigid Stacey
37	The Royal College of Physicians identified that there is a risk to the sustainability of the Hyper Acute Stroke Unit at CRHFT and therefore to service provision for the population of North Derbyshire.	Quality & Performance Committee	3	4	**12**	The Royal College of Physicians identified that there is a risk to the sustainability of the Hyper Acute Stroke Unit at CRHFT and therefore to service provision for the population of North Derbyshire.	3	4	**12**	Quality & Performance Committee	Dr Buk Dhadda	Brigid Stacey
42	If the CCG does not prioritise the importance of climate change it will have a negative impact on its requirement to meet the NHS's Net Carbon Zero targets and improve health and patient care and reducing health inequalities and build a more resilient healthcare system that understands and responds to the direct and indirect threats posed by climate change	Governance Committee	3	3	**9**	If the ICB does not prioritise the importance of climate change it will have a negative impact on its requirement to meet the NHS's Net Carbon Zero targets and improve health and patient care and reducing health inequalities and build a more resilient healthcare system that understands and responds to the direct and indirect threats posed by climate change	3	3	**9**	Audit & Governance Committee	Sue Sunderland	Helen Dillistone
46	Risk of population continuing to wait in excess of NHS constitutional standards for Mental Health services - in particular waiting times for:- > CAMHS services - average of 17 weeks against 4weeks standard > Adult community mental health services - average 21 weeks wait > Autism Assessment services - average 59 weeks wait for adult assessment	Quality & Performance Committee	3	3	**9**	RECOMMEND FOR CLOSURE				**Recommended for closure** at June Quality & Performance Committee and the risk is transferred to MH, LD&ASC System Delivery Board.	n/a	n/a

Risk Reference	CCG Risk Description	CCG Committee	Residual/ Current Risk			ICB Risk Description	ICB Residual/ Current Risk			ICB Committee / Other notes	Committee Chair	Lead Executive
			Probability	Impact	Rating		Probability	Impact	Rating			
48	There is a risk that the DDCCG NHS Mail container includes NHS Mail accounts for individuals who are not directly employed by the CCG, but by other clinical services. Employees external to the CCG are potentially accessing NHS Mail services (including MS Teams and One Drive) to which they may not be entitled. This generates a cost to the CCG for each additional user.	Governance Committee	4	4	**16**	There is a risk that the ICB NHS Mail container includes NHS Mail accounts for individuals who are not directly employed by the ICB, but by other clinical services. Employees external to the ICB are potentially accessing NHS Mail services (including MS Teams and One Drive) to which they may not be entitled. This generates a cost to the ICB for each additional user.	4	4	**16**	Audit & Governance Committee	Sue Sunderland	Helen Dillistone
49	Existing human resource in the Communications and Engagement Team may be insufficient. This may impact on the team's ability to provide the necessary advice and oversight required to support the system's ambitions and duties on citizen engagement. This could result in non-delivery of the agreed ICS Engagement Strategy, lower levels of engagement in system transformation and non-compliance with statutory duties.	Engagement Committee	3	3	**9**	Existing human resource in the Communications and Engagement Team may be insufficient. This may impact on the team's ability to provide the necessary advice and oversight required to support the system's ambitions and duties on citizen engagement. This could result in non-delivery of the agreed ICS Engagement Strategy, lower levels of engagement in system transformation and non-compliance with statutory duties	3	3	**9**	Public Partnerships Committee New risk in June 2022.	Julian Corner	Helen Dillistone
TRANSITION WORKING GROUP AND TRANSITION ASSURANCE COMMITTEE												
TWG Risk 8	Progress to develop inter-relations and operations, in particular with Integrated Care Board statutory Boards and Integrated Care partnerships are unable to progress at the pace required due to continued ambiguity and evolving policy, including implications for existing HWB structures.	Transition Working Group and Transition Assurance Committee	3	3	**9**	RECOMMEND FOR CLOSURE				Recommend for closure as no further guidance or policy development is expected at this time and both the ICB and ICP have met in shadow form and are ready to be formally established from 1 July.	n/a	n/a

Risk Reference	CCG Risk Description	CCG Committee	Residual/ Current Risk			ICB Risk Description	ICB Residual/ Current Risk			ICB Committee / Other notes	Committee Chair	Lead Executive
			Probability	Impact	Rating		Probability	Impact	Rating			
TWG Risk 13	There is a risk that the Providers could have parallel processes in place with the ICB and collective mechanisms will be required to develop collaborative partnerships.	Transition Working Group and Transition Assurance Committee	2	3	**6**	System partners could potentially have parallel processes to the new ICB processes and collective mechanisms will be required to develop collaborative partnerships and limit duplication.	2	3	**6**	**Risk description re-worded.** The various governance processes that are in place across the system might be duplicated in some areas Audit & Governance Committee	Sue Sunderland	Helen Dillistone
TWG Risk 15	There is a risk that focus and capacity required to respond to the national public inquiry on the Covid response will detract from the focus and resource available to effect a successful transition to the ICB and that organisational memory and records required could be lost during transition.	Transition Working Group and Transition Assurance Committee	2	5	**10**	RECOMMEND FOR CLOSURE				**Risk recommended for closure** as the full requirements of the Covid Inquiry have not yet emerged and therefore the risk to transition has not been realised. The ICB will keep this under review as and when further information on the Inquiry is released and will be added to the ICB Risk Register if appropriate.	n/a	n/a
TWG Risk 22	There is a risk that the operating model being developed by NHSEI ready to delegate services and functions to ICBs may not have sufficient staffing and capacity.	Transition Working Group and Transition Assurance Committee	4	4	**16**	The ICB may not have sufficient resource and capacity to service the functions to be delegated by NHSEI	4	4	**16**	**Risk description re-worded**. Audit & Governance Committee.	Sue Sunderland	Helen Dillistone
CCG TRANSITION PROJECT GROUP												
TPG Risk 14	There is a risk that external auditors will not be available in July 2022 if an audit is required for 1st quarter of 2022/23.	CCG Transition Project Group	1	5	**5**	Risk that the ICB Board choose not to appoint KPMG on 1st July and the ICB is then without an External Auditor (therefore technically in breach of the Local Audit and Accountability Act 2014). The ICB will have to appoint a new External Auditor when it is widely recognised this is a challenging market from which to appoint External Auditors.	1	5	**5**	**Risk description re-worded.** A process has been undertaken to appoint KPMG as the ICB External Auditors, but this can not be formally approved until the first ICB Board meeting on 1st July 2022. Audit & Governance Committee.	Sue Sunderland	Helen Dillistone

Risk Reference	CCG Risk Description	CCG Committee	Residual/ Current Risk			ICB Risk Description	ICB Residual/ Current Risk			ICB Committee / Other notes	Committee Chair	Lead Executive
			Probability	Impact	Rating		Probability	Impact	Rating			
GLOSSOP TRANSITION STEERING GROUP												
Glossop FC21	Risk to one or both GM or Derbyshire of stranded costs following the transition	Glossop Transition Risk Log	3	3	**9**	RISK RECOMMENDED FOR CLOSURE				**Risk recommended for closure.** There is no risk of any Derbyshire standard costs as a result of the boundary change. There is concern in T&GCCG that they will have some standard costs and there is a proposal that Derbyshire ICB has an SLA in place for services to be received from Greater Manchester ICB for some commissioning services until 31/03/2023. No final agreement has been reached with T&GCCG.	n/a	n/a
Glossop CE07	Inequity of service provision between Glossop and the rest of the county based on no change for Glossop for 12 months - risk of complaints and litigation in relation to variation.	Glossop Transition Risk Log	3	3	**9**	There is risk of challenge from patients relating to inequity of service provision during the first year of Glossop being included in the Derbyshire ICB due to differing clinical policies currently in place. These specifically relate to IVF and Gluten-Free prescribing policies	3	3	**9**	**Risk description re-worded.** Zara Jones discussing whether this should be added to the Population Health & Strategic Commissioning Committee or specific Delivery Board at the pre-meet w/c 20.06.22 Population Health & Strategic Commissioning Committee	Julian Corner	Zara Jones

Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

INAUGURAL MEETING

1st July 2022

	Item No: 011

Report Title	Arrangements and process for appointing External Auditors							
Author	Donna Johnson, Acting Assistant Chief Finance Officer							
Sponsor (Executive Director)	Keith Griffiths, Executive Director of Finance							
Presenter	Keith Griffiths, Executive Director of Finance							
Paper purpose	Decision	☒	Discussion	☐	Assurance	☐	Information	☐
Appendices	Appendix A – Extract of National Guidance Surrounding Novation of CCG Contracts.							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	CCG Audit Panel, 20th January 2022 CCG Governing Body, February 2022							

Recommendations
The Board are recommended to **AGREE** the arrangements and process for appointing External Auditors, which includes: a) forming an Audit Panel consisting of members of the Board; b) the Audit Panel considering the specifications of the novated contract of the CCG's External Audit to ensure this meets the needs of the ICB; and c) the Audit Panel recommending to the Board a decision on whether to appoint the CCG's External Auditor under the terms of the novated contract. Due to the breach of the LAA Act, it is proposed the above will be actioned promptly on the ICB's establishment.
Purpose
To move towards the formal appointment of the Integrated Care Board's External Auditors in line with the Local Audit & Accountability Act 2014.
Background
During the process of transitioning from the Clinical Commissioning Group (CCG) to the Integrated Care Board (ICB), guidance was issued detailing that the ICB would need to make the decision to appoint its own external auditors; it could not simply accept the novation of the CCG's external audit contract.

Report Summary
This paper outlines: 1) the steps the CCG followed to appoint KPMG as its external auditors, alongside other NHS members of the JUCD; 2) the national guidance issued with regards the novation of CCG contracts into the ICB, revealing that external audit contracts are unique and formal appointment must be made by the ICB; and 3) the proposed process for the ICB to appoint its external auditors, including the recommendation to promptly form an Audit Panel.
Identification of Key Risks
Without the appointment of an external auditor, the ICB will be in breach of the Local Audit & Accountability Act 2014. Without detailed consideration of the inherited KPMG contract by its own Audit Panel, the ICB is at risk of being party to an external audit contract that does not meet its ongoing needs.
Have any conflicts of interest been identified throughout the decision-making process?
None have been identified.
Project Dependencies
Completion of Impact Assessments

Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☒	No☐	N/A☐	**Summary:** Involvement of other NHS members of the JUCD in the procurement process to appoint a system external auditor.

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☒	Inclusive leadership	☒

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
Not considered applicable for this paper.

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Not considered applicable for this paper.					

Derby and Derbyshire
Integrated Care Board

Arrangements and process for appointing External Auditors

Introduction

During the process of transitioning from the Clinical Commissioning Group (CCG) to the Integrated Care Board (ICB), guidance was issued detailing that the ICB would need to make the decision to appoint its own external auditors; it could not simply accept the novation of the CCG's external audit contract.

This paper outlines the steps the CCG followed to appoint the external audit contract, the national guidance issued, and the proposed process for the ICB to appoint its external auditors.

CCG Appointment of External Auditors

The CCG had been required to tender for a new External Audit Contract as its existing contract expired on 31st March 2022. As a result of the requirement for Audit firms to separate the consultancy arm of their organisation from the Audit arm, it had proved increasing difficulty for NHS bodies to attract potential Auditors. It was decided to proceed with a joint procurement across the JUCD footprint to increase the attractiveness of the offer and secure the best value for money.

The tender close date for the procurement was the 10th December 2021 and only a single bid was received from KPMG. The CCG undertook an evaluation on 20th December 2021 with members of the CCG Audit Committee and found that the bid from KPMG clearly met the criteria and confirmed that KPMG were appointable.

A CCG Auditor Panel recommended KPMG to the Governing Body, which was subsequently approved in February 2022. The CCG signed a contract, alongside Chesterfield Royal Hospital FT, for 2022/23 onwards on a 3+2-year basis. It is anticipated that EMAS, would sign for 2023/24 onwards on a 2+2-year basis. The other JUCD organisations currently intend to extend their existing contracts with other Auditors until 2025/26, which coincides with the end of the initial 3 years with KPMG and then the option to extend would be subject to agreement by all parties.

National Guidance Surrounding Novation of CCG Contracts

Relevant Extracts of the national guidance issued by NHS England & Improvement (NHSEI) during the transition process can be found in Appendix A.

From this guidance, it was concluded that the CCG did have the legal power (and legal obligation) to enter into a contract for its own audit. That contract extended beyond the period of the CCG's continuing operations and so is inherited by the ICB, through a process of novation. The entire JUCD NHS system was participant in the specification of the procurement for the contract, and four of the six organisations committed to the outcome through their own governance processes (meeting point 5 and applying point 6 of the guidance).

The guidance asks about the appointment of auditors in point 25. This is not the same thing as inheriting a contract. The CCG did not enter into a binding contractual obligation on behalf of its successor. It did, within the terms of its authority, entered into a binding contractual obligation on behalf of itself, and that obligation has been inherited by the ICB. This guidance says that the ICB will need to make an active decision to appoint the auditor under the terms of the contract in situ, or choose not to do so and to put in place alternative arrangements.

The guidance appears to state that because that decision will be outstanding at the point at which the ICB is established, there will inevitably be a breach of the Local Audit & Accountability (LAA) Act. That breach is notifiable, and is most easily rectified by a decision to appoint the CCG's existing Auditor under the terms of the novated contract, but this remains a choice which must be made by the ICB following its constitution.

Proposed Process to Appoint External Auditors in the ICB

The action taken by the CCG gives the ICB a straightforward route to the appointment of an external auditor. KPMG were procured via a process carried out jointly with each of its JUCD NHS stakeholder organisations, and therefore has inherited a contract which it can continue or choose not to continue under the terms of that contract. The specification already allows for the fact of the CCG demise and that the ICB will inherit the contract, and may require differential audit arrangements; giving the ICB an option which it can tailor to its needs as they develop.

Recommendation

It is proposed that the Board AGREE to:

a) form an Audit Panel consisting of members of the Board;
b) the Audit Panel considering the specifications of the novated contract of the CCG's External Audit to ensure this meets the needs of the ICB; and
c) the Audit Panel recommending to the Board a decision on whether to appoint the CCG's External Auditor under the terms of the novated contract.

Due to the breach of the LAA Act, it is proposed the above will be actioned promptly on the ICB's establishment.

Appendix A – National Guidance Surrounding Novation of CCG Contracts

5. How should ICBs be involved in making decisions for future contracts prior to their establishment?

CCGs should be ensuring that ICB designates are involved and consulted on commissioning decisions for healthcare services and contracting decisions for non-healthcare services from the date of this publication up to the point of transfer. This is important to ensure that ICB designates are involved in determining future commissioning need and decisions and to enable contracts to be extended / renewed as appropriate.

6. Can CCGs enter into contracts for the ICB?

Any contract that a CCG enters that continues beyond the transfer date will transfer to the ICB. Therefore, whilst CCGs do not have any legal power to enter a contractual obligation in the name of an ICB, any contract that the CCG does enter will be binding on the successor organisation. It is essential that appropriate arrangements are in place to ensure continuity of clinical care for patients and service users during the transition. As discussed above, it is therefore important that ICB designates are consulted in relation to all commissioning and contracting decisions.

25. ICBs will need an auditor from the point of establishment but will not have the authority to appoint before that so how should this be managed?

As outlined above CCGs have no legal powers to enter a binding contractual obligation on behalf of a different (albeit successor) organisation, or one that does not exist. Any contract sitting with a CCG will be transferred to a receiving ICB under the Staff and Property Transfer Scheme but the CCG has to have the legal ability to enter into the contract in the first place.

It is possible for preparatory work to be carried out for the ICB, say running a procurement process for auditors, but the decision to appoint would need to be taken following the establishment of the ICB.

That means that there will be a breach of the requirement of Section 7 of the Local Audit & Accountability Act 2014 (which will be amended to replace obligations currently on CCGs with the same obligations on ICBs) for ICBs to have an external auditor appointed by 31 December in the prior financial year.

Although non appointment of auditors by 31 December for ICBs will represent a technical breach it is an unavoidable consequence of ICB legislation timing. It will only arise at the point that the relevant consequential provisions of the Health and Care Bill come into force (presumably at the same date as ICBs are created) at which point the breach could be swiftly remedied. The sanction (at Section 13) is to inform NHSE, who in turn must inform the Secretary of State if the breach is not addressed by 25 March in the preceding financial year (who can direct NHSE or the ICB to appoint an auditor). The provisions cannot bind the ICB until it exists so in year one the provisions cannot operate as the Act intends.

NHS DERBY AND DERBYSHIRE ICB BOARD

INAUGURAL MEETING

1st July 2022

Item: 012

Report Title	Closing Due Diligence Checklist for NHS Derby and Derbyshire CCG							
Author	Chrissy Tucker, Director of Corporate Delivery							
Sponsor (Executive Director)	Helen Dillistone, Executive Director of Corporate Affairs							
Presenter	Helen Dillistone, Executive Director of Corporate Affairs							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☒
Appendices	Appendix 1 Derby & Derbyshire CCG Closure Report Appendix 2 Boundary Change Report Appendix 3 Changes to Due Diligence Checklist Appendix 6 Letter from CCG AO							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	CCG Extraordinary Audit Committee, 18th May 2022							

Recommendations
The Board is asked to **NOTE** the contents of this report for assurance and information.
Purpose
The purpose of this paper is to appraise and assure the Board of the work undertaken to close down the Derby and Derbyshire CCG safely and legally, in order to establish the Derby and Derbyshire Integrated Care Board.
Background
In spring 2021 the Government announced plans for the abolishment of CCGs and the establishment of Integrated Care Systems, to be enacted, subject to the passage of the Bill through parliament, in April 2022 (subsequently delayed until July 2022). Following the announcement, the CCG, working with JUCD colleagues, set up systems and processes to close down the CCG and prepare for the establishment of the new ICS including the statutory body of the Integrated Care Board. In preparation for a submission to NHSEI of our Due Diligence Checklist and staff and property lists on 20th May, an Extraordinary Audit Committee of the CCG was convened to review the processes undertaken and the evidence provided in support, for both the Derby and Derbyshire CCG and for the Glossop element of Tameside & Glossop CCG relating to the boundary change announced by the Secretary of State. Reports were provided for both the Derby and Derbyshire CCG process and the Glossop process. These are attached at Appendices 1 and 2. A number of

appendices were also provided. (The appendices included in those reports are not included in this paper).

Appendix 3	Due Diligence Checklist showing staff, property and matters to be transferred from Derby and Derbyshire CCG to the Derby and Derbyshire ICB Board. Appendix 3 identifies the changes made to the Due Diligence Checklist since 20th May.
Appendix 4	Level 3 Template reflecting property to be transferred from Tameside & Glossop CCG pertaining to Glossop. There are no staff to transfer. The Level 3 template is the version submitted on 20th May, it has been confirmed there are no changes. The level 3 template has not been provided as an appendix to this report due to the confidential data included in the document.
Appendix 5	Level 4 Template reflecting staff and property to be transferred from Derbyshire Healthcare Foundation Trust, who host the Joined Up Care Derbyshire team who will transfer into the Derby and Derbyshire Integrated Care Board. The Level 4 template is the version submitted on 20th May, it has been confirmed there are no changes. Derby and Derbyshire CCG staff information was submitted confidentially to NHSEI. Since 20th May, 8 staff have left the organisation and there has been 6 new starters (up to 30th June 2022). The Level 4 templates have not been provided as an appendix to this report due to the confidential data included in the documents.

CCGs have continued their business as usual functions since the submission of the above materials on 20th May and it is therefore possible that new staff or property matters may arise between 20th May and 1st July and that will require transfer to the ICB. To account for this, records have been updated and those that have been updated are indicated above.

As part of the programme of work for transition, risk registers have been maintained. A number of these risks have been closed and any residual risks have been allocated within the ICB as appropriate and included in the risk reports presented at this meeting today.

All Due Diligence evidence was submitted to NHSEI with no concerns raised, and the CCG Accountable Officer wrote to the ICB Chair and the NHSEI Midlands Regional Director on 1st June 2022 to confirm that he was assured of this. The letter is attached at Appendix 6.

Identification of Key Risks

Not applicable.

Have any conflicts of interest been identified throughout the decision-making process?

None identified.

Project Dependencies

Not applicable.

Completion of Impact Assessments

Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☒	Inclusive leadership	☒

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
Not applicable for this report

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
Not applicable

Appendix 1

Derby and Derbyshire Clinical Commissioning Group

EXTRAORDINARY AUDIT COMMITTEE

18th May 2022

Closure of NHS Derby and Derbyshire CCG

Background

In spring 2021 the Government announced plans for the abolishment of CCGs and the establishment of Integrated Care Systems, to be enacted, subject to the passage of the Bill through parliament, in April 2022. Following the announcement, the CCG, working with JUCD colleagues, set up systems and processes to close down the CCG and prepare for the establishment of the new ICS including the statutory body of the Integrated Care Board. This paper outlines the work and progress to date of the arrangements to close down the CCG.

Management of Work Programme

The Executive Director of Corporate Strategy and Delivery was nominated as the Senior Responsible Officer for CCG closure and to support of ICB transition. To enable the delivery of the work programme, members of CCG staff assumed responsibility for different areas, including oversight of the programme as a whole, and leadership on particular functions within the programme. Delivery and assurance groups were also established to take the programme forward and to provide check and challenge where appropriate. Roles, groups and functions are set out below:

Role	Function
Executive Director of Corporate Strategy & Delivery	SRO
Director of Corporate Delivery	Programme Lead
Corporate Estates Manager	Due Diligence Checklist Lead
Project Manager	Project Plan Lead
CCG Directors and Senior Managers	Lead for functional areas
Transition Senior Management Team, meeting weekly	Jointly led by SIRO and ICS Director Lead to manage transition programme including assurance on due diligence, also attended by NHSEI colleagues
CCG Transition Project Group, meeting monthly	Management of project plan and Due Diligence Checklist
CCG Transition Working Group, meeting monthly	Assurance and advisory check and challenge group providing support to the programme
System Transition Assurance Committee, meeting monthly	Assurance on CCG closure to support establishment of ICB
CCG Governing Body, meeting monthly	Assurance on CCG closure
Internal Audit (360 Assurance)	Assurance as to management of process and in attendance at CCG Transition Project Group and System Transition Assurance Committee

Risk logs were developed and maintained, overseen by the CCG Transition Project Group and reported to the Transition Working Group for CCG Closure, with an ICB Transition risk log also developed and including any due diligence risks which were reported to the System Transition Assurance Committee. The risk log for CCG Closure is attached at Appendix 1 for information. The majority of the risks are medium or low and none of the risks within the log will prevent the

closure of the CCG. There is one new very high risk, which will be removed from the log at the next update as it relates to a generic risk and not one that specifically affects our ability to close the CCG.

NHSEI Assurance Requirements

CCGs have worked to a national timeline set by NHSEI which has been updated periodically since the commencement of the preparation period. A Due Diligence Checklist has also been provided which has been periodically updated and which the CCG has worked through with functional leads regularly. The Due Diligence Checklist superceded the original project plan that had been developed.

The Midlands Regional team have set slightly earlier target dates in order that key documents and plans can be reviewed and assured ahead of national submission. There have been regular checkpoints with NHSEI colleagues, with feedback given on progress and areas for improvement.

NHSEI have determined a number of levels to support the transfer process:

- Level One - one CCG transferring to one ICB
- Level Two - multiple CCGs transferring to an ICB
- Level Three - CCGs 'split' by ICS boundary changes; staff and property to be apportioned between ICBs
- Level Four - staff and property (eg staff records) being transferred from non-CCGs to ICBs

NHSEI have identified that all four levels apply to Derbyshire.

The final submission date for a number of ICB establishment documents and due diligence documents is Friday 20th May and, in terms of requirements for due diligence, the following is required:

1) Updated Due Diligence Checklist, detailing staff, property and matters to be transferred from NHS Derby and Derbyshire CCG to NHS Derby and Derbyshire ICB (covers Levels 1 and 2 described above).
2) Level 3 Template detailing property to be transferred from NHS Tameside & Glossop CCG specifically relating to the Glossop locality.
3) Level 4 Template detailing staff and property to be transferred from the Joined Up Care Derbyshire Team.

Appendices for Review

1 Transition Project Group Risk Log

2 Due Diligence Checklist. The Checklist includes property to be transferred. The staff list at tab 2.2 is not populated due to the confidential nature of its content. The CCG is awaiting guidance from NHSEI as to the way in which this information can be provided on 20th May within GDPR regulations. Contracts and equipment lists are not specifically requested to be shared on 20th May as finance colleagues have recently shared them. However, they are provided here for Audit Committee's information. A small number of updates are outstanding in terms of confirmation of completion; these will be concluded prior to submission to NHSEI. Please also note that the greyed out areas relate to ICB transition actions which are accounted for and updated in the ICB transition programme plan.

3 Level 3 Template confirming property to be transferred from Glossop. There are no staff to be transferred. For submission, the Template must be signed by the CEO for the transferring organisation and for the receiving organisation, ie the CEO for T&G CCG and the CEO Designate for the ICB.

4 Level 4 Template confirming staff and property to be transferred from non-CCG organisations, namely JUCD for our system. For submission, the Template must be signed

by the CCG for the transferring organisation and for the receiving organisation, i.e. the CEO for Derbyshire Healthcare NHS Foundation Trust and the CEO Designate for the ICB.

Outstanding matters

Some matters relating to the CCG cannot be actioned prior to the transition date of 1st July and will be for the ICB to action. These relate to the assurance of the CCG's accounts and annual reports:

- Accounts and annual report for the 12 months to 31st March 2022 will be presented to the CCG Audit Committee in May 2022.
- Accounts and annual report for the final 3 months of the CCG from 1st April 2022 to 30th June 2022 (Q1) will be presented to the ICB Audit & Governance Committee in late summer 2023.

Discussions are in progress with external auditors as to timetabling of audit of these reports prior to presentation to the ICB Audit & Governance Committee in line with NHSEI requests and are not yet finalised.

Finally, the CCG financial ledger will continue to operate after 1st July to allow access to audit. A new financial ledger will be in operation from 1st July for the ICB in parallel to this.

Next Steps

Following Audit Committee's review of the process and appendices, the documents will be uploaded to NHS Futures on 20th May. It will be reviewed by the regional team who will prepare a report for the national team. Following this the CCG will be provided with a template letter from the CCG CEO providing assurance to the NHSEI Midlands Regional Director on the safe and legal closure of the CCG. The legal instruments will then be prepared.

All four documents listed above will continue to be updated until 24th June, when the CCG will stop receiving new matters, which will be held over for the ICB to take on from 1st July. The inaugural meeting of the ICB Board will receive a closure pack containing an updated report, checklist and templates. Where risks cannot be closed in advance of this date, they will be transferred to the ICB risk register.

Appendix 2

Derby and Derbyshire Clinical Commissioning Group

EXTRAORDINARY AUDIT COMMITTEE

18th May 2022

Boundary Change

Background

As part of the proposal for the creation of ICSs within the Government's Health Bill, the decision was taken by the Government to propose the amendment of a small number of geographical health boundaries so that health and social care is co-terminus. One of these is the boundary between Derby and Derbyshire CCG (DDCCG) and the Derby and Derbyshire Integrated Care System and Tameside and Glossop CCG (TGCCG) and the Greater Manchester ICS, so that the responsibility for Glossop's health provision moves from Tameside and Glossop CCG into Derby and Derbyshire CCG. The benefits of the decision are that alignment enables more opportunities for joined-up working with the local authority and the creation of joined-up plans for prevention and population health.

Management of Work Programme

DDCCG and TGCCG have come together to develop a programme of work to support and deliver the transition. The DDCCG Executive Director of Corporate Strategy and Delivery was nominated as the Senior Responsible Officer for the boundary change in line with responsibility for CCG closure, together with TGCCG's Director of Commissioning. To enable the delivery of the work programme, members of both CCGs staff assumed responsibility for different areas, including oversight of the programme as a whole, and leadership on particular functions within the programme. Delivery and assurance groups were also established to take the programme forward and to provide check and challenge where appropriate. Roles, groups and functions are set out below:

Role	Function
DDCCG Executive Director of Corporate Strategy & Delivery	SRO
TGCCG Director of Commissioning	SRO (TGCCG)
DDCCG Senior Programme Manager	Overall Programme Lead
Steering Group	Meets monthly to provide oversight of the programme delivery, risks and issues. Receives updates and assurance from workstreams on progress. Provides assurance to DDCCG Transition Working Group and the Board
DDCCG Internal Glossop Meeting	Management of the action plan, associated risks, and issues.
FICE Workstream	Meets monthly Delivery of actions relating to Finance, IT, Contracts, Primary Care and Estates. Provides due diligence in the transfer of Glossop-related assets and liabilities from TGCCG to DDCCG Provides assurance of progression and escalation of risks/issues to Steering group

Role	Function
Statutory Duties Workstream	Meets monthly Delivery of actions relating to Statutory Functions and Governance. Focussed on the safe and effective transfer of the responsibility for the commissioning of health services. Provides assurance of progression and escalation of risks/issues to Steering group
Neighbourhood Workstream	Meets 6-weekly Delivery of the actions relating to Neighbourhood Development to enable the transfer from TGCCG's existing arrangements of the commissioning, delivery, and support for neighbourhood models of care and population health. Provides assurance of progression and escalation of risks/issues to Steering group
Communications Workstream	Meets monthly Delivery of the actions relating to communications and engagement to ensure consistent messaging to public and staff during the transition process. Provides assurance of progression and escalation of risks/issues to Steering group
Transition Senior Management Team, meeting weekly	Jointly led by SIRO and ICS Director Lead to manage transition and boundary change programme, including assurance on due diligence, also attended by NHSEI colleagues
CCG Transition Project Group, meeting monthly	Management of project plan and Due Diligence Checklist, including Glossop transfer
CCG Transition Working Group, meeting monthly	Assurance and advisory check and challenge group providing support to the programme, receiving assurance on Glossop transfer
System Transition Assurance Committee, meeting monthly	Assurance on CCG closure to support establishment of ICB
CCG Governing Body, meeting monthly	Assurance on CCG closure and boundary change
Internal Audit (360 Assurance)	Assurance as to management of process and in attendance at CCG Transition Project Group and System Transition Assurance Committee

Risk and issues logs were developed and maintained by the Senior Programme Manager overseen by the Glossop Steering Group and reported through both CCG's transition governance groups for assurance (Transition Working Group for DDCCG). The risk log for the Glossop transition is attached at Appendix 7 for information. The risks are medium or low (with the highest risk scoring 12). None of the risks within the log will prevent the transition of Glossop into DDCCG. There is a known risk relating to the difference in clinical policies that exist between the two CCGs. An approach has been agreed which has been presented to DDCCG Senior Leadership Team, Clinical and Lay Commissioning Committee and Engagement Committee is included for information at Appendix 8.

Full details of the property to be transferred to the Derbyshire ICB from Tameside and Glossop are included in the Level 3 Template included in this pack of papers. With regard to contracts, only those pertaining fully to Glossop are included. However, there are a significant number of contracts currently held by TGCCG relating to healthcare and non-healthcare services. GMICB will

continue to be the lead commissioner for these contracts and DDICB will become an associate commissioner. These are included in Appendices 9 and 9a.

NHSEI Assurance Requirements

TGCCG sit within NHSE/I Northwest Region and they liaise with their NHSE/I regional lead on all matters relating to the Due Diligence process and the transfer of Glossop to Derbyshire. TGCCG have also received support and advice from their legal advisers, Browne Jacobson, to enable them to provide assurance to DDCCG of their close down process and associated actions.

DDCCG has received support from NHSE/I Midlands team and has provided assurance to them of the ongoing transition process.

Appendices for Review

3 Level 3 Template confirming property to be transferred from Glossop

7 Glossop Transition Risk Register

8 Paper describing the planned approach to risk relating to clinical policy

9 Report on contracts to which DDICB will be associate commissioner

Outstanding matters

Whilst an agreement in principle has been reached, there is a discussion between the CFOs of both DDCCG and TGCCG to address the ongoing issue relating to stranded costs. This includes the option for Service Level Agreements for several TGCCG-delivered services relating to Medicines Management, Nursing and Quality and safeguarding.

The Steering Group and associated workstreams will work with the operational teams to complete the transition work by 1st July 2022 but there is recognition that there may be further understanding of finance required post-transition. As a result of the anomalies created by the COVID pandemic, the work done to date to establish the percentage allocation split may not align to real-time activity and costs in 22/23. DDCCG and TGCCG colleagues have agreed to work collaboratively on this so that neither party is disadvantaged and will identify these areas as early as possible and agree:

- A person responsible for the action
- The required outcome and a plan of action to achieve this
- A timeline for completion
- Governance mechanisms for assurance or escalation.

Throughout the post-transition period, as Derbyshire moves to operationalise the services, DDICB colleagues will continue to liaise with their counterparts (who will move from TGCCG into GMICB) to enable discussion on outstanding actions, queries and details about service provision and plans for future commissioning. The principle stands that both will prioritise patient outcomes and experience during this time.

Next Steps

Following Audit Committee's review of the process and appendices, the Level 3 template will be uploaded to NHS Futures on 20th May. It will be reviewed by the regional team who will prepare a report for the national team. On 1st June 2022, TGCCG AO will formally write to DDCCG AO to provide assurance that TGCCG have followed a robust process of due diligence to prepare for closedown and for the safe transfer of staff and property relating to Glossop to DDICB. The legal instruments will then be prepared.

Appendix 3 – Changes to Due Diligence Checklist since 20th May 2022

Tab	Ref	Due Diligence Area for Review	CCG close down	ICB setup	Responsible Lead	RAG	Comments
1.Core Due Diligence Checklist	1.4.2	Open outstanding / ongoing complaints that would transfer	Y	Y	Suzanne Pickering	Complete	20/06/22 6 open complaint cases to be transferred over
1.Core Due Diligence Checklist	1.4.7	Open Individual Funding Requests or appeals that would transfer	Y	Y	Slak Dhadli	Complete	20/06/22 1 open IFR
1.Core Due Diligence Checklist	1.4.11ii	Number of Looked After Children cases to be transferred	Y	Y	Michelina Racioppi	Complete	20/06/22 - There are currently 6 child practice reviews, 1 serious case review and two rapid reviews we are processing. In regard to the child death overview panel processes we have currently 73 open cases to review - of which 13 are categorised as green , 23 categorised as amber and 37 categorised as red making a total of 73
1.Core Due Diligence Checklist	1.4.11iii	Number of Deprivation of Liberty Safeguarding (DOLS) cases to be transferred	Y	Y	Michelina Racioppi	Complete	20/06/22 - update of figures There are 19 DCC CLA living in Glossop area 22 DCC Care Leavers living in Glossop area (includes any/all Care Leavers up to age 25) 29 Other LA CLA Living in Glossop area. In Derbyshire County there are 945 Derbyshire looked after children in total. there are also 575 Looked after children in placed in Derbyshire County that are from other Local Authorities placed in the Derbyshire county area . Also In Derby City there are 624 Derby City Local Authority looked after children placed in the City and 155 looked after children placed in the City from other Local Authorities
3.1. Financial - Governance	3.1.13	Ensure process in place to produce and submit end of year taxation returns (P11D and P60) (also included on HR tab 2.1)	Y	Y	Darran Green	**On track - partly complete**	20/06/22 P11d's aren't submitted by payroll until 19th July HMRC deadline. P60s will also be complete after the cessation of the CCGs.

Tab	Ref	Suggested Actions	CCG close down	ICB setup	Responsible Lead	RAG	Comments
3.2.Financial - Accs & Audit	3.2.13.3	Ensure an agreed LCFS work plan is in place which should include (not exhaustive): -consideration of proactive work both before and after the establishment of the ICB in the light of the risks that it poses and adjust the nature and timing of work accordingly. -fraud risk assessment activity considering increased risk of fraud and asset loss during times of change (this is a major risk on reorganisation). -appropriate action to ensure compliance with the NHS Requirements of the Government Functional Standard GovS013 Counter Fraud	Y	Y	Darran Green	**On track - partly complete**	20/06/22 LCFS plan will be finalised once the new Exec DoF has started.
3.3.Financial - Ledger Requirements	3.3.4	Notify the NHSE cash funding team of the chief financial officer's name, the ICB's address and the GBS account number nhsenglandcash.management@nhs.net	N	Y	Donna Johnson	Complete	20/06/22 NHSEI have now been notified of the ICB's appointed DoF
3.3.Financial - Ledger Requirements	3.3.35	Prepare and agree and ICB financial plan	N	Y	Donna Johnson	Complete	16/06/22 Following the NHSEI escalation meetings, the system will submit its final breakeven plan on 20th June

Tab	Ref	Suggested Actions	CCG close down	ICB setup	Responsible Lead	RAG	Comments
3.3.Financial - Ledger Requirements	3.3.37	Review the cost improvement programmes and determine a new programme for the ICB	N	Y	Darran Green	On track - partly complete	22/06/22 The plan was submitted on 21/06/22 and had total system efficiencies of £116m to be delivered in 2022/23, split £57m with the ICB and £59m with the JUCD Providers. Reporting of this will be developed in the coming weeks.
3.4.Financial - Banking	3.4.17	Ensure new stationery (e.g. payable orders (POs) and cheques) is ordered and received with name of the ICB and safe arrangements for storage made. To include new VAT number and GBS / bank account details	N	Y	Donna Johnson	Complete	19/06/22 Contact details have been obtained for stationary requests once the bank account name has been changed on 1st July
5.0.DSPT Checklist	5.13	IG governance process established (in shadow form until ICB established) - Structure agreed - Terms of Reference agreed - Meetings scheduled - Risk register agreed	Y		Ruth Lloyd	Complete	*20.*.06.22 - IGAF meetings will continue in the ICB structures
5.0.DSPT Checklist	5.35	Registration of ICB - Removal of previous CCG registration(s)	Y	Y	Ruth Lloyd	Complete	20.06.22 - ICO registration will be possible on the 4th July where new financial transactions can be undertaken as QJ2

Appendix 6

Derby and Derbyshire
Clinical Commissioning Group

1st Floor North
Cardinal Square
10 Nottingham Road
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DE1 3QT
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30th May 2022

John MacDonald
Chair Designate
NHS Derby and Derbyshire Integrated Care Board

Dear John,

CLOSURE OF NHS DERBY & DERBYSHIRE CCG

I am writing to provide assurance that NHS Derby and Derbyshire CCG has followed a robust due diligence process to prepare for closedown and for the safe transfer of staff and property (in its widest sense) to NHS Derby and Derbyshire ICB on 1 July 2022.

A staff list has been prepared in line with tab 2.2 of the NHSEI due diligence checklist and has been shared on a strictly 'need to know'* basis. It will be kept up to date for 1 July 2022.

Records of NHS Derby & Derbyshire CCG property (tangible and intangible assets (including contracts), rights and liabilities) are in good order, to provide the relevant teams in the ICB with a clear baseline position at 1 July 2022.

This assurance is based on review of relevant documentation and assurances that I have received from my senior team, internal auditors and our Extraordinary Audit Committee held on 18 May 2022. The relevant documentation appended is listed below:

1) Internal Audit Reports (a, b and c)
2) Extraordinary Audit Committee Report A - Derby and Derbyshire CCG
3) Extraordinary Audit Committee Report B - Glossop
4) Minutes of the Extraordinary Audit Committee
5) Due Diligence Checklist for Derby and Derbyshire CCG
6) Level 3 Template - Glossop
7) Level 4 Template – Derbyshire Healthcare Foundation Trust (Joined Up Care Derbyshire)

Our preparations have taken account of the NHSEI ICS implementation guidance: 'Due diligence, transfer of people and property from CCGs to ICBs and CCG close down' and the accompanying due diligence checklist, covering all aspects of current operations, including people, quality, finance and commissioning.

*Person identifiable information will be managed in accordance with the UK General Data Protection Regulation (GDPR) and the Data Protection Act 2018 and should be processed and shared in a secure manner i.e. only with people who have a legitimate need to have access to it and to be held no longer than is necessary for the specified purpose. Commercially sensitive data will be handled in the same manner.

The CCG has undertaken all the necessary actions prior to close down. Where there are outstanding matters relating to the CCG(s), which cannot be actioned prior to 1 July 2022(for example, the closure of legacy bank accounts and the finalisation of the 2021/22 annual report and accounts) these have been clearly documented in the Extraordinary Audit Committee report and identified for the ICB for action. The ICB Board will receive an updated version of these reports at its inaugural meeting on 1 July 2022.

It is understood that the Staff, Property, Rights and Liabilities Transfer Scheme to be made by the NHS Commissioning Board (NHS England) will give legal effect to the transfer of staff and property from the CCG(s) to the ICB on 1 July 2022.

The CCG's risk register will be updated prior to 1 July and shared so that the risks to be taken on by the ICB are clear. These will be presented to the ICB Board on 1 July 2022.

With regard to the boundary change and the absorption of Glossop into the Derby & Derbyshire ICB, collaborative due diligence work has taken place between Tameside & Glossop CCG and Derby & Derbyshire CCG. Assurance on the process was received at the Derby & Derbyshire CCG Extraordinary Audit Committee on 18 May 2022 and at the Tameside & Glossop Audit Committee on 18 May 2022. The Level 3 template for Staff, Property, Rights and Liabilities Transfer Scheme shows the property to be transferred to the Derby and Derbyshire ICB and is attached for information. There are no staff to transfer to Derby and Derbyshire ICB.

Please also see attached the Level 4 template for Staff, Property, Rights and Liabilities Transfer Scheme which shows the staff and property to be transferred from Derbyshire HealthCare NHS Foundation Trust to the Derby and Derbyshire ICB. Assurance on the process was received at the Derby & Derbyshire Extraordinary Audit Committee on 18 May 2022.

All templates and checklists have been provided to NHSEI Regional Team in accordance with their guidelines.

Should you have any queries regarding the due diligence process or assurance provided, please do not hesitate to contact me.

Yours sincerely

Dr Chris Clayton
Chief Executive Officer
NHS Derby and Derbyshire CCG

Cc Dale Bywater, NHSEI Midlands Regional Director

Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

INAUGURAL MEETING

1st July 2022

Item: 013

Report Title	Delegation of Services from NHS England to Integrated Care Boards							
Author	Hannah Belcher, Assistant Director GP Commissioning and Development							
Sponsor (Executive Director)	Zara Jones, Executive Director Strategy and Planning							
Presenter	Zara Jones, Executive Director Strategy and Planning							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☒
Appendices	Appendix 1 – Summary report NHSEI Midlands and East Appendix 2 – Delegation agreement for NHS Derby and Derbyshire ICB							
Assurance Report Signed off by Chair	N/A							
Which committee has the subject matter been through?	N/A							

Recommendations

The Board are recommended to **NOTE** the Delegation of Services from NHS England to Integrated Care Boards on 1st July 2022.

Purpose

The purpose of the report is to :

1. provide a summary of the delegation agreement areas of responsibility (Appendix 1) and next steps for the NHSEI services that will transition to ICSs as follows:
   - Primary Medical Services on the 1st July 2022;
   - Complaints functions associated with Primary Medical Services;
   - Primary Pharmacy, Optometry and Primary and Secondary Dental Services on 1st April 2023;
   - complaints functions associated with Primary Pharmacy, Optometry and Primary and Secondary Dental Services on 1st April 2023; and
   - specified specialised services from April 2023;

2. provide an overview of the Operating Model principles agreed for the delegation of Pharmacy, Optometry and Dental Services and next steps;

3. provide an update on the collaborative work with NHSEI Midlands and East, Midlands and East Integrated Care Systems and the Chief Executive sponsors relating to workforce, finance, nursing and quality; and

4. receive the NHS Derby and Derbyshire ICB Delegation Agreement for information (Appendix 2).

Background

The attached paper (Appendix 1) has been prepared by NHSEI to support the Board with understanding the delegation requirements in relation to the following NHS England services:

- Primary Medical Services on the 1st July 2022;
- complaints functions associated with Primary Medical Services;
- Primary Pharmacy, Optometry and Primary and Secondary Dental Services on 1st April 2023;
- complaints functions associated with Primary Pharmacy, Optometry and Primary and Secondary Dental Services on 1st April 2023; and
- specified specialised services from April 2023.

In all cases the responsibility and liability for the planning, performance, finance, quality, and improvement will move from NHSE to ICBs upon delegation. However, in all cases NHSEI remains accountable to the Secretary of State for the services, which means that NHSEI will have oversight, set standards and service specifications for the services.

To ensure that any transition is safe, effective and benefits are maximised, NHSEI and ICB Designate Chief Executives have agreed a phased transition to our future state through 2022 to 2024.

Report Summary

The attached summary report provided by NHSEI Midlands and East Regional Team provides details for the delegation of Primary Medical Services to ICBs on 1st July 2022 and an overview of the operating model for the delegation functions including Pharmacy, Optometry and Dental Services and the approach for the delegation of complaints functions to ICBs.

Identification of Key Risks

NHSEI Midlands and East Regional Primary Care Team has confirmed that there will no transfer of existing work from NHSEI to ICBs in 2022/23 for the Pharmacy, Optometry and Dental Primary Care functions.

There will be a resource requirement for ICBs to send officer representatives to attend NHSEI governance meetings and working groups that have been established to support the transition during 2022/23.

There are a number of areas which are still to be worked through relating to workforce, governance, finance, nursing and quality, complaints, reserved/retained functions by NHSEI where the outcome of this work then may lead to specific risks being identified and additional resource required.

A risk remains that the outstanding areas to be worked through may not be completed prior to the Pre Delegation Assurance Framework in Mid-September and therefore there could be additional gaps, risks and impact on the ICB resources (particularly financial and workforce issues) that arise during 2022/23.

Have any conflicts of interest been identified throughout the decision-making process?

Not applicable.

Project Dependencies				
Completion of Impact Assessments				
Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☒	Inclusive leadership	☒

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
Not applicable.

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
Not applicable.

ICS Executive & ICS Board Briefing Paper

Date: 14th June 2022

Agenda item:

Paper Title: Delegation of Services from NHS England to ICS Boards

NHSE Executive Lead: Roz Lindridge, Regional Director of Commissioning

ICS Executive Lead:

Executive summary: This paper provides details for the delegation of Primary medical Services to ICBs on 1st July 2022 and an overview of the operating model for the delegation of Pharmacy, Optometry & Dental Services and the approach for the delegation of complaints functions to ICBs

1 Introduction and purpose of the paper

1.1 By delegating commissioning functions to ICBs the aim is to break down barriers and join up fragmentated pathways to deliver better health and care so that our patients can receive high quality services that are planned and resourced where people need it. This paper aims to support the ICS Board with understanding the delegation requirements in relation to the following NHS England services

- Primary Medical Services on the 1st July 2022
- Complaints functions associated with Primary Medical Services
- Primary Pharmacy, Optometry & Primary and Secondary Dental Services on 1st April 2023
- Complaints functions associated with Primary Pharmacy, Optometry & Primary and Secondary Dental Services on 1st April 2023
- Specified Specialised Services from April 2023

1.2 Delegation of these services is a national policy. In all cases the responsibility and liability for the planning, performance, finance, quality, and improvement will move from NHS England to ICBs upon delegation. However, in all cases NHS England remains accountable to the Secretary of State for the services, which means that NHSE will have oversight, set standards and service specifications for the services.

1.3 To ensure that any transition is safe, effective and benefits are maximised, NHSEI and ICB Designate Chief Executives have agreed a phased transition to our future state through 2022 to 2024.

1.4 We have designed and developed a joint approach and through collaboration and co-production with ICS teams, working together to produce operating frameworks that maximise ICS decision making whilst retaining the specialist knowledge and skills of staff.

1.5 Through delegation ICB must:

- at all times have regard to the Triple Aim

- at all times act in good faith and with integrity
- conduct all the required commissioning functions in respect of Primary medical service outline and defined in the delegation agreement
- consider how it can meet its legal duties to involve patients and the public in shaping the provision of services, including by working with local communities, consider how in performing their obligations they can address health inequalities
- at all times exercise functions effectively, efficiently and economically
- act in a timely manner
- share information and best practice, and work collaboratively to identify solutions and enhance the evidence base for the commissioning and provision of health services, eliminate duplication of effort, mitigate risk and reduce cost.

1.6 The 11 Midlands ICB Designate Chief Executives have reviewed the NHSEI Commissioning portfolio over the past 12 months, and agreed that:

- Primary Care decision making is best undertaken at an ICS level
- Specialised Service decision making is best undertaken at a Multi-ICS level due to the complexity and risks associated with these services.

2. Primary Medical Services

2.1 Primary medical services are currently delegated to CCGs. As ICBs become legal entities and CCGs dissolved, ICBs will automatically take on Primary Medical services without undertaking further due diligence. The new ICB delegation agreement in a new agreement and now included the delegation of liabilities. As with current arrangements, an MoU will cover the support arrangements (known as GMAST) until the agreed transfer in line with Pharmacy, Optometry and Dental services

2.2 There is a nationally defined process for sign off of new Delegation Agreements, with sign off required by the CEO of the ICB on the 1st July 2022. The Delegation Agreement will be sent to ICBs from 20th June.

3. Complaints functions associated with Primary Medical Services

3.1 Handling of complaints made in respect of primary medical services in accordance with the Complaints Regulations will be delegated to ICBs.

3.2 As a principle, the complaints functions will be delegated at the same time as the primary functions they support; as such the responsibility for the management of complaints is delegated to ICBs for primary medical services from 1st July. However, the national task and finish groups for the oversight of complaints has recently convened, therefore the national policy for this is underdevelopment.

3.3 All 11 ICB Designate Chief Executives have agreed on the advice of the Regional Director of Nursing and Quality to a 3 month transition from the 1st July to the 30th September whereby the ICB will delegate back the responsibility for complaints to delegated senior officers within NHSE will continue to sign off complaints. This will provide an appropriate and timebound period to enable further detailed work to be carried out in relation to the transfer of this responsibility.

3.4 The workforce supporting the complaint functions for Primary Medical Services will be included in the operating model and workforce model under the wider primary care (Primary Dental, Optometry & Pharmacy Services (POD) delegation work.

4. Primary Pharmacy, Optometry & Primary and Secondary Dental Services

4.1 NHSEI, ICB Designate Chief Executives have been working together to plan and develop our joint approach to delegation of these services to ensure the safe and effective transition to a more integrated way of working.

4.2 In order to achieve the April 2023 delegation requirement, applications are required to be submitted by each **ICB by mid-September 2022 for** Primary Care Pharmacy, Optometry & Dental. Each ICB is required to sign off an Operating and Workforce model in advance of the September 2022 assurance process.

4.3 The principles within this Operating Model have been developed jointly between ICBs and NHSE. However, the ability to influence future transformation of these services is limited due to the national stipulations and constraints of the contracts.

4.4 To support a safe and ordered transition during 2022/23, joint working groups are in place to manage the risks, information governance and appropriate due diligence to ensure a transparent and smooth transfer of responsibilities to ICBs.

4.5 There are risks to taking on these delegated functions. Specifically, workforce capacity and an agreed model across systems in the East and West Midlands. Working together, mitigations will be put in place. **John Turner, Designate Chief executive for Lincolnshire ICS has agreed to be the ICB executive sponsor** for the workforce modelling working with ICS representatives and NHSE. The agreed principles for the workforce modelling are:

- Minimum disruption for staff
- Ensure that where possible our NHS talent is retained and deployed to support systems in an agile way driving forward the 'one NHS workforce' ambition
- Take steps to plan and implement the transition, encouraging best people practices throughout and enabling the right conditions for our teams to deliver the primary care function for the ICBs as responsible organisations and a team to provide oversite and assurance for the NHSE region.

4.6 The **operating model for the delegation of pharmacy, optometry and dental services** will be through **two primary care teams one East midlands team and one West Midlands team** to deliver the functions on behalf of the 5 East Midlands and 6 West Midlands ICBs.

4.7 The team will provide a clear and definable service detailed through an MOU to enable the primary care delegated functions to be delivered. ICBs will provide the leadership and strategic guidance to ensure that the team can deliver the function effectively, including:

- **Collaboration between ICBs** will be key to ensure the team can fulfil day to day functions and agreement on use of the team when there are competing priorities for their capacity, e.g. procurements, service developments etc.

- **Managing contractual relationships will be guided by nationally stipulated standardised frameworks**, but there remains a need for some local judgement and flexibility. Where standard procedures are not in place, and they cannot cover every eventuality, the teams will use their judgement and be guided by the culture, values and expected behaviours promoted by the ICBs working in collaboration to deliver these services moted by the ICBs working in collaboration to deliver these services

- **Reserved NHSE Functions:** The majority of policy setting comes from the national team. The regional team's function will be improvement, assurance, and oversight, to ensure the delegated functions are successfully being delivered and to design and deliver transformation programmes in support of national priorities

- **Interdependencies:** This operating model focuses on the Primary Care Commissioning and contracting functions. The model will also apply to the complaints function that is being delegated from April 2023 and the primary care finance team, clinical advisor support and quality functions who will form part of the delegated function.

- **Transformation and service improvement** in terms of service delivery will take place within the ICS within the structures and capacity developed as part of the ICS establishment

5. Complaints functions associated with Primary Pharmacy, Optometry & Primary and Secondary Dental Services

5.1 The complaints functions will be delegated at the same time as the primary functions they support, as such the responsibility for the management of complaints will be delegated to ICBs for Pharmacy, Optometry and Dental services from 1st April 2023.

5.2 The national task and finish group for the oversight of complaints will provide further advice and guidance in due course.

6. Specified Specialised Services

6.1 Prevention, diagnosis, acute treatment, chronic management and specialised services are planned and commissioned by different organisations with plans based on different historic views resulting in misaligned priorities. Moving to a single planning structure with aligned incentives and plans based across whole patient pathway aims to enable greater innovation and collaboration and more joined up services across the patient pathway.

6.2 There are circa 150 services categorised as specialised services that NHS England commissions; 65 of these services have been assessed as suitable and ready for delegation to ICBs. Due to the complexity and risks associated with these services, ICB Designate Chief Executives and NHSE have agreed that they are best undertaken at a Multi-ICS level.

6.3 The national 'roadmap' for specialised acute services published in May outlined the process for the delegation. The road map outlines the following:

- All services will continue to be prescribed specialised services
- As with Primary Care services, NHSE retains accountability for the entire portfolio of specialised services
- All specialised services will be subject to national service specifications and evidence-based clinical policies that will continue to be developed by NHSE
- Universal access to provision of services across the country will be maintained no matter where patients live
- Services will be commissioned on an appropriate geographical footprint, determined by factors including population base and patient flows, between NHSE and (multiple) ICBs
- The clinical leadership infrastructure that supports specialised commissioning will continue and be strengthened
- We will ensure continued involvement of patients and the public in specialised commissioning
- Commissioning expertise will be maintained in the NHSE national and regional teams in 2022/23, increasingly facing towards ICSs from 23/24
- Future delegation arrangements will be underpinned by robust governance and oversight arrangements

6.4 For those specialised acute services which are delegated to the ICB, the ICB will be required under the delegation agreement to come together on a multi-ICS footprint to jointly commission these services. The mechanism for this will be through formal Joint Committees with NHSEI retaining a seat at the table in decision making. NHSEI will retain those services currently not deemed suitable for immediate delegation.

6.5 To support ICBs understand current decision making process in acute specialised services, and to enable greater joint working in 22/23, ICS representatives (or representatives of the agreed multi-ICS footprint(s) will be invited to attend the current Midlands Formal Acute Specialised Commissioning Group (FAMSCG). We also agreed to review the name of this decision making committee to enable a smooth evolution in 23/24 when some formal delegation commences for specialised services,

6.6 The operating model will be co-produced with ICS representatives through two Midlands wide working groups (commissioning and finance). The working groups will model options for both a Midlands-wide and East & West Midlands options, which will be presented to ICB Chief executives early September. This will be informed by appropriate provider engagement.

7. **Agreed Next Steps**

7.1 Delegation agreements for Primary Medical Services will be sent to ICS from 20th June for 1st July signature. These must be returned to NHS England on the 1st July.

7.2 The modelling for workforce to support the delegation of Pharmacy, Optometry and Dental services will now be completed.

7.3 A dedicated deep dive on finance session for ICB Chief Executives and Directors of Finance for Pharmacy, Optometry and Dental services and Specialised Services will be set for early July to support the ongoing joint development of our approach to delegation.

7.4 Further work will be undertaken to co-produce with ICBs the operating model for specialised service delegation.

7.5 With Chief Executive sponsors (Simon Whitehouse Shropshire, Telford & Wrekin ICS and Toby Sanders of Northamptonshire ICS) NHS England will work though the joint working groups to develop robust governance to support delegation across all functions.

7.6 Jointly develop our approaches to Professional leadership with ICB medical directors and Directors of nursing

Recommendation

My appreciation and gratitude go to the ICB teams and ICB designate chief executives for their ongoing commitment and collaboration with other ICBs and NHSE to co-produce the operating model and approach to delegation. Together we have built a great platform for future joint working and the exploration of opportunities for collaboration.

I would like request that ICS Boards note the content of this briefing and approve the approach and way forward detailed above. Could you please get back to me in confirmation of your agreement, thus providing a myself and the Chief Executives the joint mandate to take the work forward

Kind Regards

Roz Lindridge
Regional Director of Commissioning

DATED: 2022

Delegation Agreement in respect of:

(i) Primary Medical Services

between:

NHS England

-and-

NHS Derby and Derbyshire Integrated Care Board

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Delegation Agreement for Primary Care & Dental Functions

1. PARTICULARS

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

Integrated Care Board	**NHS Derby and Derbyshire Integrated Care Board**
Area	**Area of the ICB as defined in its Constitution**
Date of Agreement	**The date stated on the front page of this document**
Effective Date of Delegation	**1 July 2022**
ICB Representative	**Chris Clayton**
ICB Email Address for Notices	**chris.clayton2@nhs.net**
NHS England Representative	**Dale Bywater**
NHS England Email Address for Notices	**dale.bywater1@nhs.net**

The following parts of Schedule 2 are included in this Agreement[1]:

Schedule 2A – Primary Medical Services	**Yes**
Schedule 2B – Primary Dental Services and Prescribed Dental Services	**Primary Dental Services: No** **Prescribed Dental Services: No**
Schedule 2C – Primary Ophthalmic Services	**No**
Schedule 2D – Pharmaceutical Services and Local Pharmaceutical Services	**No**

1.2 This Agreement comprises:

1.2.1 the Particulars (clause 1);

1.2.2 the Terms and Conditions (clauses 2 to 31); and

1.2.3 the Schedules.

[1] This table must be completed to indicate which services are included in the Delegation.

Signed by **NHS England**

Dale Bywater

Regional Director for the Midlands

(for and on behalf of NHS England)

Signed by **NHS Derby and Derbyshire Integrated Care Board**

Chris Clayton

Chief Executive Officer

(for and on behalf of NHS Derby and Derbyshire Integrated Care Board)

Terms and Conditions

2. **INTERPRETATION**

2.1 This Agreement is to be interpreted in accordance with SCHEDULE 1 (Definitions and Interpretation).

2.2 If there is any conflict or inconsistency between the provisions of this Agreement, that conflict or inconsistency must be resolved according to the following order of priority:

2.2.1 the Particulars and Terms and Conditions (clauses 1 to 31);

2.2.2 SCHEDULE 1 to SCHEDULE 6, SCHEDULE 8 and SCHEDULE 9 to this Agreement; and

2.2.3 SCHEDULE 7 (Local Terms).

2.3 This Agreement constitutes the entire agreement and understanding between the Parties relating to the Delegation and supersedes all previous agreements, promises and understandings between them, whether written or oral, relating to its subject matter.

2.4 Where it is indicated that a provision in this Agreement is not used, that provision is not relevant and has no application in this Agreement.

2.5 Where a particular clause is included in this Agreement but is not relevant to the ICB because that clause relates to matters which do not apply the ICB (for example, if the clause only relates to functions that are not Delegated Functions in respect of the ICB), that clause is not relevant and has no application to this Agreement.

3. **BACKGROUND**

3.1 By this Agreement NHS England delegates the Delegated Functions to the ICB under section 65Z5 of the NHS Act while retaining the Reserved Functions.

3.2 Arrangements made under section 65Z5 may be made on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the ICB.

3.3 This Agreement sets out the terms that apply to the exercise of the Delegated Functions by the ICB and the Parties' associated responsibilities and measures required to ensure the effective and efficient exercise of the Delegated Functions and Reserved Functions.

4. **TERM**

4.1 This Agreement has effect from the Date of Agreement set out in the Particulars and will remain in force unless terminated in accordance with clause 27 *(Termination)* below.

5. **PRINCIPLES**

5.1 In complying with the terms of this Agreement, NHS England and the ICB must:

5.1.1 at all times have regard to the Triple Aim;

5.1.2 at all times act in good faith and with integrity towards each other;

5.1.3 have regard to the intention that commissioning functions in respect of Primary Medical Services, Primary Dental Services and Primary Ophthalmic Services will in future be directly conferred on the ICB;

5.1.4 consider how it can meet its legal duties to involve patients and the public in shaping the provision of services, including by working with local

communities, under-represented groups and those with protected characteristics for the purposes of the Equality Act 2010;

5.1.5 consider how in performing their obligations they can address health inequalities;

5.1.6 at all times exercise functions effectively, efficiently and economically;

5.1.7 act in a timely manner;

5.1.8 share information and best practice, and work collaboratively to identify solutions and enhance the evidence base for the commissioning and provision of health services, eliminate duplication of effort, mitigate risk and reduce cost; and

5.1.9 have regard to the needs and views of the other Party and as far as is lawful and reasonably practicable, take such needs and views into account.

6. DELEGATION

6.1 In accordance with its statutory powers under section 65Z5 of the NHS Act, NHS England hereby delegates the exercise of the Delegated Functions to the ICB to empower it to commission a range of services for the people of the Area, as further described in this Agreement ("**the Delegation**").

6.2 The Delegated Functions are the functions described as being delegated to the ICB in such of the following Schedules as have been marked as included within this Agreement:

6.2.1 Schedule 2A: Primary medical services;

6.2.2 Schedule 2B: Primary dental services and prescribed dental services;

6.2.3 Schedule 2C: Primary ophthalmic services;

6.2.4 Schedule 2D: Pharmaceutical services and local pharmaceutical services.

6.3 The Delegation has effect from the Effective Date of Delegation.

6.4 NHS England may by Contractual Notice allocate Primary Care Contracts or Arrangements and Prescribed Dental Services Contracts in place at the Effective Date of Delegation to the ICB for the purposes of determining the scope of the Delegated Functions. The Delegated Functions must be exercised both in respect of the relevant Primary Care Contract or Arrangement or Prescribed Dental Services Contract and any related matters concerning the Primary Care Provider that is a party to that Primary Care Contract or Arrangement, or provider of Prescribed Dental Services that is party to that Prescribed Dental Services Contract.

6.5 Subsequent to the Effective Date of Delegation and for the duration of this Agreement, any new Primary Care Contract or Arrangement entered into in respect of premises in the Area shall be managed by the ICB in accordance with the provisions of this Agreement as if it had been allocated to the ICB in accordance with clause 6.4.

6.6 NHS England may by Contractual Notice add or remove Primary Care Contracts or Arrangements or Prescribed Dental Services Contracts to or from the list of those allocated to the ICB for the purposes of this Agreement. In particular, NHS England may add or remove Primary Care Contracts or Arrangements or Prescribed Dental Services Contracts where this is associated with an extension or reduction of the scope of the Delegated Functions.

6.7 Decisions of the ICB in respect of the Delegated Functions and made in accordance with the terms of this Agreement shall be binding on NHS England and the ICB.

6.8 The ICB is not authorised by this Agreement to take any step or make any decision in respect of Primary Care Services or Prescribed Dental Services beyond the scope of the Delegated Functions.

6.9 NHS England may, at its discretion, substitute its own decision for any decision which the ICB purports to make that is outside the scope of the Delegated Functions. This will take the form of NHS England considering the issue and decision purportedly made by the ICB and then making its own decision. The ICB must provide any information, assistance and support as NHS England requires to enable it to determine whether to make any such decision. In any event such a decision by NHS England shall not extend to those actions or decisions that are of themselves not capable of being delegated by NHS England to the ICB.

6.10 The terms of clause 6.9 are without prejudice to the ability of NHS England to enforce the terms of this Agreement or otherwise take action in respect of any failure by the ICB to comply with this Agreement.

7. EXERCISE OF DELEGATED FUNCTIONS

7.1 The ICB agrees that it will exercise the Delegated Functions in accordance with:

7.1.1 the terms of this Agreement;

7.1.2 any Contractual Notices, including without limitation any Standing Financial Instructions;

7.1.3 all applicable Law and Guidance;

7.1.4 the ICB's constitution;

7.1.5 the requirements of any assurance arrangements made by NHS England, and;

7.1.6 Good Practice.

7.2 In exercising the Delegated Functions, the ICB must comply with the Mandated Guidance set out at SCHEDULE 9 or otherwise referred to in this Agreement and such further Mandated Guidance as may be issued by NHS England from time to time, including on the Direct Commissioning Guidance Webpage.

7.3 NHS England may, at its discretion, issue Contractual Notices from time to time relating to the manner in which the Delegated Functions must be exercised by the ICB. Contractual Notices will have effect as variations to this Agreement.

7.4 The ICB must establish effective, safe, efficient and economic arrangements for the discharge of the Delegated Functions.

7.5 The ICB must give due consideration to whether any of the Delegated Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under sections 65Z5 and 75 of the NHS Act.

7.6 The ICB must develop an operational scheme of delegation defining those individuals or groups of individuals, including committees, who may discharge aspects of the Delegated Functions. For the purposes of this clause, the ICB may include the operational scheme of delegation within its general organisational scheme of delegation.

7.7 Subject to clauses 7.1 to 7.6, the ICB may determine the arrangements for the exercise of the Delegated Functions.

7.8 The ICB must perform the Delegated Functions:

7.8.1 in such a manner as to ensure NHS England's compliance with NHS England's statutory duties in respect of the Delegated Functions and to enable NHS England to fulfil its Reserved Functions; and

7.8.2 having regard to NHS England's accountability to the Secretary of State and Parliament in respect of both the Delegated Functions and Reserved Functions.

8. PERFORMANCE OF THE RESERVED FUNCTIONS

8.1 NHS England will exercise the Primary Care Functions and functions in respect of Prescribed Dental Services, other than the Delegated Functions, including but not limited to those set out in SCHEDULE 3 to this Agreement ("the Reserved Functions").

8.2 For the avoidance of doubt, the Parties acknowledge that the Delegation may be amended, and additional functions may be delegated to the ICB, in which event consequential changes to this Agreement shall be agreed with the ICB pursuant to clause 25 *(Variations)* of this Agreement.

8.3 NHS England will work collaboratively with the ICB when exercising the Reserved Functions.

8.4 If there is any conflict or inconsistency between functions that are named as Delegated Functions and functions that are named as Reserved Functions, then such functions shall be interpreted as Reserved Functions.

8.5 The Parties acknowledge that, as from the date of this Agreement, the ICB shall provide administrative and management services to NHS England in relation to certain Reserved Functions and that such administrative and management services are as follows:

8.5.1 the administrative and management services in relation to the Capital Expenditure Functions and the Capital Expenditure Funds as more particularly set out in clauses 9.14 to 9.17; and

8.5.2 the administrative and management services in relation to the Section 7A Functions and Section 7A Funds as more particularly set out in clauses 9.18 to 9.21.

8.6 The Parties further acknowledge that NHS England may ask the ICB to provide certain administrative and management services to NHS England in relation to other Reserved Functions.

8.7 Notwithstanding any arrangement for or provision of administrative or management services in respect of certain Reserved Functions, NHS England shall retain and be accountable for the exercise of such Reserved Functions.

9. FINANCE

9.1 Without prejudice to any other provision in this Agreement, the ICB must comply with the NHS England central finance team's operational process (as such process is updated from time to time) for the reporting and accounting of funds used for the purposes of the Delegated Functions.

9.2 The ICB acknowledges that it will receive funds from NHS England in respect of the Delegated Functions (the "Delegated Funds") and that these are in addition to the funds allocated to it within its Annual Allocation.

9.3 Subject to clause 9.4, the ICB may use:

9.3.1 its Annual Allocation and the Delegated Funds in the exercise of the Delegated Functions; and

9.3.2 the Delegated Funds and its Annual Allocation in the exercise of the ICB's functions other than the Delegated Functions.

9.4 The ICB's expenditure on the Delegated Functions must be no less than that necessary to:

9.4.1 ensure that NHS England is able to fulfil its functions, including without limitation the Reserved Functions, effectively and efficiently;

9.4.2 meet all liabilities arising under or in connection with all Primary Care Contracts and Arrangements allocated to the ICB in accordance with clauses 6.4 to 6.6;

9.4.3 meet all liabilities arising under or in connection with all Prescribed Dental Services Contracts allocated to the ICB in accordance with clauses 6.4 to 6.6 in so far as they relate to the Delegated Functions; and

9.4.4 meet national commitments from time to time on expenditure on specific Delegated Functions including, without limitation, the Community Pharmacy Contractual Framework.

9.5 NHS England may increase or reduce the Delegated Funds in any Financial Year, by sending a notice to the ICB of such increase or decrease:

9.5.1 in order to take into account any monthly adjustments or corrections to the Delegated Funds that NHS England considers appropriate, including without limitation adjustments following any changes to the Delegated Functions, changes in allocations, changes in Primary Care Contracts or Arrangements or otherwise;

9.5.2 in order to comply with a change in the amount allocated to NHS England by the Secretary of State pursuant to section 223B of the NHS Act;

9.5.3 to take into account any Losses of NHS England for which the ICB is required to indemnify NHS England under clause 15;

9.5.4 to take into account any adjustments that NHS England considers appropriate (including without limitation in order to make corrections or otherwise to reflect notional budgets) to reflect funds transferred (or that should have been transferred) to the ICB in respect of the Delegated Functions and/or funds transferred (or that should have been transferred) to the ICB and in respect of which the ICB has management or administrative responsibility under clauses 9.14 to 9.23 of this Agreement; or

9.5.5 in order to ensure compliance by NHS England with its obligations under the NHS Act (including without limitation, Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State in respect of NHS England under the NHS Act.

9.6 NHS England acknowledges that the intention of paragraph 9.5 is to reflect genuine corrections and adjustments to the Delegated Funds and may not be used to change

the allocation of the Delegated Funds unless there are significant or exceptional circumstances that would require such corrections or adjustments.

9.7 The ICB acknowledges that it must comply with its statutory financial duties, including those under Part 11 of the NHS Act to the extent that these sections apply in relation to the receipt of the Delegated Funds.

9.8 NHS England may in respect of the Delegated Funds:

9.8.1 notify the ICB regarding the required payment of sums by the ICB to NHS England in respect of charges referable to the valuation or disposal of assets and such conditions as to records, certificates or otherwise;

9.8.2 by notice, require the ICB to take such action or step in respect of the Delegated Funds, in order to ensure compliance by NHS England of its duties or functions under the NHS (including without limitation, Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State under the NHS Act.

9.9 SCHEDULE 5 (Financial Provisions and Decision Making Limits) sets out further financial provisions in respect of the exercise of the Delegated Functions and, in particular, Table 1 in SCHEDULE 5 (*Financial Provisions and Decision Making Limits)* sets out certain financial limits and approvals required in relation to the exercise of the Delegated Functions.

9.10 NHS England may issue Mandated Guidance in respect of the use of funds for the purposes of the Delegated Functions.

Payment and Transfer

9.11 NHS England will pay the Delegated Funds to the ICB monthly using the same revenue transfer process as used for the Annual Allocation or using such other process as notified to the ICB from time to time.

9.12 Without prejudice to any other obligation upon the ICB, the ICB agrees that it must use its resources for the purposes of the Delegated Functions in accordance with:

9.12.1 the terms and conditions of this Agreement;

9.12.2 the business rules as set out in NHS England's planning guidance or such other documents issued by NHS England from time to time;

9.12.3 any Capital Investment Guidance;

9.12.4 any Mandated Guidance issued by NHS England from time to time in relation to the use of resources for the purposes of the Delegated Functions (including in relation to the form or contents of any accounts); and

9.12.5 the HM Treasury guidance *Managing Public Money* (dated July 2013 and found at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212123/Managing_Public_Money_AA_v2_-_chapters_annex_web.pdf).

9.13 Without prejudice to any other obligation upon the ICB, the ICB agrees that it must provide all information, assistance and support to NHS England in relation to the audit and/or investigation (whether internal or external and whether under Law or otherwise) in relation to the use of or payment of resources for the purposes of the Delegated Functions and the discharge of those functions.

Administrative and/or Management Services and Funds in relation to the Capital Expenditure Functions

9.14 The Parties acknowledge that the Capital Expenditure Functions are a Reserved Function.

9.15 The Parties further acknowledge that:

9.15.1 accordingly, the Delegated Funds do not include any funds in respect of amounts payable in relation to the Capital Expenditure Functions (**"Capital Expenditure Funds"**); and

9.15.2 NHS England remains responsible and accountable for the discharge of the Capital Expenditure Functions and nothing in clauses 9.14 to 9.17 shall be construed as a divestment or delegation of NHS England's Capital Expenditure Functions.

9.16 Without prejudice to clause 9.15 above, the ICB will comply with any Mandated Guidance issued in relation to the Capital Expenditure Functions and shall (on request from NHS England) provide the following administrative services to NHS England in respect of the Capital Expenditure Funds:

9.16.1 the administration and payment of sums that NHS England has approved as payable in relation to the Capital Expenditure Functions;

9.16.2 if requested by NHS England and taking into account (i) any other support or services provided to NHS England by NHS Property Services Limited or otherwise and (ii) any Mandated Guidance issued in respect of the Capital Expenditure Functions, the provision of advice and/or recommendations to NHS England in respect of expenditure to be made under the Capital Expenditure Functions; and

9.16.3 such other support or administrative assistance to NHS England that NHS England may reasonably request in order to facilitate the discharge by NHS England of its responsibilities under or in respect of the Capital Expenditure Functions.

9.17 NHS England may, at the same time as it allocates the Delegated Funds to the ICB under paragraph 9.11, transfer to the ICB such amounts as are necessary to enable the discharge of the ICB's obligations under this clause 9 *(Finance)* in respect of the Capital Expenditure Functions.

Administrative and/or Management Services and Funds in relation to Section 7A Functions

9.18 The Parties acknowledge that the Section 7A Functions are part of the Reserved Functions.

9.19 The Parties further acknowledge that:

9.19.1 accordingly, the Delegated Funds do not include any funds in respect of amounts payable in relation to the Section 7A Functions (whether such arrangements are included in or under Primary Care Contracts or Arrangements or not) (**"Section 7A Funds"**); and

9.19.2 NHS England remains responsible and accountable for the discharge of the Section 7A Functions and nothing in this clause 9 *(Finance)* shall be construed as a divestment or delegation of the Section 7A Functions.

9.20 The ICB will provide the following services to NHS England in respect of the Section 7A Funds:

9.20.1 the administration and payment of sums that NHS England has approved as payable under or in respect of arrangements for the Section 7A Functions; and

9.20.2 such other support or administrative assistance to NHS England that NHS England may reasonably request in order to facilitate the discharge by NHS England of its responsibilities under or in respect of the Section 7A Funds.

9.21 NHS England shall, at the same time as it allocates the Delegated Funds to the ICB under paragraph 9.11, allocate to the ICB such amounts as are necessary to enable the discharge of the ICB's obligations under this clause 9 *(Finance)* in respect of the Section 7A Funds.

Administrative and/or Management Services and Funds in relation to other Reserved Functions

9.22 NHS England may ask the ICB to provide certain management and/or administrative services to NHS England (from a date to be notified by NHS England to the ICB) in relation to the carrying out of any of the Reserved Functions.

9.23 If NHS England makes such a request to the ICB, then the ICB will, but only if the ICB agrees to provide such services, from the date requested by NHS England, comply with:

9.23.1 provisions equivalent to those set out above in relation to the Capital Expenditure Functions (clauses 9.14 to 9.17) and the Section 7A Functions (clauses 9.18 to 9.21) including in relation to the administration of any funds for such functions but only to the extent that such provisions are relevant to the management or administrative services to be provided; and

9.23.2 such other provisions in respect of the carrying out of such management and administrative services as agreed between NHS England and the ICB.

Pooled Funds

9.24 The ICB may, for the purposes of exercising the Delegated Functions under this Agreement, establish and maintain a pooled fund in respect of any part of the Delegated Funds with:

9.24.1 NHS England in accordance with sections 13V or 65Z6 of the NHS Act;

9.24.2 one or more ICBs in accordance with section 65Z6 of the NHS Act as part of a Further Arrangement; or

9.24.3 NHS England and one or more ICBs in accordance with section 13V of the NHS Act; and

9.24.4 NHS England and one or more ICBs in accordance with section 65Z6 of the NHS Act.

9.25 At the date of this Agreement, details of the pooled funds (including any terms as to the governance and payments out of such pooled fund) of NHS England and the ICB are set out in the Local Terms.

10. INFORMATION, PLANNING AND REPORTING

10.1 The ICB must provide to NHS England:

10.1.1 all information or explanations in relation to the exercise of the Delegated Functions (including in relation to this Agreement), (and in such form) as requested by NHS England from time to time; and

10.1.2 all such information (and in such form), that may be relevant to NHS England in relation to the exercise by NHS England of its other duties or functions including, without limitation, the Reserved Functions.

10.2 The provisions of this clause 10 are without prejudice to the ability of NHS England to exercise its other powers and duties in obtaining information from and assessing the performance of the ICB.

Forward Plan and Annual Report

10.3 Before the start of each Financial Year, the ICB must describe in its joint forward plan prepared in accordance with section 14Z52 of the NHS Act how it intends to exercise the Delegated Functions.

10.4 The ICB must report on its exercise of the Delegated Functions in its annual report prepared in accordance with section 14Z58 of the NHS Act.

Risk Register

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

11. FURTHER ARRANGEMENTS

11.1 The ICB must give due consideration to whether any of the Delegated Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under sections 65Z5 and 75 of the NHS Act.

11.2 The ICB may only make arrangements with another person (a "Sub-Delegate") concerning the exercise of the Delegated Functions ("Further Arrangements"), including without limitation arrangements under sections 65Z5 and 75 of the NHS Act, with the prior written approval of NHS England.

11.3 The approval of any Further Arrangements may:

11.3.1 include approval of the terms of the proposed Further Arrangements; and

11.3.2 require conditions to be met by the ICB and the Sub-Delegate in respect of that arrangement.

11.4 All Further Arrangements must be made in writing.

11.5 The ICB must not:

11.5.1 terminate Further Arrangements; or

11.5.2 make any material changes to the terms of Further Arrangements;

without the prior written approval of NHS England.

11.6 If the ICB enters into a Further Arrangement it must ensure that the Sub-Delegate does not make onward arrangements for the exercise of any or all of the Delegated Functions without the prior written approval of NHS England.

11.7 The terms of this clause 11 do not prevent the ICB from making arrangements for assistance and support in the exercise of the Delegated Functions with any person, where such arrangements reserve the consideration and making of any decision in respect of a Delegated Function to the ICB.

11.8 NHS England requires the ICB to make arrangements for assistance and support in the exercise of the Delegated Functions with those persons described at SCHEDULE 6 and such other persons as NHS England may require from time to time.

11.9 Where Further Arrangements are made, any positive obligation or duty on the part of the ICB under this Agreement that is relevant to those Further Arrangements shall also require the ICB to ensure that all Sub-Delegates comply with that positive obligation or duty and support the ICB in doing so. In the same way, any negative duty or obligation on the part of the ICB under this Agreement that is relevant to Further Arrangement shall also require the ICB to ensure that all Sub-Delegates comply with that negative obligation or duty and support the ICB in doing so.

12. STAFFING

12.1 Subject to the terms of this Agreement, the Delegated Functions will be carried out by NHS England Staff in accordance with decisions concerning the Delegated Functions made by the ICB unless the Staff carrying out the Delegated Functions have transferred to the ICB (and/or the ICB has engaged or employed Staff for that purpose).

12.2 SCHEDULE 8 makes further provision about deployment of NHS England Staff to the ICB for the purposes of carrying out the relevant Delegated Functions.

12.3 The ICB must comply with any Mandated Guidance issued by NHS England from time to time in relation to the NHS England Staff.

12.4 For the avoidance of doubt, any breach by the ICB of the terms of this clause 12 (Staffing), including any breach of any Mandated Guidance issued in accordance with clause 12.3 above, will be a breach of the terms and conditions of this Agreement for the purposes of clauses 9.5 and 15.3.

13. BREACH

13.1 If the ICB does not comply with the terms of this Agreement, then NHS England may:

13.1.1 exercise its rights under this Agreement; and/or

13.1.2 take such steps as it considers appropriate in the exercise of its other functions concerning the ICB.

13.2 Without prejudice to clause 13.1, if the ICB does not comply with the terms of this Agreement (including if the ICB exceeds its delegated authority under the Delegation), NHS England may (at its sole discretion):

13.2.1 waive its rights in relation to such non-compliance in accordance with clause 13.3;

13.2.2 ratify any decision in accordance with clause 6.9;

13.2.3 revoke the Delegation and terminate this Agreement in accordance with clause 25.7 *(Termination)* below;

13.2.4 exercise the Escalation Rights in accordance with clause 14 *(Escalation Rights)*; and/or

13.2.5 exercise its rights under common law.

13.3 NHS England may waive any non-compliance by the ICB with the terms of this Agreement provided that the ICB provides a written report to NHS England as required by clause 13.4 and, after considering the ICB's written report, NHS England is satisfied that the waiver is justified.

13.4 If:

13.4.1 the ICB does not comply (or, based on the risk register maintained by the ICB in accordance with clause 10.5 or any other information available to it the ICB considers that it may not be able to comply) with this Agreement; or

13.4.2 NHS England notifies the ICB that it considers the ICB has not complied, or may not be able to comply with, this Agreement;

then the ICB must provide a written report to NHS England within ten (10) Operational Days of the non-compliance (or the date on which the ICB considers that it may not be able to comply with this Agreement) or such notification pursuant to clause 13.4.2 setting out:

13.4.3 details of and reasons for the non-compliance (or likely non-compliance) with the Agreement and/or the Delegation; and

13.4.4 a plan for how the ICB proposes to remedy the non-compliance.

14. ESCALATION RIGHTS

14.1 If the ICB does not comply with this Agreement, NHS England may exercise the following Escalation Rights:

14.1.1 NHS England may require a suitably senior representative of the ICB to attend a review meeting within ten (10) days of NHS England becoming aware of the non-compliance; and

14.1.2 NHS England may require the ICB to prepare an action plan and report within twenty (20) days of the review meeting (to include details of the non-compliance and a plan for how the ICB proposes to remedy the non-compliance).

14.2 Nothing in clause 14 *(Escalation Rights)* will affect NHS England's right to revoke the Delegation and/or terminate this Agreement in accordance with clause 26 *(Termination)* below.

15. LIABILITY AND INDEMNITY

15.1 NHS England is liable in respect of any Losses arising in respect of NHS England's negligence, fraud, recklessness or deliberate breach in respect of the Delegated Functions and occurring after the Effective Date of Delegation and, if the ICB suffers any Losses in respect of such actions by NHS England, NHS England shall make such adjustments to the Annual Allocation (or other amounts payable to the ICB) in order to reflect any Losses suffered by the ICB (except to the extent that the ICB is liable for such Losses pursuant to clause 15.3).

15.2 For the avoidance of doubt, NHS England remains liable for a Claim relating to facts, events or circumstances concerning the Delegated Functions before the Effective Date of Delegation.

15.3 The ICB is liable to (and shall pay) NHS England for any Losses suffered by NHS England that result from or arise out of the ICB's negligence, fraud, recklessness or breach of the Delegation (including any actions that are taken that exceed the authority conferred by the Delegation) or this Agreement and, in respect of such Losses, NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB or make such adjustments to the Delegated Funds pursuant to clause 9.5. The ICB shall not be liable to the extent that the Losses arose prior to the date of this Agreement.

15.4 Each Party acknowledges and agrees that any rights acquired, or liabilities (including liabilities in tort) incurred, in respect of the exercise by the ICB of any Delegated

Function are enforceable by or against the ICB only, in accordance with s65Z5(6) of the NHS Act.

15.5 The ICB indemnifies NHS England and shall keep it indemnified on a continuing basis from and against any and all Losses which NHS England may incur by reason of any claim by any NHS England Staff:

15.5.1 arising out of a breach of duty by the ICB (whether under common law, statute or otherwise) to the extent that such claim is not met by either the ICB's or NHS England's insurance or indemnity cover;

15.5.2 under the Equality Act 2010 or Part V of the Employment Rights Act 1996 arising out of acts or omissions by the ICB (or any of its employees, directors or officers);

15.5.3 arising from any acts or omissions by the ICB resulting in the termination of their employment, including any claim arising from any instruction by the ICB to NHS England to discipline or dismiss any person.

15.6 Each Party shall co-operate with the other in making all reasonable efforts to minimise any liabilities and Losses in connection with the employment of NHS England Staff in Delegated Functions.

15.7 Each Party will at all times take all reasonable steps to minimise and mitigate any Losses or other matters for which one Party is entitled to be indemnified by or to bring a claim against the other under this Agreement.

16. CLAIMS AND LITIGATION

16.1 Nothing in this clause 16 *(Claims and Litigation)* shall be interpreted as affecting the reservation to NHS England of the Reserved Functions.

16.2 Except in the circumstances set out in clause 16.5 and subject always to compliance with this clause 16 *(Claims and Litigation)*, the ICB shall be responsible for and shall retain the conduct of any Claim.

16.3 The ICB must:

16.3.1 comply with any policy issued by NHS England from time to time in relation to the conduct of or avoidance of Claims and/or the pro-active management of Claims;

16.3.2 if it receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim, immediately notify NHS England and send to NHS England all copies of such correspondence;

16.3.3 co-operate fully with NHS England in relation to such Claim and the conduct of such Claim;

16.3.4 provide, at its own cost, to NHS England all documentation and other correspondence that NHS England requires for the purposes of considering and/or resisting such Claim; and/or

16.3.5 at the request of NHS England, take such action or step or provide such assistance as may in NHS England's discretion be necessary or desirable having regard to the nature of the Claim and the existence of any time limit in relation to avoiding, disputing, defending, resisting, appealing, seeking a review or compromising such Claim or to comply with the requirements of the provider of an Indemnity Arrangement in relation to such Claim.

16.4 Subject to clauses 16.3 and 16.5 and SCHEDULE 5 (Financial Provisions and Decision Making Limits) the ICB is entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit.

NHS England Stepping into Claims

16.5 NHS England may, at any time following discussion with the ICB, send a notice to the ICB stating that NHS England will take over the conduct of the Claim and the ICB must immediately take all steps necessary to transfer the conduct of such Claim to NHS England. In such cases:

16.5.1 NHS England shall be entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit, provided that if NHS England wishes to invoke clause 16.5.3 it agrees to seek the ICB's views on any proposal to pay or settle that Claim prior to finalising such payment or settlement; and

16.5.2 the Delegation shall be treated as being revoked to the extent that and for so long as NHS England has assumed responsibility for exercising those of the Delegated Functions that are necessary for the purposes of having conduct of the Claim; and

16.5.3 NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or make an adjustment to the Delegated Funds pursuant to clause 9.5.3 for the purposes of meeting any Claim Losses associated with that Claim.

Claim Losses

16.6 The ICB and NHS England shall notify each other within a reasonable time period of becoming aware of any Claim Losses.

16.7 The ICB acknowledges that NHS England will pay to the ICB the funds that are attributable to the Delegated Functions. Accordingly, the ICB acknowledges that it must pay any Claim Losses out of either the Delegated Funds or its Annual Allocation. NHS England may, in respect of any Claim Losses, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or pursuant to clause 9.5.3 make such adjustments to the Delegated Funds to take into account the amount of any Claim Losses (other than any Claim Losses in respect of which NHS England has retained any funds, provisions or other resources to discharge such Claim Losses). For the avoidance of doubt, in circumstances where NHS England suffers any Claim Losses, then NHS England shall be entitled to recoup such Claim Losses pursuant to clause 9.5.3. If and to the extent that NHS England has retained any funds, provisions or other resources to discharge such Claim Losses, then NHS England may either use such funds to discharge the Claim Loss or make an upward adjustment to the amounts paid to the ICB pursuant to clause 9.5.3.

17. DATA PROTECTION, FREEDOM OF INFORMATION AND TRANSPARENCY

17.1 The Parties must ensure that all Personal Data processed by or on behalf of them in the course of carrying out the Delegated Functions and Reserved Functions is processed in accordance with the relevant Party's obligations under Data Protection Legislation and Data Guidance and the Parties must assist each other as necessary to enable each other to comply with these obligations.

17.2 The ICB must respond to any information governance breach in accordance with IG Guidance for Serious Incidents. If the ICB is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach then as soon as reasonably practical and in any event on or before the first such notification is made the ICB must fully inform NHS England of the

information governance breach. This clause does not require the ICB to provide NHS England with information which identifies any individual affected by the information governance breach where doing so would breach Data Protection Legislation.

17.3 Whether or not a Party is a Data Controller or Data Processor will be determined in accordance with Data Protection Legislation and any Data Guidance from a Regulatory or Supervisory Body. The Parties acknowledge that a Party may act as both a Data Controller and a Data Processor.

17.4 Each Party acknowledges that the other is a public authority for the purposes of the Freedom of Information Act 2000 (**"FOIA"**) and the Environmental Information Regulations 2004 (**"EIR"**).

17.5 Each Party may be statutorily required to disclose further information about the Agreement and the Relevant Information in response to a specific request under FOIA or EIR, in which case:

17.5.1 each Party shall provide the other with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR;

17.5.2 each Party shall consult the other regarding the possible application of exemptions in relation to the information requested; and

17.5.3 subject only to clause 16 *(Claims and Litigation)*, each Party acknowledges that the final decision as to the form or content of the response to any request is a matter for the Party to whom the request is addressed.

17.6 NHS England may, from time to time, issue a FOIA or EIR protocol or update a protocol previously issued relating to the dealing with and responding to of FOIA or EIR requests in relation to the Delegated Functions. The ICB shall comply with such FOIA or EIR protocols.

17.7 SCHEDULE 4 makes further provision about information sharing and information governance.

18. IT INTER-OPERABILITY

18.1 NHS England and the ICB will work together to ensure that all relevant IT systems operated by NHS England and the ICB in respect of the Delegated Functions and the Reserved Functions are inter-operable and that data may be transferred between systems securely, easily and efficiently.

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

19. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

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

19.2 Without prejudice to the general obligations set out in clause 19.1, the ICB must maintain a register of interests in respect of all persons making decisions concerning the Delegated Functions. This register must be publicly available. For the purposes of this clause, the ICB may rely on an existing register of interests rather than creating a further register.

20. PROHIBITED ACTS AND COUNTER-FRAUD

20.1 The ICB must not commit any Prohibited Act.

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

20.2.1 to revoke the Delegation; and

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

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

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

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

20.5 The ICB must implement any reasonable modifications to its counter-fraud arrangements required by a person referred to in clause 20.4 in order to meet the appropriate standards within whatever time periods as that person may reasonably require.

20.6 The ICB must, on becoming aware of:

20.6.1 any suspected or actual bribery, corruption or fraud involving public funds; or

20.6.2 any suspected or actual security incident or security breach involving Staff or involving NHS resources;

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

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

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

20.7.2 all Staff who may have information to provide;

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

21. CONFIDENTIAL INFORMATION OF THE PARTIES

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

21.2 Subject to clauses 21.3 to 21.5, the receiving Party agrees:

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

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

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

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

21.3.1 in connection with any Dispute Resolution;

21.3.2 in connection with any litigation between the Parties;

21.3.3 to comply with the Law;

21.3.4 to any appropriate Regulatory or Supervisory Body;

21.3.5 to its Staff, who in respect of that Confidential Information will be under a duty no less onerous than the Receiving Party's duty under clause 21.2;

21.3.6 to NHS Bodies for the purposes of carrying out their functions;

21.3.7 as permitted under or as may be required to give effect to clause 20 (*NHS Counter-Fraud*); and

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

21.4 The obligations in clauses 21.1 and 21.2 will not apply to any Confidential Information which:

21.4.1 is in or comes into the public domain other than by breach of this Agreement;

21.4.2 the receiving Party can show by its records was in its possession before it received it from the disclosing Party; or

21.4.3 the receiving Party can prove it obtained or was able to obtain from a source other than the disclosing Party without breaching any obligation of confidence.

21.5 This clause 21 does not prevent NHS England making use of or disclosing any Confidential Information disclosed by the ICB where necessary for the purposes of exercising its functions in relation to the ICB.

21.6 The Parties acknowledge that damages would not be an adequate remedy for any breach of this clause 21 by the receiving Party, and in addition to any right to damages the disclosing Party will be entitled to the remedies of injunction, specific performance and other equitable relief for any threatened or actual breach of this clause 21.

21.7 This clause 21 will survive the termination of this Agreement for any reason for a period of 5 years.

21.8 This clause 21 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

22. INTELLECTUAL PROPERTY

22.1 The ICB grants to NHS England a fully paid-up, non-exclusive, perpetual licence to use the ICB Deliverables for the purposes of the exercise of its statutory and contractual functions.

22.2 NHS England grants the ICB a fully paid-up, non-exclusive licence to use the NHS England Deliverables for the purpose of performing this Agreement and the Delegated Functions.

22.3 The ICB must co-operate with NHS England to enable it to understand and adopt Best Practice (including the dissemination of Best Practice to other commissioners or providers of NHS services), and must supply such materials and information in relation to Best Practice as NHS England may reasonably request, and (to the extent that any IPR attaches to Best Practice), grants NHS England a fully paid-up, non-exclusive, perpetual licence for NHS England to use Best Practice IPR for the commissioning and provision of NHS services and to share any Best Practice IPR with other commissioners of NHS services (and other providers of NHS services) to enable those parties to adopt such Best Practice.

23. NOTICES

23.1 Any notices given under this Agreement must be sent by e-mail to the other Party's address set out in the Particulars.

23.2 Notices by e-mail will be effective when sent in legible form, but only if, following transmission, the sender does not receive a non-delivery message.

24. DISPUTES

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

24.2 If a Dispute arises out of or in connection with this Agreement then the Parties must follow the procedure set out in this clause:

24.2.1 either Party must give to the other written notice of the Dispute, setting out its nature and full particulars ("**Dispute Notice**"), together with relevant supporting documents. On service of the Dispute Notice, the Agreement Representatives must attempt in good faith to resolve the Dispute;

24.2.2 if the Agreement Representatives are, for any reason, unable to resolve the Dispute within twenty (20) days of service of the Dispute Notice, the Dispute must be referred to the Chief Executive Officer (or equivalent person) of the ICB and a director of or other person nominated by NHS England (and who has authority from NHS England to settle the Dispute) who must attempt in good faith to resolve it; and

24.2.3 if the people referred to in clause 24.2.2 are for any reason unable to resolve the Dispute within twenty (20) days of it being referred to them, the Parties may attempt to settle it by mediation in accordance with the CEDR model mediation procedure. Unless otherwise agreed between the Parties, the mediator must be nominated by CEDR Solve. To initiate the mediation, a Party must serve notice in writing ('Alternative Dispute Resolution' (**ADR**) **notice**) to the other Party to the Dispute, requesting a mediation. A copy of the ADR notice should be sent to CEDR Solve. The mediation will start not later than ten (10) days after the date of the ADR notice.

24.3 If the Dispute is not resolved within thirty (30) days after service of the ADR notice, or either Party fails to participate or to continue to participate in the mediation before the expiration of the period of thirty (30) days, or the mediation terminates before the expiration of the period of thirty (30) days, the Dispute must be referred to the Secretary of State, who shall resolve the matter and whose decision shall be binding upon the Parties.

25. VARIATIONS

25.1 The Parties acknowledge that the scope of the Delegated Functions may be reviewed and amended from time to time including by revoking this Agreement and making alternative arrangements.

25.2 NHS England may notify the ICB of a Variation Proposal in respect of this Agreement.

25.3 The Variation Proposal will set out the variation proposed and the date on which NHS England requires the variation to take effect.

25.4 The ICB must respond to a Variation Proposal within thirty (30) Operational Days following the date that it is issued by serving notice on NHS England confirming either:

25.4.1 that it accepts the Variation Proposal; or

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

25.5 If the ICB accepts the Variation Proposal, the ICB agrees (without delay) to take all necessary steps (including executing a variation agreement) in order to give effect to any variation by the date on which the proposed variation will take effect as set out in the Variation Proposal.

25.6 If the ICB refuses to accept the Variation Proposal or to take such steps as are required to give effect to the variation, NHS England may terminate this Agreement in respect of some or all of the Delegated Functions.

25.7 The provisions of this clause 25 are without prejudice to the ability of NHS England to issue Contractual Notices which have the effect of varying this Agreement.

25.8 The Parties acknowledge that this Agreement is likely to require variation to take effect from 1 April 2023 as initial delegation arrangements are developed further. Accordingly, both Parties agree to engage constructively with a view to agreeing any such variation proposal in line with the provisions of this clause 25. In particular, the Parties agree to act reasonably and with the understanding that a single variation proposal will need to be accepted by all ICBs to ensure consistency across all delegation arrangements.

26. TERMINATION

26.1 The ICB may:

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

26.1.2 terminate this Agreement;

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

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

26.1.4 the ICB meets with NHS England within ten (10) Operational Days of NHS England receiving the notice set out at clause 26.1.3 above to discuss arrangements for termination and transition of the Delegated Functions to a successor commissioner;

in which case NHS England shall revoke the Delegation and this Agreement shall terminate with effect from the end of 31 March in the next calendar year.

26.2 NHS England may revoke the Delegation at the end of 31 March in any year, provided that it gives notice to the ICB of its intention to terminate the Delegation on or before 30 September in the year prior to the year in which the Delegation will terminate, and in which case clause 26.4 will apply.

26.3 The Delegation may be revoked, and this Agreement may be terminated by NHS England at any time, including in (but not limited to) the following circumstances:

26.3.1 the ICB acts outside of the scope of its delegated authority;

26.3.2 the ICB fails to perform any material obligation of the ICB owed to NHS England under this Agreement;

26.3.3 the ICB persistently commits non-material breaches of this Agreement;

26.3.4 NHS England is satisfied that its intervention powers under section 14Z61 of the NHS Act apply;

26.3.5 to give effect to legislative changes, including conferral of any of the Delegated or Reserved Functions on the ICB;

26.3.6 failure to agree to a variation in accordance with clause 25 *(Variations)*;

26.3.7 NHS England and the ICB agree in writing that the Delegation shall be revoked and this Agreement shall terminate on such date as is agreed; and/or

26.3.8 the ICB merges with another ICB or other body.

26.4 This Agreement will terminate upon revocation or termination of the Delegation (including revocation and termination in accordance with this clause 26 *(Termination)*) except that the provisions referred to at clause 28 (*Provisions Surviving Termination*) will continue in full force and effect.

26.5 Without prejudice to clause 13.3 and to avoid doubt, NHS England may waive any right to terminate this Agreement under this clause 26 *(Termination)*. Any such waiver is only effective if given in writing and shall not be deemed a waiver of any subsequent right or remedy.

26.6 As an alternative to termination of the Agreement in respect of all the Delegated Functions, NHS England may alternatively terminate the Agreement in respect of specified Delegated Functions (or aspects of such Delegated Functions) only, in which case this Agreement shall otherwise remain in effect.

27. CONSEQUENCE OF TERMINATION

27.1 Termination of this Agreement, or termination of the ICB's exercise of any of the Delegated Functions, will not affect any rights or liabilities of the Parties that have accrued before the date of that termination or which later accrue.

27.2 Subject to clause 27.4, on or pending termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, NHS England, the ICB and if appropriate any successor delegate will:

27.2.1 agree a plan for the transition of the Delegated Functions from the ICB to the successor delegate, including details of the transition, the Parties' responsibilities in relation to the transition, the Parties' arrangements in respect of those staff engaged in the Delegated Functions and the date on which the successor delegate will take responsibility for the Delegated Functions;

27.2.2 implement and comply with their respective obligations under the plan for transition agreed in accordance with clause 27.2.1 above; and

27.2.3 act with a view to minimising any inconvenience or disruption to the commissioning of healthcare in the Area.

27.3 For a reasonable period before and after termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, the ICB must:

27.3.1 co-operate with NHS England and any successor delegate in order to ensure continuity and a smooth transfer of the Delegated Functions; and

27.3.2 at the reasonable request of NHS England:

(a) promptly provide all reasonable assistance and information to the extent necessary to effect an orderly assumption of the Delegated Functions by a successor delegate;

(b) deliver to NHS England all materials and documents used by the ICB in the exercise of any of the Delegated Functions; and

27.3.3 use all reasonable efforts to obtain the consent of third parties to the assignment, novation or termination of existing contracts between the ICB and any third party which relate to or are associated with the Delegated Functions.

27.4 Where any or all of the Delegated Functions or Reserved Functions are to be directly conferred on the ICB, the Parties will co-operate with a view to ensuring continuity and a smooth transfer to the ICB.

28. PROVISIONS SURVIVING TERMINATION

28.1 Any rights, duties or obligations of any of the Parties which are expressed to survive, including those referred to in clause 28.2, or which otherwise by necessary implication survive the termination for any reason of this Agreement, together with all indemnities, will continue after termination, subject to any limitations of time expressed in this Agreement.

28.2 The surviving provisions include the following clauses together with such other provisions as are required to interpret and give effect to them:

28.2.1 Clause 9 (Finance);

28.2.2 Clause 12 (Staffing);

28.2.3 Clause 15 (Liability and Indemnity);

28.2.4 Clause 16 (Claims and Litigation);

28.2.5 Clause 17 (Data Protection, Freedom of Information and Transparency);

28.2.6 Clause 24 (Disputes);

28.2.7 Clause 26 (Termination);

28.2.8 SCHEDULE 4 (Further Information Governance and Sharing Provisions).

29. COSTS

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

30. SEVERABILITY

30.1 If any provision or part of any provision of this Agreement is declared invalid or otherwise unenforceable, that provision or part of the provision as applicable will be

severed from this Agreement. This will not affect the validity and/or enforceability of the remaining part of that provision or of other provisions.

31. **GENERAL**

31.1 Nothing in this Agreement will create a partnership or joint venture or relationship of principal and agent between NHS England and the ICB.

31.2 A delay or failure to exercise any right or remedy in whole or in part shall not waive that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy.

31.3 This Agreement does not give rise to any rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this Agreement.

SCHEDULE 1

Definitions and Interpretation

1. The headings in this Agreement will not affect its interpretation.

2. Reference to any statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance, includes a reference to that statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance as from time to time updated, amended, extended, supplemented, re-enacted or replaced in whole or in part.

3. Reference to a statutory provision includes any subordinate legislation made from time to time under that provision.

4. References to clauses and schedules are to the clauses and schedules of this Agreement, unless expressly stated otherwise.

5. References to any body, organisation or office include reference to its applicable successor from time to time.

6. Any references to this Agreement or any other documents or resources includes reference to this Agreement or those other documents or resources as varied, amended, supplemented, extended, restated and/or replaced from time to time and any reference to a website address for a resource includes reference to any replacement website address for that resource.

7. Use of the singular includes the plural and vice versa.

8. Use of the masculine includes the feminine and all other genders.

9. Use of the term “including” or “includes” will be interpreted as being without limitation.

10. The following words and phrases have the following meanings:

Additional Pharmaceutical Services	Services provided in accordance with a direction under section 127 of the NHS Act (also referred to as advanced services and enhanced services in the Pharmaceutical Regulations);
Agreement	means this agreement between NHS England and the ICB comprising the Particulars, the Terms and Conditions and the Schedules;
Agreement Representatives	means the ICB Representative and the NHS England Representative as set out in the Particulars;
Annual Allocation	means the funds allocated to the ICB annually under section 223G of the NHS Act;
APMS Contract	means an agreement or contract for the provision of primary medical services made under section 83(2) of the NHS Act (including any arrangements which are made in reliance on a combination of that section and other powers to arrange for primary medical services);
Area	means the area described in the Particulars;

Assigned Staff	means those NHS England staff as agreed between NHS England and the ICB from time to time;
Best Practice	means any methodologies, pathway designs and processes relating to this Agreement or the Delegated Functions developed by the ICB or its Staff for the purposes of delivering the Delegated Functions and which are capable of wider use in the delivery of healthcare services for the purposes of the NHS, but not including inventions that are capable of patent protection and for which patent protection is being sought or has been obtained, registered designs, or copyright in software;
Caldicott Principles	means the patient confidentiality principles set out in the report of the Caldicott Committee (December 1997 as amended by the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*) and now included in the NHS Confidentiality Code of Practice, as may be amended from time to time;
Capital	shall have the meaning set out in the Capital Investment Guidance or such other replacement Mandated Guidance as issued by NHS England from time to time;
Capital Expenditure Functions	means those functions of NHS England in relation to the use and expenditure of Capital funds (but excluding the Premises Costs Directions Functions);
Capital Investment Guidance	means any Mandated Guidance issued by NHS England from time to time in relation to the development, assurance and approvals process for proposals in relation to: - the expenditure of Capital, or investment in property, infrastructure or information and technology; and - the revenue consequences for commissioners or third parties making such investment;
CEDR	means the Centre for Effective Dispute Resolution;
Claims	means, for or in relation to the Delegated Functions (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or the Secretary of State, any governmental, regulatory or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by, any governmental, regulatory or similar body or agency;
Claim Losses	means all Losses arising in relation to any Claim;

Combined Authority	means a body of that name established under the provisions of the Local Democracy, Economic Development and Construction Act 2009;
Community Dental Services	means specialised dental services commissioned for patients who are unable to access treatment from Primary Dental Services due to a disability or medical condition, being a form of Prescribed Dental Service;
Community Pharmacy Contractual Framework	means the Community Pharmacy Contractual Framework as published by the Department of Health and Social Care from time to time;
Complaints Regulations	means the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009/309;
Confidential Information	means any information or data in whatever form disclosed, which by its nature is confidential or which the disclosing Party acting reasonably states in writing to the receiving Party is to be regarded as confidential, or which the disclosing Party acting reasonably has marked 'confidential' (including, financial information, strategy documents, tenders, employee confidential information, development or workforce plans and information, and information relating to services) but which is not information which is disclosed in response to an FOIA request, or information which is published as a result of NHS England or government policy in relation to transparency;
Contractual Notice	means a contractual notice issued by NHS England to the ICB, or some or all ICBs (as the case may be), from time to time and relating to allocation of contracts for the purposes of the Delegated Functions and/or the manner in which the Delegated Functions should be exercised by the ICB;
CQC	means the Care Quality Commission;
Data Controller	shall have the same meaning as set out in the UK GDPR;
Data Guidance	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency and the Information Commissioner;

Data Processor	shall have the same meaning as set out in the UK GDPR;
Data Protection Legislation	means the UK GDPR, the Data Protection Act 2018 and all applicable Law concerning privacy, confidentiality or the processing of personal data including but not limited to the Human Rights Act 1998, the Health and Social Care (Safety and Quality) Act 2015, the common law duty of confidentiality and the Privacy and Electronic Communications (EC Directive) Regulations 2003;
Data Subject	shall have the same meaning as set out in the UK GDPR;
Delegated Functions	means the functions delegated by NHS England to the ICB under the Delegation and as set out in detail in this Agreement;
Delegated Funds	means the funds defined in paragraph 9.2;
Delegation	means the delegation of the Delegated Functions from NHS England to the ICB as described at clause 6.1;
Dental Care Services	means: (i) Primary Dental Services; and (ii) the Prescribed Dental Services;
Dental Services Contract	means: (i) a GDS Contract; (ii) a PDS Agreement (except for any Community Dental Services PDS Agreement, which constitutes a Prescribed Dental Services Contract); and (iii) any other contract for the provision of health services made pursuant to NHS England's functions under Part 5 of the NHS Act; in each case as amended or replaced from time to time and including all ancillary or related agreements directly relating to the subject matter of such agreements, contracts or arrangements;
Dental Services Provider	means a natural or legal person who holds a Dental Services Contract;
Direct Commissioning Guidance Webpage	means the webpage maintained by NHS England at https://www.england.nhs.uk/commissioning/how-commissioning-is-changing/;
Dispute	a dispute, conflict or other disagreement between the Parties arising out of or in connection with this Agreement;

Effective Date of Delegation	means the Effective Date of Delegation as set out in the Particulars;
EIR	means the Environmental Information Regulations 2004;
Enhanced Services	means the nationally defined enhanced services, as set out in such directions made by the Secretary of State pursuant to his powers contained in sections 98A, 114A, 125A and 168A of the NHS Act as are in force from time to time, or which may be prescribed by NHS England under its Reserved Functions, and any other enhanced services schemes locally developed by the ICB in the exercise of its Delegated Functions (and excluding, for the avoidance of doubt, any enhanced services arranged or provided pursuant to the Section 7A Functions);
Escalation Rights	means the escalation rights as defined in clause 14 *(Escalation Rights)*;
Financial Year	shall bear the same meaning as in section 275 of the NHS Act;
FOIA	the Freedom of Information Act 2000;
Further Arrangements	means arrangements for the exercise of Delegated Functions as defined at clause 11.2;
GDS Contract	means a General Dental Services contract made under section 100 of the NHS Act;
GMS Contract	means a General Medical Services contract made under section 84(1) of the NHS Act;
Good Practice	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;
Guidance	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the ICB has a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified to the ICB by any relevant Regulatory or Supervisory Body but excluding Mandated Guidance;
HSCA	means the Health and Social Care Act 2012;

ICB	means an Integrated Care Board established pursuant to section 14Z25 of the NHS Act and named in the Particulars;
ICB Deliverables	all documents, products and materials developed by the ICB or its Staff in relation to this Agreement and the Delegated Functions in any form and required to be submitted to NHS England under this Agreement, including data, reports, policies, plans and specifications;
IG Guidance for Serious Incidents	IG Guidance for Serious Incidents NHS Digital's Checklist Guidance for Information Governance Serious Incidents Requiring Investigation June 2013, available at: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-informationgovernance/data-security-and-protection-toolkit ;
Indemnity Arrangement	means either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);
Information Law	the UK GDPR, the Data Protection Act 2018, regulations and guidance made under section 13S and section 251 of the NHS Act; guidance made or given under sections 263 and 265 of the HSCA; the Freedom of Information Act 2000; the common law duty of confidentiality; the Human Rights Act 1998 and all other applicable laws and regulations relating to processing of Personal Data and privacy;
IPR	means inventions, copyright, patents, database right, trademarks, designs and confidential know-how and any similar rights anywhere in the world whether registered or not, including applications and the right to apply for any such rights;
Law	means any applicable law, statute, rule, bye-law, regulation, direction, order, regulatory policy, guidance or code, rule of court or directives or requirements of any regulatory body, delegated or subordinate legislation or notice of any regulatory body (including any Regulatory or Supervisory Body);
Local Authority	means a county council in England, a Combined Authority, a district council in England, a London borough council, the Common Council of the City of London or the Council of the Isles of Scilly;
Local Incentive Schemes	means an incentive scheme developed by the ICB in the exercise of its Delegated Functions to extend the range or quality of essential and additional services provided under a Primary Medical Services Contract and support

	national frameworks in order to meet differing local population needs;
Local Pharmaceutical Services Contract	means - a contract entered into pursuant to section 134 of the NHS Act; or - a contract entered into pursuant to Paragraph 1 of Schedule 12 to the NHS Act;
Local Terms	means the terms set out in SCHEDULE 7 *(Local Terms)*;
Losses	means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services) proceedings, demands and charges whether arising under statute, contract or common law;
Managing Conflicts of Interest in the NHS	the NHS publication by that name available at: https://www.england.nhs.uk/about/board-meetings/committees/coi/ ;
Mandated Guidance	means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of the Delegated Functions and issued by NHS England to the ICB from time to time, in accordance with clause 7.2**;**
Need to Know	has the meaning set out in paragraph 6.2 of SCHEDULE 4 (*Further Information Governance and Sharing Provisions)*;
NHS Act	means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022 or other legislation from time to time);
NHS Business Services Authority	means the Special Health Authority established under the NHS Business Services Authority (Establishment and Constitution Order) 2005 SI 2005/2414;
NHS Counter Fraud Authority	means the Special Health Authority established by and in accordance with the NHS Counter Fraud Authority (Establishment, Constitution, and Staff and Other Transfer Provisions) Order 2017/958;
NHS England	means the body established by section 1H of the NHS Act;
NHS England Deliverables	means all documents, products and materials NHS England in which NHS England holds IPRs which are relevant to this Agreement, the Delegated Functions or the Reserved Functions in any form and made available by NHS England to the ICB under this Agreement,

	including data, reports, policies, plans and specifications;
Non-Personal Data	means data which is not Personal Data;
Out of Hours Contract	means a primary medical services contract for the provision of primary medical services solely during the out of hours period (6.30pm Monday to Thursday until 8am the next day, 6.30pm Friday to 8am Monday, Christmas Day, Good Friday and bank holidays);
Operational Days	a day other than a Saturday, Sunday, Christmas Day, Good Friday or a bank holiday in England;
Particulars	means the Particulars of this Agreement as set out in clause 1 *(Particulars)*;
Party/Parties	means a party or both parties to this Agreement;
PDS Agreement	means a Personal Dental Services Agreement made under section 107 of the NHS Act;
Performers Lists	The lists of healthcare professionals maintained by NHS England pursuant to the National Health Service (Performers Lists) (England) Regulations 2013;
Personal Data	shall have the same meaning as set out in the UK GDPR and shall include references to Special Category Personal Data where appropriate;
Personal Data Agreement	means the agreement governing Information Law issues completed further to SCHEDULE 4 (Further *Information Governance and Sharing Provisions)*;
Pharmaceutical List	means a list of persons who undertake to provide pharmaceutical services pursuant to regulation 10 of the Pharmaceutical Regulations;
Pharmaceutical Regulations	means the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013/349;
Pharmaceutical Services	means: (i) services provided pursuant to arrangements under section 126 of the NHS Act; and (ii) Additional Pharmaceutical Services;
Pharmaceutical Services Arrangement	means an arrangement for the provision of Pharmaceutical Services, including inclusion in a Pharmaceutical List;
Pharmaceutical Services Provider	means a natural or legal person who is party to a Pharmaceutical Services Arrangement or Local Pharmaceutical Services Contract;

PMS Agreement	means an agreement made in accordance with section 92 of the NHS Act;
Premises Agreements	means tenancies, leases and other arrangements in relation to the occupation of land for the delivery of services under the Primary Medical Services Contracts;
Premises Costs Directions	means the National Health Service (General Medical Services Premises Costs) Directions 2013, as amended;
Premises Costs Directions Functions	means NHS England's functions in relation to the Premises Costs Directions;
Prescribed Dental Services	means the dental services prescribed by such regulations made pursuant to section 3B(1)(a) of the NHS Act as are in force from time to time (including, for the avoidance of doubt, services commonly known as secondary care dental services and Community Dental Services);
Prescribed Dental Services Contract	means any contract for the provision of Prescribed Dental Services;
Primary Care Contract or Arrangement (PCCA)	means: (i) a Primary Medical Services Contract; (ii) a Dental Services Contract; (iii) a Primary Ophthalmic Services Contract; (iv) a Local Pharmaceutical Services Contract; and (v) a Pharmaceutical Services Arrangement.
Primary Care Functions	means: (i) the statutory functions conferred on NHS England under Parts 4, 5, 6 and 7 of the NHS Act and secondary legislation made under those Parts; and (ii) the other statutory functions conferred on NHS England by either primary legislation, secondary legislation or by arrangement with another person in so far as they are applicable to the discharge of those functions set out at (i) above;
Primary Care Provider	means a natural or legal person who holds a Primary Care Contract, or is a Pharmaceutical Services Provider;
Primary Care Provider Personnel	means all persons (whether clinical or non-clinical) employed or engaged by a Primary Care Provider or by any Sub-Contractor (including volunteers, agency, locums, casual or seconded personnel) in the provision

	of Services or any activity related to or connected with the provision of the Services;
Primary Care Services	means the services in respect of which NHS England has a duty or power to make arrangements pursuant to the Primary Care Functions;
Primary Dental Services	means primary dental care services provided under arrangements made pursuant to Part 5 of the NHS Act, and in accordance with a Dental Services Contract;
Primary Medical Services	means primary medical services provided under arrangements made pursuant to Part 4 of the NHS Act, and in accordance with a Primary Medical Services Contract;
Primary Medical Services Contract	means: (i) a PMS Agreement; (ii) a GMS Contract; (iii) an APMS Contract; and (iv) any other contract for the provision of health services made pursuant to NHS England's functions under Part 4 of the NHS Act; in each case as amended or replaced from time to time and including all ancillary or related agreements directly relating to the subject matter of such agreements, contracts or arrangements but excluding any Premises Agreements and excluding any Out of Hours Contracts[2];
Primary Medical Services Provider	means a natural or legal person who holds a Primary Medical Services Contract;
Primary Ophthalmic Services	means primary ophthalmic services provided under arrangements made pursuant to Part 6 of the NHS Act, and in accordance with a Primary Ophthalmic Services Contract;
Primary Ophthalmic Services Contract	means: (i) a General Ophthalmic Services Contract; and (ii) any other contract for the provision of health services made pursuant to NHS England's functions under Part 6 of the NHS Act; in each case as amended or replaced from time to time and including all ancillary or related agreements directly relating to the subject matter of such agreements, contracts or arrangements;

[2] Arrangements for Out of Hours Contracts are dealt with under separate Directions outside of this Agreement and do not form part of any Delegated Functions.

Primary Ophthalmic Services Provider	means a natural or legal person who holds a Primary Ophthalmic Services Contract;
Principles of Best Practice	means the Mandated Guidance in relation to property and investment which is to be published either before or after the date of this Agreement;
Prohibited Act	the ICB: (i) offering, giving, or agreeing to give NHS England (or an of their officers, employees or agents) any gift or consideration of any kind as an inducement or reward for doing or not doing or for having done or not having done any act in relation to the obtaining of performance of this Agreement, the Reserved Functions, the Delegation or any other arrangement with the ICB, or for showing or not showing favour or disfavour to any person in relation to this Agreement or any other arrangement with the ICB; and (ii) in connection with this Agreement, paying or agreeing to pay any commission, other than a payment, particulars of which (including the terms and conditions of the agreement for its payment) have been disclosed in writing to NHS England; or (iii) committing an offence under the Bribery Act 2010;
QOF	means the quality and outcomes framework;
Regulatory or Supervisory Body	means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: (i) CQC; (ii) NHS England; (iii) the Department of Health and Social Care; (iv) NICE; (v) Healthwatch England and Local Healthwatch; (vi) the General Medical Council; (vii) the General Dental Council; (viii) the General Optical Council; (ix) the General Pharmaceutical Council; (x) the Healthcare Safety Investigation Branch; and

(xi) the Information Commissioner;

Relevant Information	means the Personal Data and Non-Personal Data processed under the Delegation and this Agreement, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*);
Reserved Functions	means the functions which are reserved to NHS England (and are therefore not delegated to the ICB under the Delegation) and as set out in detail in clause 8 and SCHEDULE 3 (Reserved Functions) of this Agreement;
Secretary of State	means the Secretary of State for Health and Social Care from time to time;
Section 7A Functions	means those functions of NHS England exercised pursuant to section 7A of the NHS Act and relating to Primary Care Services;
Section 7A Funds	shall have the meaning in clause 9.19.1;
Special Category Personal Data	shall have the same meaning as in UK GDPR;
Specified Purpose	means the purpose for which the Relevant Information is shared and processed, being to facilitate the exercise of the ICB's Delegated Functions and NHS England's Reserved Functions as specified in paragraph 2.1 of SCHEDULE 4 *(Further Information Governance and Sharing Provisions)* to this Agreement;
Staff or Staffing	means the Parties' employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of either Party (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel;
Staffing Model	means the employment model as defined in Appendix 2 of the NHS England and NHS Improvement operating models: HR Framework for developing Integrated Care;
Statement of Financial Entitlements Directions	means the General Medical Services Statement of Financial Entitlements Directions 2021, as amended or updated from time to time;
Sub-Delegate	shall have the meaning in clause 11.2;
Transfer Regulations	means the Transfer of Undertakings (Protection of Employment) Regulations 2006, as amended;

Triple Aim	means the duty to have regard to wider effect of decisions, which is placed on each of the Parties under section 13NA (as regards NHS England) and section 14Z43 (as regards the ICB) of the NHS Act;
UK GDPR	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018;
Variation Proposal	means a written proposal for a variation to the Agreement, which complies with the requirements of clause 25.3.

SCHEDULE 2

Delegated Functions

Schedule 2A: Primary Medical Services

Part 1: General Obligations

1. Introduction

1.1 This Part 1 of Schedule 2A *(Primary Medical Services)* sets out further provision regarding the carrying out of those Delegated Functions relating to Primary Medical Services, being in summary:

1.1.1 decisions in relation to the commissioning and management of Primary Medical Services;

1.1.2 planning Primary Medical Services in the Area, including carrying out needs assessments;

1.1.3 undertaking reviews of Primary Medical Services in respect of the Area;

1.1.4 management of the Delegated Funds in the Area;

1.1.5 co-ordinating a common approach to the commissioning and delivery of Primary Medical Services with other health and social care bodies in respect of the Area where appropriate; and

1.1.6 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

2. General Obligations

2.1 The ICB is responsible for planning the commissioning of primary medical services.

2.2 The role of the ICB includes:

2.2.1 carrying out needs assessments, and regular reviews of such assessments, to determine the needs of the population in the Area; and

2.2.2 identifying and implementing changes to meet any unmet needs which may be met through the delivery of Primary Medical Services.

2.3 In respect of integrated working, the ICB must:

2.3.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Authorities, Healthwatch, acute and community providers, the Local Medical Committee, and other stakeholders;

2.3.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Primary Medical Services generally; and

2.3.3 work with NHS England to coordinate the exercise of their respective performance management functions.

2.4 In relation to the Delegated Functions, the ICB agrees to perform the following general obligations:

2.4.1 to manage the Primary Medical Services Contracts and perform all of NHS England's obligations under each of the Primary Medical Services Contracts

in accordance with the terms of the Primary Medical Services Contracts as if it were named in the contract in place of NHS England;

2.4.2 actively manage the performance of the Primary Medical Services Provider in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches, serve notices or provide discretionary support;

2.4.3 ensure that it obtains value for money on behalf of NHS England, and avoids making any double payments under any Primary Medical Services Contracts;

2.4.4 notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the ICB of its obligations to perform any of NHS England's obligations under the Primary Medical Services Contracts;

2.4.5 undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;

2.4.6 keep a record of all of the Primary Medical Services Contracts that the ICB manages setting out the following details in relation to each Primary Medical Services Contract:

2.4.6.1 name of the Primary Medical Services Provider;

2.4.6.2 the name by which the Primary Medical Services Provider is known (if different to the name recorded under paragraph 2.4.6.1);

2.4.6.3 location of provision of services; and

2.4.6.4 amounts payable under the Primary Medical Services Contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.5 Without prejudice to clause 9 (Finance) of the Agreement or paragraph 2.4 above, the ICB must actively manage each of the relevant Primary Medical Services Contracts including by:

2.5.1 reviewing the performance of the relevant Primary Medical Services Contract, including in respect of quality standards, incentives and the QOF, observance of service specifications, and monitoring of activity and finance;

2.5.2 assessing quality and outcomes (including clinical effectiveness, patient experience, patient safety and addressing inequalities);

2.5.3 managing variations to the relevant Primary Medical Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.5.4 agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);

2.5.5 agreeing local prices, managing agreements or proposals for local variations and local modifications;

2.5.6 conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes; and

2.5.7 complying with and implementing any relevant Mandated Guidance issued from time to time.

2.6 This paragraph is without prejudice to clause 10 (Information, Planning and Reporting) or any other provision in this Agreement. The ICB must provide NHS England with:

2.6.1 such information relating to individual Primary Medical Services Providers in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the commissioning or performance of Primary Medical Services Providers;

2.6.2 such data/data sets as required by NHS England to ensure population of any national dashboards;

2.6.3 any other data/data sets as required by NHS England; and

2.6.4 the ICB shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

2.7 It should be noted that while the ICB is also required to exercise functions in respect of dispensing doctors, arrangements in respect of these functions are described in Schedule 2D (Pharmaceutical Services).

Part 2: Specific Obligations

3. Introduction

This Part 2 of Schedule 2A (Delegated Functions – Primary Medical Services) sets out further provision regarding the carrying out of each of the Delegated Functions.

4. Primary Medical Services Contract Management

The ICB must comply with any future national Mandated Guidance on equitable funding as may apply from time to time.

5. Enhanced Services

5.1 The ICB must manage the design (where applicable) and commissioning of any Enhanced Services, including re-commissioning these services annually where appropriate.

5.2 The ICB may consider any local enhanced services entered into with Primary Medical Services Providers in its Area using NHS Standard Contracts. Where these would continue to be beneficial to the Area, the ICB may manage the ongoing design and commissioning (including re-commissioning) of these services via a Local Incentives Scheme.

5.3 The ICB must ensure that it complies with any Mandated Guidance in relation to the design and commissioning of Enhanced Services.

5.4 When commissioning newly designed Enhanced Services the ICB must:

5.4.1 consider the needs of the local population in the Area;

5.4.2 develop the necessary specifications and templates for the Enhanced Services, as required to meet the needs of the local population in the Area;

5.4.3 when developing the necessary specifications and templates for the Enhanced Services, ensure that value for money will be obtained;

5.4.4 consult with Local Medical Committees and other stakeholders and comply with the duty of public involvement and consultation under section 14Z45 of the NHS Act;

5.4.5 liaise with system providers and representative bodies to ensure that the system in relation to the Directed Enhanced Services, NHS England Enhanced Services and Local Enhanced Services will be functional and secure;

5.4.6 support Data Controllers in providing 'fair processing' information as required by the UK GDPR; and

5.4.7 support Primary Medical Services Providers in entering into data processing agreements with data processors in the terms required by the UK GDPR.

6. Design of Local Incentive Schemes

6.1 The ICB may design and offer Local Incentive Schemes for Primary Medical Services Providers, sensitive to the differing needs of their particular communities. This includes in addition to or as an alternative to the national contractual frameworks (including as an alternative to QOF or Enhanced Services), provided that such schemes are voluntary, and the ICB continues to offer the national schemes.

6.2 There is no formal approvals process that the ICB must follow to develop a Local Incentive Scheme, although when designing and implementing any proposed new Local Incentive Scheme the ICB must:

6.2.1 consider the needs of the local population in the Area;

6.2.2 develop the specifications and templates for the Local Incentive Scheme;

6.2.3 consult with Local Medical Committees and other stakeholders and comply with the duty of public involvement and consultation under section 14Z45 of the NHS Act;

6.2.4 liaise with system providers and representative bodies to ensure that the system in relation to the Local Incentive Schemes will be functional and secure;

6.2.5 support Data Controllers in providing privacy information as required by the UK GDPR; and

6.2.6 support Primary Medical Services Providers in entering into data processing agreements with data processors in terms required by the UK GDPR.

6.3 The ICB must be able to:

6.3.1 demonstrate improved outcomes, reduced inequalities and value for money;

6.3.2 support ongoing national reporting requirements (where applicable); and

6.3.3 must reflect the changes agreed as part of the national PMS reviews (https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/05/implement-pms-fund-changes.pdf) .

6.4 The ongoing assurance of any new Local Incentive Schemes will form part of the ICB's assurance process under any applicable assurance framework.

6.5 Any new Local Incentive Scheme must be implemented without prejudice to the right of Primary Medical Services Providers operating under a GMS Contract to obtain their entitlements which are negotiated and set nationally.

6.6 NHS England will continue to set national standing rules, to be reviewed annually, and the ICB must comply with these rules which shall for the purposes of this Agreement be Mandated Guidance.

7. Making Decisions on Discretionary Payments or Support

7.1 The ICB must manage and make decisions in relation to any discretionary payments or discretionary support to be made to Primary Medical Services Providers in a consistent, open and transparent way.

7.2 The ICB must exercise its discretion to determine the level of payment or type of support to Primary Medical Services Providers, in accordance with any relevant Mandated Guidance.

8. Making Decisions about Commissioning Urgent Care for Out of Area Registered Patients

8.1 The ICB must manage the design and commissioning of urgent care services (including home visits as required) for its patients registered out of area (including re-commissioning these services annually where appropriate).

8.2 The ICB must ensure that it complies with any Mandated Guidance in relation to the design and commissioning of these services.

8.3 For the purposes of paragraph 2.15, urgent care means the provision of primary medical services on an urgent basis.

9. Transparency and freedom of information

9.1 The ICB must:

9.1.1 Respond to requests for information from members of the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

9.1.2 Provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

10. Planning the Provider Landscape

10.1 The ICB must plan the primary medical services provider landscape in the Area, including considering and taking decisions in relation to:

10.1.1 establishing new Primary Medical Services Providers in the Area;

10.1.2 managing Primary Medical Services Providers providing inadequate standards of patient care;

10.1.3 the procurement or award of new Primary Medical Services Contracts (in accordance with any procurement protocol or Guidance issued by NHS England from time to time);

10.1.4 closure of practices and branch surgeries;

10.1.5 dispersing the patient lists of Primary Medical Services Providers; and

10.1.6 agreeing variations to the boundaries of Primary Medical Services Providers.

10.2 In relation to any new Primary Medical Services Contract to be entered into, the ICB must, without prejudice to any obligation in paragraph 16 (Procurement and New Contracts) below, and paragraph 2.5 of Part 1 of this Schedule 2A:

10.2.1 consider and use the form of Primary Medical Services Contract that will ensure compliance with NHS England's obligations under Law taking into account the persons to whom such Primary Medical Services Contracts may be awarded;

10.2.2 provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law; and

10.2.3 for the avoidance of doubt, Schedule 5 (Financial Provisions and Decision Making Limits) deals with the sign off requirements for Primary Medical Services Contracts.

11. Primary Care Networks

11.1 In managing the design and commissioning of the Network Contract Directed Enhanced Services, including re-commissioning these services annually where appropriate, the ICB must plan and manage the Primary Care Networks in the Area, complying with published specifications and Mandated Guidance, including to:

11.1.1 maintain or establish identified Network Areas to support the local population in the Area;

11.1.2 review any waived PCN list size requirements wherever possible and appropriate to best support the local population in the Area;

11.1.3 ensure that each PCN has at all times an accountable Clinical Director;

11.1.4 align each PCN with an ICB that would best support delivery of services to the local population in the Area; and

11.1.5 collaborate and work with other ICBs as appropriate to agree which ICB will be the lead ICB for the PCN.

12. Approving Primary Medical Services Provider Mergers and Closures

12.1 The ICB is responsible for approving Primary Medical Services Provider mergers and Primary Medical Services Provider closures in the Area.

12.2 The ICB must undertake all necessary consultation when taking any decision in relation to Primary Medical Services Provider mergers or Primary Medical Services Provider closures in the Area, including those set out under section 14Z45 of the NHS Act (duty for public involvement and consultation). The consultation undertaken must be appropriate and proportionate in the circumstances and should include consulting with the Local Medical Committee.

12.3 Prior to making any decision in accordance with this paragraph 12 (Approving Primary Medical Services Provider Mergers and Closures), the ICB must be able to clearly demonstrate the grounds for such a decision and must have fully considered any impact on the Primary Medical Services Provider's registered population and that of surrounding practices. The ICB must be able to clearly demonstrate that it has considered other options and has entered into dialogue with the Primary Medical Services Provider as to how any closure or merger will be managed.

12.4 In making any decisions pursuant to this paragraph 12 (Approving Primary Medical Services Provider Mergers and Closures), the ICB shall act in accordance with relevant Mandated Guidance and also take account of its obligations as set out in paragraph 16 *(Procurement and New Contracts)*, below, where applicable.

13. Making Decisions in relation to Management of Poorly Performing Primary Medical Services Providers

13.1 The ICB must make decisions in relation to the management of poorly performing Primary Medical Services Provider including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the Performers List).

13.2 In accordance with paragraph 13.1 above, the ICB must:

13.2.1 ensure regular and effective collaboration with the CQC to ensure that information on general practice is shared and discussed in an appropriate and timely manner;

13.2.2 ensure that any risks identified are managed and escalated where necessary;

13.2.3 respond to CQC assessments of Primary Medical Services Providers where improvement is required;

13.2.4 where a Primary Medical Services Provider is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and

13.2.5 take appropriate contractual action, including (without limitation) in response to CQC findings.

14. Premises Costs Directions Functions

14.1 The ICB must comply with the Premises Costs Directions and will be responsible for making decisions in relation to the Premises Costs Directions Functions.

14.2 In particular, but without limiting paragraph 14.1, the ICB shall make decisions concerning:

14.2.1 applications for new payments under the Premises Costs Directions (whether such payments are to be made by way of grants or in respect of recurring premises costs); and

14.2.2 revisions to existing payments being made under the Premises Costs Directions.

14.3 The ICB must comply with any decision-making limits set out in Schedule 5 (Financial Provisions and Decision Making Limits) when taking decisions in relation to the Premises Costs Directions Functions.

14.4 The ICB will comply with any Guidance issued by the Secretary of State or NHS England in relation to the Premises Costs Directions, including the Principles of Best Practice, and any other Mandated Guidance in relation to the Premises Costs Directions.

14.5 The ICB must work to ensure that the premises estate is properly managed and maintained, including by ensuring strategic estates planning is in place, and work cooperatively with other ICBs as appropriate.

14.6 The ICB must ensure it maintains comprehensive records of the primary care estate and any changes to it.

14.7 The ICB must liaise where appropriate with NHS Property Services Limited and Community Health Partnerships Limited in relation to the Premises Costs Directions Functions.

14.8 The ICB must prioritise the following measures in respect of management of the primary care estate in the Area:

14.8.1 working collaboratively with landlords and tenants to maximise the use of existing estate;

14.8.2 effective asset management practices including (without limitation) regularisation of the occupation of the estate, lease events, rent reviews and up-to-date documentation management; and

14.8.3 seeking the resolution of premises disputes in a timely manner.

15. Maintaining the Performers List

On receiving a notice from a practitioner (who is party to a Primary Medical Services Contract) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the Performers List as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.

16. Procurement and New Contracts

16.1 Until any new arrangements for awarding Primary Medical Services Contracts comes into force, the ICB will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

16.2 In discharging its responsibilities set out in this Schedule 2A, the ICB must comply at all times with Law and any relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services).

16.3 On the coming into force of new arrangements for awarding Primary Medical Services Contracts, the ICB will make decisions on awarding new contracts relevant to the exercise of the Delegated Functions.

16.4 When the ICB makes decisions in connection with the awarding of Primary Medical Services Contracts it should ensure that it is able to demonstrate compliance with requirements for the award of Primary Medical Services Contracts, including that the decision was:

16.4.1 made in the best interest of patients, taxpayers and the population;

16.4.2 robust and defensible, with conflicts of interests appropriately managed;

16.4.3 made transparently; and

16.4.4 compliant with the rules of the regime as set out in NHS England guidance.

16.5 Where the ICB wishes to develop and offer a locally designed contract, it must ensure that it has consulted with the relevant Local Medical Committees in relation to the proposal and that it can demonstrate that the scheme will:

16.5.1 improve outcomes for patients;

16.5.2 reduce inequalities in the population; and

16.5.3 provide value for money.

17. Complaints

17.1 The ICB will handle complaints made in respect of Primary Medical Services in accordance with the Complaints Regulations.

18. Commissioning ancillary support services

18.1 The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

18.1.1 collection and disposal of clinical waste;

18.1.2 provision of translation and interpretation services;

18.1.3 occupational health services for performers registered on the Performers List.

18.2 The arrangements for the provision of ancillary services to Primary Medical Services Providers are described in Schedule 7 (Local Terms).

19. Finance

Further requirements in respect of finance will be specified in Mandated Guidance.

20. Workforce

20.1 The arrangements for the provision and maintenance of sufficient and appropriately qualified, trained and experienced Staff in order for the ICB to fulfil its responsibilities for each of the Delegated Functions ("the Staffing Model"), will be communicated formally to the ICB by NHS England following recommendations made by the National Moderation Panel.

20.2 The ICB is not permitted to vary the Staffing Model agreed with NHS England as part of its application for delegation of the said functions however a variation can be applied for by the ICB and considered by the National Moderation Panel at any time.

Schedule 2B: Dental Care Services

The provisions of this Schedule 2B form part of this Agreement only where indicated in the Particulars.

Part 1A: General Obligations – Primary Dental Services

1. Introduction

1.1 This Part 1A of Schedule 2B *(Dental Care Services)* sets out general provisions regarding the carrying out of those Delegated Functions relating to Primary Dental Services, being in summary:

1.1.1 decisions in relation to the commissioning and management of Primary Dental Services;

1.1.2 planning Primary Dental Services in the Area, including carrying out needs assessments;

1.1.3 undertaking reviews of Primary Dental Services in the Area;

1.1.4 management of the Delegated Funds in the Area;

1.1.5 co-ordinating a common approach to the commissioning and delivery of Primary Dental Services with other health and social care bodies in respect of the Area where appropriate; and

1.1.6 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

2. General Obligations

2.1 The ICB is responsible for planning the commissioning of Primary Dental Services.

2.2 When planning and commissioning Primary Dental Services, the ICB must comply with Mandated Guidance issued by NHS England.

2.3 In respect of integrated working, the ICB must:

2.3.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Dental Professional Networks, Local Authorities, Healthwatch, acute and community providers, the Local Dental Committee, and other stakeholders;

2.3.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Primary Dental Services generally; and

2.3.3 work with NHS England to coordinate the exercise of their respective performance management functions.

2.4 In relation to the Delegated Functions, the ICB agrees to perform the following general obligations with regard to Dental Services Contracts:

2.4.1 to manage the Dental Services Contracts and perform all of NHS England's obligations under each of the Dental Services Contracts in accordance with the terms of the Dental Services Contracts as if it were named in the contract in place of NHS England;

2.4.2 working with other organisations, including the NHS Business Services Authority and the NHS England specialised commissioning team as appropriate, actively manage the performance of the Dental Services Provider in order to secure the needs of people who use the services,

improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches, serve notices or provide discretionary support;

2.4.3 ensure that it obtains value for money on behalf of NHS England, including by avoiding making any double payments under any Dental Services Contracts and reducing the number of contracts which are under-delivering so that funds can be reallocated to meet local oral health needs;

2.4.4 notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the ICB of its obligations to perform any of NHS England's obligations under the Dental Services Contracts;

2.4.5 undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;

2.4.6 keep a record of all of the Dental Services Contracts that the ICB manages on behalf of NHS England setting out the following details in relation to each Dental Services Contract:

2.4.6.1 name of Dental Services Provider;

2.4.6.2 any practice or trading name by which the Dental Services Provider is known (if different to the name recorded under paragraph 2.4.6.1);

2.4.6.3 location of provision of services; and

2.4.6.4 amounts payable under the contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.5 Without prejudice to clause 9 *(Finance)* or paragraph 2.4 above, the ICB must actively manage each of the relevant Dental Services Contracts including by:

2.5.1 reviewing and monitoring spending on services provided pursuant to Dental Services Contracts in the Area;

2.5.2 reviewing and monitoring spending on Primary Dental Services commissioned in the Area;

2.5.3 creating purchase orders, coding invoices and making appropriate amendments within the Compass contractor payments system;

2.5.4 managing the relevant Dental Services Contract, including in respect of quality standards, incentives, observance of service specifications, and monitoring of activity and finance;

2.5.5 assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);

2.5.6 managing variations to the relevant Dental Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.5.7 agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);

2.5.8 undertaking annual contract activity negotiations, including agreeing local prices, managing agreements or proposals for local variations and local modifications;

2.5.9 conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes;

2.5.10 allocating sufficient resources for undertaking contract mediation; and

2.5.11 complying with and implementing any relevant Mandated Guidance issued from time to time.

2.6 This paragraph is without prejudice to clause 10 *(Information, Planning and Reporting)* or any other provision in this Agreement. The ICB must provide NHS England with:

2.6.1 such information relating to individual providers of Primary Dental Services in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the commissioning or performances of providers of Primary Dental Services;

2.6.2 such data/data sets as required by NHS England to ensure population of any national dashboards;

2.6.3 any other data/data sets as required by NHS England; and

2.6.4 the ICB shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

Part 1B: General Obligations – Prescribed Dental Services (applicable only if Prescribed Dental Services are included in the Particulars)

1. Introduction

1.1 This Part 1B of Schedule 2B *(Dental Care Services)* sets out general provisions regarding the carrying out of those Delegated Functions relating to Prescribed Dental Services.

1.2 For the purposes of Paragraph 2.1 of this Part 1B of Schedule 2B *(Dental Care Services)*, the term "Population" refers to a group of people for whom the ICB has core responsibility, as established under the rules published by NHS England under section 14Z31 of the Act.

1.3 Community Dental Services are a form of Prescribed Dental Services. However, they may be governed by the terms of either an NHS Standard Contract or a PDS Agreement, as appropriate to the particular service. Accordingly:

1.3.1 where Community Dental Services are commissioned on PDS Agreement terms (or it is appropriate to commission any new PDS Agreement for such services), those contracts must be managed in accordance with the relevant provisions of Part 1A of this Schedule 2B as if they were Primary Dental Services for the purposes of that Part only. The provisions of this Part 1B of Schedule 2B also apply, with the exception of paragraphs 2.5.2 and 2.5.3; and

1.3.2 where Community Dental Services are commissioned on NHS Standard Contract terms, the provisions of this Part 1B of Schedule 2B apply in full.

2. General Obligations

2.1 NHS England may, by Contractual Notice, designate the ICB as the body responsible for commissioning Prescribed Dental Services for its Population and allocate Prescribed Dental Contracts to the ICB in accordance with clause 6.4 of this Agreement.

2.2 Each Contractual Notice referred to in paragraph 2.1 above will set out, in relation to each Prescribed Dental Services Contract, which rights, obligations and duties under that Presecribed Dental Services Contract are to be delegated to the ICB and which are to be retained by NHS England.

2.3 In respect of integrated working, the ICB must take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Dental Professional Networks, Local Authorities, Healthwatch, acute and community providers, the Local Dental Committee, and other stakeholders.

2.4 When planning and commissioning Prescribed Dental Services, the ICB must comply with Mandated Guidance issued by NHS England.

2.5 In awarding any new contract for Prescribed Dental Services, the ICB must:

2.5.1 comply with Law and all relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services);

2.5.2 subject to paragraph 1.3.1 of this Part 1B, use the current NHS Standard Contract published by NHS England from time to time; and

2.5.3 subject to paragraph 1.3.1 of this Part 1B, pay for the Services in accordance with the National Tariff or the NHS Payment Scheme (each as defined in the Health and Social Care Act 2012) as applicable from time to time.

Part 2: Specific Obligations – Primary Dental Services only

1. Introduction

1.1 This Part 2 of Schedule 2B *(Dental Care Services)* sets out further provision regarding the carrying out of each of the Delegated Functions in relation to Primary Dental Services.

2. Dental Services Contract Management

2.1 The ICB must:

2.1.1 comply with all current and future relevant national Mandated Guidance regarding contract reviews;

2.1.2 monitor contract performance and primary care dental spending, with a view in particular to achieving a reduction in the number of contract holders who are under-delivering, and the reallocation of unused resources to meet the oral health needs of the Area; and

2.1.3 in cooperation with the NHS Business Services Authority, monitor contract performance with a view in particular to addressing patient safety concerns and promoting patient safety.

2.2 The ICB must undertake the annual reconciliation of monies claimed by providers against the services provided under a GDS Contract, PDS Agreement and Personal Dental Services Plus Agreement procuring such ancillary support services as are required for the performance of this function.

3. Transparency and freedom of information

3.1 The ICB must:

3.1.1 respond to requests for information from members of the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

3.1.2 provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

4. Planning the Provider Landscape

4.1 The ICB must plan the provider landscape in the Area, including considering and taking decisions in relation to:

4.1.1 establishing new Dental Services Providers in the Area;

4.1.2 managing Dental Services Providers providing inadequate standards of patient care;

4.1.3 the procurement or award of new Dental Services Contracts (in accordance with any procurement protocol or Guidance issued by NHS England from time to time); and

4.1.4 closure of practices.

4.2 In relation to any new Dental Services Contract to be entered into, the ICB must, without prejudice to any obligation in paragraph 10 (Procurement and New Contracts), below:

4.2.1 consider and use the form of Dental Services Contract that will ensure compliance with NHS England's obligations under Law taking into account the persons to whom such Dental Services Contracts may be awarded;

4.2.2 provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law; and

4.2.3 for the avoidance of doubt, Schedule 5 (Financial Provisions and Decision Making Limits) deals with the sign off requirements for Dental Services Contracts.

5. Finance

5.1 Further requirements in respect of finance will be specified in Mandated Guidance.

6. Workforce

6.1 The arrangements for the provision and maintenance of sufficient and appropriately qualified, trained and experienced Staff in order for the ICB to fulfil its responsibilities for each of the Delegated Functions ("the Staffing Model"), will be communicated formally to the ICB by NHS England following recommendations made by the National Moderation Panel. Further requirements in respect of workforce will be specified in Mandated Guidance.

6.2 The ICB is not permitted to vary the Staffing Model agreed with NHS England as part of its application for delegation of the said functions however a variation can be applied for by the ICB and considered by the National Moderation Panel at any time.

7. Integrating dentistry into communities at Primary Care Network level

7.1 The ICB must exercise the Delegated Functions with a view to achieving greater integration of dentists into the Integrated Care System at the Primary Care Network level.

8. Making Decisions in relation to Management of Poorly Performing Dental Services Providers

8.1 The ICB must make decisions in relation to the management of poorly performing Dental Services Provider including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the Performers List).

8.2 In accordance with paragraph 8.1 above, the ICB must:

8.2.1 ensure regular and effective collaboration with the CQC to ensure that information is shared and discussed in an appropriate and timely manner;

8.2.2 ensure that any risks identified are managed and escalated where necessary;

8.2.3 respond to CQC assessments of Dental Services Providers where improvement is required;

8.2.4 where a Dental Services Provider is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and

8.2.5 take appropriate contractual action, including (without limitation) in response to CQC findings.

9. Maintaining the Performers List

9.1 On receiving a notice from a practitioner (who is party to a Dental Services Contract) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the Performers List as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.

10. Procurement and New Contracts

10.1 Until any new arrangements for awarding Dental Services Contracts comes into force, the ICB will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

10.2 In discharging its responsibilities set out in this Schedule 2B, the ICB must comply at all times with Law and all relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services).

10.3 On the coming into force of new arrangements for awarding Dental Services Contracts, the ICB will make decisions on awarding new contracts relevant to the exercise of the Delegated Functions.

10.4 When the ICB makes decisions in connection with the awarding of Dental Services Contracts it should ensure that it is able to demonstrate compliance with requirements for the award of Dental Services Contracts, including that the decision was:

10.4.1 made in the best interest of patients, taxpayers and the population;

10.4.2 robust and defensible, with conflicts of interests appropriately managed;

10.4.3 made transparently, and

10.4.4 compliant with the rules of the regime as set out in NHS England guidance.

11. Complaints

11.1 The ICB will handle complaints made in respect of Primary Dental Services in accordance with the Complaints Regulations.

12. Commissioning Ancillary Support Services

12.1 The arrangements for the provision of ancillary services to Primary Dental Services Providers are described in Schedule 7 (Local Terms).

Schedule 2C: Primary Ophthalmic Services

The provisions of this Schedule 2C form part of this Agreement only where indicated in the Particulars.

Part 1: General Obligations

1. Introduction

1.1 This Part 1 of Schedule 2C *(Primary Ophthalmic Services)* sets out general provisions regarding the carrying out of the Delegated Functions, being, in summary:

1.1.1 decisions in relation to the management of Primary Ophthalmic Services;

1.1.2 undertaking reviews of Primary Ophthalmic Services in the Area;

1.1.3 management of the Delegated Funds in the Area;

1.1.4 co-ordinating a common approach to the commissioning of Primary Ophthalmic Services with other commissioners in the Area where appropriate; and

1.1.5 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

2. General Obligations

2.1 The ICB is responsible for managing the provision of Primary Ophthalmic Services.

2.2 When carrying out Delegated Functions in respect of Primary Ophthalmic Services, the ICB must comply with all Mandated Guidance issued by NHS England.

2.3 The role of the ICB includes identifying and seeking to address any unmet needs which may be met through the delivery of Primary Ophthalmic Services.

2.4 In respect of integrated working, the ICB must:

2.4.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Eye Health Networks, Local Authorities, Healthwatch, acute and community providers, Local Optical Committees, and other stakeholders;

2.4.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Primary Ophthalmic Services generally; and

2.4.3 work with NHS England to coordinate the exercise of their respective performance management functions.

2.5 In relation to the Delegated Functions, the ICB agrees to perform the following general obligations:

2.5.1 to manage the Primary Ophthalmic Services Contracts on behalf of NHS England and perform all of NHS England's obligations under each of the Primary Ophthalmic Services Contracts in accordance with the terms of the Primary Care Contracts as if it were named in the contract in place of NHS England;

2.5.2 working with other organisations, including the NHS Business Services Authority and NHS England as appropriate, actively manage the performance of the Primary Ophthalmic Services Provider in order to secure the needs of people who use the services, improve the quality of services

and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches, serve notices or provide discretionary support;

2.5.3 ensure that it obtains value for money on behalf of NHS England and avoids making any double payments under any Primary Ophthalmic Services Contracts;

2.5.4 notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the ICB of its obligations to perform any of NHS England's obligations under the Primary Ophthalmic Services Contracts;

2.5.5 undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;

2.5.6 keep a record of all of the Primary Ophthalmic Services Contracts that the ICB manages on behalf of NHS England setting out the following details in relation to each Primary Ophthalmic Services Contract:

2.5.6.1 name of the Primary Ophthalmic Services Provider;

2.5.6.2 any practice or trading name by which the Primary Ophthalmic Services Provider is known (if different to the name recorded under paragraph 2.5.6.1);

2.5.6.3 location of provision of services; and

2.5.6.4 amounts payable under the Primary Ophthalmic Services Contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.6 Without prejudice to clause 9 *(Finance)* or paragraph 2.5 above, the ICB must actively manage each of the relevant Primary Ophthalmic Services Contracts including by:

2.6.1 managing the relevant Primary Ophthalmic Services Contract, including in respect of quality standards, incentives, observance of service specifications, and monitoring of activity and finance;

2.6.2 assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);

2.6.3 managing variations to the relevant Primary Ophthalmic Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.6.4 agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);

2.6.5 conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes; and

2.6.6 complying with and implementing any relevant Mandated Guidance issued from time to time.

2.7 This paragraph is without prejudice to clause 10 (Information, Planning and Reporting) or any other provision in this Agreement. The ICB must provide NHS England with:

2.7.1 such information relating to individual providers of Primary Ophthalmic Services in the Area as NHS England may reasonably request, to ensure

that NHS England is able to continue to gather national data regarding the commissioning or performances of providers of Primary Ophthalmic Services;

2.7.2 such data/data sets as required by NHS England to ensure population of any national dashboards;

2.7.3 any other data/data sets as required by NHS England; and

2.7.4 the ICB shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

Part 2: Specific Obligations

3. Introduction

3.1 This Part 2 of Schedule 2C *(Primary Ophthalmic Services)* sets out further provision regarding the carrying out of each of the Delegated Functions.

4. Primary Ophthalmic Services Contract Management

4.1 The ICB must:

4.1.1 comply with all current and future relevant national Mandated Guidance regarding General Ophthalmic Contract reviews and any other contract reviews;

4.1.2 take on the responsibility for existing services provided pursuant to a Primary Ophthalmic Services Contract, and for commissioning new services;

4.1.3 assume the responsibility for the award of new Primary Ophthalmic Services Contracts; and

4.1.4 monitor contract performance with a view to achieving assurance and improvement in the delivery of services in the context of the ICB;

in each case acknowledging that the NHS Business Services Authority provides end-to-end support services in relation to these functions, as referred to in Schedule 6. The ICB accordingly agrees to co-operate with the NHS Business Services Authority in the delivery of these functions.

5. Transparency and freedom of information

5.1 The ICB must:

5.1.1 Respond to requests for information from members and the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

5.1.2 Provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

6. Maintaining the Performers List

6.1 On receiving a notice from a practitioner (who is party to a Primary Ophthalmic Services Contract) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the performers list as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.

7. Finance

7.1 Further requirements in respect of finance will be specified in Mandated Guidance.

8. Workforce

8.1 The arrangements for the provision and maintenance of sufficient and appropriately qualified, trained and experienced Staff in order for the ICB to fulfil its responsibilities for each of the Delegated Functions ("the Staffing Model"), will be communicated formally to the ICB by NHS England following recommendations made by the National Moderation Panel. Further requirements in respect of workforce will be specified in Mandated Guidance.

8.2 The ICB is not permitted to vary the Staffing Model agreed with NHS England as part of its application for delegation of the said functions however a variation can be applied for by the ICB and considered by the National Moderation Panel at any time.

9. Integrating optometry into communities at Primary Care Network level

9.1 The ICB must exercise the Delegated Functions with a view to achieving greater integration of optometrists into the Integrated Care System at the Primary Care Network level.

10. Complaints

10.1 The ICB will handle complaints made in respect of primary ophthalmic services in accordance with the Complaints Regulations.

11. Commissioning ancillary support services

11.1 The arrangements for the provision of ancillary services to Primary Ophthalmic Services Providers are described in Schedule 7 (Local Terms).

Schedule 2D: Delegated Functions – Pharmaceutical Services

The provisions of this Schedule 2D form part of this Agreement only where indicated in the Particulars.

1. In this Schedule, the following additional definitions shall apply:

Advanced Services	has the meaning given to that term by the Pharmaceutical Regulations
Conditions of Inclusion	means those conditions set out at Part 9 of the Pharmaceutical Regulations
Delegated Pharmaceutical Functions	the functions set out at paragraph 2 of this Schedule
Designated Commissioner	has the meaning given to that term at paragraph 2.3 of this Schedule
Dispensing Doctor	has the meaning given to that term by the Pharmaceutical Regulations
Dispensing Doctor Decisions	means decisions made under Part 8 of the Pharmaceutical Regulations
Dispensing Doctor Lists	has the meaning given to that term by the Pharmaceutical Regulations
Drug Tariff	has the meaning given to that term by the Pharmaceutical Regulations
Electronic Prescription Service	has the meaning given to that term by the Pharmaceutical Regulations
Enhanced Services	has the meaning given to that term by the Pharmaceutical Regulations
Essential Services	is to be construed in accordance with paragraph 3 of Schedule 4 to the Pharmaceutical Regulations
Fitness to Practise Functions	has the meaning given to that term at paragraph 2.1.10 of this Schedule
Locally Commissioned Services	means services which are not Essential Services, Advanced Services, Enhanced Services or services commissioned under an LPS Scheme
LPS Chemist	has the meaning give to that term by the Pharmaceutical Regulations
LPS Scheme	has the meaning given to that term by Paragraph 1(2) of Schedule 12 to the NHS Act
NHS Chemist	has the meaning given to that term by the Pharmaceutical Regulations

Pharmaceutical Lists	has the meaning given to that term at paragraph 2.1.1. of this Schedule and any reference to a Pharmaceutical List should be construed accordingly
Pharmaceutical Regulations	means the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and reference to a Regulation refers to a provision of the Pharmaceutical Regulations, unless otherwise stated
Rurality Decisions	means decisions made under Part 7 of the Pharmaceutical Regulations
Terms of Service	means the terms upon which, by virtue of the Pharmaceutical Regulations, a person undertakes to provide Pharmaceutical Services

Delegated Pharmaceutical Functions

2. Except in so far as they fall within the scope of the Reserved Functions, and subject to paragraphs 2.2, 2.3, 4 and 5, the ICB agrees to perform the following functions of NHS England in respect of the Area (the "Delegated Pharmaceutical Functions"), in all cases in accordance with relevant Law, Mandated Guidance and other Guidance:

2.1.1. preparing, maintaining and submitting for publication by NHS England lists of persons, other than medical practitioners or dental practitioners, who have undertaken to provide pharmaceutical services from premises situated within the Area[3], specifically:

2.1.1.1. lists of persons who have undertaken to provide pharmaceutical services in particular by way of the provision of drugs;

2.1.1.2. lists of persons who have undertaken to provide pharmaceutical services only by way of the provision of appliances; and

2.1.1.3. lists of persons participating in the Electronic Prescription Service[4]

collectively referred to in this Schedule as the "Pharmaceutical Lists". In doing so, it is sufficient for the lists referred to at paragraphs 2.1.1.1 and 2.1.1.2 to include a marker showing which persons are also participating in the Electronic Prescription Service, rather than preparing a separate list for the purposes of paragraph 2.1.1.3.

2.1.2. managing and determining applications by persons for inclusion in a Pharmaceutical List[5];

[3] Including (without limitation) updates to those lists following any removal under regulation 115 of the Pharmaceutical Regulations
[4] Regulation 10 of the Pharmaceutical Regulations
[5] Schedule 2 of the Pharmaceutical Regulations

2.1.3. managing and determining applications by persons included in a Pharmaceutical List;

2.1.4. responsibilities for financial resources related to the Delegated Pharmaceutical Functions as described in Mandated Guidance issued by NHS England;

2.1.5. overseeing the compliance of those included in the Pharmaceutical Lists with:

2.1.5.1. their Terms of Service and identifying and investigating breaches, including possible breaches, of those terms;

2.1.5.2. relevant Conditions of Inclusion; and

2.1.5.3. requirements of the Community Pharmacy Contractual Framework.

2.1.6. exercising powers in respect of Performance Related Sanctions and Market Exit[6];

2.1.7. exercising all other rights, and complying with all other obligations, of NHS England in respect of the Terms of Service and Conditions of Inclusion of those included in the Pharmaceutical Lists;

2.1.8. communicating to those included in the Pharmaceutical Lists any announcement made by NHS England modifying Terms of Service of any person included in the Pharmaceutical Lists as a consequence of a disease being, or in anticipation of a disease being imminently:

2.1.8.1. pandemic; and

2.1.8.2. a serious risk or potentially a serious risk to human health[7];

2.1.9. communicating to those included in the Pharmaceutical Lists any other matters which NHS England may require the ICB to communicate from time to time;

2.1.10. performing functions in respect of the disqualification of practitioners, and related measures concerning a practitioners inclusion in the Pharmaceutical Lists, set out in Chapter 6 of Part 7 to the NHS Act and the provisions of the Pharmaceutical Regulations made under that Chapter ("the Fitness to Practise Functions");

2.1.11. performing functions in respect of enforcement, reviews and appeals relating to the Fitness to Practise Functions[8];

2.1.12. making LPS Schemes[9], subject to the requirements of paragraph 5;

2.1.13. overseeing the compliance of those who are party to Local Pharmaceutical Services Contracts with the terms of those contracts and identifying and investigating breaches, including possible breaches, of the terms of those contracts;

2.1.14. exercising all rights, and complying with all obligations, of NHS England under Local Pharmaceutical Services Contracts;

2.1.15. determining LPS matters[10] in respect of LPS Schemes;

2.1.16. determining Rurality Decisions and other rurality matters[11];

2.1.17. determining Dispensing Doctor Decisions[12];

[6] Part 10 of the Pharmaceutical Regulations
[7] Regulation 11(3) of the Pharmaceutical Regulations
[8] Part 11 of the Pharmaceutical Regulations
[9] Section 134 NHS Act and Part 13 of the Pharmaceutical Regulations.
[10] Part 13 of the Pharmaceutical Regulations
[11] Part 7 of the Pharmaceutical Regulations
[12] Part 8 of the Pharmaceutical Regulations

2.1.18. preparing and maintaining Dispensing Doctor Lists[13];

2.1.19. making arrangements for the provision of adequate pharmaceutical service delivery across the ICB area;

2.1.20. making arrangements for the delivery of Essential Services, Advanced Services and Enhanced Services;

2.1.21. supporting implementation and delivery of all elements of the Community Pharmacy Contractual Framework;

2.1.22. consulting with patients, the public and other stakeholders to the extent required by the duty of public involvement and consultation under section 14Z45 of the NHS Act;

2.1.23. responding to Appeals to the Secretary of State and First Tier Tribunal in respect of the Delegated Pharmaceutical Functions[14];

2.1.24. responding to Claims in respect of the Delegated Pharmaceutical Functions;

2.1.25. recovering overpayments from NHS Chemists, LPS Chemists, Dispensing Doctors and Primary Medical Services Providers[15];

2.1.26. bringing any legal proceedings in respect of the Delegated Pharmaceutical Functions;

2.1.27. making any notifications to, and consulting with, third parties in respect of the Delegated Pharmaceutical Functions;

2.1.28. recognising one or more Local Pharmaceutical Committees which it considers are representative of Pharmaceutical Services Providers in the ICB's Area and liasing with and consulting such Local Pharmaceutical Committees as required by the Pharmaceutical Regulations;

2.1.29. commissioning the provision of NHS Smartcards to Pharmaceutical Services Providers and their staff by registration authorities;

2.1.30. making any payments due to NHS Chemists suspended from a Pharmaceutical List in accordance with the determination made by the Secretary of State in respect of such payments; and

2.1.31. undertaking any investigations relating (among other things) to whistleblowing claims (relating to a superintendent pharmacist, a director or the operation of a pharmacy contractor), infection control and patient complaints.

2.2. Where the Area comprises the areas of two or more Health and Wellbeing Boards in their entirety:

2.2.1. the Delegated Pharmaceutical Functions shall be exercised so as to maintain separately in respect of each Health and Wellbeing Board area:

2.2.1.1. Pharmaceutical Lists in respect of premises in that Health and Wellbeing Board area;

2.2.1.2. a list of LPS Chemists providing local pharmaceutical services at or from premises in that Health and Wellbeing Board area[16]; and

2.2.1.3. a Dispensing Doctor List (together the "Relevant Lists"); and

[13] Regulation 46 of the Pharmaceutical Regulations
[14] Schedule 3 of the Pharmaceutical Regulations
[15] Regulation 94 of the Pharmaceutical Regulations
[16] Regulation 114 of the Pharmaceutical Regulations

2.2.2. the ICB shall comply with such Contractual Notices as NHS England may issue from time to time concerning the arrangements for the exercise of the Delegated Pharmaceutical Functions across two or more Health and Wellbeing Board areas.

2.3. Where the Area comprises part of the area of a Health and Wellbeing Board (the "Relevant Health and Wellbeing Board"):

2.3.1. NHS England shall by Contractual Notice designate:

2.3.1.1. the ICB;

2.3.1.2. another ICB whose area comprises in part the area of the Relevant Health and Wellbeing Board; or

2.3.1.3. NHS England;

as the body responsible for maintaining the Relevant Lists (as defined in paragraph 2.2.1 of this Schedule 2D) in respect of the Relevant Health and Wellbeing Board ("the Designated Commissioner");

2.3.2. the ICB shall exercise the Delegated Pharmaceutical Functions in respect of that part of the Relevant Health and Wellbeing Board's area that falls within the Area but in doing so shall liaise with any Designated Commissioner for the purposes of maintaining the accuracy of the Relevant Lists (as defined in paragraph 2.2.1 of this Schedule 2D) in respect of the Relevant Health and Wellbeing Board; and

2.3.3. the ICB shall comply with all Contractual Notices issued by NHS England for the purposes of determining responsibilities in the circumstances described in this paragraph 3.3.

Prescribed Support

3. Notwithstanding the inclusion of the following within the Delegated Functions, the ICB shall discharge the functions set out at:
   3.1. Paragraph 3.1.1 (maintaining Pharmaceutical Lists)
   3.2. Paragraph 3.1.2 (managing applications for inclusion)
   3.3. Paragraph 3.1.3 (managing applications from those included in a list)
   3.4. Paragraph 3.1.5 (overseeing compliance with Terms of Service and Conditions of Inclusion)
   3.5. Paragraph 3.1.10 (Fitness to Practise)
   3.6. Paragraph 3.1.18 (maintaining and publishing Dispensing Doctors Lists)
   3.7. Paragraph 3.1.25 (recovery of overpayments)

   with the assistance and support of the NHS Business Services Authority, Primary Care Support England or such other person as NHS England shall designate by Contractual Notice for these purposes from time to time and in accordance with the allocation of operational responsibilities described by NHS England in Mandated Guidance.

LPS Schemes

4. The ICB shall not without the prior written consent of NHS England make any new LPS Schemes.

Barred Persons

5. The ICB must ensure that persons barred from involvement in specific elements of the Delegated Functions are excluded from such involvement in accordance with the Pharmaceutical Regulations.

Other Services

6. The provisions of this schedule are without prejudice to the ability of the ICB to make arrangements for the provision of Locally Commissioned Services for the purposes of the NHS in accordance with its own commissioning functions and using its own financial resources.

Payments

7. In exercising the Delegated Pharmaceutical Functions, the ICB must ensure that:

    7.1. all payments to which the Drug Tariff applies are made solely in accordance with the Drug Tariff; and

    7.2. any other payments for services (including without limitation those relating to LPS Schemes and Enhanced Services) are made in accordance with recognised contractual mechanisms intended to apply to those services.

Flu vaccinations

8. The Parties acknowledge and agree that:

    8.1. responsibility for arranging any national scheme for flu vaccinations remains with NHS England as part of its Section 7A Functions; and

    8.2. where any such national scheme is arranged by NHS England, the ICB is required to commission flu vaccines as Advanced Services. For the purposes of this Agreement, this forms part of the ICB's responsibilities under clause 9.20.

Integration

9. In respect of integrated working, the ICB must:

    9.1.1. take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Authorities, Healthwatch, acute and community providers, professional representative groups, contractor representative groups and other stakeholders;

    9.1.2. work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Pharmaceutical Services generally; and

    9.1.3. work with NHS England to coordinate the exercise of their respective performance management functions.

Integrating pharmacy into communities at Primary Care Network level

10. The ICB must exercise the Delegated Functions with a view to achieving greater integration of community pharmacy into the Integrated Care System at the Primary Care Network level including participation in network governance arrangements.

Complaints

11. The ICB will handle complaints made in respect of Pharmaceutical Services and Local Pharmaceutical Services in accordance with the Complaints Regulations.

Commissioning ancillary support services

12. The arrangements for the provision of ancillary services to Pharmaceutical Services Providers are described in Schedule 7 (Local Terms).

13. **Finance**

    13.1. Further requirements in respect of finance will be specified in Mandated Guidance.

14. **Workforce**

    14.1. Further requirements in respect of workforce will be specified in Mandated Guidance.

SCHEDULE 3

Reserved Functions

1. Introduction

1.1 In accordance with clause 8.4 of this Agreement, all functions of NHS England other than those defined as Delegated Functions are Reserved Functions.

1.2 This SCHEDULE 3 (Reserved Functions) sets out further provision regarding the carrying out of the Reserved Functions.

1.3 The ICB will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions.

2. Management of the national performers list

2.1 Subject to Paragraph 2.2, NHS England will continue to perform its functions under the National Health Service (Performers Lists) (England) Regulations 2013.

2.2 The ICB will carry out administrative tasks in respect of the Performers Lists as described at:

2.2.1 Paragraph 9 of Part 2, Schedule 2A;

2.2.2 Paragraph 9 of Part 2, Schedule 2B; and

2.2.3 Paragraph 6 of Part 2, Schedule 2C.

2.3 NHS England's functions in relation to the management of the national performers list include:

2.3.1 considering applications and decision-making in relation to inclusion on the national performers list, inclusion with conditions and refusals;

2.3.2 identifying, managing and supporting primary care performers where concerns arise; and

2.3.3 managing suspension, imposition of conditions and removal from the national performers list.

2.4 NHS England may hold local Performance Advisory Group ("PAG") meetings to consider all complaints or concerns that are reported to NHS England in relation to a named performer and NHS England will determine whether an initial investigation is to be carried out.

2.5 NHS England may notify the ICB of all relevant PAG meetings at least seven (7) days in advance of such meetings. NHS England may require a representative of the ICB to attend such meetings to discuss any performer concerns and/or quality issues that may impact on individual performer cases.

2.6 The ICB must develop a mechanism to ensure that all complaints regarding any named performer are escalated to the Local NHS England Team for review. The ICB will comply with any Mandated Guidance issued by NHS England in relation to the escalation of complaints about a named performer.

3. Management of the revalidation and appraisal process

3.1 NHS England will continue to perform its functions under the Medical Profession (Responsible Officers) Regulations 2010 (as amended by the Medical Profession (Responsible Officers) (Amendment) Regulations 2013).

3.2 All functions in relation to GP appraisal and revalidation will remain the responsibility of NHS England, including:

3.2.1 the funding of GP appraisers;

3.2.2 quality assurance of the GP appraisal process; and

3.2.3 the responsible officer network.

3.3 Funding to support the GP appraisal is incorporated within the global sum payment to Primary Medical Services Provider.

3.4 The ICB must not remove or restrict the payments made to Primary Medical Services Provider in respect of GP appraisal.

3.5 Appraisal arrangements in respect of all other primary care practitioner groups shall also be Reserved Functions.

4. Administration of payments and related performers list management activities

4.1 NHS England reserves its functions in relation to the administration of payments to individual performers and related performers list management activities under the National Health Service (Performers Lists) (England) Regulations 2013 and other relevant legislation.

4.2 NHS England may continue to pay practitioners who are suspended from the national performers list in accordance with relevant determinations made by the Secretary of State.

4.3 For the avoidance of doubt, the ICB is responsible for any ad hoc or discretionary payments to Primary Medical Services Providers (including those under section 96 of the NHS Act) in accordance with SCHEDULE 2 (Delegated Functions) Part 1 paragraphs 7.1 and 7.2 of this Agreement, including where such payments may be considered a consequence of actions taken under the National Health Service (Performers Lists) (England) Regulations 2013.

5. Section 7A and Capital Expenditure Functions

5.1 In accordance with clause 9.18, NHS England retains the Section 7A Functions and will be responsible for taking decisions in relation to the Section 7A Functions.

5.2 In accordance with clauses 9.20 and 9.21, the ICB will provide certain management and/or administrative services to NHS England in relation to the Section 7A Functions.

5.3 In accordance with clause 9.14, NHS England retains the Capital Expenditure Functions and will be responsible for taking decisions in relation to the Capital Expenditure Functions.

5.4 In accordance with clauses 9.16 and 9.17, the ICB will provide certain management and/or administrative services to NHS England in relation to the Capital Expenditure Functions.

6. Such other ancillary activities that are necessary in order to exercise the Reserved Functions

6.1 NHS England will continue to comply with its obligations under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

6.2 The ICB must assist NHS England's controlled drug accountable officer ("CDAO") to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

6.3 The ICB must nominate a relevant senior individual within the ICB (the "ICB CD Lead") to liaise with and assist NHS England to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

6.4 The ICB CD Lead must, in relation to the Delegated Functions:

6.4.1 on request provide NHS England's CDAO with all reasonable assistance in any investigation involving the Delegated Functions;

6.4.2 report all complaints involving controlled drugs to NHS England's CDAO;

6.4.3 report all incidents or other concerns involving the safe use and management of controlled drugs to NHS England's CDAO;

6.4.4 analyse the controlled drug prescribing data available; and

6.4.5 on request supply (or ensure organisations from whom the ICB commissions services involving the regular use of controlled drugs supply) periodic self–declaration and/or self-assessments to NHS England's CDAO.

7. Reserved Functions – Primary Medical Services

7.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Medical Services Functions"):

7.1.1 determining the outcomes expected from Primary Medical Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes and the Department of Health and Social Care mandate;

7.1.2 designing and delivering national transformation programmes in support of national priorities;

7.1.3 the negotiation and agreement of matters concerning General Medical Services contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary medical services nationally;

7.1.4 the development of national standard Primary Medical Service contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Medical Services providers;

7.1.5 the provision of commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

7.1.6 the provision of nationally contracted services delivering digital, logistical and support services for Primary Medical Services in England (including but not limited to):

7.1.6.1 Payments;

7.1.6.2 Pensions;

7.1.6.3 Patient Registration;

7.1.6.4 Medical Records;

7.1.6.5 Performer List;

7.1.6.6 Supplies;

7.1.6.7 Call and Recall for Cervical screening (CSAS); and

7.1.6.8 Pharmacy Market Management.

7.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

8. Reserved Functions – Primary Dental Services

8.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Dental Services Functions"):

8.1.1 determining the outcomes expected from Primary Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

8.1.2 the negotiation and agreement of matters concerning Dental Services Contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

8.1.3 the development of national standard Dental Service Contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Dental Services providers;

8.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties; and

8.1.5 the provision of nationally contracted services delivering digital, logistical and support services for Primary Dental Services in England (including but not limited to):

8.1.5.1 Payments;

8.1.5.2 Pensions;

8.1.5.3 Performer List; and

8.1.5.4 Market Management.

8.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

9. Reserved Functions – Primary Ophthalmic Services

9.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Ophthalmic Functions"):

9.1.1 the Primary Ophthalmic Services Contracts policy and associated documentation;

9.1.2 the negotiation and agreement of matters concerning Primary Ophthalmic Services with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of Ophthalmic Services nationally; and

9.1.3 the provision of nationally contracted services delivering digital, logistical and support services for Primary Ophthalmic Services in England (including but not limited to):

9.1.3.1 Payments;

9.1.3.2 Performers List;

9.1.3.3 Market Management/Entry; and

9.1.3.4 Contract management, assurance and post-payment verification.

9.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

10. Reserved Functions – Pharmaceutical Services and Local Pharmaceutical Services

10.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Pharmaceutical Functions"):

10.1.1 publication of Pharmaceutical Lists;

10.1.2 functions of NHS England as a determining authority in relation to pharmaceutical remuneration under Part 12 of the Pharmaceutical Regulations;

10.1.3 functions in respect of lists of performers of pharmaceutical services and assistants, noting that as at the date of this Agreement regulations for the purposes of these functions have not been made[17];

10.1.4 the negotiation and agreement of matters concerning NHS pharmaceutical services with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of Pharmaceutical Services nationally;

10.1.5 the provision of commissioning and contracting policy and guidance to support ICBs to meet their delegated duties; and

10.1.6 administration of the pharmacist pre-registration training grant scheme.

[17] Part 7, Chapter 4A of the NHS Act (not currently in force)

SCHEDULE 4

Further Information Governance and Sharing Provisions

1. Introduction

1.1. The purpose of this Schedule 4 *(Further Information Governance and Sharing Provisions)* and the Personal Data Agreement at the Annex is to set out the scope for the secure and confidential sharing of information between the Parties on a **Need To Know** basis, in order to enable the Parties to exercise their functions in pursuance of this Agreement.

1.2. References in this Schedule 4 *(Further Information Governance and Sharing Provisions)* to the **Need to Know** basis or requirement (as the context requires) should be taken to mean that the Data Controllers' personnel will only have access to Personal Data or Special Category Personal Data if it is lawful for such personnel to have access to such data for the Specified Purpose in paragraph 2.1 and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Special Category Personal Data specified.

1.3. This Schedule and the Personal Data Agreement is designed to:

1.3.1. provide information about the reasons why Relevant Information may need to be shared and how this will be managed and controlled by the Parties;

1.3.2. describe the purposes for which the Parties have agreed to share Relevant Information;

1.3.3. set out the lawful basis for the sharing of information between the Parties, and the principles that underpin the exchange of Relevant Information;

1.3.4. describe roles and structures to support the exchange of Relevant Information between the Parties;

1.3.5. apply to the sharing of Relevant Information relating to

1.3.5.1. Primary Care Providers and Primary Care Provider Personnel; and

1.3.5.2. Dental Services Providers and their personnel;

1.3.6. apply to the sharing of Relevant Information whatever the medium in which it is held and however it is transmitted;

1.3.7. ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and how this sharing will be managed;

1.3.8. apply to the activities of the Parties' personnel; and

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

2. Purpose

2.1. The Specified Purpose of the data sharing is to facilitate the exercise of the ICB's Delegated Functions and NHS England's Reserved Functions as described in this Agreement.

2.2. Specific and detailed purposes are set out in the Personal Data Agreement annexed to this Schedule.

3. Benefits of information sharing

3.1. The benefits of sharing information are the achievement of the Specified Purpose set out above, with benefits for service users and other stakeholders in terms of the improved local delivery of Primary Care Services and Primary Dental Services.

4. Lawful basis for Sharing

4.1. Each Party shall comply with all relevant Information Law requirements and good practice in relation to the processing of Relevant Information shared further to this Agreement.

4.2. The Parties shall identify the lawful basis for sharing Relevant Information for each purpose and data flow, and document these in the Personal Data Agreement annexed to this Schedule.

5. Relevant Information to be shared

5.1. The Relevant Information to be shared is set out in the Personal Data Agreement annexed to this Schedule.

6. Restrictions on use of the Shared Information

6.1. Each Party shall only process the Relevant Information as is necessary to achieve the Specified Purpose, and, in particular, shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.

6.2. Access to, and processing of, the Relevant Information provided by a Party must be the minimum necessary to achieve the Specified Purpose. Information and Special Category Personal Data will be handled at all times on a restricted basis, in compliance with Information Law requirements, and the parties' personnel should only have access to Personal Data on a justifiable **Need to Know** basis.

6.3. Neither the provisions of this Schedule 4 *(Further Information Governance and Sharing Provisions)* nor the Personal Data Agreement annexed to this Schedule should be taken

to permit unrestricted access to data held by any Party. It lays the parameters for the safe and secure sharing and processing of information on a justifiable **Need to Know** basis.

6.4. Neither Party shall subcontract any processing of the Relevant Information without the prior written consent of the other Party. Where a Party subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor which imposes the same obligations as are imposed on the Data Controllers under this Agreement.

6.5. Neither Party shall cause or allow Data to be transferred to any territory outside the United Kingdom without the prior written permission of the responsible Data Controller.

6.6. Any particular restrictions on use of certain Relevant Information are included in the Personal Data Agreement annexed to this Schedule.

7. Ensuring fairness to the Data Subject

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

7.1.1. amendment of internal guidance to improve awareness and understanding among personnel;

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

7.1.3. ensuring that information and communications relating to the processing of data is easily accessible and easy to understand, and that clear and plain language be used; and

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

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

7.3. Each Party shall reasonably cooperate with the other in undertaking any Data Protection Impact Assessment associated with the processing of data further to this Agreement, , and in doing so engage with their respective Data Protection Officers in the performance by them of their duties pursuant to Article 39 UK GDPR.

7.4. Further provision in relation to specific data flows is included in the Personal Data Agreement annexed to this Schedule.

8. Governance: personnel

8.1. Each Party must take reasonable steps to ensure the suitability, reliability, training and competence, of any personnel who have access to the Personal Data (and Special Category Personal Data) including reasonable background checks and evidence of completeness should be available on request by each Party.

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

8.3. Each Party shall ensure that all personnel required to access the Personal Data (including Special Category Personal Data) are informed of the confidential nature of the Personal Data and each Party shall include appropriate confidentiality clauses in employment/service contracts of all personnel that have any access whatsoever to the Relevant Information, including details of sanctions for acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure provisions of Information Law requirements, or causes damage to or loss of the Relevant Information.

8.4. Each Party shall provide evidence (further to any reasonable request) that all personnel that have any access to the Relevant Information whatsoever are adequately and appropriately trained to comply with their responsibilities under Information Law and this Agreement.

8.5. Each Party shall ensure that:

8.5.1. only those personnel involved in delivery of the Agreement use or have access to the Relevant Information; and

8.5.2. that such access is granted on a strict **Need to Know** basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited. Evidence of audit should be made freely available on request by the originating Data Controller. These access controls are set out in the Personal Data Agreement annexed to this Schedule; and

8.5.3. specific limitations on the personnel who may have access to the Information are set out in the Personal Data Agreement annexed to this Schedule.

9. Governance: Protection of Personal Data

9.1. At all times, the Parties shall have regard to the requirements of Information Law and the rights of Data Subjects.

9.2. Wherever possible (in descending order of preference), only anonymised information, or strongly or weakly pseudonymised information will be shared and processed by Parties, without the need to share easily identifiable Personal Data. The Parties shall cooperate in exploring alternative strategies to avoid the use of Personal Data in order to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data/Special Category Personal Data.

9.3. Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a **Need to Know** basis. If either Party:

9.3.1. becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or

9.3.2. becomes aware of any security vulnerability or breach,

in respect of the Relevant Information it shall promptly (and within 48 hours) notify the other Party. The Parties shall fully cooperate with one another to remedy the issue as soon as reasonably practicable, and in making information about the incident available to the Information Commissioner and Data Subjects where required by Information Law.

9.4. In processing any Relevant Information further to this Agreement, each Party shall:

9.4.1. process the Personal Data (including Special Category Personal Data) only in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only in accordance with written instructions from the originating Data Controller in respect of its Relevant Information;

9.4.2. process the Personal Data (including Special Category Personal Data) only to the extent as is necessary for the provision of the Specified Purpose or as is required by law or any regulatory body;

9.4.3. process the Personal Data (including Special Category Personal Data) only in accordance with Information Law requirements and shall not perform its obligations under this Agreement in such a way as to cause any other Data Controller to breach any of their applicable obligations under Information Law; and

9.4.4. process the Personal Data in accordance with the requirements of Information Law and in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) UK GDPR.

9.5. Each Party shall act generally in accordance with Information Law requirements, and in particular shall implement, maintain and keep under review appropriate technical and organisational measures to ensure and to be able to demonstrate that the processing of Personal Data is undertaken in accordance with Information Law, and in particular to protect the Personal Data (and Special Category Personal Data) against unauthorised

or unlawful processing and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:

9.5.1. Take account of the nature, scope, context and purposes of processing as well as the risks of varying likelihood and severity for the rights and freedoms of Data Subjects; and

9.5.2. Be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data (and Special Category Personal Data) and having regard to the nature of the Personal Data (and Special Category Personal Data) which is to be protected.

9.6. In particular, each Party shall:

9.6.1. ensure that only personnel authorised under this Agreement have access to the Personal Data (and Special Category Personal Data);

9.6.2. ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display or distribution, of the Relevant Information;

9.6.3. obtain prior written consent from the originating Party in order to transfer the Relevant Information to any third party;

9.6.4. permit the other Party or their representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors or assigns) and comply with all reasonable requests or directions to enable each Party to verify and/or procure that the other is in full compliance with its obligations under this Agreement; and

9.6.5. if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.

9.7. Each Party shall adhere to the specific requirements as to information security set out in the Personal Data Agreement.

9.8. Each Party shall use best endeavours to achieve and adhere to the requirements of the NHS Digital Data Security and Protection Toolkit.

9.9. The Parties' Single Points of Contact set out in paragraph 14 *(Governance: Single Points of Contact)* below will be the persons who, in the first instance, will have oversight of third party security measures.

10. Governance: Transmission of Information between the Parties

10.1. This paragraph supplements paragraph 9 *(Governance: Protection of Personal Data)* of this Schedule.

10.2. Transfer of Personal Data between the Parties shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net / gcsx) email.

10.3. Wherever possible, Personal Data should be transmitted (and held) in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, so as to ensure that the correct patient record / data is identified.

10.4. Any other special measures relating to security of transfer are specified in the Personal Data Agreement annexed to this Schedule.

10.5. Each Party shall keep an audit log of Relevant Information transmitted and received in the course of this Agreement.

10.6. The Parties' Single Point of Contact notified pursuant to paragraph 14 *(Governance: Single Points of Contact)* will be the persons who, in the first instance, will have oversight of the transmission of information between the Parties.

11. Governance: Quality of Information

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

11.2. Special measures relating to ensuring quality are set out in the Personal Data Agreement annexed to this Schedule.

12. Governance: Retention and Disposal of Shared Information

12.1. The non-originating Party shall securely destroy or return the Relevant Information once the need to use it has passed or, if later, upon the termination of this Agreement, howsoever determined. Where Relevant Information is held electronically the Relevant Information will be deleted and formal notice of the deletion sent to the Party that shared the Relevant Information. Once paper information is no longer required, paper records will be securely destroyed or securely returned to the Party they came from.

12.2. Each Party shall provide an explanation of the processes used to securely destroy or return the information, or verify such destruction or return, if requested by the other Party and shall comply with any request of the Data Controllers to dispose of data in accordance with specified standards or criteria.

12.3. If either Party is required by any law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy under this paragraph 12 *(Governance: Retention and Disposal of Shared Information)*, it shall notify the other Party in writing of that retention, giving details of the documents or materials that it must retain.

12.4. Retention of any data shall comply with the requirements of Article 5(1)(e) GDPR and with all good practice including the Records Management NHS Code of Practice, as updated or amended from time to time.

12.5. Any special retention periods are set out in the Personal Data Agreement annexed to this Schedule.

12.6. Each Party shall ensure that Relevant Information held in paper form is held in secure files, and, when it is no-longer needed, destroyed using a cross cut shredder or subcontracted to a confidential waste company that complies with European Standard EN15713.

12.7. Each Party shall ensure that, when no longer required, electronic storage media used to hold or process Personal Data are destroyed or overwritten to current policy requirements.

12.8. Electronic records will be considered for deletion once the relevant retention period has ended.

12.9. In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Party shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

13. Governance: Complaints and Access to Personal Data

13.1. Each Party shall assist the other in responding to any request made under Information Law made by persons who wish to access copies of information held about them ("**Subject Access Requests**"), as well as any other purported exercise of a Data Subject's rights under Information Law or complaint to or investigation undertaken by the Information Commissioner.

13.2. Complaints about information sharing shall be routed through each Party's own complaints procedure but reported to the Single Points of Contact set out in paragraph 14 *(Governance: Single Points of Contact)* below.

13.3. The Parties shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Agreement or any data processing carried out further to it.

13.4. Basic details of the Agreement shall be included in the appropriate log under each Party's Publication Scheme.

14. Governance: Single Points of Contact

14.1. The Parties each shall appoint a Single Point of Contact to whom all queries relating to the particular information sharing should be directed in the first instance. Details of the single points of contact shall be set out in the Personal Data Agreement.

15. Monitoring and review

15.1. The Parties shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Information Law and best practice. Specific monitoring requirements are set out in the Personal Data Agreement annexed to this Agreement.

Annex

Template Personal Data Agreement

Data flow subject matter: [Description]
Data flow duration: *The duration of the delegation arrangement* **[OR Insert alternative period]**
Nature and purpose of processing: *Described in the Delegation Agreement at Schedule 4 paragraph 2.1 above*

Description of information flow and Single Points of Contact for parties involved

Originating Data Controller	[Insert:]			
Contact details for Single Point of Contact for Originating Data Controller	**Name of point of contact**	**Title**	**Contact (email)**	**Contact (phone)**
Recipient Data Controller	[Insert:]			
Contact details for Single Point of Contact of Recipient Data Controller	**Name of point of contact**	**Title**	**Contact (email)**	**Contact (phone)**

Description of information to be shared

Comprehensive description of Relevant Information to be shared – including the type(s) of personal data to be shared and categories of personal data	[Insert:]
Anonymised / not information about individual persons	**Yes / No**
Strongly pseudonymised	**Yes / No**

Weakly pseudonymised	**Yes / No**
Person -identifiable data	**Yes / No**
Justification for the level of identifiability required	[Insert or N/A:]

Legal basis for disclosure and use

GDPR Article 6 Legitimising Condition/s	[Insert or N/A:]	
GDPR Article 9 Exemption/s	[Insert or N/A:]	
Confidentiality	**Explicit consent**	Yes / No [If yes, how documented?:]
	Implied Consent	Yes / No [If yes, how have you implied consent?:]
	Statutory required/permitted disclosure	[Insert statutory basis:]
	Public interest disclosure	[Insert how the public interest favours use/disclosure of the information:]
	Other legal basis	[Insert:]
s. 13Z3 / 14Z61 NHS Act 2006 justification	**S. 13Z3 condition(s) to permit disclosure**	[Insert:]
	S. 14Z23 condition(s) to permit disclosure	[Insert:]
Other specific legal considerations		

Restrictions on use of information

[Insert:]

Governance arrangements

Specific measures to ensure fairness to the Data Subject, including privacy impact assessments undertaken	[Insert:]
Access controls on use of information	[Insert:]
Specific limitations on Personnel who may access information	[Insert:]
Other specific security requirements (transmission)	[Insert:]
Other specific security requirements (general)	[Insert:]
Specific requirements as to ensuring quality of information	[Insert:]
Specific requirements for retention and destruction of information	[Insert:]
Specific monitoring and review arrangements	[Insert:]

SCHEDULE 5

Financial Provisions and Decision Making Limits

Financial Limits and Approvals

1. The ICB shall ensure that any decisions in respect of the Delegated Functions and which exceed the financial limits set out below are only taken:

   1.1 by the following persons and/or individuals set out in column 2 of Table 1 below; and

   1.2 following the approval of NHS England (if any) as set out in column 3 of the Table 1 below.

2. NHS England may, from time to time, update Table 1 by sending a notice to the ICB of amendments to Table 1.

Table 1 – Financial Limits		
Decision	**Person/Individual**	**NHS England Approval**
General		
Taking any step or action in relation to the settlement of a Claim, where the value of the settlement exceeds £100,000	ICB Chief Executive Officer or Chief Finance Officer or Chair	NHS England Head of Legal Services and Local NHS England Team Director or Director of Finance
Any matter in relation to the Delegated Functions which is novel, contentious or repercussive	ICB Chief Executive Officer or Chief Finance Officer or Chair	Local NHS England Team Director or Director of Finance or NHS England Region Director or Director of Finance or NHS England Chief Executive or Chief Financial Officer
Revenue Contracts		
The entering into of any Primary Care Contract or Arrangement which has or is capable of having a term which exceeds five (5) years	ICB Chief Executive Officer or Chief Finance Officer or Chair	Local NHS England Team Director or Director of Finance
Capital Note: As at the date of this Agreement, the ICB will not have delegated or directed responsibility for decisions in relation to Capital expenditure (and these decisions are retained by NHS England) but the ICB may be required to carry out certain administrative services in relation to Capital expenditure under paragraph 13 *(Financial Provisions and Liability).*		

SCHEDULE 6

Mandated Assistance and Support

1. Primary Dental Services

2.1 NHS Business Services Authority has existing agreements with NHS England to support its delivery of the following services:

2.1.1 Contract management – end-to-end administration of contract variations and other regional team/ICB support activities;

2.1.2 Performance management - provide mid and end of year administration process to support regional teams and ICBs and undertake risk based assurance reviews - PPV can also be instigated by the ICS or Counter Fraud;

2.1.3 Clinical assurance reviews – provide clinical assurance of quality of dental services delivered, working in collaboration with regional teams/ICBs to identify and seek to address any concerns;

2.1.4 Provide data reports to teams defining quantity and service delivery at a contractor level.

3. Primary Ophthalmic Services

3.1 NHS Business Services Authority have existing agreements with NHS England to support its delivery of the following services:

3.1.1 Contract management. End-to-end administration of new contract applications, contract variations and contract terminations.

3.1.2 Contract assurance. Administration of the annual contractor assurance declaration and additional in-depth assurance declaration where appropriate. Provision of assurance reports at ICS and contractor level, supporting further assurance decisions.

3.1.3 GOS complaints. Administration of the annual GOS complains survey.

3.1.4 Post-Payment Verification (PPV). End-to-end process for identifying and verifying GOS claims as part of the national PPV framework. This includes obtaining and reviewing claims and carrying out a financial recovery where appropriate. PPV can also be instigated by the ICS or Counter Fraud.

3.1.5 GOS 4 pre-authorisation of repair or replacement glasses.

4 **Pharmaceutical Services and Local Pharmaceutical Services**

4.1 NHS Business Services Authority has existing agreements with NHS England to support ICBs to discharge their assurance responsibilities by the delivery of the following services to ICBs:

4.1.1 Performance management – direct support to commissioners and community pharmacy contractors to implement corrective and preventative intervention;

4.1.2 Contract assurance – administration of the annual contractor assurance declaration and additional in-depth assurance declaration where appropriate, provision of assurance reports at ICS and contractor level supporting further assurance decisions by the ICB;

4.1.3 Post-Payment Verification (PPV) – end-to-end process for identifying and verifying claims as part of the national PPV framework to support ICBs to play their part in ensuring compliance with contractual requirements and delivery of quality and value for money. This includes obtaining and reviewing claims, investigation of outliers and other potential inappropriate claims, along with referrals and investigatory reports to the ICB to consider and decide overpayment recoveries, and carrying out the financial recovery where appropriate. PPV can also be instigated by the ICS or Counter Fraud.

5 Support Services directed by DHSC

5.1 NHS Business Services Authority is directed by DHSC to undertake specific activities as well as having existing agreements with NHS England to support its delivery of primary care services. These include (without limitation):

5.1.1 The administration of national payment platforms for primary care services to dentists, pharmacy contractors, appliance contractors, oxygen contractors and special school eye care providers;

5.1.2 The calculation of payment for covid-19 and flu vaccinations to PCNs and GP practices as well as payments to Dispensing Doctors and prescribing only doctors for personal administration claims and sharing this information accurately and in a timely manner;

5.1.3 Clinical advisory support;

5.1.4 Administration functions;

5.1.5 Assurance services - performance and contract management of primary care providers;

5.1.6 The provision of information to primary care organisations for all contractor groups via standardised reporting (eg. ePACT2, eDEN and eOPS);

5.1.7 Working with NHS England and ICB Counter Fraud Teams to reduce loss across the system.

SCHEDULE 7

Local Terms

None

SCHEDULE 8

Deployment of NHS England Staff to the ICB

Note:
This schedule relates to the Deployment of Staff who are employed by NHS England only.

Deployment of NHS England Staff

1. NHS England may deploy Staff to the ICB for the purposes of carrying out the Delegated Functions.

2. The Parties have agreed that arrangements for the provision of NHS England Staff and the associated employment model envisaged by section 5.9 of the HR Framework **https://www.england.nhs.uk/wp-content/uploads/2021/06/B1427-Human-resources-framework-for-developing-integrated-care-boards-version-2-March-2022.pdf**) will be determined by the National Moderation Panel convened for this purpose and endorsed by NHS England's Executive Group.

3. The Parties agree and acknowledge that the Staffing Models will be developed in conjunction with the ICB and are subject to the decision of the National Moderation Panel and cannot be varied without the express agreement of NHS England.

4. A proposal for a variation to any Staffing Model must be made by means of a formal submission to the National Moderation Panel which will determine the proposal, following which the proposal if approved, will be endorsed by NHS England's Executive Group.

5. Subject to any variation made in accordance with paragraphs 3 and 4 above, a Staffing Model determined in accordance with paragraph 2 will apply for the duration of this Agreement.

Availability of NHS England Staff

1. In addition to any Staff deployed in any communicated Staffing Model arrangement, NHS England may deploy additional Staff to the ICB to perform administrative and management support services together with such other services specified in SCHEDULE 7 (Local Terms) (the "Services") so as to facilitate the ICB in undertaking the Delegated Functions pursuant to the terms of this Agreement.

2. NHS England will take all reasonable steps to ensure that the NHS England Staff deployed for the purposes of carrying out the Delegated Functions shall:

   2.1 faithfully and diligently perform duties and exercise such powers as may from time to time be reasonably assigned to or vested in them; and

   2.2 perform all duties assigned to them pursuant to this Schedule 8.

3. The ICB shall notify NHS England if the ICB becomes aware of any act or omission by any NHS England Staff which may have a material adverse impact on the provision of the Services or constitute a material breach of the terms and conditions of employment of the NHS England Staff.

4. NHS England shall use all reasonable efforts to make its Staff available for the purposes of this Schedule 8 whilst the NHS England Staff are absent:

   4.1 by reason of industrial action;

4.2 as a result of the suspension or exclusion of employment or secondment of any Staff by NHS England;

4.3 in accordance with the NHS England Staff's respective terms and conditions of employment and policies, including, but not limited to, by reason of training, holidays, sickness, injury, trade union duties, paternity leave or maternity or where absence is permitted or required by Law;

4.4 if making the NHS England Staff available would breach or contravene any Law;

4.5 as a result of the cessation of employment of any individual NHS England Staff; and/or

4.6 at such other times as may be agreed between NHS England and the ICB.

Employment of the NHS England Deployed Staff

1. NHS England shall employ their Staff and shall be responsible for the employment of their Staff at all times on whatever terms and conditions as NHS England and their Staff may agree from time to time.

2. NHS England shall pay their Staff their salaries and benefits and make any deductions for income tax liability and national insurance or similar contributions it is required to make from the Staff's salaries and other payments.

3. NHS England shall not, and shall procure that the NHS England Staff shall not, hold themselves out as employees of the ICB.

Management of NHS England staff

1. NHS England where appropriate, shall in consultation with the ICB, make arrangements to ensure the day-to-day control of the activities of their Staff is shared with the ICB and deal with any relevant management issues concerning their Staff including, without limitation, performance appraisal, discipline and leave requests.

2. The ICB agrees to provide all such assistance and co-operation that NHS England may reasonably request from time to time to resolve grievances raised by NHS England Staff and to deal with any disciplinary allegations made against NHS England Staff arising out of or in connection with the provision of the Services which shall include, without limitation, supplying NHS England with all information and the provision of access to all documentation and NHS England Staff as NHS England requires for the purposes of considering and dealing with such issues and participating promptly in any action which may be necessary.

Conduct of Claims

1. If the ICB becomes aware of any matter that may give rise to a claim by or against a member of NHS England Staff, notice of that fact shall be given as soon as possible to NHS England. NHS England and the ICB shall co-operate in relation to the investigation and resolution of any such claims or potential claims.

2. No admission of liability shall be made by or on behalf of the ICB and any such claim shall not be compromised, disposed of or settled without the consent of NHS England.

Confidential Information and Property

1. For the avoidance of doubt, this paragraph 17 (Confidential Information and Property) is without prejudice to any other provision of this Agreement in relation to confidential information.

2. It is acknowledged that to enable the NHS England Staff to provide the Services, the Parties may share Confidential Information.

3. The Parties agree to adopt all such procedures as the other party may reasonably require and to keep confidential all Confidential Information.

Intellectual Property

1. All IPR made, written, designed, discovered or originated by Staff (People Resources) deployed by NHS England, shall be the property of NHS England to the fullest extent permitted by Law and NHS England shall be the absolute beneficial owner of the copyright in any such IPR.

SCHEDULE 9

Mandated Guidance

Primary Medical Care

- Primary Medical Care Policy and Guidance Manual.
- The 'Principles of Best Practice' and any other guidance relating to *the Premises Cost Directions 2013.*
- Guidance relating to the Minimum Practice Income Guarantee.
- Guidance relating to Primary Medical Care discretionary payments.
- Guidance for Commissioners: Interpreting and Translation Services in Primary Care.
- Framework for Patient and Public Participation in Primary Care Commissioning.
- NHS England National Primary Care Occupational Health Service Specification.
- Guidance relating to list cleansing in relation to Primary Medical Care providers.
- Guidance relating to mergers and closures of GP practices and/or Primary Medical Care providers.
- Guidance relating to Primary Medical Care and POD contract reviews.
- Guidance relating to the escalation of complaints from a named 'performer'.
    - Including: *Framework for Managing Performer Concerns.*

Pharmaceutical Services and Local Pharmaceutical Services

- Pharmacy Manual.

Primary Ophthalmic Services

- Policy Book for Eye Health.

Primary and Prescribed Dental Services

- Policy Book for Primary Dental Services.
- Securing Excellence in Commissioning NHS Dental Services.
- Securing Excellence in Commissioning NHS Dental Services: Key facts.
- Securing Excellence in Commissioning NHS Dental Services: FAQs.
- Quick Guide: Best use of unscheduled dental care services.
- How to update NHS Choices for Dental Practices.
- Flowchart for managing patients with a dental problem/pain.
- Guidance on NHS 111 Directory of Services for dental providers.
- Definitions – Unscheduled Dental Care.
- Introductory Guide for Commissioning Dental Specialties.
- Guide for Commissioning Dental Specialties: Orthodontics.
- Guide for Commissioning Dental Specialties: Oral Surgery and Oral Medicine.
- Guide for Commissioning Dental Specialties: Special Care Dentistry.
- Guide for Commissioning Service Standards: Conscious Sedation in a Primary Care Setting.
- Commissioning Standard for Dental Specialties: Paediatric Dentistry.
- Commissioning Standard for Urgent Dental Care.
- Commissioning Standard for Restorative Dentistry.
- Commissioning Standard for Dental Care for People with Diabetes.
- Accreditation of Performers and Providers of Level 2 Complexity Care.

Finance

- Guidance on NHS System Capital Envelopes.
- Finance and Payments Guidance for Community Pharmacy, Dental and Primary Care Ophthalmology Services Delegated to ICBs from 2022.
- Managing Public Money (HM Treasury).
- Guidance relating to Personal Service Medical Reviews.
    - Including: *Implementing Personal Medical Services Reviews.*

Workforce

- Guidance on the Employment Commitment.

Other Guidance

- National Guidance on System Quality Groups.
- Managing Conflicts of Interest in the NHS.
- Arrangements for Delegation and Joint Exercise of Statutory Functions.
- Guidance relating to procurement and provider selection.
- IG Guidance relating to serious incidents.
- All other applicable IG and Data Protection Guidance.
- Any applicable Freedom of Information protocols.
- Any applicable guidance on Counter Fraud, including from The NHS Counter Fraud Authority.
- Any applicable guidance relating to the use of data and data sets for reporting.
- Any applicable guidance relating to the commissioning and management of clinical waste in primary care e.g.
    - Including: Management and disposal of healthcare waste

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

INAUGURAL MEETING

1st July 2022

Item: 014

Report Title	Transition Assurance Committee – Final Report and minutes, June 2022							
Author	Chrissy Tucker, Director of Corporate Delivery							
Sponsor (Executive Director)	Helen Dillistone, Executive Director of Corporate Affairs							
Presenter	Helen Dillistone, Executive Director of Corporate Affairs							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☒
Appendices	Appendix 1 - Transition Assurance Committee - minutes - 9.6.2022 Appendix 2 - Transition Assurance Report 9.6.2022							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	Transition Assurance Committee 9th June 2022							

Recommendations
The Board are requested to **NOTE** the contents of the Transition Assurance Committee – Final Report and minutes, June 2022.
Purpose
The purpose of this report is to inform the Board of the matters discussed at the final Transition Assurance Committee on 9th June 2022 and to note the progress described in the Transition Assurance Report. Both documents are appended to this paper.
Background
The Transition Assurance Committee was established in April 2021 to provide expertise and assurance to the Joined Up Care Derbyshire Board relating to the establishment of the Integrated Care Board, to oversee the delivery of the Transition Programme Plan and to ensure cohesion of the structures and partners within the Derbyshire Integrated Care System.
Report Summary
The minutes of the final meeting of the Transition Assurance Committee are appended and describe the conversations relating to establishment guidance, progress of the Transition Programme Plan (also attached) and the risk register. In particular the committee discussed the need for development matters post-transition to be carried forward by the ICB, including: • Monitoring of the ICB as it develops during the initial six months of establishment

- Organisational development
- System development

Identification of Key Risks

Not applicable.

Have any conflicts of interest been identified throughout the decision-making process?

None identified.

Project Dependencies

Not applicable.

Completion of Impact Assessments

Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable

Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable

Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:

Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☒	Inclusive leadership	☒

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?

Not applicable for this report.

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Not applicable for this report.

Minutes of the System Transition Assurance Sub-Committee
Held on 9th June 2022
Via Microsoft Teams

UNCONFIRMED

Present:		
Dr Avi Bhatia	AB	Clinical Chair, (Meeting Chair) Derby and Derbyshire CCG
Jill Dentith	JD	Lay Member for Governance, Derby and Derbyshire CCG
Helen Dillistone	HD	Executive Director of Corporate Strategy and Delivery, Derby and Derbyshire CCG
Sarah Draper	SD	Assistant Director of Strategic Transformation NHS England and Improvement
Ian Gibbard	IG	Lay Member for Audit, Derby and Derbyshire CCG
Helen Jones	HJ	Director of Adult Social Care, Derbyshire County Council
Geoff Lewins	GL	Non-Executive Director, Derbyshire Healthcare Foundation Trust
Martin Whittle	MW	Lay Member for Patient and Public Involvement / Vice Chair Derby and Derbyshire CCG
Apologies		
Dr Chris Clayton	CC	Chief Executive Officer, Derby and Derbyshire CCG / Designate CEO, Derby and Derbyshire ICS
Kathy Farndon	KF	Non-Executive Director, University of Derby and Burton Hospitals Foundation Trust
Sue Glew	SG	Non-Executive Director, Chesterfield Royal Hospital Foundation Trust
Asma Nafees	AN	Non-Executive Director, Derbyshire Community Health Services Foundation Trust
In Attendance:		
Dawn Litchfield	DL	Executive Assistant to the Governing Body, Derby and Derbyshire CCG (Minute Taker)
Chrissy Tucker	CT	Director of Corporate Delivery, Derby and Derbyshire CCG

NOTE: The meeting was audio recorded for the purpose of accurately transcribing the minutes

133.	**Welcome, apologies and quoracy**	
	Dr Avi Bhatia (AB) welcomed everyone to the meeting. Apologies were received as above. It was confirmed that the meeting was quorate.	
134.	**Declarations of Interest**	
	AB requested members to raise any further Declarations of Interest pertaining to today's agenda, in addition to those already noted in the Register. No additional Declarations of Interest were made, and no amendments were requested to the Register.	

135.	**Draft minutes of the previous meeting – 12.5.2022**	
	The minutes of the meeting held on 12th May 2022 were approved as a true and accurate reflection of the discussions.	
136.	**Action Log – May 2022**	
	All actions on the action log are either on-going or completed.	
137.	**National Guidance**	
	Helen Dillistone (HD) advised that no new guidance has been published since the last meeting. A national consultation has been launched relating to Foundation Trust Governors; the consultation looks at the role of Governors in the broader ICS. A session will be hosted by JM and CC on 11th July for Non-Executive Trust Directors to share information around what is happening more broadly across the ICS and gauge thoughts as to how they want to be engaged and involved going forward. The following questions were raised: • It was requested that a link to consultation be circulated to Committee members to allow them to understand the proposals (JD). • Confirmation was requested that the legislation to create ICB's has been passed (GL). HD confirmed that the legislation has now received Royal Assent and is going ahead from 1st July 2022 as planned. • National guidance is still awaited as to whether Quarter 1 2022/23 will be subject to an external audit of accounts. This is unfinished business from the CCG with no-one around to handle it once the CCG's NEDs have left. **The Committee NOTED the update provided for assurance purposes**	
138.	**Transition Assurance Report**	
	HD presented the Transition Assurance Report which provides assurance to the Committee in relation to the progress made against the key milestones and delivery dates set out in the ICS Transition Plan. The following points of note were made: • Closure is being reached of this stage of the transition. The Readiness To Operate Statement (ROS) and checklist, and the updated System Development Plan (SDP) were submitted to NHSEI on 20th May, together with a plethora of evidence to support the progress made. • CC, HD and CT attended a ROS meeting with NHSEI on Monday where the evidence submitted received final assurance, with one area being flagged as amber to take into the ICB; this relates to resources to undertake the Category 1 response level for EPRR, as this requires specific qualifications and a level of expertise to coordinate. • All other areas are on track, notwithstanding the complexities of the financial position; whilst the deficit position does not trigger an amber/red rating, it is more about ensuring that the structures, processes, and governance are in place to support it. • The Constitution, Governance Handbook, Terms of References, and decisions map have been submitted and signed off by the Regional and National Team. A letter was received thanking the System for its work and confirming that Constitutions have been published on NHSEI's website. • The Due Diligence checklist has been submitted, including details around the transfer of assets and liabilities, and the Glossop work; the CCG held an extraordinary Audit Committee meeting to review this submission and take assurance from the process undertaken and documentary evidence.	

	• NHSEI has been most interested in ensuring a safe closedown and transfer and readiness to operate from 1st July. The ongoing conversations with the System will be around further developments and maturity. • The Due Diligence checklist will be updated up to 24th June, at which point it will close and transfer into the ICB. A CCG closure report will be taken to the CCG's Governing Body on 16th June and will form part of the inaugural ICB meeting on 1st July. • Work is already underway on the ICP arrangements. • Discussions are ongoing on the escalation process for finance and operational planning. The following question was raised: • It was enquired what is happening regarding the TUPE of staff (GL). HD responded that a staff consultation commenced on 11th April for all affected staff; this included all CCG staff and the ICS core team below the Executive Board level roles. This is not a TUPE transfer but a TUPE-like transfer. All staff were written to confirming that their terms and conditions, key policies and contracts would transfer at midnight on 30th June. No concerns were received from the CCG staff. Questions were received from the ICS core team around changes of base. Some queries were rasied around on-call arrangements for the senior team. ESR needs to capture all of this. There is a national action to ensure that systems and staff be recognised and transferred over. **The Committee NOTED the report provided for assurance purposes**	
139.	**Risk Register**	
	Chrissy Tucker (CT) presented the Risk Register, which highlights areas of organisational risk relating to the transition from the CCG to the ICB. The following amendments were requested: The closure of the following 6 risks was recommended: • Risk 01 relating to staff retention and morale during the transition – There is more certainty around the process; regular communications are held with staff as to what is happening, and no significant turnover or concerns have been reported. Workforce will form part of the opening risks for the ICB. • Risk 03 relating to the project team capacity to support and deliver the transition process not being sufficient – The majority of work is now completed, with no concerns raised around capacity to cover the remaining actions. • Risk 07 relating to the system operating model not being fully established if the CCG is not ready to transfer its functions or has failed to comprehensively and legally close down the organisation – The Due Diligence report was reviewed at the CCG's Audit Committee and submitted to NHSEI on 20th May. No concerns have been raised since this submission. • Risk 15 relating to the risk that focus and capacity required to respond to the national public inquiry on the COVID response will detract from the focus and resource available to affect a successful transition to the ICB – Nothing has materialised on this during the transition process. This may need to be added to the ICB's Risk Register going forward.	

	• Risk 21 relating to the risk to the delivery of the Transition Programme should there be a change or delay in the parliamentary process – Royal Assent has now been given and there will be no delays to the programme. • Risk 22 relating to the risk that the operating model being developed by NHSEI ready to delegate services and functions to ICBs may not have sufficient staffing and capacity – This work is still in development. Derbyshire will not be taking on the pharmacy, optometry, and dental delegated functions until 2023. This risk will close from the CCG's Risk Register and be added to the ICB's Risk Register in due course. The Committee also approved the decreasing of 11 risks (as detailed below). Any residual risks will be reviewed and assessed as to which Committee they need to be transferred into as part of the opening ICB Risk Register. The following questions were raised: • Risk 21 has the wrong wording in the title (JD). • Some of the risks will be closed on CCG's Risk Register and added as new risks for the ICB. It was enquired whether cross referring will be undertaken between this Risk Register and the CCG's Risk Register to ensure that any residual risks are mirrored (JD). CT confirmed that this is happening; a process is being undertaken to gather all sources together to ensure that everything is captured. • Regarding the Glossop angle, it was queried where the issue of engagement will sit; managerial changes do not require a consultation process; however, some of Derbyshire's policies are different from those of Glossop and there are some material changes which should have been consulted upon (MW). HD responded that for some clinical policies there are differences between what is offered in Derbyshire and Glossop; for example, whereas Derbyshire offers 1 cycle of IVF, Glossop offer 3 cycles. Through detailed project work, specifics have been set out for known policy changes. It is not being stipulated that everyone in Glossop will automatically receive the same as Derbyshire; consultation and engagement discussions will need to be undertaken with Glossop residents around any proposed changes. Agreement has been reached with the regional team that nothing will change in the first 12 months. One of the principles of a smooth transfer is to keep contracts the same whilst then working out what needs to be done going forward. HD confirmed that CC has raised with the regional team the potential for all ICBs with boundary changes being open to the bigger risk of postcode lottery within a single organisation; whilst known that CCGs within one ICB area may have different policies, this will be different in that ICBs will be single organisations with multiple different policies. The risk is that Derbyshire patients could say that they are part of an organisation whereby some people are being offered 3 cycles of IVF whilst others are only offered 1. A national steer has been requested on this as it could be a significant risk for ICBs. Derbyshire went through the process of standardising its policies upon merging the 4 CCGs a few years ago. • Regarding the transition to Place and Provider Collaboratives, a meeting has now been held and a convergence of ideas obtained, which is helpful. It was enquired as to the ongoing role of this Committee; it was asked if it is the intention for this Committee to wind down or continue to look at Place and Provider Collaboratives, and any other transition issues. AB acknowledged that this will be discussed as part of the next agenda item. • AB enquired how this is logistically being passed over to the ICB on 1st July. HD responded that the ICB will meet in public on 1st July and receive the	

opening Board Assurance Framework (BAF), setting out all of the strategic risks to be overseen; detailed work is being undertaken to achieve this. The sources used to inform it include the CCG's closing position, the System BAFs, any strategic risks managed through SORG and any outstanding risks from this Committee. Risks will be assigned to the new ICB Committees. The Operational Risk Register, which the ICB will require to have oversight of, will also be presented. The opening position will be based on these sources of information and evidence.

The Committee:

- **RECEIVED and DISCUSSED the risks detailed on the ICB System Transition Risk Register as of May 2022**

- **APPROVED the DECREASE in risk score for:**

  - **Risk 02 relating to the system's capacity to effectively deliver transition being compromised if system future functions are not aligned and do not have access to the skills, resources and capacity required to establish the ICB**

  - **Risk 04 relating to transformative system being compromised due the focus on arrangements required to establish the ICB by July 2022**

  - **Risk 05 relating to the system operating model (functions, governance and accountabilities) not being clearly defined or established if Place is not fully integrated in the approach**

  - **Risk 06 relating to the system operating model (functions, governance and accountabilities) not being clearly defined or established if Provider collaboratives are not fully integrated in the approach**

  - **Risk 09 relating to the ICB not being ready to receive functions from the CCG and to operate as a statutory ICB (i.e. readiness to safely transition) and to deliver the four core purposes of an ICS by July 22**

  - **Risk 10 relating to due to the pace of change, building and sustaining communication and engagement momentum and pace with stakeholders during a significant change programme may be compromised**

  - **Risk 13 relating to a risk that the Providers could have parallel processes in place with the ICB and collective mechanisms will be required to develop collaborative partnerships**

  - **Risk 16 relating to delays in publication of further ICB Guidance and HR framework impacting on system ability to meet target development milestones and may result in some taking place after July 2022**

  - **Risk 17 relating to a risk that the requirements to establish the statutory ICB by July 2022 are not proportionate to current system pressures and demands, which may compromise capacity to respond to operational delivery and performance improvement**

	• **Risk 18 relating to a risk that some of the statutory functions and duties that the ICB is accountable for may not have a natural governance home in the Board and Committee structures** • **Risk 20 relating to increased transition turbulence as a result of the delay to establishing the ICB and close down of the CCG, and therefore ensuring continuity of business for a protracted period of time** • **APPROVED the CLOSURE of:** • **Risk 01 relating to staff retention and morale during transition** • **Risk 03 relating to the project team capacity to support and deliver the transition process not being sufficient** • **Risk 07 relating to the system operating model not being fully established if the CCG is not ready to transfer its functions or has failed to comprehensively and legally close down the organisation** • **Risk 15 relating to the risk that focus and capacity required to respond to the national public inquiry on the Covid response will detract from the focus and resource available to affect a successful transition to the ICB** • **Risk 21 relating to the risk to the delivery of the Transition Programme should there be a change or delay in the parliamentary process** • **Risk 22 relating to the risk that the operating model being developed by NHSEI ready to delegate services and functions to ICBs may not have sufficient staffing and capacity.**	
140.	**Proposal for Assurance and Closedown**	
	AB advised that theoretically this is the last Committee meeting. Opinion was sought on whether the risks identified are handed just over and the committee ceases to exist from 30th June or whether a proposal should be made to the ICB that it needs some way of monitoring itself, and areas identified as not being as well advanced as others, in the first few months. Thoughts were requested as to how best this could be done. The following points were noted: • It was enquired whether this related to some form of report going forward to the ICB or a corporate body meeting going forward; if the latter, this will not be possible as the Committee will not have a mandate after 30th June as some of its members will no longer be employed by the NHS (MW). AB considered that a concept, not necessarily this group, should be continued. The ICB is new and will have some learning and development to do in its first 3 to 6 months. AB wants to highlight that it may be useful to have a function going forward to ensure continued monitoring; it is appropriate for this Committee to discharge its duties from a governance perspective when handing over the baton. • It is right to raise the issue. The finance committee and people committee of the ICB have System-wide remits, whereas the audit and risk committee is specifically about the ICB. It was asked, when considering risk, whether something broader is required to prevent a gap (GL).	

	• Transition, by definition, finishes on 30th June. The organisational development of the ICB seems to be core business. To create a functioning objective is a core strategic aim, which needs to be front and centre for the first year (IG). AB considered that the concept needs to be adhered to that this work has been closed down properly. • This could be included in matters for escalation to the ICB Board. The process adopted and rigour implemented from the people doing the work, as well as those providing the assurance, has been well documented throughout the process. The Committee is blown away by the amount of work completed by the team, which has done a fantastic job in providing the required assurance; however, the new organisation needs to ensure that this is picked up as part of its core business. There are a few outstanding areas in the Risk Register and BAF which need to be captured and passed on (JD). • HD confirmed that this Committee was set up to manage and oversee the process of the transition, which ends on 30th June and handed over to the ICB. The three core purposes of the ICB are to become an organisation its own right, be seen as a System facilitate across NHS organisations, and a System facilitator / convenor with a broader partnership, including the Local Authority. Thinking about the ongoing developments, it would be duplicative if this Committee was still meeting, as it is the role of the ICB to help support and develop the different parts of the System through the roles in place. Formally closing down everything that this Committee has worked through over the last few months; whilst it is now 95% of the way there, there are still a few things to be tidied up in the last few weeks. In was queried whether a final virtual meeting should be convened to receive and close things off up to 30th June. • From a Local Authority lens, HJ is conscious that there is outstanding work and risks relating to the partnership work however there will be Local Authority representation on the ICB Board, and the local government will also have statutory responsibilities to ensure things happen. • It was suggested recommending to the ICB that it needs to look at what is handed over in order to ensure that it has a home in the future as part of the develop programme (MW). AB concluded that there is a function and ethos to be put across regarding the closedown, however there is not an appetite for this Committee to meet again in this setting, unless the ICB wants to convene something themselves with a different membership. HD advised that, prior to 30th June, the Committee will receive sight of the final closedown report to be handed over to the ICB; this will include the work being done around bringing the risks together. A formal recommendation could be included in the opening report that the ICB needs to ensure that any ongoing developments and components have a home and are formally considered as part of the development programme. This Committee will feed into the Strategic Oversight Board on 16th June; however, due to the number of apologies received, CC and JM are currently deciding if that meeting will go ahead. The minutes of this Committee will feed into the ICB Board.	
141.	**Any Other Business**	
	To consider any other matters requiring urgent attention – none raised Confirm key messages to go to other areas of governance – consideration of the oversight of continued monitoring, as discussed during the meeting.	

	Any matters for escalation to the JUCD ICS Board - none raised HD emphasised how valuable this Committee has been in the transition journey; it has helped to work through the broader complexities during the last year, from a challenge perspective. HD thanked everyone for that. AB concurred that the work undertaken on this transition has been immense, particularly when working at home, making it harder. AB was pleased to have chaired this meeting over the past year. Everyone was thanked for their input and for giving up their time.	

System Transition Assurance Sub-Committee						
DATE OF MEETING:	9th June 2022		AGENDA ITEM NO:		138	
DOCUMENT/REPORT TITLE:	Transition Assurance Report – May 2022					
PRESENTER	Vikki Ashton Taylor, JUCD ICS Director Lead Helen Dillistone, Executive Director of Corporate Strategy and Delivery					
SENIOR RESPONSIBLE OFFICER	Dr Chris Clayton, JUCD ICS Chair Designate / DDCCG CEO					
CONTENTS OF PAPER WERE PREVIOUSLY DISCUSSED BY:	Transition Assurance Committee and Transition Senior Leadership Team					
AUTHOR/TITLE:	Chrissy Tucker, Director of Corporate Delivery					
CONTACT EMAIL AND TELEPHONE NUMBER:	Chrissy.tucker@nhs.net 07919 299679					
DOCUMENT IS FOR:	INFORMATION	✓	DECISION		ASSURANCE	✓

PURPOSE

The purpose of this paper is to provide assurance to the committee in relation to the status and progress against the key milestones and delivery dates set out in the ICS Transition Plan.

BACKGROUND

A joint transition project plan covering all necessary tasks to establish the ICB as a statutory organisation has been developed. Due to the many interdependencies, the plan covers all component parts required to establish the ICS with the ICB as the receiving organisation and the CCG elements as the transferring organisation. The joint plan is continually reviewed by the Senior Leadership Team.

Relevant leads continue to work through the guidance as and when received, to ensure all aspects are incorporated into the transition plan and work continues to progress. It is important to note as national guidance and intelligence filters through we are continually adjusting timescales accordingly to ensure the plan remains live and responsive. This is particularly pertinent with the changes to the ICB establishment from 1 April to 1 July 2022 and the revised timescales as described in this report.

As previously reported the joint transition plan has been reviewed and amended to reflect the Readiness to Operate Statement (ROS) requirements which will be the basis by which we will evidence readiness to proceed on 1 July 2022. Whilst taking a pragmatic approach to focus on the ICB establishment 'must do's', the plan also includes developmental areas to ensure the focus is not lost during the transition.

MATTERS FOR CONSIDERATION

Transition Progress

The Readiness to Operate Statement (ROS) checklist and refreshed system development plan (SDP) was successfully submitted on 20 May 2022, together with other evidence of progress requested by NHSEI colleagues. This is a regional checkpoint which will allow for a final ROS evidence review and further sign-off of ROS components before a final Readiness to Operate Statement is provided on 10 June.

During the period of 20 May to 10 June there will be an opportunity to check any outstanding areas by exception (with the expectation that most will have been reviewed/agreed prior to the 10 June final ROS submission). A meeting has been arranged for 7 June with the ICS Designate CEO and Executive Transition leads and NHSEI regional leads to focus on ICS readiness in advance of the 10 June final ROS submission. The purpose is to confirm any areas of the ROS checklist which have been confirmed as not requiring additional work and those areas where additional focus is required to enable Regional Director sign-off on receipt of 10 June Readiness to Operate Statements and ROS checklists.

A submission also took place on 20th May of the CCG Due Diligence Checklist, the Level 3 template reflecting property transfers relating to Glossop, and the Level 4 template reflecting staff and property transfers from non-CCG organisations to the Derby and Derbyshire ICB, namely Joined Up Care Derbyshire staff transferring from the employ of Derbyshire Healthcare Foundation Trust. Derby and Derbyshire CCG staff lists are included within a tab of the overall Checklist, however the level of information required to be provided is potentially sensitive and therefore has been submitted under separate cover to a single individual within NHSEI. The CCG Audit Committee held an Extraordinary meeting on 18th May to review and take assurance from the reports on the process and the documentary evidence of matters to transfer, prior to submission to NHSEI. A letter of assurance on the process for due diligence has been sent from the CCG Accountable Officer to the ICB Chair and the NHSEI Midlands Regional Director on 1 June.

The last submission of the Constitution and Governance Handbook was also submitted on 20th May following the publication of a further refreshed model constitution on 13th May. The Regional Team have approved the final draft for submission to the NHSEI Midlands Regional Director on 26th May. Following review, it will be passed to the national team for publication on their website. Copies of these documents are available from Dawn Litchfield (dawn.litchfield1@nhs.net) upon request.

Appendix A sets out the current position in relation to all project plan top level activities. A status RAG explanation is provided for each of the areas where potential issues have been identified or where an update is deemed helpful to provide assurance to the committee.

- The continued areas of focus and delivery during Q1 will be:
- The continued updating of the Due Diligence Checklist up to 24 June.
- Preparation of an updated CCG closure report for the inaugural ICB Board meeting on 1 July as part of the broader agenda.
- Further develop ICP arrangements.
- Continue financial and operational planning processes.
- Finalise the close down of the CCG committees and the transfer of live matters and risks to the new ICB committees.
- Continue to work with NHSEI to finalise arrangements in preparation for the publication of the statutory instruments and Establishment Order.

RECOMMENDATIONS

The System Transition Assurance Sub-Committee is requested to:

- Note the report and issues highlighted

FINANCIAL IMPACT

To be considered and developed as part of the developments.

FURTHER INFORMATION AND APPENDICES

Appendix A - 260522 ICS Transition Plan (Revised based on 1 July ICB Establishment Date)

MONITORING INFORMATION	
PATIENT, PUBLIC AND STAKEHOLDER INVOLVEMENT	To be undertaken as part of specific activities as necessary.
EQUALITY AND DIVERSITY IMPACT	To be undertaken as part of specific activities as necessary.
ENVIRONMENTAL IMPACT	To be undertaken as part of specific activities as necessary.
QUALITY IMPACT	To be undertaken as part of specific activities as necessary.
WORKFORCE IMPACT	To be undertaken as part of specific activities as necessary.