NHS
Hertfordshire and
West Essex
Integrated Care Board

Herts and West Essex Integrated Care Board (ICB)

Governance Handbook

September 2024 V5.3

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Document Control

Version	Page	Initials	Date	Details of amendment
V2.0	8	IK	18/11/2023	Updated governance structure chart
	11	IK		5.2 – Update to Executive Team including place directors
	18	IK		Update to Board and committee meeting programme
	23-24	SS		ICB's Financial Authorisation Limits – 1 written quote to be obtained for clinical and non-clinical tenders and quotations with a value of up to £24,999 (inclusive of VAT). Updated sign-off limits.
	36-91	IK		Update to committee Terms of Reference - v2 Audit and Risk Committee Remuneration Committee Population Outcome and Improvement Committee Quality Committee Performance Committee
	236	SS		Quality Committee – update to Health and Care Bill 2021 to Act 2022
	237	SS		Change Commissioning Board to Committee. Addition of delegated authority to approve ICB Policies
		SS		Change Performance Board to Committee
	238	SS		Addition of s.75 etc. to Decisions and Functions Delegated by the Board to other Statutory Bodies
	240	SS		Addition – CEO – Authenticate use of seal
	281	SS		Addition of "m" missing off second paragraph to £2m if contract exceeds 12 months
V3.0	79	IK	27/01/2023	ICB Quality Committee ToR v3
	60	IK		ICB Population Outcome and Improvement Committee ToR v3
	9	IK		Update ICB Board Structure Chart to include VCSFE Representative
	10	IK		Update to Board membership and Terms of Office to include VCSFE Representative
V3.1	233	SS	24/03/2023	Update to Scheme of Reservation and Delegation
	74	IK		ICB People Board Terms of Reference
	86	IK		ICB Performance Committee Terms of Reference
	101	IK		Update to front sheet and report template
	104	IK		Update to meeting agenda template
	105	IK		Update to meeting minutes template
V4.0	9	IK	26/05/2023	Update to sub-committee structure chart
	23	IK		Update to Financial limits
	27	IK		Update to Board and Committee Governance
	32	JD		New Guidance for the Development / Review of Policies
	42 56 61	IK		Update to Terms of Reference: Audit and Risk Committee, Commissioning Committee and; Primary Care Board
	98	IK		Updated Integrated Care Partnership Constitution and Standing Orders
	115	IK		New templates for minutes and notes and actions
	132	JD		Updated template for Equality, quality, impact assessments and Data Protection impact assessments
	142	SS		Updated Risk Management Framework
	254	SS		Updated Scheme of Reservation and Delegation
	284	SS		Updated Standing Financial Instructions
	468	NM		Updated Working in Partnership with People and Communities Strategy
V4.1	11	IK		Update to Board membership and terms of office to include Natalie Hammond
	17	IK		Amendment to Executive Lead for Quality Committee
	19	IK		Amendment to Executive Lead for Quality Committee
	20	IK		Update to Executive Structure chart to include Natalie Hammond
V4.2	20	IK	24/11/2023	Updated ICB Exec Structure Chart
	72	LA		Updated Finance and Investment committee terms of reference
	98	SS		Updated ICP Constitution and Standing Orders
	199	JD		Updated Standards of Business Conduct and Conflicts of Interest Policy
	256	SS		Updated Scheme of Reservation and Delegation
V4.3	10	IK	26/01/2024	Update to include fifth Non-Executive Member
	11	IK		Update to include fifth Non-Executive Member
	38	IK		Amendment to Practice lists:

				Hertsmere Locality – Theobald Medical Centre amended from list following merger with Manor View Practice. Watford and Three Rivers Locality - Pathfinder Practice amended from list following merger with Manor View Practice.
V4.4	287	SS		Update to SFIs – Paragraphs 7.1.1, 7.1.2, 7.1.8, 7.2.1, 7.2.2, 7.2.3, 7.2.3
	256	SS		Update to SoRD – page 11
V5		IK / SS		Governance Handbook has been updated following the governance review. This includes update to the Board membership, SoRD, SFIs and all Committee Terms of References.
V5.1		IK/ SS	26/07/2024	Amendment to the SFIs – Appendix 1 Delegated limits
		SS		Amendment to Strategy Committee Terms of Reference – para 3.1
V5.2	12	IK / SS	27/09/2024	Amendment to the Executive Team Chart
	13			Update to the structure chart
	19			Update to Decisions Map to inc. ICB Committees
	230			Standing Financial Instructions – delegation levels, revised Primary Care Commissioning Committee delegation limits.
	52			System Transformation and Quality Improvement Committee Terms of Reference.

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1. Introduction

The purpose of this document is to bring together a range of corporate statutory documents in one place and is described as the NHS Herts and West Essex Integrated Care Board (ICB) Governance Handbook which supports the Constitution. This document ensures all governance structures and arrangements reflect best practice across the NHS and public sector in England.

This handbook is intended to ensure that everyone is clear on expectations of individuals and teams in relation to corporate governance.

The implementation of this handbook is **mandatory** for all staff, board and members of its committees.

The highest-level governance structure comprises an Integrated Care Board (ICB) (known as "the board"), board"), ten board committees, two of which are required by statute (audit and risk committee and remuneration committees) and eight of which have been put in place by the ICB as standing committees. These are Health and Care Partnership Boards (East and North Herts, South West Herts, West Essex and Mental Health and Learning Disabilities and Autism), Strategic Finance and Commissioning Committee, System Transformation and Quality Improvement Committee, Strategy Committee and People Committee.

Additionally, there is an executive team which meets weekly to oversee the operational aspects of the ICB business.

2. Principles

Herts and West Essex ICB is committed to the highest standards of corporate governance. The function of good governance is to: "ensure that an organisation fulfils its overall purpose, achieves its intended outcomes for citizens or service users, and operates in an effective, efficient and ethical manner" [1]

The underlying principles of all good governance are listed as follows in the UK Corporate Governance Code 2018[2] :

- Accountability
- Transparency
- Probity
- Focus on sustainable success of an entity over the longer term

2.1 Accountability

The ICB Board is accountable to NHS England and to the population of Hertfordshire and west Essex, which is facilitated by the strategic alignment with the Hertfordshire Health and Wellbeing Board and Essex Health and Wellbeing Board.

[1] Office of Public Management and Chartered Institute of Public Finance and Accountancy, 2004

[2] https://www.frc.org.uk/directors/corporate-governance-and-stewardship/uk-corporate-governance-code July 2018

2.2 Transparency

The ICB is transparent in its decision making and provides clarity on how and where decisions are made. Key decisions will be made by the board in public unless this is precluded by commercial sensitivities.

2.3 Probity

In May 1995, the Committee on Standards in Public Life, under the Chairmanship of Lord Nolan, established the Seven Principles of Public Life, also known as the "Nolan principles" [3]. These principles are the basis of the ethical standards expected of all public office holders.

The Herts and West Essex ICB Constitution recognises that in all its work it must seek to meet the highest expectations for public accountability, standards of conduct and transparency. It will therefore ensure that the Nolan principles, listed below, are taken fully into account in its decision making and its policies in relation to standards of behaviour.

The ICB will adopt strong ethical standards and leadership based on honesty and decency. The board has established values and standards of conduct for all members of staff.

The seven principles of public life will be adhered to by all:

- Selflessness
- Integrity
- Objectivity
- Accountability
- Openness
- Honesty
- Leadership

2.4 Focus on sustainable success of an entity over the longer term

The board will ensure the sustainable success of the ICB in the long term by taking account of the longer-term consequences of all decisions and strategy.

2.5 Herts and West Essex ICB governance principles

In addition to the above nationally accepted principles, Herts and West Essex ICB has established their own standards, which include:

2.5.1 Integrated governance

which can be defined as "systems, processes and behaviours by which organisations lead, direct and control their functions in order to achieve their objectives".

2.5.2 The use of the Board Assurance Framework to drive committee agendas.

This means that we make sure we focus on the key risks to delivering our strategic objectives.

2.5.3 Focus on assurance, not reassurance. Reassurance is when someone tells you all is well; assurance is when they tell you what's happening, show you the evidence and you can judge for yourself if all is well.

3. Key corporate documents

3.1 Scheme of Reservation and Delegation

The Scheme of Reservation and Delegation sets out those decisions that are reserved for the HWE ICB Board and those that have been delegated to the Committees of the Board, to postholders such as the Chief Executive Officer, Chief Finance Officer and Executive Directors.
The Scheme of Reservation and Delegation can be found at Appendix 6.

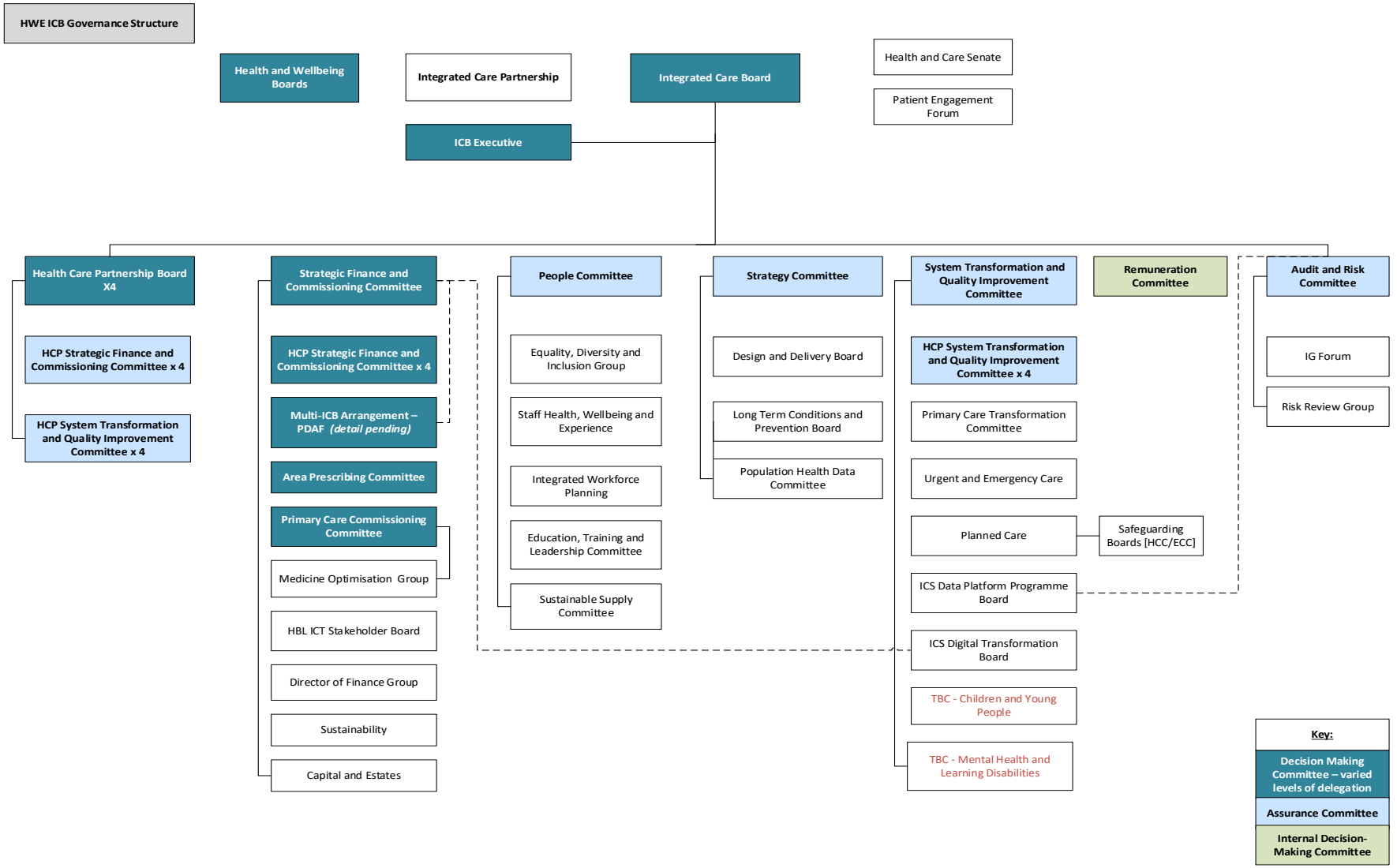
3.2 Standing Financial Instructions

The Standing Financial Instructions (SFIs) provides detail of the financial responsibilities, policies and procedures that have been adopted by the ICB Board. They are designed to ensure the ICB's regularity and propriety of financial transactions.
SFIs should be read in conjunction with the Scheme of Reservation and Delegation.
All Executive members, Non-Executive Members and staff within the ICB should be aware of these documents.
The Standing Financial Instructions can be found at Appendix 7.

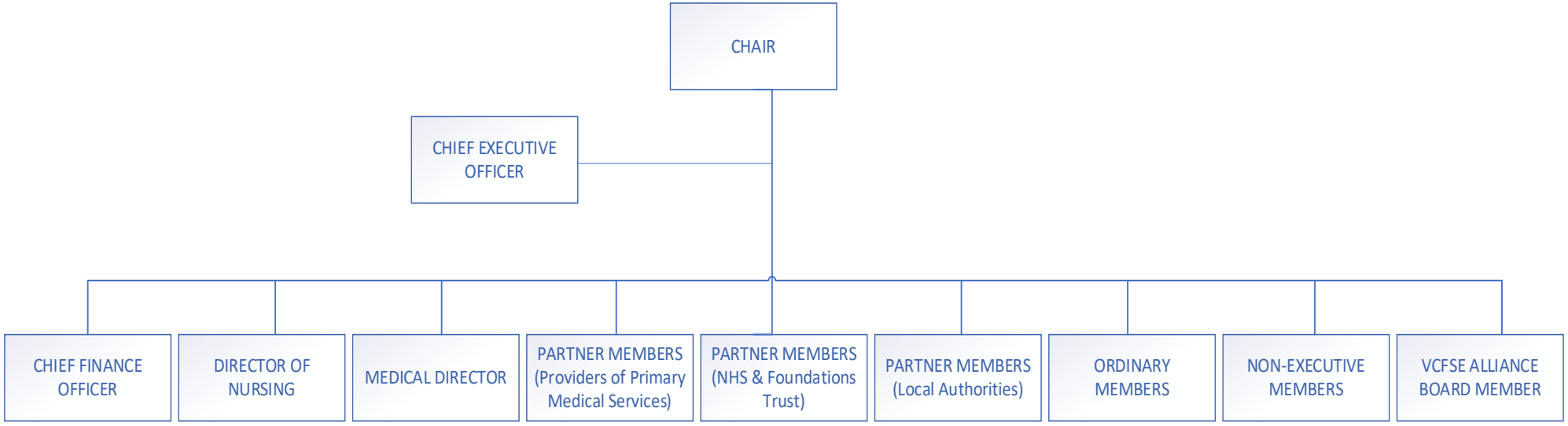
3.3 Policies and Procedures

The ICB uses key policies and procedural documents to keep staff safe and provide a road map for day-to-day operations. They ensure compliance with laws and regulations, provide guidance for decision making and streamline internal processes. Policy documents for the ICB can be found on the website.
Standards of Business Conduct incorporating Conflicts of Interest Policy can be found at Appendix 5.

4. Governance Structure



5. ICB Board structure



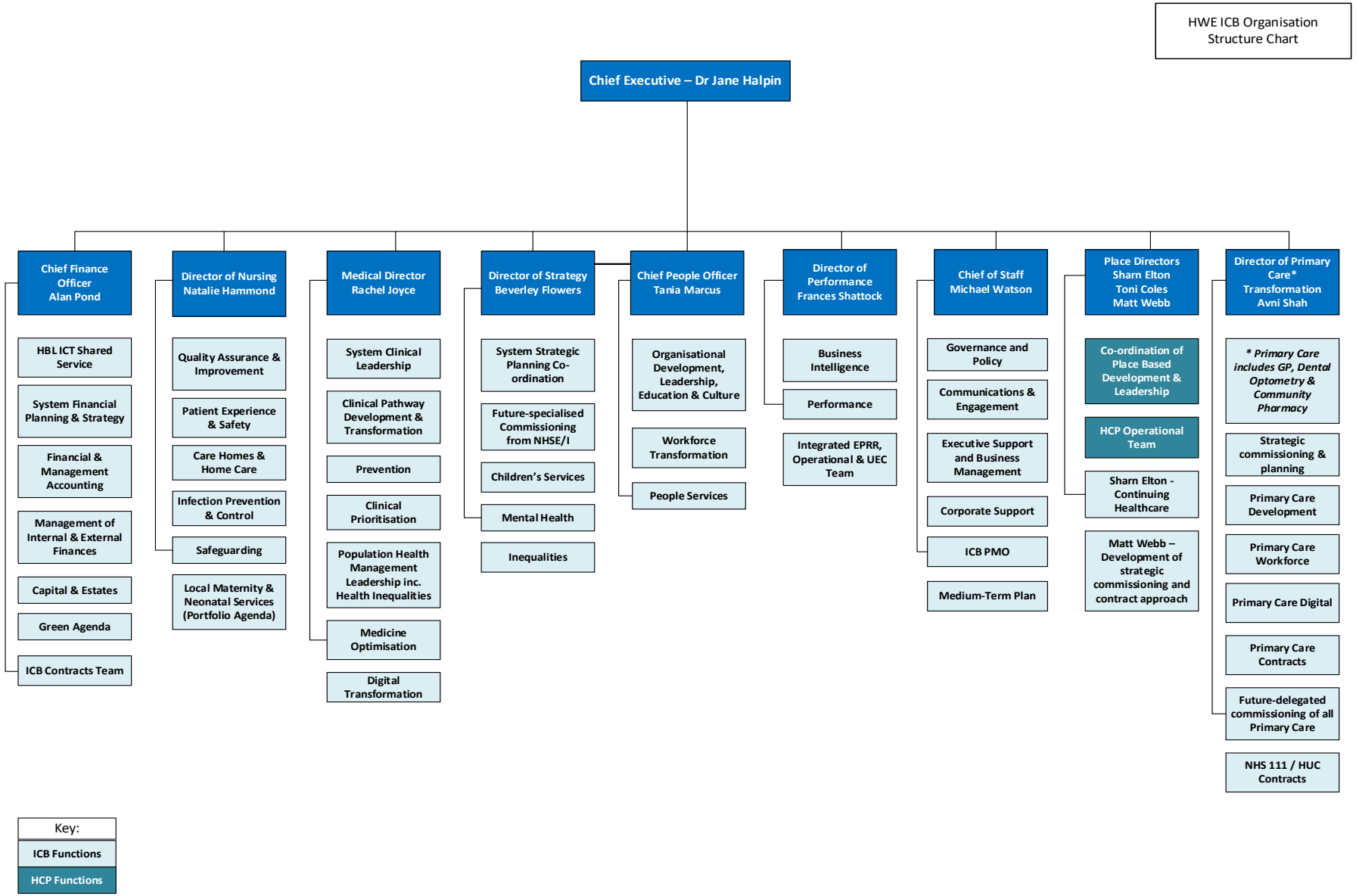
5.1 Board membership

Name	Role	Start Date	Completion of Terms of Office
Paul Burstow	Chair	01 July 2022	30 June 2025
Ruth Bailey	Deputy Chair / Non-Executive Director	01 July 2022	30 June 2025
Matthew Coats	Senior Responsible Officer South West Herts HCP	01 July 2024	30 June 2026
Dr Jane Halpin	Chief Executive Officer	01 July 2022	*Not Applicable*
Alan Pond	Chief Finance Officer	01 July 2022	*Not Applicable*
Natalie Hammond	Director of Nursing and Quality	31 July 2023	*Not Applicable*
Dr Rachel Joyce	Medical Director	01 July 2022	*Not Applicable*
Elliot Howard-Jones	Joint Senior Responsible Officer East and North Herts HCP	01 July 2024	30 June 2026
Thom Lafferty	Senior Responsible Officer West Essex HCP	04 November 2024	03 November 2026
Karen Taylor	Senior Responsible Officer Mental Health & Learning Disabilities & Autism HCP	01 July 2024	30 June 2026
Dr Prag Moodley	Partner member, Primary Medical Services	01 July 2024	30 June 2026
Dr Ian Perry	Partner member, Primary Medical Services	01 July 2024	30 June 2026
Dr Trevor Fernandes	Partner member, Primary Medical Services	01 July 2024	30 June 2026
Adam Sewell-Jones	Joint Senior Responsible Officer East and North Herts HCP	01 July 2024	30 June 2026
Christopher Martin	Partner member, Local Authority, ECC	*(Interim member)*	
Angie Ridgwell	Partner member, Local Authority, HCC	04 November 2024	03 November 2026
Catherine Dugmore	Non-Executive Member	01 July 2022	25 February 2025
Gurch Randhawa	Non-Executive Member	01 July 2022	30 June 2025
Thelma Stober	Non-Executive Member	01 July 2022	30 June 2025
Nick Moberly	Non-Executive Member	01 December 2023	30 November 2026
Joanna Marovitch	VCFSE Alliance Board Member	04 January 2023	30 June 2025

5.2 Executive Team

Name	Role
Beverley Flowers	Director of Strategy and Deputy Chief Executive Officer
Frances Shattock	Director of Performance
Avni Shah	Director of Primary Care Transformation
Tania Marcus	Chief People Officer
Michael Watson	Chief of Staff
Adam Lavington	Director of Digital Transformation
Phil Turnock	Managing Director HBL ICT
Sharn Elton	Place Based Director - East and North Herts
Toni Coles	Place Based Director - West Essex
Matthew Webb	Place Based Director - Southwest Herts

6. ICB Executive Structure Chart



7. HWE Integrated Care Partnership

Hertfordshire and West Essex ICP is a statutory joint committee which brings together organisations and representatives involved with improving the care, health, and wellbeing of the population. As a statutory committee, ICPs will be required to be established in every system, have a minimum membership required in law (the ICB and local authorities), and will be tasked with producing an integrated care strategy for their area by March 2023.

The legislation surrounding ICP's is permissive and not prescriptive, allowing local areas to determine the scope and delivery of their own ICP. The government has produced guidance to inform local development of ICPs. This includes the Integrated Care System Design Framework.

The Integrated Care System Design Framework advises that ICPs should be:

- A partnership at system level established by the NHS and local government as equal partners.

- A forum to bring partners – local government, NHS, and others, together across the ICS area to align purpose and ambitions with plans to integrate care and improve health and wellbeing outcomes for their population.

- A partnership to facilitate joint action to improve health and care services and to influence the wider determinants of health and broader social and economic development.

It also invited systems to consider the role of the partnership in establishing the culture and behaviours of the system, including working under a distributed leadership model, committing to working together equally, and using a collective model of decision-making and a collective model of accountability, where partners hold each other mutually accountable for their shared and individual organisational contributions to shared objectives.

The ICP's relationship to the ICB

- The ICB and the ICP will have distinct but complementary roles.

- The ICB is the body responsible for planning and delivery of health and care services, allocating resources for and arranging for provision of NHS services across the system.

- The ICP is a forum for the wider community to come together to agree shared objectives and work on complex issues. The ICP also sets the integrated care strategy which the ICB and upper tier local authorities are required by law to have regard to when making decisions, and when commissioning and delivering services.

The Chairs of the ICP and the ICB will agree how the ICP board will influence the ICB with its NHS priorities, and how the ICB will influence the ICP with its broader remit.

The ICP's relationship to the Health and Wellbeing Boards

Health and Wellbeing Boards (HWBs) were established as part of the Health and Social Care Act 2012 and became statutory committees of local authorities in April 2013. They provide a vehicle for political, clinical, professional and community leaders to develop a shared ambition for improving health and wellbeing and addressing health inequalities. This is undertaken through joint strategic needs assessments (JSNAs) and the agreement of a joint health and wellbeing strategy (JHWS), which clinical commissioning groups (CCGs) must take into account in developing their

commissioning plans.

The scope, function, and membership of ICPs are similar to Health and Wellbeing Boards. Both are intended to be partnership bodies rather than executive decision-making committees. Both bring together representatives of organisations concerned with health and care to agree plans to integrate care and improve health and wellbeing outcomes for their population.

The government has signalled that it will refresh guidance for Health and Wellbeing Boards (HWB) in the light of the wider health and care system changes, and those proposed in the Integration White Paper. The updated guidance is not expected until July 2022.

The proposed membership of the HWE ICP has been aligned as closely as possible with the existing membership of the Hertfordshire and Essex Health and Wellbeing Boards. This approach has been adopted to ensure efficient and streamlined strategic planning.

Membership of the HWE ICP will not be identical to the Hertfordshire HWB, because of the wider geographic footprint of the ICP, which requires additional Essex/West Essex members, but also because of the need to ensure that the four Health and Care partnerships, not currently represented on the HWBs, each have a seat on the ICP.

Early discussions will take place to determine the best relationship between the Hertfordshire and Essex Health and Wellbeing Boards and the Integrated Care Partnership.

The Constitution and Standing Financial Instructions for HWE can be found at Appendix 2 and 3.

8. Decision Making

8.1 Financial Authorisation Limits

Commitment of Healthcare, non-healthcare contracts and expenditure			
Committee	**Role**	**Approval expenditure, business cases and contract award** **All expenditure must be authorised against known and agreed budget and cannot be exceeded** **All figures cited below include individual contracts or services where a perceived monetary value has been calculated – e.g., where a service is being offered to the ICB for free or at a reduced market rate. In such cases, and in support of full transparency a cost figure will be identified alongside an anticipated market value.**	**Authorisation for payment of prior approved expenditure**
ICB Board / Governing Body		Unlimited	n/a
Strategic Finance and Commissioning Committee		**Approve** proposals on individual contracts or services of a capital or revenue nature amounting to, or likely to amount to £7.5m (or up to £15m if contract exceeds 12 months): **With delegated approval for the above sums to the ICBs Primary Care Commissioning Committee** in respect: • GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract). • Newly designed Local Enhanced Services and Directed Enhanced Services. • Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF). • Decision making on whether to establish new GP practices in an area. • Delegation of Pharmacy, Optometry and Dental Commissioning, Section 7A Public health functions and Health and Justice Commissioning – oversight of future model, governance and financial impacts. • **For Primary Care Commissioning Committee - Recommend** to the Board for approval all proposals on individual contracts or services of a capital or revenue nature amounting to, or likely to amount to over £2.5m (or £5m if contract exceeds 12 months.	**n/a**

Remuneration Committee		up £100k, for clinical and non-clinical	**n/a**
Health and Care Partnership/Place		**Approve** – • Authority to approve where the source of funds and its use is determined nationally • Proposals on individual contracts or services of a capital or revenue nature amount to, or likely to amount to £1m (or up to £2m if contract exceeds 12 months). **Recommend** to the Commissioning Committee for approval all proposals on individual contracts or services of a capital or revenue nature amount to, or likely to amount to £2.5, (or up to £5m if the contract exceeds 12 months)	
	CEO	up to £2.5m	Unlimited
	CFO	up to £1000k	Unlimited
	Deputy CFO	up to £50k	£29,999.999
	Other Directors	up to £100k	£ 999,999
	Deputy/Assistant/Associate Directors	up to £50k	£49,999
	Other budget holders*	Up to £25k	£24,999
	Senior Finance Manager	Up to £5k	£1,499,000
	Other Managers*		£4,999
	Continuing Health Care Placements (Operational leads)*	Approve care packages > £1.5K per week	£9,999
	Continuing Health Care Placements (Senior leads)*	Approve care packages < £2.5K per week	£24,999
	Continuing Health Care Placements (Assistant Director)	Approve care packages < £5K per week	£99,999
	Continuing Health Care Placements (Director Nursing)	Approve care packages > £5K per week	£ 999,999

	Financial Services (T10s) For urgent payments	up to £5k	£99.999
Tenders and quotations for non-clinical services			
	1 written quote with evidence to be obtained for contracts	£0 to £24,999	
	3 written quotes – Competitive invitation to quote supported by a specification and evaluation or the use of an appropriate framework	£25,000 to £216,446	
	Formal procedure in line with the Public Contract regulations	£213,447	
Tenders and quotations for clinical services			
	1 written quote with evidence to be obtained for contracts	Up to £24,999	
	3 written quotes – Competitive invitation to quote supported by a specification and evaluation or the use of an appropriate framework	£25,001 to £299,999	
	4 written quotes – Competitive invitation to quote supported by a specification and evaluation or the use of an appropriate framework	£300,000 to £663,539	
	Formal process in line with the Public Contract Regulations	£663,539 & above	

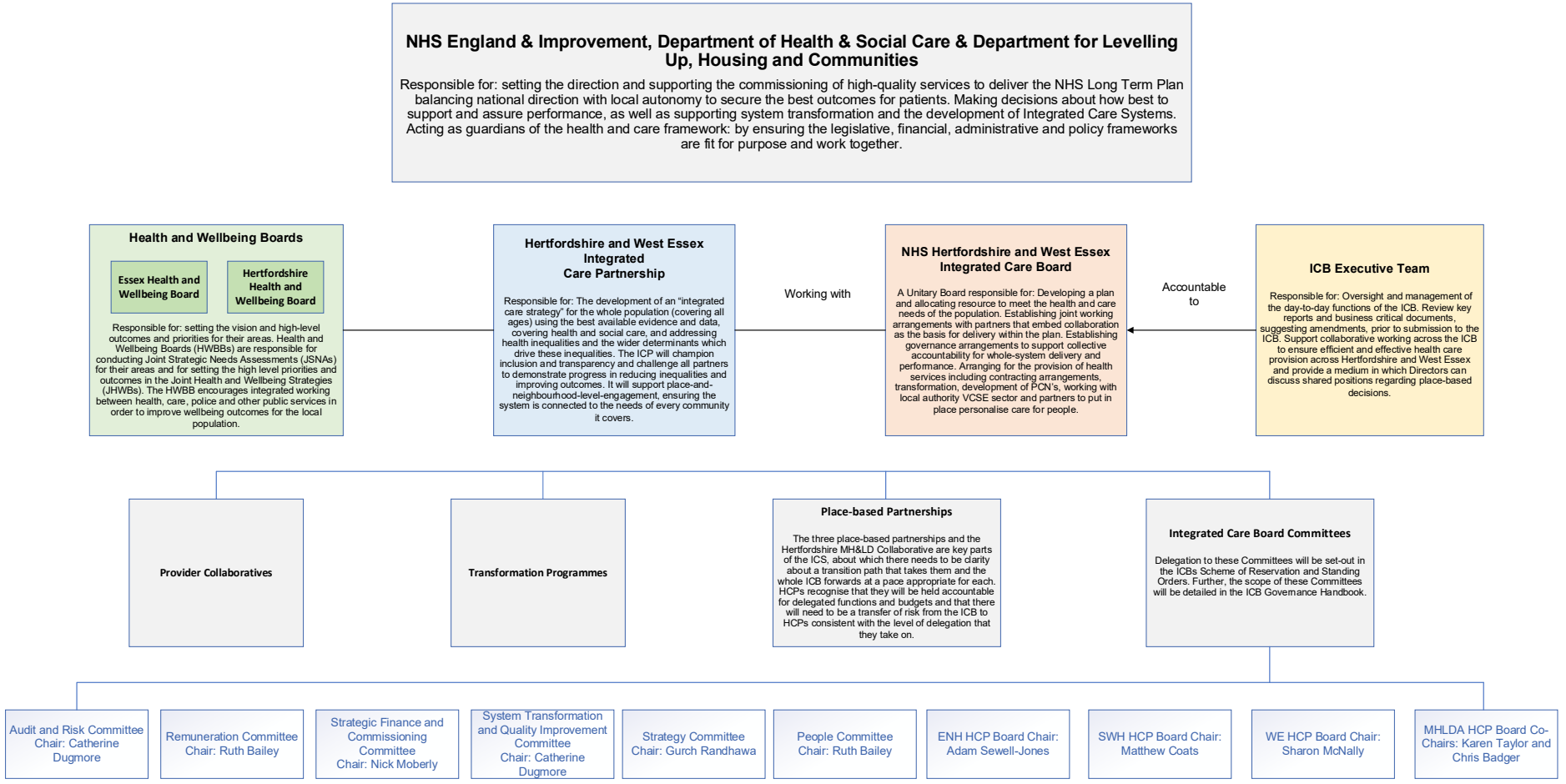
9. Functions and Decision Map

NHS Hertfordshire and West Essex Integrated Care Board
Functions and Decisions Map

The Hertfordshire and West Essex Functions and Decision 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 details the (draft) health commissioning duties of NHS Hertfordshire and West Essex Integrated Care Board, it does not detail the wider system duties of the Integrated Care Partnership or the Integrated Care System.

This document should be read in conjunction with the ICB Constitution, ICB Statutory Functions document and the Scheme of Reservations and Delegations document.



10. Relevant Providers of Primary Medical (As referenced in HWE ICB Constitution paragraph 3.6.2)

	Practice Name	Address	Postcode
	North Hertfordshire Locality		
1.	Ashwell Surgery	Lawyers Close, Ashwell	SG7 5PY
2.	Baldock Surgery	Astonia House, High Street, Baldock	SG7 6BP
3.	Bancroft Medical Centre	Bancroft Court, Hitchin	SG5 1LH
4.	Nevells Road Surgery	Nevells Road, Letchworth	SG6 4TS
5.	Portmill Surgery	114 Queens Street, Hitchin	SG4 9TH
6.	Regal Chambers Surgery	50 Bancroft, Hitchin	SG5 1LL
7.	The Birchwood and Sollershott Surgeries	232-240 Nevells Road, Letchworth	SG6 4UB
8.	The Garden City Surgery	Station Road, Letchworth	SG6 3BJ
9.	Whitwell Surgery	60 High Street, Whitwell	SG4 8AG
	Lower Lea Valley Locality		
10.	Abbey Road Surgery	63 Abbey Road, Waltham Cross	EN8 7LJ
11.	Cromwell and Wormley Medical Centres	11-11A Cromwell Avenue, Chestnut	EN7 5DL
12.	Cuffley & Goffs Oak Medical Centre	Maynards Place, Cuffley	EN6 4JA
13.	High Street Surgery	13-15 High Street, Chestnut	EN8 0BX
14.	Stanhope Surgery	Stanhope Road, Waltham Cross	EN8 7DJ
15.	Stockwell Lodge Medical Centre	Rosedale Way, Chestnut	EN7 6HL
16.	The Maples Health Centre	Vancouver Road, Broxbourne	EN10 6FD
17.	Warden Lodge Medical Practice	Glen Luce, Chestnut	EN8 8NW
	Stevenage Locality		
18.	Bedwell and Roebuck Surgery	Sinfield Close, Stevenage	SG1 1LQ
19.	King George & Manor House Surgeries	135 High Street, Stevenage	SG1 3HT
20.	Knebworth & Marymead Medical Practice	7 St Martin's Road Knebworth	SG3 6ER
21.	Shephall Health Centre	Ridlins End, Stevenage	SG2 9QZ
22.	Stanmore Medical Group	5 Stanmore Road	SG1 3QA
23.	Symonds Green Health Centre	Filey Close, Stevenage	SG1 2JW
	Welwyn and Hatfield Locality		
24.	Burvill House Surgery	52/54 Dellfield Road	AL10 8HP
25.	Hall Grove Group Practice	4 Hall Grove	AL7 4PL
26.	Lister House Surgery	The Common	AL10 0NL
27.	Peartree Group Practice	110 Peartree Lane	AL7 3UJ
28.	Potterells Medical Centre	Station Road, Brookmans Park	AL9 7SN
29.	Spring House Medical Centre	Ascots Lane	AL7 4HL
30.	The Garden City Practice	Birdcroft Road	AL8 6EH
31.	Wrafton House	9-11 Wellfield Road	AL10 0BS
	Upper Lead Valley Locality		

32.	Amwell Surgery	Fawkon Walk, Hoddesdon	EN11 8FG
33.	Bridge Cottage Surgery	41 High Street, Welwyn	AL6 9EF
34.	Buntingford & Puckeridge Medical Centre	White Hart Close, Buntingford	SG9 9DQ
35.	Dolphin House Surgery	Burgage Lane, Ware	SG12 9FT
36.	Hailey View Surgery	39 Christian Close, Hoddesdon	EN11 9FF
37.	Hanscombe House Surgery	52A St Andrew Street, Hertford	SG14 1JA
38.	Lea Wharf Medical	17 Bircherley Green, Hertford	SG14 1BN
39.	New River Health	St Marys Courtyard, Church Street	SG12 9EF
40.	Park Lane Surgery	8 Park Lane, Broxbourne	EN107NQ
41.	The Limes Surgery	Limes Court, Conduit Lane,	EN11 8EP
42.	Watton Place Clinic	60 High Street, Watton-At-Stone	SG14 3SY
	Stort Valley and Villages Locality		
43.	Central Surgery	Bell Street	CM21 9AQ
44.	Church Street Partnership	30a Church Street	CM23 2LY
45.	Gardens & Jacobs Medical Partnership	High Wych Road	CM210HH
46.	Helix Medical Centre	Herts & Essex Hospital, Cavell Drive	CM23 5JH
47.	Much Hadham Health Centre	Ash Meadow	SG10 6DE
48.	South Street Surgery	83 South Street	CM23 3AP
	Dacorum Locality		
49.	Archway Surgery	52 High Street	HP3 0HJ
50.	Bennetts End Surgery	Gatecroft	HP3 9LY
51.	Everest House Surgery	Everest Way	HP2 4HY
52.	Fernville Surgery	Midland Road	HP2 5BL
53.	Gossoms End Surgery	Victory Road	HP4 1DL
54.	Grovehill Medical Centre	Kilbride Court	HP2 6AD
55.	Haverfield Surgery	1 Langley Hill	WD4 9HA
56.	Highfield Surgery	Cambrian Way	HP2 5TA
57.	Lincoln House Surgery	163 London Road	HP3 9SQ
58.	Manor Street Surgery	Annandale House, Manor Street	HP4 2DL
59.	Parkwood Surgery	Parkwood Drive	HP1 2LD
60.	Rothschild House Surgery	Chapel Street	HP23 6PU
61.	The Nap (Kings Langley Surgery)	Kings Langley	WD4 8ET
62.	Woodhall Farm Medical Centre	Valley Green, Off Shenley Road	HP2 7RJ
	Hertsmere Locality		
63.	Annandale Surgery	The Elms, High Street	EN6 5DA
64.	Fairbrook Medical Centre	4 Fairway Avenue	WD6 1PR
65.	Highview Medical Centre	The Elms, High Street	EN6 5DA
66.	Little Bushey Surgery	California Lane	WD23 1EZ
67.	Parkfield Medical Centre	The Walk	EN6 1QH
68.	Schopwick Surgery	Romeland, Elstree	WD6 3BJ
69.	The Grove Medical Centre	Borehamwood Shopping Park	WD6 4PR
70.	The Red House Group	124 Watling Street	WD7 7JQ

	St Albans & Harpenden		
71.	Davenport House Surgery	Bowers Way, Harpenden	AL5 4HX
72.	Grange Street Surgery	2 Grange Street	AL3 5NF
73.	Harvey Group Practice	Harvey House Surgery 13-15 Russell Avenue	AL3 5HB
74.	Hatfield Road Surgery	2 The Parade	AL1 3FY
75.	Midway Surgery	93 Watford Rd	AL2 3JX
76.	Parkbury House Surgery	St Peters Street	AL1 3HD
77.	Summerfield Health Centre	Caledon Rd, London Colney	AL2 1PU
78.	The Elms Medical Practice	5 Stewart Road	AL5 4QA
79.	The Lodge Surgery	Normandy Road	AL3 5NP
80.	The Maltings Surgery	8-14 Victoria Street	AL1 3JB
81.	The Village Surgery	Amenbury Lane	AL5 2BT
82.	Verulam Medical Group Colney	45-47 Kings Road	AL2 1ES
	Watford and Three Rivers Locality		
83.	Abbotswood Medical Centre	12 Katherine Place, Off College Road	WD5 0BT
84.	Attenborough Surgery	Bushey Health Centre, London Road	WD23 2NN
85.	Baldwins Lane Surgery	266 Baldwins Lane	WD3 3LG
86.	Bridgewater Surgeries	7 Printers Avenue	WD18 7QR
87.	Chorleywood Health Centre	15 Lower Road	WD3 5EA
88.	Gade Surgery	99b Uxbridge Road	WD3 7DJ
89.	Garston Medical Centre	6a North Western Avenue	WD25 9GP
90.	Manor View Practice	London Road, Bushey	WD23 2NN
91.	New Road Surgery	166 New Road, Croxley Green	WD3 3HD
92.	Sheepcot Medical Centre	6 Cunningham Way	WD25 7NL
93.	South Oxhey Surgery	Oxhey Drive	WD19 7SF
94.	Suthergrey House Medical Centre	37a St Johns Road	WD17 1LS
95.	The Colne Practice	99a Uxbridge Road	WD3 7DJ
96.	The Consulting Rooms	Oxhey Drive	WD19 7RU
97.	The Elms Surgery	38 The Avenue	WD17 4NT
98.	Vine House Health Centre	87-89 High Street	WD5 0AL
99.	Watford Health Centre	Ground Floor, Colne House, 21 Upton Road	WD18 0JP

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Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Hertfordshire and West Essex Integrated Care Board

Audit and Risk Committee

Terms of Reference v1

1. Constitution

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

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

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

2. Authority

2.1 The Audit and Risk Committee is authorised by the Board to:

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

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

- Add any exceptions agreed by the board.

3. Purpose

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

3.2 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.

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

4. Responsibilities of the Committee

The Committee's duties can be categorised as follows:

4.1 Integrated governance, risk management and internal control

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

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

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

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

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

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

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

4.2 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 Board. This will be achieved by:

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

4.3 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:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit;
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan;
- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee; and
- Reviewing all external audit reports, including to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

4.4 Other assurance functions

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

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

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

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

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

4.5 Counter fraud

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

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

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

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

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

4.6 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.

4.7 Information Governance (IG)

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

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

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

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

4.8 Financial reporting

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

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

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

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

4.9 Conflicts of Interest

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

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

4.10 Management

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

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

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

4.11 Communication

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

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

5. Composition and Quoracy

5.1 This section sets out the meeting composition and quoracy arrangements:

Arrangement	Description of expectation
Chair and Vice Chair	In accordance with the constitution, the Committee will be chaired by an Independent Non-Executive Member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee. The Chair of the Committee shall be independent and therefore may not chair any other committees. In so far as it is possible, they will not be a member of any other committee. Committee members may appoint a Vice Chair who ICB to add any local specifications about who may be vice chair. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.
Membership	The Committee members shall be appointed by the Board in accordance with the ICB Constitution. The Board will appoint no fewer than three members of the Committee who are Independent Non-Executive Members of the Board. Neither the Chair of the Board, nor employees of the ICB will be members of the Committee. Members will possess between them knowledge, skills and experience in:

	accounting, risk management, internal, external audit; and technical or specialist issues pertinent to the ICB's business. When determining the membership of the Committee, active consideration will be made to diversity and equality. **Committee Members:** • ICB Non-Executive Member (Chair) • ICB Non-Executive Member (Vice Chair) • ICB Non-Executive Member
Attendees	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: • Director of Finance or their nominated deputy; • Chief Executive Officer; • Representatives of both internal and external audit; • Individuals who lead on risk management and counter fraud matters; • Chief of Staff; • Head of IG and Risk; • Risk Review Group Chair; • Executive Administrator; • Executive leads for Digital and Information Governance.
Procedure for attendance	The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Board(s), Secondary and Community Providers. The Chief Executive should be invited to attend the meeting at least annually. 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. Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair. Regardless of attendance, External Audit, Internal Audit, Local Counter Fraud and Security Management providers will have full and unrestricted rights of access to the Audit Committee.
Meeting frequency and Quorum	The Audit Committee will meet at least four times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required. The Board, Chair or Chief Executive may ask the Audit Committee to convene further meetings to discuss particular issues on which they want

	the Committee's advice. In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum. For a meeting to be quorate a minimum of **two Non-Executive Members** of the Board are required, including the Chair or Vice Chair of the Committee. If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
Decision making and voting	Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote. Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

6. Behaviours and Conduct

6.1 ICB values

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.

6.2 Equality and diversity

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

7. Accountability and Reporting

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

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

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

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

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

8. Secretariat, Administration and Review

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

Distribution of papers	The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
Monitor attendance	Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
Maintain records	Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.
Minute taking	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.
Support the Chair and Committee	The Chair is supported to prepare and deliver reports to the Board.
Updates	The Committee is updated on pertinent issues/ areas of interest/ policy developments. Action points are taken forward between meetings and progress against those actions is monitored.
Review	The Committee will review its effectiveness at least annually. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Document Control:

Version	Date	Approved By	Review	Change made
V1	Friday 26 April 2024	HWE ICB Board	Annually	n/a

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board

Remuneration Committee

Terms of Reference v1

1. Constitution

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

1.2 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 Board.

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

2. Authority

2.1 The Remuneration Committee is authorised by the Board to:

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

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

3. Purpose

3.1 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:

- 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.

- The Board has also delegated the following functions to the Committee: This might include functions such as:
- Elements of the nominations and appointments process for Board members;
- Oversight of executive board member performance.

4. Responsibilities of the Committee

4.1 The Committee's duties are as follows:

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;
- Determine arrangements for termination of employment and other contractual terms and non-contractual terms.
- For all staff:
- 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.

4.2 Possible additional functions that ICBs might choose to include in the scope of the committee include:

- Functions in relation to nomination and appointment of (some or all) Board members;
- Functions in relation to performance review/ oversight for directors/senior managers;
- Succession planning for the Board;
- 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).

5. Composition and Quoracy

5.1 This section sets out the meeting composition and quoracy arrangements:

Arrangement	Description of expectation
Chair and Vice Chair	In accordance with the constitution, the Committee will be chaired by an independent non-executive member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee. Committee members may appoint a Vice Chair from amongst the members. In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number Chair the meeting. The Chair will be responsible for agreeing the agenda and ensuring matters

	discussed meet the objectives as set out in these Terms of Reference.
Membership	The Committee members shall be appointed by the Board in accordance with the ICB Constitution. The Board will appoint no fewer than three members of the Committee including two independent members of the Board. Other members of the Committee need not be members of the board, but they may be. The Chair of the Audit Committee may not be a member of the Remuneration Committee. The Chair of the Board may be a member of the Committee but may not be appointed as the Chair. When determining the membership of the Committee, active consideration will be made to diversity and equality. **Committee members:** • ICB Non-Executive Member (Chair) • ICB Primary Care Partner Member (Vice-Chair) • ICB Non-Executive Member x3 • ICB Primary Care Partner Member
Attendees	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. 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: • The ICB's most senior HR Advisor or their nominated deputy • Director of Finance or their nominated deputy • Chief Executive or their nominated deputy
Procedure for attendance	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. No individual should be present during any discussion relating to: • Any aspect of their own pay; • Any aspect of the pay of others when it has an impact on them.
Meeting frequency and Quorum	The Committee will meet in **private.** 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. The Board, Chair or Chief Executive may ask the Remuneration Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

	In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum. For a meeting to be quorate a minimum of **three ICB Board members** required. If any member of the Committee has been disqualified from participating on item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
Decision making and voting	Decisions will be 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. Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote. Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

6. Behaviours and Conduct

6.1 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.

6.2 ICB values

Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

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

6.3 Equality diversity and inclusion

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

7. Accountability and Reporting

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

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

The Remuneration Committee will submit copies of its minutes and a report to the Board following each of its meetings. Where minutes and reports identify individuals, they will not be made public and will be presented at part B of the Board. Public reports will be made as appropriate to satisfy any requirements in relation to disclosure of public sector executive pay.

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

8. Secretariat, Administration and Review

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

Distribution of papers	The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
Monitor attendance	Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
Maintain records	Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.
Minute taking	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.
Support the Chair and Committee	The Chair is supported to prepare and deliver reports to the Board.
Updates	The Committee is updated on pertinent issues/ areas of interest/ policy developments. Action points are taken forward between meetings and progress against those actions is monitored.
Review	The Committee will review its effectiveness at least annually. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Document Control:

Version	Date	Approved By	Review	Change made
V1	Friday 26 April 2024	HWE ICB Board	Annually	n/a

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board

Strategic Finance and Commissioning Committee

Terms of Reference v1

1. Constitution

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

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

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

2. Authority and Purpose

2.1 The Strategic Finance and Commissioning Committees is delegated by the Board to focus its purpose on improving the health and wellbeing outcomes of the ICBs population taking into account financial resource alongside national and local evidence to support affordability. It will do this through:

2.1.1 Oversight and development of strategic finance management:

- Consider Commissioning and investment proposals based on their contribution to the overall delivery of the ICB objectives
- Oversee the development and delivery of a robust, viable and sustainable system financial plan. This will include:
  - financial performance of the ICB
  - financial performance of NHS organisations within the ICB footprint;
- To seek assurance that an effective system financial framework and operating model (for capital and revenue funding) is in place for collectively distributing and managing resources, and that they can be used in accordance with the ICB's Integrated Care Strategy.

2.1.2 Oversight and accountability of strategic commissioning:

- Oversee procurement and contracting processes.
- Make decisions about proceeding with commissioning changes including commissioning of new services, significant commissioning changes, decommissioning, and redesign of health services with proposals supported by completed or proposed evaluation.
- Identify opportunities for commissioning services at scale, including sharing of best practice and innovation across the ICS, and identifying opportunities for improvement, cost efficiency and sustainability.

2.1.3 Oversight and assurance in the delivery of ICB strategic priorities by HWE Health Care Partnerships:

- To ensure an assurance framework is effectively in place to proactively oversee system productivity and efficiency programmes to meet agreed priorities.
- To monitor financial performance against approved budgets, ensuring alignment with ICB strategic priorities.
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation but may not delegate any decisions to such groups.

2.2 For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference other than the Committee.

3. Objectives

3.1 Linking to the Committees purpose, the Strategic Finance and Commissioning Committees objectives are:

- To contribute to the overall delivery of the ICB objectives but primarily responsible for **Objective 5 Achieve a balanced financial position annually** by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial plan. This includes:
    - Financial performance of the ICB
    - Financial performance of NHS organisations within the ICB footprint
    - Medium term plans

- To drive the strategic commissioning function of the ICS including proactively identifying opportunities for service integration, transformation and re-alignment to improve health and wellbeing outcomes.
- To make effective and timely decisions within the delegations afforded by the ICB Board, including approving or rejecting proposals within Delegated Financial Limits (DFL), or making recommendations to the ICB for proposals above the DFL.
- To make recommendations to the ICB Board on decisions outside of the Committee's financial delegation.
- To provide oversight and seek assurance that the operational arrangements in place across the ICB to support the commissioning of services/care to the local population are in line with the agreed system and place strategic plans.
- To provide oversight and seek assurance that the commissioning arrangements in place across the ICB, including those to deliver delegated or joint services with NHSE/I, are in line with agreed principles.
- Oversee the process for the further delegation of commissioning functions to the ICB.
- Oversee the process of devolving commissioning to place and/or provider collaboratives.
- To provide the health oversight and assurance needed to support the delivery of the joint commissioning agenda with Local Government.
- Identify areas for improvement to be delivered by the system, including ensuring delivery of value for money and affordability, and best outcomes.

4. Composition and Quoracy

4.1 This section sets out the meeting composition and quoracy arrangements:

Arrangement	Description of expectation
Chair and Vice Chair	In accordance with the constitution, the Committee will be chaired by the Chair of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee. The Chair of the Committee shall be independent and therefore may not chair any other committees. Committee members may appoint a Vice Chair from amongst the members. In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number Chair the meeting. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference.
Membership	The Committee members shall be appointed by the Board in accordance with the ICB Constitution. The Committee will appoint no fewer than four members of the Committee including two independent members of the Board. **Committee Members:** • ICB Non-Executive Member (Chair) • ICB Non-Executive Member (Vice Chair) • ICB Non-Executive Member • ICB Chief Finance Officer (or Deputy) • ICB Director of Operations (or Deputy) • ICB Director of Performance • ICB Director of Nursing and Quality • ICB Chief People Officer (or Deputy) • ICB Medical Director (or Deputy) • ICB Director of Primary Care (or Deputy) • Nominated representative from each HCP sub-committee x4 • Partner Member – Primary Medical Services • One nominated director from Essex County Council, and one nominated director from Hertfordshire County Council • VCFSE Alliance Representative When determining the membership of the Committee, active consideration will be made to diversity and equality.
Attendees	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: • ICB Chief of Staff

	• Senior Responsible Officers (SROs) for identified quality and performance areas • SROs and programme lead(s) for transformation programmes • Specific project or programme leads from across the system • Governance Lead • Executive Administrator
Procedure for attendance	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. 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.
Meeting frequency and Quorum	The Committee will meet at least four times each year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required. The Board, Chair or Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice. In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum. The Committee will meet formally every other month. For a meeting to be quorate **at least 50% of the Committee membership will be in attendance with a minimum of two independent Non-Executive Members of the Board, including the Chair or Vice Chair of the Strategic Finance and Commissioning Committee.** If any member of the Committee has been disqualified from participating on item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
Decision making and voting	Decisions will be 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. Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote. Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

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

5. Behaviours and Conduct

5.1 Benchmarking and Guidance

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

5.2 ICB Values

Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

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

5.3 Conflicts of Interest

In discharging duties transparently, conflicts of interest must be considered, recorded and managed. Members should have regard to both the ICB's policies and national guidance on managing conflicts of interest.

All potential conflicts of interest must be declared and recorded at the start of each meeting. A register of interests must be maintained by the Chair and submitted to the Board. If the Chair considers a conflict of interest exists then the relevant person must not take part in that item, and the Chair may require the affected member to withdraw at the relevant point.

5.4 Equality Diversity and Inclusion

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

6. Accountability and Reporting

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

The minutes of the meetings shall be formally recorded by the secretary, with a summary being submitted to the Board.

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

7. Secretariat, Administration and Review

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

Distribution of papers	The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
Monitor attendance	Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
Maintain records	Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.
Minute taking	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.
Support the Chair and Committee	The Chair is supported to prepare and deliver reports to the Board.
Updates	The Committee is updated on pertinent issues/ areas of interest/ policy developments. Action points are taken forward between meetings and progress against those actions is monitored.
Review	The Committee will review its effectiveness at least annually. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Document Control:

Version	Date	Approved By	Review	Change made
V1	Friday 26 April 2024	HWE ICB Board	Annually	n/a

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board

Strategy Committee

Terms of Reference V1.1

1. Constitution

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

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

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

2. Authority

2.1 The Strategy Committee is authorised by the Board to:

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

2.2 For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference.

3. Objectives

3.1 The Committee Objectives:

- Having oversight, assurance and providing constructive challenge to ensure that NHS Herts & West Essex ICB and partner organisations are supporting alignment on the delivery of its strategic priorities:
  - Increasing healthy life expectancy and reduce inequality
  - Give every child the best start in life
  - Improving Access to Health and Care Services
  - Increasing the number of citizens taking steps to improve their wellbeing
  - Successfully delivering our financial plan each year

- Consider the progress of the organisation in implementation of the Integrated Care Boards Medium Term Plan, Joint Forward Plan and Health Creation Strategy, recommending amendments as needed.
- Advise the Integrated Care Board on the alignment of plans and strategies across the ICB.
- Promoting the adoption of Population Health Management across the ICS and provide regular updates to the board on progress in this area.
- Promoting the adoption and strategic direction across the ICB surrounding the use digital tools and use of data to support evidencing and evaluation.
- Promote and facilitate the use of research and evidence generated by research.

4. Composition and Quoracy

4.1 This section sets out the meeting composition and quoracy arrangements:

Arrangement	Description of expectation
Chair and Vice Chair	In accordance with the constitution, the Committee will be chaired by an independent non-executive member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee. Committee members may appoint a Vice Chair from amongst the members. In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number Chair the meeting. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

Membership	The Committee members shall be appointed by the Board in accordance with the ICB Constitution.
	
	The Committee will appoint no fewer than four members of the Committee including two independent members of the Board.
	
	Committee Members:
	• ICB Non-Executive Member (Chair)
	• ICB Non-Executive Member (Vice Chair)
	• ICB Director of Strategy (Vice Chair)
	• ICB Chief Executive Officer
	• Partner Members representing from across the sectors, to include
	  • 1 x Primary Medical Service Partner member
	  • 1 x Local Government Partner Member (both to be invited but can alternate in attendance)
	• 4 x Health Care Partnership Senior Responsible Officers
	• HWE ICB Medical Director
	• HWE ICB Nursing and Quality Director
	• HWE ICB Chief Finance Officer

	When determining the membership of the Committee, active consideration will be made to diversity and equality.
Attendees	• HWE ICB Chair • HWE ICB Director of Operations • HWE ICB Director of Performance • HWE ICB Director of Primary Care • HWE Chief of Staff • Governance Lead • Executive Administrator
Procedure for attendance	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. 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. 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.
Meeting frequency and Quorum	The Committee will meet at least six times each year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required. The Board, Chair or Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice. In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum. The Committee will meet every other month. A programme of meeting dates is set annually and advised to all members. The Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever: publicity 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. For a meeting to be quorate a **minimum of six members** including at least **two Partner Members or Non-Executive Members are required, including the Chair or Vice Chair.**

	If any member of the Committee has been disqualified from participating on item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
Decision making and voting	Decisions will be 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. Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote. Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

5. Behaviours and Conduct

5.1 Benchmarking and Guidance

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

5.2 ICB Values

Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

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

5.3 Conflicts of Interest

In discharging duties transparently, conflicts of interest must be considered, recorded and managed. Members should have regard to both the ICB's policies and national guidance on managing conflicts of interest.

All potential conflicts of interest must be declared and recorded at the start of each meeting. A register of interests must be maintained by the Chair and submitted to the Board. If the Chair considers a conflict of interest exists then the relevant person must not take part in that item, and the Chair may require the affected member to withdraw at the relevant point.

5.4 Equality Diversity and Inclusion

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

6. Accountability and Reporting

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

The minutes of the meetings shall be formally recorded by the secretary, with a summary being submitted to the Board.

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

7. Secretariat, Administration and Review

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

Distribution of papers	The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
Monitor attendance	Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
Maintain records	Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.
Minute taking	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.
Support the Chair and Committee	The Chair is supported to prepare and deliver reports to the Board.
Updates	The Committee is updated on pertinent issues/ areas of interest/ policy developments. Action points are taken forward between meetings and progress against those actions is monitored.
Review	The Committee will review its effectiveness at least annually. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Document Control:

Version	Date	Approved By	Review	Change made
V1	04.24	HWE ICB Board	Annually	Changes triggered by ICB Governance Review.
V1.1	26.07.24	HWE ICB Board	Mid year review	Paragraph 3.1 – amendment to objectives

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Hertfordshire and West Essex Integrated Care Board

System Transformation and Quality Improvement Committee

Terms of Reference v1.2

1. Constitution

1.1 The System Transformation and Quality Improvement Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

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

1.3 The Committee is a non-executive chaired committee of the Board, and its members are bound by the Standing Orders and other policies of the ICB.

2. Accountability and Delegated Authority

2.1 The System Transformation and Quality Improvement Committee is a formal committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation set out in the Constitution as may be amended from time to time.

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

2.2 The Committee is authorised by the ICB to:

- Investigate any activity within these Terms of Reference;
- The Committee will drive improvement in performance and ensure oversight of the delivery of key performance standards by healthcare providers, performance of the system against the NHS Outcomes Framework https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022 and delivery against system Operational Plan This includes the performance review and management of system providers and health care partnerships.
- The committee will have a strong focus for identifying and driving improvement:
- Have oversight to monitor and drive improvements in performance at system, place, and organisation level within the ICS.
- Providing the oversight of the development and delivery of system delivery plans, working with organisations and Health Care Partnerships to agreeing objectives, indicators and quality and performance measures at system, place & individual organisational level.
- Linking where necessary with the ICB People Committee to focus on the system's performance against agreed outcome measures which includes NHS constitutional standards, CQC requirements, Operational Planning Guidance, and System and NHSE agreed transformation programmes.
- Provide specific oversight and seek assurance from organisations and Health Care Partnerships with regard to workforce delivery challenges impacting on performance

and, identify and seek assurance on any system wide workforce issues which are blockages to system wide performance improvement.

- Provide a forum to work with NHSE on any place based or individual organisations intervention undertaken as part of the national system oversight & assurance framework.
- Seek any information it requires from any member, officer or employee who are directed to co-operate with any request made by the Committee;
- Commission any reports it deems necessary to help fulfil its obligations;
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice; and
- 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.
- Delegate tasks to such individual members, sub-committees, or individuals as it shall see fit, provided that any such delegations are consistent with the parties' relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest.

3. Purpose of the Committee

3.1 The System Transformation and Quality Improvement 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 services, against each of the dimensions of quality set out by NHS England and the National Quality Board and enshrined in the Health and Care Act 2022.

The Committee will have a duty to be mindful of all five ICB Strategic Objectives with a primary responsibility for, **Objective 2 Give every child the best start in life and Objective 3 Improve access to health and care services.**

3.2 The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality and performance governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care.

3.3 It is recognised that each provider has its own statutory responsibilities as individual statutory bodies in their own right, linked into CQC and NHSE. The Committee will however, drive system level initiatives and performance but in the most part this will be in the context of the system not at individual organisational level.

3.4 The Committee will play a key role in ensuring delivery of key national policy areas such as Long term Plan (LTP) requirements, Operating Plan, Fuller Recommendations, Primary Care contractual requirements and oversight of transformation with a view to continuously improve quality and enhance performance.

3.5 The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

3.6 For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference of the Committee.

4. Responsibilities of the Committee

4.1 The responsibilities of the System Transformation and Quality Improvement Committee will be authorised by the ICB Board.

It is expected that the Committee will:

4.2 Quality:

- Be assured that there are robust processes in place for the effective management of quality.
- Scrutinise structures in place to support quality planning, control and improvement, to be assured that the structures operate effectively, and timely action is taken to address areas of concern.
- Agree and submit to ICB put forward the key quality priorities that are included within the ICB strategy/ annual plan.
- Oversee and monitor delivery of the ICB key statutory requirements (e.g. Continuing Health Care) as applicable to quality.
- Review and monitor those risks on the Strategic and Corporate Risk Register which relate to quality, and high-risk operational risks which could impact on care. Ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner.
- Oversee and scrutinise the ICB's response to all relevant (as applicable to quality) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the Department of Health and Social Care (DHSC), NHS England (NHSE) and other regulatory bodies / external agencies (e.g. Care Quality Committee (CQC), National Institute for Health and Care Excellence (NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained.
- Maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation as applicable to quality and assure the ICB that these are disseminated and implemented across all sites.
- Oversee and seek assurance on the effective and sustained delivery of the ICB Quality Improvement Programmes.
- Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place.
- 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.
- Receive assurance that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from death (including coronial inquests and Prevention of Future Death (PFD) report).
- To be assured that service users are systematically and effectively involved as equal partners in quality activities.
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children.
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for infection prevention and control.

- Clinical or Quality related policies should come through the Quality committee for oversight, scrutiny and comment prior to approval and adoption by the ICB. Policy approval will be met through compliance with the ICBs Scheme of Reservation and Delegation.
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety.
- Have oversight of the Terms of Reference and work programmes for the groups reporting into the Quality Committee (e.g. System Quality Groups, Infection Prevention and Control, Local Maternity and Neonatal System Partnership Board, Quality Patient Group etc).

4.3 Performance:

- The Terms of Reference sets out how Hertfordshire and West Essex ICB will work in partnership with the regional and national NHS England teams to provide effective, streamlined oversight for quality, performance, collective use of resources, and delivery of the 2024/25 Operational Planning requirements.
- These requirements include: Covid-19 restoration and recovery, a greater emphasis on population health management, and improving health inequalities, outcomes, and access.
- The Committee is the primary governance forum to oversee the Partnership's mutual accountability arrangements. Its primary function is to monitor system performance and provide assurance relating to quality, finance, workforce and operational performance against constitutional standards, national priorities, and local strategic plans.
- The TOR describe the scope, function, and ways of working for the Committee. They should be read in conjunction with the Hertfordshire and West Essex (HWE) Partnership Memorandum of Understanding.

4.4 Primary Care:

- Oversight of the delivery of national and local strategic plan for primary care and identify the key priority areas needing change.
- Enable system discussions integrating primary care into system transformation and enabling system wide discussions on impact of quality and performance standards across providers on primary care to support interface/end to end pathway.
- Set out the principles and methodology for transformation in the strategic delivery plan.
- Drive quality and reduce unwarranted variation in outcomes for patients in primary care across HWE through Health and Care Partnerships

4.5 System Transformation:

- Oversight of the delivery of system wide agreed Medium Term Plan priorities and the transformation work delivered through HCP Delivery Plans.
- Enable system discussions regarding implementation of Transformation work, ensuring learning and the benefits or disbenefits are shared across the Health Care Partnerships, with a parallel view of impact on system performance and quality.
  Provide a forum to foster greater integration of system wide transformation with Primary Care.

5. Composition and Quoracy

5.1 This section sets out the meeting composition and quoracy arrangements:

Arrangement	Description of expectation
Chair and Vice Chair	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. If a Chair has a conflict of interest, then the co-chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.
Membership	The Committee members shall be appointed by the Board in accordance with the ICB Constitution. The Board will appoint no fewer than four members of the Committee including two who are Non-Executive Members of the Board. Other attendees of the Committee need not be members of the Board, but they may be. When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion. 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. **Committee Members:** • ICB Non-Executive Member (Chair) • ICB Partner Member – Primary Medical Services (Vice Chair) • ICB Non-Executive Member x2 • ICB Director of Nursing • ICB Medical Director • ICB Director of Performance • ICB Director of Primary Care Transformation • ICB Deputy Director of Transformation Other representatives: • Directors of Nursing aligned to each Organisation • Directors of Performance aligned to each Organisation • Chairs of HCP equivalent committees • 1 x primary care representative • 1 x local authority lead from each local authority • 1 x Healthwatch (alternate between Essex and Hertfordshire) • 2 x Patient Safety Partners • System Quality Director • Medication Safety Officer and Medical Devices Safety Officer

Attendees	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: • ICB Continuing Healthcare lead • Members of the Nursing and Quality, Performance and Primary Care Teams dependent on agenda e.g. Deputy Directors and Assistant Directors • Head of Community Resilience • ICB Quality committee governance lead • ICB Quality committee secretarial • Clinical Quality Director, NHS England • Specific project or programme leads from across the system.
Procedure for attendance	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. 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.
Meeting frequency and Quorum	The Committee will meet every other month. Additional meetings may be convened on an exceptional basis and at the discretion of the Committee Chair. Arrangements and notice for calling meetings are set out in the Standing Orders. For a meeting to be quorate there will be a minimum of the **Chair or Vice Chair, plus at least the Director of Nursing or Medical Director, Director of Performance, and one provider representative, one Local Authority representative.** Where members are unable to attend, they should ensure that a named and briefed deputy is in attendance who is able to participate on their behalf.
Decision making and voting	Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote. Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes. If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

6. Behaviours and Conduct

6.1 ICB values

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.

6.2 Equality and diversity

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

7. Accountability and Reporting

7.1 The Committee is directly accountable to the ICB. The minutes of meetings shall be formally recorded. The Chair of the Committee shall report to the Board (public session) after each meeting and provide a report on assurances received, escalating any concerns where necessary.

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

7.3 The Committee will receive scheduled assurance report from its delegated groups. Any delegated groups would need to be agreed by the ICB Board.

7.4 All members, ex-officio members and those in attendance must declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

8. Secretariat, Administration and Review

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

Distribution of papers	The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
Monitor attendance	Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
Maintain records	Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.
Minute taking	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.
Support the Chair and Committee	The Chair is supported to prepare and deliver reports to the Board.

Updates	The Committee is updated on pertinent issues/ areas of interest/ policy developments. Action points are taken forward between meetings and progress against those actions is monitored.
Review	The Committee will review its effectiveness at least annually. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Document Control:

Version	Date	Approved By	Review	Change made
V1	Friday 26 April 2024	HWE ICB Board	Annually	n/a
V1.1	Friday 24 May 2024	HWE ICB Board	Amendements made	Amendments to committee membership and section 4.4
V1.2	Friday 26 September 2024	HWE ICB Board	Amendements made	Inclusion of 4.5 and 5.1 membership

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Hertfordshire and West Essex Integrated Care Board
People Committee
Terms of Reference v1.1

1. Introduction

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

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

1.3 These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Hertfordshire and West Essex (HWE) Integrated Care System (ICS) People Committee.

2. Purpose of the Committee

2.1 The Hertfordshire and West Essex People Committee will seek to deliver genuine partnership working, with a committed approach to integration, innovation and transformation where it leads to improvements in quality of patient care and support for our staff.

2.2 The purpose of the HWE ICB People Committee is to:

- Set and monitor delivery of the system's People Strategy.
- Support our workforce, enabling them to study, work and live in a welcoming, healthy and compassionate workplace.
- Develop a clear understanding of the current and future workforce challenges – through robust service, workforce and skills intelligence.
- Build and develop workforce capacity and capability to meet the system's population health needs.
- Develop innovative ways to ensure the supply of the right workforce, with the right skills and knowledge at the right time to deliver high quality patient care.
- Support implementation of the priorities set out in system, regional and national strategies and work streams.

3. Role and Responsibility

3.1 The People Committee will be responsible for:

- Strategic workforce leadership supporting care and health service delivery and transformation and developing innovative new working practices and meeting workforce challenges within the system and the emerging Integrated Care Partnership.
- Provide workforce leadership and support for emerging ICPs and oversight of system wide strategic workforce challenges and solutions.
- Play a key role in future proofing workforce challenges and ensuring plans are developed to minimise future stresses.
- Supporting the development of the health and social care sector as anchor institutions,

supporting the economic and social development of our community.

- Effective workforce planning at an ICS and ICP level.
- Ensuring a truly equal, diverse and inclusive approach to attracting, supporting and developing the health and care workforce across the system.
- Fostering effective cross-organisational, multi-disciplinary working is enabled across the health and social care system, and incorporates wider stakeholders such as Education, Housing, and the Voluntary, Community and Social Enterprise sectors.
- Overseeing the workforce transformation programme with specific responsibility for effective delivery of system wide initiatives and the broader People Strategy, including the six identified workstreams: integrated workforce planning; innovation and new ways of working; sustainable workforce supply; equality and inclusion; staff wellbeing and experience; and education, training and leadership development.

4. Accountability and Governance Structure

There will be accountability through the People Committee Chair to:

- The HWE ICS Executive and wider ICB Governance Structure
- Hertfordshire and West Essex Integrated Care Partnership
- East of England Regional People Board
- NHS England and Health Education England Executives.

4.1 The People Committee will be underpinned by good governance principles and robust assurance processes, to ensure accountability to the public as patients, citizens or taxpayers.

5. Operating Principles

5.1 Each work stream delivery group established to support the People Committee will include a Senior Responsible Officer (SRO) to support programme delivery. The SRO for each People Committee work stream will be a member of the People Committee, responsible for the vision and delivery of the People Plan and needs to be clear on the time commitments necessary to fulfil the position.

5.2 The focus and commissioning of work from the work streams will be driven by the People Committee and will be in line with the ICS' priorities.

5.3 The membership of each work stream will comprise of subject matter experts relating to the functions outlined in the People Strategy.

5.4 The work streams will need to agree how they function, not necessarily meeting regularly as they may operate as a virtual forum.

6. Reporting Responsibilities

6.1 The Hertfordshire and West Essex People Committee is accountable to the ICB Board and the Regional People Committee.

- On behalf of the ICS, the Chair is responsible for ensuring the SRO's are held to account for the successful implementation of agreed schemes to support financial, quality and operational improvements.
- Members must ensure that they have the necessary delegated permissions and processes are

in place for them to act on behalf of the organisations which they represent.

- Each member on the Group is there in an individual capacity, acting for the benefit of the system as a whole and not for any organisation that they may also be employed by.
- The People Committee will be supported by a number of work stream delivery groups, chaired by appropriate senior responsible officers (SROs) focussed on the improvement areas to deliver the required system wide benefits.
- Work steams are accountable to the People Committee, which reports into the ICB Board and Regional People Board.

7. Membership and Chairing Arrangements

7.1 This section sets out the meeting composition and quoracy arrangements:

Arrangement	Description of expectation
Chair and Vice Chair	The People Committee will be representative of the HWE health and social care community to ensure diverse input and decision making. Membership will be reviewed annually by the Chair. The Chair may appoint advisors to provide specialist input/challenge.
Membership	Membership will be made up of appropriate representation from the following areas and ensuring representation and membership across all constituent organisations of the ICS, including: • ICB Non-Executive Member (Chair) • ICB Non-Executive Member • ICB Board Member Voluntary, Community and Social Enterprise Alliance • ICB Partner Member – Community Trust • ICB Partner Member – Primary Medical Services • ICB Chief People Officer (or Deputy) • Workforce Transformation Lead • Associate Director for Education, Culture and Organisational Development (OD) • Integrated Workforce Planning workstream SRO • Innovation and New Ways of Working Committee SRO • Sustainable Workforce Supply SRO • Equality and Inclusion SRO • Staff Wellbeing and Experience SRO
Attendees	Education Talent and Leadership Development SRO Representation from the ICB. NHS Trust and Primary Care constituents of Hertfordshire and West Essex, including: • HR Director representation • Clinical Leader representation • Allied Health Professionals Council representation • Integrated Care Partnership leadership representative • Primary Care representation

	Representation from social care and local authority, including: • Directors of Adult Social Care Services • Integration and Transformation Directors • HR Director representation • Public Health representation Representation from wider constituents and key stakeholders, including: • Trade Union representation • Higher/Further Education representation • Representation from the Voluntary, Community and Social Enterprise sector • EDI/BAME network representation • Patient/Carer representation There will be additional representation invited to attend People Board for discussion on key topics of interest/relevance: • District Council and Housing representation • Health Education England representation • Clinical Leader representation • Skills for Care representation • Local Enterprise Partnership representative
Member Roles and Responsibilities	Each member of the People Committee will have a responsibility to work in the interests of the ICS fully utilising their local and national networks to bring added benefit and focus. Members will support the identification and adoption of best practice within the ICS. As well as delivering the duties outlined, members of the People Committee will: • Provide good governance. • Identify requirements and sources of funding to support the delivery of the workforce programme across the ICS. • Be responsible for the utilisation of funds and resources allocated to the People Committee. • Provide a forum for sharing and disseminating national and local best practice. Nominated members will chair / lead sub-stream groups and work programmes. All members will lead and participate in the delivery of the People Plan. All members will take responsibility for reporting to colleagues within their own organisations and professional groups as well as representing the views of colleagues at the People Committee. Members will represent the People Committee at other ICS meetings, organisational groups and other appropriate forums.

Code of Conduct	It is the role of the Chair of the People Committee, to ensure all members: Adhere to the requirement to comply with the Code of Conduct and Code of Accountability for NHS and local authority Boards. Uphold service values including the Seven Principles of Public Life. Contribute to, and exercise, their role as members and not as representatives of a specific interest or stakeholder group. Adhere to Standing Orders, Standing Financial Instructions, Scheme of Delegation, etc. and be subject to audit by internal and/or external auditors. Comply with the governance framework, relevant legal and regulatory frameworks and codes of good practice. Observe respect for confidentiality and information governance.
Meeting frequency and Quorum	The full membership of the People Board will meet at least five times a year, with work stream SROs and members supporting programme delivery joining working group meetings in the intervening months. Members who cannot attend will be expected to send deputies. A meeting will be considered quorate in the following circumstances: At least **five members** are present, which must include either the Chair or Vice-Chair. There must be representation from each of the membership groups. This should include equitable representation and voice from NHS, primary care and social care sectors. No formal business shall be transacted where a quorum is not reached.
Decision making and voting	Conflicts of interest will be considered on a case-by-case basis with the chair and chief people officer. The ICB workforce programme team will maintain a schedule of Declarations of Interests. Members will be required to notify the secretariat of any changes. The schedule will be available to all members on request. Members will be required to declare relevant interests verbally at the start of a meeting and, at the Chair's discretion, they may be asked to leave the meeting while a particular topic is being discussed.

8. Secretariat, Administration and Review

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

Distribution of papers	The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
Monitor attendance	Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
Maintain records	Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.
Minute taking	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.
Support the Chair and Committee	The Chair is supported to prepare and deliver reports to the Board.
Updates	The Committee is updated on pertinent issues/ areas of interest/ policy developments. Action points are taken forward between meetings and progress against those actions is monitored.
Review	The Committee will review its effectiveness at least annually. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Document Control:

Version	Date	Approved By	Review	Change made
V1	Friday 26 April 2024	HWE ICB Board	Annually	n/a

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board

East and North Hertfordshire Health Care Partnership Board

Terms of Reference_2024 v1

1. Constitution

1.1 The East and North Hertfordshire Health and Care Partnership Board ('the board') is established by the Hertfordshire and West Essex ICB to provide strategic leadership for the East and North Hertfordshire Health and Care Partnership ('the HCP').

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

2. Authority

2.1 The East and North Hertfordshire Health and Care Partnership ("the HCP") has the following vision: Working as one for healthier communities.

The role of the East and North Hertfordshire Health Care Partnership Board ("HCP Board") is to provide the multi-agency, system leadership to the HCP.

2.2 The HCP Board is authorised by the ICB Board to:

- Convene and support all partners across the HCP to work together to transform health and care delivery that achieves patient-centred improvements in health and care services
- Develop and deliver the HCP's delivery plan, including relevant national priorities/ targets.
- Utilise population health management approaches, to identify and develop evidence-based pathways and models of preventive and proactive care
- Drive a fundamentally different model of care and services that support people at or closer-to-home, ensuring avoiding requirement for more costly services that may also lead to poorer outcomes and experience
- Be accountable for balancing specified delegated budgets, and for the delivery of the relevant aspects ICBs strategy and priorities as agreed by the ICB Board.

2.3 For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference of this Board.

3. Responsibilities and functions

3.1 The Board shall be responsible for transacting the HCP's core business and leading strategic thinking on behalf of the HCP. The discharging these key responsibilities the HCP Board will:

Core Business

- To take accountability for the development and delivery of the overall financial plan for East

and North Hertfordshire within the specified delegated budgets of the HCP.

- To scrutinise and approve recommendations proposed by the HCP Strategic Finance & Commissioning Committee and the HCP System Transformation and Quality Improvement Committee, or through whatever model of managing these responsibilities the HCP agrees. This will include investment and spending decisions within the specified delegated budgets of the HCP.
- To approve recommendations for activity/interventions arising from the HCP's Clinical Transformation workstreams, the enabling workstreams and the task and finish groups.
- Receive updates from the HCP Finance & Commissioning Committee and the HCP System Transformation and Quality Committee (or equivalent) and to review the HCP's risk register
- To assure and drive the performance and delivery of Integrated Neighbourhood Team transformation work in East and North Hertfordshire.

Strategic Leadership

- To participate in the development of strategy across the Integrated Care System
- To take joint accountability for the development and implementation of plans to transform the delivery of health and care in East and North Hertfordshire.
- To maintain oversight, understanding and alignment of individual organisation strategies and plans.
- To bring together activity, finance, operations, and quality intelligence from NHS providers in order to drive whole-system planning and prioritisation.
- To lead the resolution of strategic challenges, issues and risks between partners.

4. Composition and Quoracy

4.1 This section sets out the meeting composition and quoracy arrangements:

Arrangement	Description of expectation
Chair and Vice Chair	The Board will be chaired by the HCP Senior Responsible Officer. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.
Membership	The Board members shall be appointed by the HCP Board in accordance with the ICB Constitution. Membership shall comprise the following roles: • HCP Senior Responsible Officer(s) (Elliot Howard-Jones and Adam Sewell-Jones) • Non-Executive Member of the Integrated Care Board • Chief Finance Officer of the ICB (or Deputy) • ICB Medical Director or Director of Nursing (or Deputy) • ICB Partner Member (Primary Care GP) Members from partner organisations within the Health Care Partnership and East and North Hertfordshire HCP Place Director.

	Members of the HCP Board will operate with the individual delegated responsibility from their employing organisation to enable the Partnership to carry out its responsibilities and functions. In some circumstances this will necessitate decisions being taken through each organisation's specific governance processes. Named deputies are permitted to attend meetings where individuals above are unable to attend. When determining the membership of the Board, active consideration will be made to diversity and equality.
Attendees	Only members of the Board have the right to attend meetings, however all meetings of this Committee will also be attended by the following individuals who are not members of this Board: • SROs and programme lead(s) for transformation programmes • Specific project or programme leads from across the system • ICB Governance lead • Secretariat The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Board(s), Secondary and Community Providers.
Procedure for attendance	Where the HCP operates a HCP Strategic Finance and Commissioning Committee and its representative (who is not a member of this Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.
Meeting frequency and Quorum	The Board will meet a minimum of six times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required. The ICB Board or the HCP Senior Responsible Officer may ask the Board to convene further meetings to discuss particular issues on which they want the committee's advice. In accordance with the ICBs Standing Orders, this Board may meet virtually when necessary and members attending using electronic means will be counted towards the quorum. **A quorum will be at least 50% of membership**, but for decisions to be taken on delegated matters, and in line with the ICBs constitution, that must include a minimum of three members of the ICB board or their deputies. If any member of the Board has been disqualified from participating in an

	item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
Decision making and voting	Voting will be taken in according with the ICBs Standing Orders. The committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote. On all matters not relating to responsibilities delegated by the ICB, all members have one vote, and a majority will be conclusive. On matters relating to ICB delegation, and where there is not a consensus opinion, only those members of the board who are also members of the Integrated Care board will be able to vote. Each member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of this Board will hold the casting vote. The Chair can ask for an indicative vote of the whole board prior to initiating the sub-committee voting process but this is not binding on those members of the ICB board that will vote. The Chief of Staff of the Integrated Care Board, or their named representative, will determine whether an area is considered a delegated responsibility and therefore point 5.9 applies. If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication. The voting requirements set out in paras 5.7-5.11 apply.

5. Behaviours and Conduct

5.1 Benchmarking and Guidance

The Board will take proper account of National Agreements and appropriate benchmarking, for example Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

5.2 ICB Values

Members will be expected to conduct business in line with the ICB values and objectives.

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

5.3 Conflicts of Interest

The members of the Board must comply fully with the NHS England Guidance and ICB Standards of Business Conduct and Conflicts of Interest Policy.

The ICB reserves the right to ask members of the Board to provide assurance that they meet the criteria set out in the ICBs Fit and Proper Persons policy, before agreeing their appointment to the committee.

5.4 Equality Diversity and Inclusion

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

6. Accountability and Reporting

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

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

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

7. Secretariat, Administration and Review

The Board shall be supported with a secretariat function operated by the Integrated Care Board governance team, which will include ensuring that:

Distribution of papers	The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
Monitor attendance	Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
Maintain records	Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.
Minute taking	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.
Support the Chair and Committee	The Chair is supported to prepare and deliver reports to the ICB Board.
Updates	The ICB Board is updated on pertinent issues/ areas of interest/ policy developments. Action points are taken forward between meetings and progress against those actions is monitored.
Review	The Board will review its effectiveness at least annually.

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

Document Control:

Version	Date	Approved By	Review	Change made
V1	Friday 24 May 2024	HWE ICB Board	Annually	N/A

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board

South West Hertfordshire Health Care Partnership Board

Terms of Reference_2024 v1

1. Constitution

1.1 The South West Hertfordshire Health and Care Partnership Board ('the board') is established by the Hertfordshire and West Essex ICB to provide strategic leadership for the South West Hertfordshire Health and Care Partnership ('the HCP').

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

2. Authority

2.1 The South West Hertfordshire Health and Care Partnership ("the HCP") has the following vision: Our vision is to be a 'single team' responsible for planning, improving and delivering population-based health and care services for the people of South-West Herts, delivered by via a locality working model.

The role of the South West Hertfordshire Health Care Partnership Board ("HCP Board") is to provide the multi-agency, system leadership to the HCP.

2.2 The HCP Board is authorised by the ICB Board to:

- Convene and support all partners across the HCP to work together to transform health and care delivery that achieves patient-centred improvements in health and care services
- Develop and deliver the HCP's delivery plan, including relevant national priorities/ targets.
- Utilise population health management approaches, to identify and develop evidence-based pathways and models of preventive and proactive care
- Drive a fundamentally different model of care and services that support people at or closer-to-home, ensuring avoiding requirement for more costly services that may also lead to poorer outcomes and experience
- Be accountable for balancing specified delegated budgets, and for the delivery of the relevant aspects ICBs strategy and priorities as agreed by the ICB Board.

2.3 For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference of this Board.

3. Responsibilities and functions

3.1 The Board shall be responsible for transacting the HCP's core business and leading strategic thinking on behalf of the HCP. The discharging these key responsibilities the HCP Board will:

Core Business

- To take accountability for the development and delivery of the overall financial plan for South West Hertfordshire within the specified delegated budgets of the HCP.
- To scrutinise and approve recommendations proposed by the HCP Strategic Finance & Commissioning Committee and the HCP System Transformation and Quality Improvement Committee, or through whatever model of managing these responsibilities the HCP agrees. This will include investment and spending decisions within the specified delegated budgets of the HCP.
- To approve recommendations for activity/interventions arising from the HCP's Clinical Transformation workstreams, the enabling workstreams and the task and finish groups.
- Receive updates from the HCP Finance & Commissioning Committee and the HCP System Transformation and Quality Improvement Committee (or equivalent) and to review the HCP's risk register
- To assure and drive the performance and delivery of Integrated Neighbourhood Team transformation work in South West Hertfordshire.

Strategic Leadership

- To participate in the development of strategy across the Integrated Care System
- To take joint accountability for the development and implementation of plans to transform the delivery of health and care in South West Hertfordshire.
- To maintain oversight, understanding and alignment of individual organisation strategies and plans.
- To bring together activity, finance, operations, and quality intelligence from NHS providers in order to drive whole-system planning and prioritisation.
- To lead the resolution of strategic challenges, issues and risks between partners.

4. Composition and Quoracy

4.1 This section sets out the meeting composition and quoracy arrangements:

Arrangement	Description of expectation
Chair and Vice Chair	The Board will be chaired by the HCP Senior Responsible Officer. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.
Membership	The Board members shall be appointed by the HCP Board in accordance with the ICB Constitution. Membership shall comprise the following roles: • HCP Senior Responsible Officer (Matthew Coats) • Non-Executive Member of the Integrated Care Board • Chief Finance Officer of the ICB (or Deputy) • ICB Medical Director or Director of Nursing (or Deputy) • ICB Partner Member (Primary Care GP) Members from partner organisations within the Health Care Partnership, and South and West Hertfordshire HCP Place Director

	Members of the HCP Board will operate with the individual delegated responsibility from their employing organisation to enable the Partnership to carry out its responsibilities and functions. In some circumstances this will necessitate decisions being taken through each organisation's specific governance processes. Named deputies are permitted to attend meetings where individuals above are unable to attend. When determining the membership of the Committee, active consideration will be made to diversity and equality.
Attendees	Only members of the Board have the right to attend meetings, however all meetings of this Board will also be attended by the following individuals who are not members of this Board: • SROs and programme lead(s) for transformation programmes • Specific project or programme leads from across the system • ICB Governance lead • Secretariat The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Board(s), Secondary and Community Providers.
Procedure for attendance	Where the HCP operates a HCP Strategic Finance and Commissioning Committee and its representative (who is not a member of this Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.
Meeting frequency and Quorum	The Board will meet a minimum of six times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required. The ICB Board or the HCP Senior Responsible Officer may ask the Board to convene further meetings to discuss particular issues on which they want the committee's advice. In accordance with the ICBs Standing Orders, this Board may meet virtually when necessary and members attending using electronic means will be counted towards the quorum. **A quorum will be at least 50% of membership**, but for decisions to be taken on delegated matters, and in line with the ICBs constitution, that must include a minimum of three members of the ICB board or their deputies.

	If any member of the Board has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
Decision making and voting	Voting will be taken in according with the ICBs Standing Orders. The committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote. On all matters not relating to responsibilities delegated by the ICB, all members have one vote, and a majority will be conclusive. On matters relating to ICB delegation, and where there is not a consensus opinion, only those members of the board who are also members of the Integrated Care board will be able to vote. Each member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of this Committee will hold the casting vote. The Chair can ask for an indicative vote of the whole board prior to initiating the sub-committee voting process but this is not binding on those members of the ICB board that will vote. The Chief of Staff of the Integrated Care Board, or their named representative, will determine whether an area is considered a delegated responsibility and therefore point 5.9 applies. If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication. The voting requirements set out in paras 5.7-5.11 apply.

5. Behaviours and Conduct

5.1 Benchmarking and Guidance

The Board will take proper account of National Agreements and appropriate benchmarking, for example Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

5.2 ICB Values

Members will be expected to conduct business in line with the ICB values and objectives.

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

5.3 Conflicts of Interest

The members of the Board must comply fully with the NHS England Guidance and ICB Standards of Business Conduct and Conflicts of Interest Policy.

The ICB reserves the right to ask members of the committee to provide assurance that they meet the criteria set out in the ICBs Fit and Proper Persons policy, before agreeing their appointment to the committee.

5.4 Equality Diversity and Inclusion

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

6. Accountability and Reporting

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

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

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

7. Secretariat, Administration and Review

The Board shall be supported with a secretariat function operated by the Integrated Care Board governance team, which will include ensuring that:

Distribution of papers	The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
Monitor attendance	Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
Maintain records	Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.
Minute taking	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.
Support the Chair and Committee	The Chair is supported to prepare and deliver reports to the ICB Board.
Updates	The ICB Board is updated on pertinent issues/ areas of interest/ policy developments. Action points are taken forward between meetings and progress against those actions is monitored.
Review	The Board will review its effectiveness at least annually.

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

Document Control:

Version	Date	Approved By	Review	Change made
V1	Friday 24 May 2024	HWE ICB Board	Annually	N/A

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board

West Essex Health Care Partnership Board

Terms of Reference_2024 v1

1. Constitution

1.1 The West Essex Health and Care Partnership Board ('the board') is established by the Hertfordshire and West Essex ICB to provide strategic leadership for the West Essex Health and Care Partnership ('the HCP').

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

2. Authority

2.1 The West Essex Health and Care Partnership ("the HCP") has the following vision: "To help everyone in our area live long and healthy lives by supporting independence and providing seamless care".

The role of the West Essex Health Care Partnership Board ("HCP Board") is to provide the multi-agency, system leadership to the HCP.

2.2 The HCP Board is authorised by the ICB Board to:

- Convene and support all partners across the HCP to work together to transform health and care delivery that achieves patient-centred improvements in health and care services
- Develop and deliver the HCP's delivery plan, including relevant national priorities/ targets.
- Utilise population health management approaches, to identify and develop evidence-based pathways and models of preventive and proactive care
- Drive a fundamentally different model of care and services that support people at or closer-to-home, ensuring avoiding requirement for more costly services that may also lead to poorer outcomes and experience
- Be accountable for balancing specified delegated budgets, and for the delivery of the relevant aspects ICBs strategy and priorities as agreed by the ICB Board.

2.3 For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference of this Board.

3. Responsibilities and functions

3.1 The Board shall be responsible for transacting the HCP's core business and leading strategic thinking on behalf of the HCP. The discharging these key responsibilities the HCP Board will:

Core Business

- To take accountability for the development and delivery of the overall financial plan for West Essex within the specified delegated budgets of the HCP.
- To scrutinise and approve recommendations proposed by the HCP Strategic Finance & Commissioning Committee and the HCP System Transformation and Quality Improvement Committee, or through whatever model of managing these responsibilities the HCP agrees. This will include investment and spending decisions within the specified delegated budgets of the HCP.
- To approve recommendations for activity/interventions arising from the HCP's Clinical Transformation workstreams, the enabling workstreams and the task and finish groups.
- Receive updates from the HCP Finance & Commissioning Committee and the HCP System Transformation and Quality Improvement Committee (or equivalent) and to review the HCP's risk register
- To assure and drive the performance and delivery of Integrated Neighbourhood Team transformation work in West Essex.

Strategic Leadership

- To participate in the development of strategy across the Integrated Care System
- To take joint accountability for the development and implementation of plans to transform the delivery of health and care in West Essex.
- To maintain oversight, understanding and alignment of individual organisation strategies and plans.
- To bring together activity, finance, operations, and quality intelligence from NHS providers in order to drive whole-system planning and prioritisation.
- To lead the resolution of strategic challenges, issues and risks between partners.

4. Composition and Quoracy

4.1 This section sets out the meeting composition and quoracy arrangements:

Arrangement	Description of expectation
Chair and Vice Chair	The Board will be chaired by the HCP Senior Responsible Officer. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.
Membership	The Board members shall be appointed by the HCP Board in accordance with the ICB Constitution. Membership shall comprise the following roles: • HCP Senior Responsible Officer (Lance McCarthy) • Non-Executive Member of the Integrated Care Board • Chief Finance Officer of the ICB (or Deputy) • ICB Medical Director or Director of Nursing (or Deputy) • ICB Partner Member (Primary Care GP) Members from partner organisations within the Health Care Partnership and West Essex HCP Place Director.

	Members of the HCP Board will operate with the individual delegated responsibility from their employing organisation to enable the Partnership to carry out its responsibilities and functions. In some circumstances this will necessitate decisions being taken through each organisation's specific governance processes. Named deputies are permitted to attend meetings where individuals above are unable to attend. When determining the membership of the Board, active consideration will be made to diversity and equality.
Attendees	Only members of the Board have the right to attend meetings, however all meetings of this Board will also be attended by the following individuals who are not members of this Board: • SROs and programme lead(s) for transformation programmes • Specific project or programme leads from across the system • ICB Governance lead • Secretariat The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Board(s), Secondary and Community Providers.
Procedure for attendance	Where the HCP operates a HCP Strategic Finance and Commissioning Committee and its representative (who is not a member of this Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.
Meeting frequency and Quorum	The Board will meet a minimum of six times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required. The ICB Board or the HCP Senior Responsible Officer may ask the Board to convene further meetings to discuss particular issues on which they want the committee's advice. In accordance with the ICBs Standing Orders, this Board may meet virtually when necessary and members attending using electronic means will be counted towards the quorum. **A quorum will be at least 50% of membership**, but for decisions to be taken on delegated matters, and in line with the ICBs constitution, that must include a minimum of three members of the ICB board or their deputies. If any member of the Board has been disqualified from participating in an

	item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
Decision making and voting	Voting will be taken in according with the ICBs Standing Orders. The committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote. On all matters not relating to responsibilities delegated by the ICB, all members have one vote, and a majority will be conclusive. On matters relating to ICB delegation, and where there is not a consensus opinion, only those members of the board who are also members of the Integrated Care board will be able to vote. Each member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of this Committee will hold the casting vote. The Chair can ask for an indicative vote of the whole board prior to initiating the sub-committee voting process but this is not binding on those members of the ICB board that will vote. The Chief of Staff of the Integrated Care Board, or their named representative, will determine whether an area is considered a delegated responsibility and therefore point 5.9 applies. If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication. The voting requirements set out in paras 5.7-5.11 apply.

5. Behaviours and Conduct

5.1 Benchmarking and Guidance

The Board will take proper account of National Agreements and appropriate benchmarking, for example Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

5.2 ICB Values

Members will be expected to conduct business in line with the ICB values and objectives.

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

5.3 Conflicts of Interest

The members of the Board must comply fully with the NHS England Guidance and ICB Standards of Business Conduct and Conflicts of Interest Policy.

The ICB reserves the right to ask members of the committee to provide assurance that they meet the criteria set out in the ICBs Fit and Proper Persons policy, before agreeing their appointment to the committee.

5.4 Equality Diversity and Inclusion

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

6. Accountability and Reporting

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

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

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

7. Secretariat, Administration and Review

The Board shall be supported with a secretariat function operated by the Integrated Care Board governance team, which will include ensuring that:

Distribution of papers	The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
Monitor attendance	Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
Maintain records	Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.
Minute taking	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.
Support the Chair and Committee	The Chair is supported to prepare and deliver reports to the ICB Board.
Updates	The ICB Board is updated on pertinent issues/ areas of interest/ policy developments. Action points are taken forward between meetings and progress against those actions is monitored.
Review	The Board will review its effectiveness at least annually. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the ICB Board for approval.

Document Control:

Version	Date	Approved By	Review	Change made
V1	Friday 24 May 2024	HWE ICB Board	Annually	N/A

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board

Hertfordshire Mental Health, Learning Disability and Autism

Health and Care Partnership Board

Terms of Reference_2024 v1

1. Constitution

1.1 The Hertfordshire Mental Health, Learning Disability and Autism (MHLDA) Health and Care Partnership Board('the board') is established by the Hertfordshire and West Essex ICB to provide strategic leadership for the Hertfordshire MHLDA Health and Care Partnership ('the HCP').

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

2. Authority

2.1 The MHLDA Health and Care Partnership ("the HCP") has the following vision: Supporting people living with mental illness, learning disabilities and autism in Hertfordshire to live longer happier and healthier lives. The role of the MHLDA Health and Care Partnership Board ("HCP Board") is to provide the multi-agency, system leadership to the HCP.

2.2 The HCP Board is authorised by the ICB Board to:

- Convene and support all partners across the HCP to work together to transform health and care delivery that achieves person-centred improvements in health and care services.
- Develop and deliver the HCP's delivery plan, including relevant national priorities/ targets.
- Utilise population health management approaches, to identify and develop evidence-based pathways and models of preventive and proactive care.
- Drive a fundamentally different model of care and services that support people at or closer-to-home, ensuring avoiding requirement for more costly services that may also lead to poorer outcomes and experience.
- Be accountable for balancing specified delegated budgets, and for the delivery of the relevant aspects ICBs strategy and priorities as agreed by the ICB Board.

2.3 For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference of this Committee.

3. Responsibilities and functions

3.1 The Board shall be responsible for transacting the HCP's core business and leading strategic thinking on behalf of the HCP. The discharging these key responsibilities the HCP Board will:

Core Business

- To take accountability for the development and delivery of the overall financial plan for MHLDA within the specified delegated budgets of the HCP. In practice this will require the MHLDA HCP Board to take accountability for the operation of the MHLDA schedule of the Section 75 agreement between HWE ICB and Hertfordshire County Council
- To scrutinise and approve recommendations proposed by the HCP Finance & Commissioning Committee and the HCP System Transformation and Quality Committee, or through whatever model of managing these responsibilities the HCP agrees. This will include investment and spending decisions related to the NHS elements of the pooled fund for MHLD within the Section 75 arrangements.
- To approve recommendations for activity/interventions arising from the HCP's sub-groups Clinical Transformation workstreams, the enabling workstreams and the task and finish groups.
- Receive updates from the HCP Finance & Commissioning Committee and the HCP System Transformation and Quality Committee (or equivalent) and to review the HCP's risk register

Strategic Leadership

- To participate in the development of strategy across the Integrated Care System
- To take joint accountability for the development and implementation of plans to transform the delivery of health and care for people with mental illness, learning disabilities and neurodivergent people.
- To maintain oversight, understanding and alignment of individual organisation strategies and plans.
- To bring together activity, finance, operations, and quality intelligence from NHS providers and wider system partners in order to drive whole-system planning and prioritisation.
- To lead the resolution of strategic challenges, issues and risks between partners.

4. Composition and Quoracy

4.1 This section sets out the meeting composition and quoracy arrangements:

Arrangement	Description of expectation
Chair and Vice Chair	The committee will be co-chaired by the HCP Senior Responsible Officers. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.
Membership	The Board members shall be appointed by the HCP Board. Membership shall comprise the following roles: • Hertfordshire Partnership University NHS Foundation Trust, Chief Executive Officer/ HCP Senior Responsible Officer (Karen Taylor) • Hertfordshire County Council, Director of Adult Care Services/ HCP Senior Responsible Officer/ Accountable Officer for Section 75

	arrangement (Chris Badger) • Non-Executive Member of the Integrated Care Board • Chief Finance Officer of the ICB (or Deputy) • ICB Medical Director or Director of Nursing (or Deputy) • ICB Partner Member (Primary Care) Members from partner organisations: • Hertfordshire and West Essex ICB, Director of Strategy and Deputy Chief Executive • Chair of South and West Hertfordshire Health and Care Partnership • Chair of East and North Hertfordshire Health and Care Partnership • Central London Community Healthcare NHS Trust, Divisional Director • West Hertfordshire Teaching Hospitals NHS Trust, Chief Executive • East and North Hertfordshire Hospitals Trust, Chief Executive • Hertfordshire Community NHS Trust, Chief Executive Officer • Hertfordshire County Council, Director of Public Health • Hertfordshire County Council, Director of Children's Services • Chair of Learning Disabilities and Autism Strategic Partnership Board • Chair of Crisis Care Partnership Board • Chair of Children and Young People Emotional and Mental Wellbeing Board • Chair of Primary and Community Mental Health Board • Chair of MHLDA HCP Clinical and Practice Advisory Committee • Chair of MHLDA VCFSE Alliance (in development) • HWE ICB MHLDA Clinical Leads • Carers in Hertfordshire, • Viewpoint, Chief Executive • Mind in Mid-Herts, Chief Executive • Hertfordshire Mind Network, Chief Executive Members of the HCP Board will operate with the individual delegated responsibility from their employing organisation to enable the Partnership to carry out its responsibilities and functions. In some circumstances this will necessitate decisions being taken through each organisation's specific governance processes. Named deputies are permitted to attend meetings where individuals above are unable to attend.
Attendees	Only members of the Board have the right to attend meetings, however all meetings of this Committee will also be attended by the following individuals who are not members of this Committee: • SROs and programme lead(s) for transformation programmes • Specific project or programme leads from across the system • ICB Governance lead/secretariat The Chair may ask any or all of those who normally attend but who are not members, to withdraw to facilitate open and frank discussion of particular

	matters. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist with its discussions on any particular matter including representatives from the Health and Wellbeing Board (s), Secondary and Community Providers.
Procedure for attendance	When an attendee of the HCP Strategic Finance and Commissioning (who is not a member of this Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.
Meeting frequency and Quorum	The committee will meet a minimum of six times a year and arrangements and notice for calling meetings are set out in the Standing Orders. https://www.healthierfuture.org.uk/sites/default/files/nhshwe-icb-constitution010722finalpending-approval-by-nhs-england.pdf Additional meetings may take place as required. The ICB Board or the HCP Senior Responsible Officer may ask the Board to convene further meetings to discuss particular issues on which they want the committee's advice. In accordance with the ICBs Standing Orders, this Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum. A quorum will be at least 50% of membership, but for decisions to be taken on delegated matters, and in line with the ICBs constitution, that must include a minimum of three members of the ICB board or their deputies. If any member of the Board has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
Decision making and voting	Voting will be taken in according with the ICBs Standing Orders. The committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote. On all matters not relating to responsibilities delegated by the ICB, all members have one vote, and a majority will be conclusive. On matters relating to ICB delegation, and where there is not a consensus opinion, only those members of the board who are also members of the Integrated Care board will be able to vote. Each member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of this Committee will hold the casting vote. The Chair can ask for an indicative vote of the whole board prior to initiating the sub-committee voting process but this is not binding on those members

of the ICB board that will vote.

The Chief of Staff of the Integrated Care Board, or their named representative, will determine whether an area is considered a delegated responsibility and therefore point 5.9 applies.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication. The voting requirements set out in paras 5.7-5.11 apply.

5. Behaviours and Conduct

5.1 Benchmarking and Guidance

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

5.2 ICB Values

Members will be expected to conduct business in line with the ICB values and objectives.

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

5.3 Conflicts of Interest

The members of the Committee must comply fully with the NHS England Guidance and ICB Standards of Business Conduct and Conflicts of Interest Policy.

The ICB reserves the right to ask members of the committee to provide assurance that they meet the criteria set out in the ICBs Fit and Proper Persons policy, before agreeing their appointment to the committee.

5.4 Equality Diversity and Inclusion

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

6. Accountability and Reporting

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

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

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

7. Secretariat, Administration and Review

The Board shall be supported with a secretariat function operated by the Integrated Care Board governance team, which will include ensuring that:

Distribution of papers	The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
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Support the Chair and Committee	The Chair is supported to prepare and deliver reports to the ICB Board.
Updates	The ICB Board is updated on pertinent issues/ areas of interest/ policy developments. Action points are taken forward between meetings and progress against those actions is monitored.
Review	The Board will review its effectiveness at least annually. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the ICB Board for approval.

Document Control:

Version	Date	Approved By	Review	Change made
V1	Friday 24 May 2024	HWE ICB Board	Annually	N/A

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Hertfordshire and West Essex Integrated Care Board

Primary Care Transformation Committee

Terms of Reference_2024 v1.1

1. Constitution

1.1 These Terms of Reference (ToR), set out the membership, remit, responsibilities and reporting arrangements of the Hertfordshire and West Essex (HWE) Integrated Care Board (ICB) Primary Care Transformation Committee.

1.2 Definition of Primary Care – Primary care services provide the first point of contact in healthcare system, acting as the 'front door' of the NHS. Primary care includes general practice, community pharmacy, dental, optometry (eye health) services.

2. Purpose and Remit

2.1 The Primary Care Transformation Committee is the key HWE ICS Primary Care forum supporting the ICB with the remit to:

- Propose the strategic direction for all primary care services;
- Identify the key priority areas needing change;
- Enable local clinical perspectives to inform strategic decision-making;
- Set the strategic context for primary care transformation and take oversight of its implementation and measuring success.
- Enable codesign/co-production across areas of primary care transformation and redesign in partnership with patients/citizens and all partners across the wider system.

2.2 The Primary Care Transformation Committee will play a key role in ensuring delivery of key national policy areas such as Long term Plan (LTP) requirements, Fuller Recommendations, GP Community, Pharmacy, Dental and Optometry contractual requirements and strategic direction; and will continuously review the annual plan and oversight of delivery of the of the HWE approved Primary Care Strategic Delivery Plan aligned to national and local strategies of ICS framework, Joint Strategic Plan, People Plan, Digital, Quality, UEC strategy and Medium Term Financial Plan.

2.3 The Committee will set out the principles and methodology for transformation in the strategic delivery plan.

3. Role and Responsibility

3.1 Strategic Oversight and Transformation:

- Oversee the implementation, delivery and monitoring of the primary care strategic delivery plan.
- Provide a single forum for the oversight of all primary care services (GP, Dental, Optometry and Community Pharmacy) transformation and innovation across the Integrated Care System, using best practice and a population health management approach to the

development and integration of services at a system, place and neighbourhood level. This includes enabling functions including workforce, digital and estates where appropriate.

- It is essential for the forum to scope opportunities of transformation through integration of primary care services with partners and oversight of delivery of transformation plan through developing Health and Care Partnerships
- To drive quality and reduce unwarranted variation in outcomes for patients in primary care across HWE using quantitative data and appropriate qualitative data from partners including Healthwatch, patient feedback through Health and Care Partnerships
- To ensure there is alignment of plans across HWE ICB system and place work programmes.

3.2 Communication and Engagement:

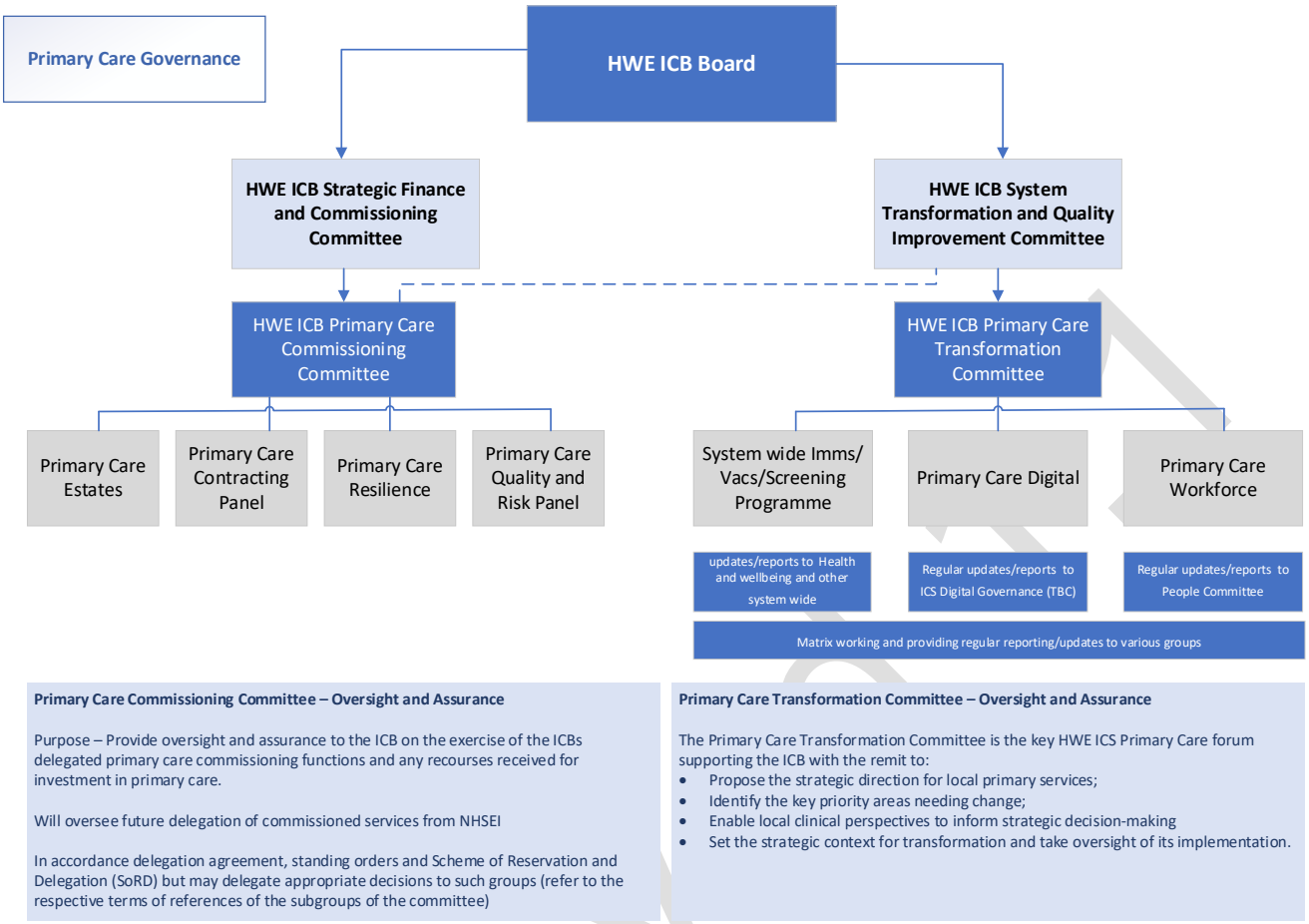
- To be the 'go-to group' to which any transformational change goes to engage primary care across HWE ICS work streams and ensure there is alignment to each place.
- Ensuring patient/citizen engagement and lived experience is at heart of transformational change through co-design using a population health management approach based on need. This needs to be practice/primary care network/Neighbourhood/locality/place/system.
- To facilitate clear communication between the HWE ICB Board, ICB System Transformation and Quality Improvement Committee, Primary Care Providers and partners across system and place and all our partner on matters relating to System development.
- Ensuring clinical debate about the key priority areas including impact on primary care in terms of workload, quality which will feed into strategic decision-making.

4. Accountability and Governance Structure

4.1 The Primary Care Transformation Committee will be underpinned by good governance principles and robust assurance processes, to ensure accountability to the public as patients, citizens or taxpayers.

The Primary Care Transformation Committee is accountable to the ICB System Transformation and Quality Improvement Committee and HWE ICB Board. Where there are financial and contractual implications of strategic decisions related to primary care providers, in line with the organisation's SFIs these will be referred to the Primary Care Commissioning Committee for a decision.

Primary Care Transformation Committee will have specific working groups reporting progress into the group in particular these will include primary care workforce and primary care digital.



5. Operating Principles

5.1 Each member on the Committee is there in an individual capacity bringing in the experience and acting for the benefit of the system as a whole and not for any organisation that they may also be employed by.

6. Reporting and Responsibilities

6.1 The Primary Care Transformation Committee is accountable to the HWE ICB System Transformation and Quality Improvement Committee.

- The Group will be supported by a number of work stream delivery groups, chaired by appropriate senior responsible officers (SROs) focussed on the improvement areas to deliver the required system wide benefits.
- On behalf of the ICB System Transformation and Quality Improvement Committee, the Chair is responsible for ensuring that workstream Senior Responsible Officer's are held to account for the successful implementation of agreed schemes to support financial, quality and operational improvements.
- Work streams are accountable to the Primary Care Transformation Committee, which reports into the ICB System Transformation and Quality Improvement Committee.
- Workstreams will provide regular highlight reports and where necessary exception reports, or in-depth reports as required by the Committee.

- The Group will have 2-way relationship with the Primary Care Commissioning Committee of the ICB.
- The Committee will receive regular updates from its subgroups and from representatives of the committee from place including locality leadership.

7. Composition and Quoracy

7.1 This section sets out the meeting composition and quoracy arrangements:

Arrangement	Description of expectation
Chair and Vice Chair	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. If a Chair has a conflict of interest, then the co-chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.
Membership	The members will be representative of the HWE health and social care community to ensure diverse input and decision making. When determining the membership, active consideration will be made to equality, diversity and inclusion. 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. **Committee Members:** • ICB Primary Care Partner Members (x3) • ICB Director of Primary Care Transformation • ICB Medical Director • Independent Clinical advisor for Dental • Chief Pharmacist AD for Primary Care Strategy and Planning • Representative from Community Provider • Representative from Mental Health • Representative from Local Authority (1 HCC / 1 ECC) • HCP Care Closer to Home GP Leads one from each place • Citizen representatives from each place X3 • PC Workforce Clinical lead • PC Digital Clinical lead • Senior Primary Care Management • Community Pharmacy PCN Engagement Clinical lead
Attendees	• Healthwatch Representative 1 representative for Hertfordshire and

	1 for Essex • Local Professional Committee representatives Hertfordshire and Essex (LMC, LPC, LOC, LDC) • Voluntary Community and Social Enterprise (VCSE) representative • ICS Clinical leads for Strategic Programmes/Enablers as appropriate –primary care transformation, primary care prescribing, workforce and digital • ICB Communications lead • Other leads including Health Education England; Education sectors; digital and other managerial leads as appropriate.
Member roles and responsibilities	All members are required to attend or send a deputy. Workstream and Portfolio leads must ensure that reports and papers are submitted to enable circulation 5 days before the meeting. All members are required to complete assigned actions and provide updates to the Group in line with the action log. All members are required to be full and active participants, to ensure that relevant expertise is available to the Board to facilitate effective management of the workstreams.
Meeting frequency and Quorum	The Primary Care Transformation Committee will meet every other month. Additional meetings may be convened on an exceptional basis and at the discretion of the Chair. This meeting provides strategic oversight and is not a forum for decision-making. A meeting will be considered quorate if 50 per cent of members are present, which must include either the Chair or Vice-Chair and one Executive Director. No formal business shall be transacted where a quorum is not reached.
Meeting Arrangements	The full membership of the Primary Care Transformation Committee will meet on a bi-monthly basis, with work stream Senior Responsible Officer's and members supporting programme delivery joining working group meetings in the intervening months. Meetings will be held in public and will be online or hybrid and in-person to ensure maximum attendance. Members who cannot attend will be expected to send deputies.

8. Behaviours and Conduct

8.1 ICB values

Members will be expected to conduct business in line with the ICB values and objectives.

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

8.2 Equality and diversity

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

9. Secretariat, Administration and Review

The Primary Care Transformation Group shall be supported with a secretariat function which will include ensuring that:

Distribution of papers	The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
Monitor attendance	Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
Minute taking	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.
Updates	The Group is updated on pertinent issues/ areas of interest/ policy developments. Action points are taken forward between meetings and progress against those actions is monitored.
Review	The Primary Care Transformation Group will review its effectiveness at least annually. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the ICB Board for approval.

Document Control:

Version	Date	Approved By	Review	Change made
V1	Friday 26 April 2024	HWE ICB Board	Annually	n/a
V1.1	Thursday 26 September 2024	ICB Primary Care Transformation Committee		Membership updated

Hertfordshire and West Essex Integrated Care Partnership

HERTFORDSHIRE AND WEST ESSEX INTEGRATED CARE PARTNERSHIP CONSTITUTION

BACKGROUND

Section 116ZA of Local Government and Public Involvement in Health Act 2007 requires the Integrated Care Board **(ICB)** and each local authority in ICB to establish an Integrated Care Partnership **(ICP)**, which is a joint committee of these bodies. The ICP may appoint other members and determine its own procedures.

ICPs have a critical role to play in Integrated Care Systems **(ICS)**, facilitating joint action to improve health and care outcomes and experiences across their populations, and influencing the wider determinants of health, including creating healthier environments and inclusive and sustainable economies.

NAME

The name of the ICP is 'The Hertfordshire and West Essex Integrated Care Partnership'

OBJECTIVES

The Hertfordshire and West Essex ICP will consider what arrangements work best in its area by creating a dedicated forum to enhance relationships between the leaders across the health and care system that:-

- build on existing governance structures such as Health and Wellbeing Boards **(HWBs)** and other place-based partnerships, and support newly forming structures to ensure governance and decision-making are proportionate, support subsidiarity and avoid duplication across the ICS

- drive and enhance integrated approaches and collaborative behaviours at every level of the system, where these can improve planning, outcomes, and service delivery

- foster, structure, and promote an ethos of partnership and co-production, working in partnership with communities and organisations within them

- address health challenges that the health and care system cannot address alone, especially those that require a longer timeframe to deliver, such as tackling health inequalities and the underlying social determinants that drive poor health outcomes, including employment, reducing offending, climate change and housing

- continue working with multiagency partners to safeguard people's rights and ensure people are free from abuse or neglect and not deprived of their liberty or subject to compulsory detainment or treatment without safeguards

- develop strategies that are focused on addressing the needs and preferences of the population including specific cohorts.

FUNCTIONS

Under s116ZB of the Local Government and Public Involvement in Health Act 2007 the Hertfordshire and West Essex ICP is required to prepare an integrated care strategy that:-

- Details how the needs of resident of its area will be met by either the ICB, NHS England, or local authorities
- Considers how NHS bodies and local authorities could work together to meet these needs using section 75 of the National Health Service Act 2006
- Must have regard to the NHS mandate and guidance published by the Secretary of State
- Involves the local Healthwatch and people who live or work in the ICP's area
- Is reviewed and revised as required when a new health and social care joint strategic needs assessment is received from a local authority within the ICP
- Considers how health related services can be more closely integrated with arrangements for the provision of health services and social care in its area
- Is published and provided to each local authority in its area and each partner Integrated Care Board of those local authorities.

Under s116B of the Local Government and Public Involvement in Health Act 2007 a local authority and each of its partner ICPs must have regard to:-

- Any joint assessment of health and social care in relation to the area for which they are responsible

- Any Integrated Care Strategy that applies to the area of the local authority
- Any Joint Health and Wellbeing Strategy prepared by the local authority and any of its partner ICB

The Hertfordshire and West Essex ICP will not perform a Health scrutiny function and will itself be subject to scrutiny by the Health Scrutiny Committees of the County Councils of Hertfordshire and Essex.

MEMBERSHIP

There are three classes of members of the ICP:

- Statutory members
- Co-opted voting members
- Co-opted non-voting members

The initial statutory membership of the Hertfordshire and West Essex ICP will be one member appointed by each of the County Councils and the ICB.

Subject to the agreement of the Hertfordshire and West Essex ICP from time to time its co-opted voting membership will comprise of the following:-

Type/Sector	Role	Herts & West Essex	Herts	Essex
County Council	Leader of the Council/Chair of Health and Wellbeing Board		1	1
County Council	Elected councillors		2	1
County Council	Director level or above		3	2
District/Borough Council	Chief executive/Elected councillors		2	1
ICB	Independent chair	1		
ICB	Chief Executive	1		
ICB	NHS Provider/Health and Care Partnership		3	2
Police /	Police and Crime Commissioner/Police,		1	1

Criminal Justice Board	Crime and Fire Commissioner/Chair of Criminal Justice Board			
Voluntary, community, faith, and social enterprise sector (VCFSE)	Chief executive/Chair		2	1
Healthwatch	Chief executive/Chair		1	1
Care providers	Chief executive/Chair		1	1
University of Hertfordshire	Vice-Chancellor or his/her nominee		1	0

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

Essex County Council, whose Health and Wellbeing Board now operates across three ICS will not be exercising Health and Wellbeing Board activity through the Hertfordshire and West Essex ICP and nor will Hertfordshire County Council.

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

PROFESSIONAL AND ADMINISTRATIVE SUPPORT

The Hertfordshire and West Essex ICP may establish Programme Boards/Advisory Sub-Groups to oversee specific work programmes or broader thematic areas as required. Programme Boards/Sub-Groups, reporting into the Hertfordshire and West Essex ICP, will be managed in accordance with separate terms of reference as agreed by the Hertfordshire and West Essex ICP

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

Administrative support to the Hertfordshire and West Essex ICP will be provided by Hertfordshire County Council and the reasonable cost of this will be split between by

the ICB, Hertfordshire County Council and Essex County Council subject to the agreement of each authority which is expected to pay.

The Hertfordshire and West Essex ICP may from time to time decide that an organisation other than Hertfordshire County Council may support the ICP.

STANDING ORDERS

The Hertfordshire and West Essex ICP is governed by Standing Orders approved and amended by the ICP from time to time. The Current standing orders are set out in Annex A attached to this Constitution.

Hertfordshire and West Essex Integrated Care Partnership

Annex A – Hertfordshire and West Essex ICP STANDING ORDERS

1. Membership

1.1 The Hertfordshire and West Essex ICP may appoint representatives to other outside bodies as co-opted members, voting or non-voting.

1.2 A representative of NHS England shall be entitled to attend meetings of the Hertfordshire and West Essex ICP as an observer and to participate in discussion but shall not be entitled to vote unless appointed as a co-opted voting member by the Hertfordshire and West Essex ICP.

2. Alternate or Substitute Members

2.1 Each voting member will be entitled to appoint from time to time one named alternate or substitute member in exceptional circumstances, who may act in all aspects as a voting member of the Hertfordshire and West Essex ICP in the absence of the voting member appointed.

2.2. The Chair of the Hertfordshire and West Essex ICP must be informed in advance of the relevant meeting of the identity of a substitute.

3. Term of Office

3.1. The term of office of voting and alternate or substitute voting members shall end:

a) if rescinded by the organisation by whom they are appointed; or

b) if a Councillor appointed by a Council cease to be a member of the appointing Council.

c) if an ex officio member cease to be appointed in that role

d) if the individual change's role within an organisation and is no longer in the role that led to their appointment to the ICP.

4. Appointment of Chair and Vice-Chair

4.1 In addition to appointing the Chair, the Hertfordshire and West Essex ICP shall appoint 2 Vice Chairs.

4.2 The Chair and vice Chair will hold office until they resign, cease to be a member of the Hertfordshire and West Essex ICP or until their successor is appointed under this paragraph and will be appointed annually at the first meeting taking place after Hertfordshire County Council and Essex County Council have held their annual meetings .

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

5. Quorum

5.1 The quorum for meetings of the Hertfordshire and West Essex ICP will be 1 voting member appointed by each of Hertfordshire County Council, Essex County Council and the ICB.

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

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

6. Member Conduct

6.1 Members of the Hertfordshire and West Essex ICP who are not Councillors or officers of a County Council shall comply with any code of conduct applicable to their professional body and/or the organisation they represent.

6.2 Members of the Hertfordshire and West Essex ICP are required to declare any interests they have in respect of matters being discussed by the Hertfordshire and West Essex ICP.

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

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

7. Meetings and Proceedings of the Hertfordshire and West Essex ICP

7.1 The Hertfordshire and West Essex ICP shall hold at least four meetings each year. Special meetings may be called at any time by (i) the Chair or (ii) by a written notice requiring a meeting to be called being served on the Chair by the ICB or Hertfordshire County Council or Essex County Council specifying the business to be transacted.

7.2 All meetings shall be open to the public except when, in the view of the Chair (or in their absence the Vice -Chair or the person presiding over the Meeting) it is likely that, due to the nature of the business to be transacted, confidential information would be disclosed to members of the public.

7.3 Any decision regarding the need to exclude the public from a meeting shall, as far as is reasonably possible, be made prior to the publication of the Agenda.

7.4 In the absence of the Chair at a meeting of the Hertfordshire and West Essex, the Vice Chair will preside over that meeting. In the event that both the Chair and Vice Chair are absent then the ICP will appoint one of its members to preside at that meeting.

7.5 The Hertfordshire and West Essex ICP may hold any meeting remotely using Zoom, Microsoft Teams, or any other suitable platform and may live stream the meeting.

7.6 The manner of Voting be determined by the person chairing the meeting.

8. Notice of and Summons to Meetings

8.1 At least five clear working days before a meeting, a copy of the agenda and relevant/associated papers shall be sent by email or post to every member of the ICP. The agenda shall include the date, time and confirmation as to whether the meeting will be held in person or virtual, whether the Public are excluded and specify the business to be transacted.

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9. Voting

9.1 Hertfordshire and West Essex ICP members commit to seek, where possible, to operate based on consensus.

9.2 If it is not possible in a specific instance to find a consensus, the issue may be deferred to a later meeting of the Hertfordshire and West Essex ICP, which may be an adjournment of the same meeting. Where an item has been deferred for lack of consensus a vote will be taken at and, if a consensus is still not achievable, the decision will be made based on a simple majority.

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

10. Reports from Health Overview and Scrutiny Committees

10.1 The Hertfordshire and West Essex ICP will receive any reports and recommendations from the Health Scrutiny Committee of both Hertfordshire and Essex County Councils and the Chairs of those Scrutiny Committees, or a nominated representative on their behalf, will be entitled to attend meetings of the Hertfordshire and West Essex ICP to represent the Committee.

11. Participation at the Hertfordshire and West Essex ICP

11,.1 All members of the Hertfordshire and West Essex ICP are entitled to speak and vote unless they have been co-opted as a non-voting member by the Hertfordshire and West Essex ICP.

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

12. Public Questions

12.1 At any meeting of the Hertfordshire and West Essex ICP, which is open to the public, a member of the public who is a resident or a registered local government elector of Hertfordshire or Essex may ask a question about any matter over which the Hertfordshire and West Essex ICP has power, or which directly affects the health and wellbeing of the population.

12.2 A member of the public who wishes to ask a question under 12.1 above must give written notice, including the text of the proposed question, to

Hertfordshire County Council's Director of Law & Governance at least 5 clear working days before the meeting.

12.3 Unless the Chair otherwise agrees and subject to 12.4 below, a member of the public may only ask one question under 12.1

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

12.5 The period allocated to questions under 12.1 shall be limited to 20 minutes unless the Chair agrees to extend this time. Any questions remaining after that period has elapsed shall be subject to a written reply within 5 working days.

12.6 Answers given orally at the meeting shall be included in the Minutes. Written replies shall be copied to all members of the Hertfordshire and West Essex ICP.

12.7 For the purposes of 11.1 to 12.3 above and for the avoidance of doubt a County Councillor, or a District Councillor for a District Council in Hertfordshire or Essex, who, in either case, is not a member of the Hertfordshire and West Essex ICP shall be regarded as a member of the public.

13. Minutes

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

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

14. Interpretation of Standing Orders

14.1 The ruling of the Chair of the Hertfordshire and West Essex ICP as to the interpretation of these Standing Orders shall be final.

15. Suspension of Standing Orders

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

APPENDIX 2: MEMBERSHIP OF THE HWE ICP AS OF OCTOBER 2023

Type/Sector	Role	Herts & West Essex	Herts	Essex
County Council	Leader of the Council/Chair of Health & Wellbeing Board		**1** **Councillor Richard Roberts, Leader of Hertfordshire County Council**	**1** **Councillor John Spence, Cabinet Member for Health and Adult Social Care and Integration**
County Council	Elected councillors		**2** **1. Cllr Tony Kingsbury, Cabinet Member for Adult Care, Health & Wellbeing** **2. Cllr Fiona Thomson, Cabinet Member for Children, YP & Families**	**1** **3. Cllr Jane Fleming, Deputy to Cabinet Member for Health and Adult Social Care and Integration**
County Council	Director level or above		**3** **1. Chris Badger, Executive Director, Adult Care Services** **2. Jo Fisher, Executive Director ,Children's Services** **3. Sarah Perman, Interim Director of Public Health**	**2** **1. Chris Martin, Director for Strategic Commissioning (Children and Families)** **2. Katherine Thompson, Consultant in Public Health**
District/borough council	Chief executive or elected councillors		**2** **1. Cllr Elizabeth Dennis-Harburg, Leader of North Herts District Council** **2. Richard Cassidy Chief Executive of East Herts District Council**	**1** **Georgina Blakemore, Chief Executive, Epping Forest District Council**

ICB	Independent chair	**1** **Paul Burstow**		
ICB	Chief Executive	**1** **Dr Jane Halpin**		
ICB	NHS provider/Health and Care Partnership		**3**	**2**
			1. Sharn Elton, Place Director, ENH HCP **2. Matthew Coats, Chair, SWH HCP Board** **3. Karen Taylor, Co-Chair, Hertfordshire MHLDA Health and Care Partnership, and CEO, HPFT**	**1. Toni Coles, Place Director, WE HCP** **2. Ms Alex Green, COO, EPUT**
Police and Crime Commissioner / Criminal Justice Board	Police and Crime Commissioner		**1** **Commissioner David Lloyd**	**1** **Chief Superintendent Leighton Hammett**
VCFSE Voluntary, community, faith and social enterprise sector	Chief executive/Chair		**2** **1. Joanna Marovitch VCFSE Alliance Chair & CEO Herts Mind Network** **2. Charlotte Blizzard-Welch VCFSE Alliance Vice Chair & CEO Citizens Advice, Stevenage**	**1** **Kate Robson VCFSE Alliance Vice Chair & CEO Uttlesford Citizens Advice**
Healthwatch	Chief executive/Chair		**1** **Neil Tester, Chair Healthwatch, Herts**	**1** **Amanda Cherry, Chair of Trustees Healthwatch Essex**
Care providers	Chief executive/Chair	**1** **Sharon Davies CEO, Herts Care Providers Association**		

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University of Hertfordshire	Vice-Chancellor or his/her nominee		**1** **Professor Jackie Kelly, Dean of School of Health and Social Work**	
		3	16	10
TOTAL		**29**		

Hertfordshire and West Essex Integrated Care Partnership – Officers

Name	Role	ICP Office Role
Cllr Richard Roberts	Leader of the Council Hertfordshire County Council	Chair
Paul Burstow	Independent Chair Hertfordshire and West Essex Integrated Care Board	Vice Chair
Cllr John Spence	Cabinet Member for Health and Social Care and Integration, Essex County Council	Vice Chair

Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

Risk Management Policy

Version 2.1

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Document Owner:	Michael Watson, Chief of Staff
Document Author(s):	Governance Manager - Risk
Version:	2.1
Approved By:	Executive Team
Date of Approval:	**8th February 2024**
Date of Review:	**February 2025**
Link to Strategic Objective(s):	• Increase life expectancy and reduce inequality • Give every child the best start in life • Improve access to health and care services • Increase the number of citizens taking steps to improve their wellbeing • Achieve a balanced position annually

Change History:

Version	Date	Reviewer(s)	Revision Description
1.0 Draft	1 July 2022	Katy Patrick, Head of Governance	Initial draft document prepared based on and to supersede existing HWECCG's Risk Management Strategies, Policies and Procedures
1.1 Draft	25 July 2022	Leon Adeleye, Corporate Governance Manager	Presented and discussed at the Executive Team: • Removed duplications, added page number to the document and formatting • Replaced the table of content to capture headings and page numbers • Updated various sections, including the terms and definitions – vocabularies in line with ISO31000:2009/18, risk appetite table, consequence table • Replaced process diagrams including the assurance process • Removed the Guidance for Datix Risk Register from the Appendices and

			provided on a separate document for regular revision Added the Data Protection Impact Assessment (DPIA) Screening Tool to the Appendices
1.2 Draft	18 August 2022	Leon Adeleye, Corporate Governance Manager	Further updates: • Full revision of the structure, content and format. • Added the Risk Management Implementation Plan for 2022/23 • More emphasis on leadership and culture, objectives, ownership risk appetite and revised the assurance • Revised the responsibilities sections, reporting arrangement table and process diagrams. Enhanced the risk matrix and the action trigger table for risk assessment across the ICB. Including risk appetite, and threshold for reportable incidents to ICO.
1.3 Draft	05 September 2022	Leon Adeleye, Corporate Governance Manager	Presented and Discussed at the Audit and Risk Committee: • Revised the risk matrix with minor changes • Added the EqIA to Appendix 4
1.4	November 2022	Leon Adeleye Governance Manager – Risk	Submitted for the Executive Team's final approval.
1.5	June 2023	Leon Adeleye, Governance Manager – Risk	Full annual review and updated with • 2022/27 ICB Strategic Objectives • ICB Risk Appetite Statements • Risk Management Implementation plans for 2023/24 • Rearticulation of various sections, including introduction, statement of commitment, roles and responsibilities, risk management principles, risk appetite, objectives, risk direction, risk scoring • Improved illustrations, appendices updates, Definition of terms moved to appendices
1.6	July 2023	Redouane Serroukh – Head of Information Governance and Risk	Executive Team feedback incorporated.
2.1	December 2023	Leon Adeleye Governance Manager – Risk / Redouane Serroukh – Head of IG and Risk	Full review of the Risk Management Policy using the new HWE ICB policy template. Rearticulation of some sections and a focus on more concise information for staff.

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1 Introduction

1.1 NHS Hertfordshire and West Essex Integrated Care Board (HWE ICB) is dedicated to building a future-ready health and care system with integrated services centred around the needs of individuals. The ICB's objectives guide its plans and decisions, ensuring stakeholders have confidence in its internal control systems.

1.2 The identification, assessment and management of risks against the ICB achieving its objectives plays a crucial role in the ICB's success. This policy outlines the ICB's commitment to fostering a culture where risk management is central and effective at both strategic and operational levels. The aim is to enhance value creation and protection within the organisation.

1.3 The ICB will seek to align risks to its strategic objectives, found under section 9.1.3.

2 Purpose

2.1 The purpose of this policy is to:

(a) Ensure all staff are aware of their responsibilities in relation to effective risk management within HWE ICB.

(b) To provide a firm commitment that HWE ICB acknowledges the importance of effective risk management in fulfilling its obligations and ensuring the achievement of its vision and purpose. The ICB adopts the framework and best practices outlined in this risk management policy. By doing so, the ICB ensures that all identified risks are adequately managed and that opportunities are also identified, evaluated, and controlled consistently.

The ICB will identify and manage risks to achieving its strategic objectives and actively discuss and mitigate against those risks so that their likelihood of materialising is continuously diminished.

3 Scope

3.1 This policy applies to all ICB staff members, including the Board and those involved in achieving the ICB strategic objectives, whether permanent, temporary or contracted-in (either as an individual or through a third-party supplier).

4 Definitions

4.1 The following definitions apply in the context of this policy:

Term	Definition
Risk	The "effect of uncertainty on objectives" (ISO, 2018). To simplify this definition, a risk is defined as a chance or possibility of loss, damage, injury, or failure to achieve objectives caused by an unwanted or uncertain action or event.
Risk identification	The process of finding, recognising, and describing risks • Risk identification involves the identification of risk sources, events, and their causes as well as their potential consequences. • Risk identification can involve historical data, theoretical analysis, informed and expert opinions, and stakeholder needs.
Risk Management Framework	According to ISO31000:2009, is a set of components that provide the foundations and organisational arrangements for designing, implementing, monitoring, reviewing and continually improving risk management throughout the organisation. The foundations include the policy, objectives, mandate, and commitment to manage risk. The organisational arrangements include plans, relationships, accountabilities, resources, processes, and activities. The risk management framework is embedded within the organisation's overall strategic and operational policies and practices.
Risk source	Element which alone or in combination has the intrinsic potential to give rise to risk.
Event	An occurrence or change of a particular set of circumstances. • An event can have one or more occurrences and can have several causes and consequences. • An event that can be expected but may not happen, or something unexpected and does • An event can be a risk.
Consequence	The outcome of an event, affecting objectives. • A consequence can be certain or uncertain and can have positive or negative, direct, or indirect, effects on objectives. • Consequences can be expressed qualitatively or quantitatively. • Any consequence can escalate through cascading and cumulative effects.
Likelihood	The chance of an event occurring, whether defined, measured, or determined objectively or subjectively, qualitatively or quantitatively, and in general or mathematical terms. • The equivalent of the term "probability."

Risk matrix	Tool for ranking and displaying risks by defining ranges for consequence and likelihood
Risk Score	Risk Score (RS) is the result of multiplying the consequence rating by Likelihood rating (i.e., C x L = RS) on the risk matrix table. This provides you with a 'level of risk'.
Risk owner	Person or entity with the accountability and authority to manage a risk. Risk owners have designated responsibilities for each reported risk, therefore they must: • Ensure compliance to the policy in respect of owned risks and the escalation of risks where required. • Ensure the risk owned is effectively always mitigated and kept up to date. • Oversee the delivery of key action plans agreed with action owners. • Monitor the status of owned risks with a particular focus on monitoring circumstances that may alter the severity of risks.
Risk lead	Risk leads have delegated responsibilities including: • Taking a lead role in embedding risk management processes in their directorates and teams. • Taking a lead role in the maintenance of risk registers via the online risk management tool (Datix, at the time of this policy review) and ensuring risks that rate a current risk score of 12 or higher are escalated and managed on the Corporate Risk Register. • Providing assurance of risk management activity through the relevant committees and the Risk Review Group.
Risk appetite	Amount and type of risk that an organisation is willing to pursue or retain i.e., the amount and type of risk that the ICB is willing to take in pursuit of its strategic objectives as determined by the Board.
Control	Measure that maintains and/or modifies risk. • Controls include, but are not limited to, any process, policy, device, practice, or other conditions and/or actions which maintain and/or modify risk. • Controls may not always exert the intended or assumed modifying effect.
Risk Register	Record of information about identified risks. • The set of risks can contain those that relate to the whole organisation, part of the organisation, or as otherwise defined. • It is presented as a list containing all identified risks faced by an organisation; controls; assurance; and mitigating actions to strengthen the controls and assurance.
Residual risk	Risk remaining after risk treatment. • Residual risk can contain unidentified risk. • Residual risk can also be known as "retained risk".
Risk Assessment	Overall process of risk identification, risk analysis and risk evaluation. It is a systematic method of identifying and prioritising risks and then determining the most appropriate risk response.

Mitigating actions	Plans are agreed in response to formal risk assessments or to strengthen existing controls where gaps are identified. Action articulation should follow best practice models, for example: 'SMART' (Specific, Measurable, Achievable, Realistic and Timely).
Assurance	A positive declaration that a thing is true or a control is indeed in place. According to the Good Governance Institute, assurance is the information and evidence provided or presented which are intended to induce confidence that a thing is true (Dower & Bullivant, 2014).
Risk Culture	Is the set of encouraged and acceptable behaviours, discussions, decisions, and attitudes toward taking and managing risk within an organisation[1]. A risk-management-friendly culture promotes open and upward communication, best practices and knowledge sharing, continuous improvement, and a strong commitment to ethical and responsible corporate behaviour. Effective risk management does not exist in a vacuum and is able to succeed with effective leadership.

5 Roles and Responsibilities

Role	Responsibilities
Board	The Board holds the ultimate responsibility for determining the level and nature of risks acceptable in pursuit of its objectives, as well as the required level of assurance for confidence. Executive members of the Board have particular responsibilities for their respective 'areas' where risk management processes, updates and accountability for risk owners are concerned. Non-executive members have particular responsibility for scrutinising and if required challenging the soundness of risk management systems and processes. Collectively, the board will fulfil its responsibility by undertaking the following: • Establish clear and measurable objectives (strategic, corporate, and operational) throughout the ICB to identify risks and obtain necessary assurance. • Scrutinise the significant risks associated with strategic objectives and ensure management has implemented effective controls to achieve those objectives. • Establish and maintain a robust and consistent risk management structure that aligns with the organisation's risk appetite, risk tolerance, and the cumulative impact and likelihood of risks on objectives. • Collaborate with the Audit and Risk Committee, to determine the need for updates or revisions to the risk management policy as part of its on-going oversight role. Review and approve the level of risk the ICB is willing to take.

[1] Risk Culture: From Theory to Evolving Practice

	• Obtain assurance that key and emerging risks within the ICB and the system are adequately identified and appropriately managed through the risk register. • Adhere to the UK Corporate Governance Code, which emphasises establishing procedures to manage risk, overseeing the internal control framework, and determining the principal risks the company is willing to accept for long-term strategic objectives. • Review risk reporting through the assurance framework and monitor 'primary risks' from the corporate risk register. • Review an annual report from the Chair of the Audit and Risk Committee on the adequacy and effectiveness of risk management within the ICB, as well as associated system risks. By fulfilling these responsibilities, the Board strengthens risk oversight, internal controls, and assurance processes, thereby ensuring effective risk management and governance throughout the organisation and with system partners.
Chief Executive	The Chief Executive ("Accountable Officer") has the overall responsibility for risk management within the ICB. As part of the assurance framework, the Accountable Officer, on behalf of the Board, prepares and publishes an Annual Governance Statement. This statement provides stakeholders with confidence that the ICB is adequately informed about its overall risks. Therefore, the Accountable Officer, with the support of the Board, assumes the following responsibilities: • Ensuring the implementation of the ICB's Risk Management Policy, throughout all areas of the organisation, fostering robust governance, risk management and internal control arrangements. • Fostering a culture of open discussion and debate, emphasising accountability among risk owners, and promoting a risk-aware culture. • Ensuring the Executive Team members' personal objectives have an appropriate focus on risk and risk management. • Setting risk appetite and tolerance levels: The Accountable Officer should work with the Board to define the organisation's risk appetite and tolerance levels. • Encouraging continuous improvement in risk management by promoting feedback, lessons learned, and sharing of best practices across the organisation.
Executive Team	The Executive Team is responsible for overseeing the implementation of the ICB's Risk Management Policy, including defining, sponsoring, supporting, debating and challenging key risk and risk management activity across the ICB. The Executive Team will review and monitor progress against the policy and play a key role in providing assurance to the Board and Audit Committee on the effectiveness of the policy, its application, and the management of key risk areas. The Executive Team will:

	• Ensure that key and emerging strategic risks are identified, assessed and managed by undertaking on-going analysis of risk information to assess risk criticality, common themes and trends; and identify areas of emerging risk requiring further quantification or scenario analysis. • Ensure that there is an appropriate reporting structure in place to support the delivery and execution of the ICB's Risk Management Policy. • Executive Team members should establish and lead the appropriate risk management processes in their respective directorates which is to include, at minimum, a monthly discussion with appropriate risk leads to monitor and review risks within their remit. • Promote a risk-aware culture and an environment that creates positive risk-taking behaviour and clear accountability.
Chief of Staff	The Chief of Staff plays a critical role in providing strategic counsel to the Accountable Officer regarding risks across the ICB. To effectively implement the requirements of the risk management policy, the Chief of Staff, with the support of the governance team, will: • Hold departments and teams within the ICB organisation accountable for the implementation of the risk management policy. • Ensure real risk are captured and have adequate oversight. • Prioritise risk as a standing agenda item for the Executive Team and the Board, ensuring that major areas of activity such as the ICB's culture and uncertainties surrounding partners, stakeholders, and regulatory compliance are not overlooked. • Establish controls, including an organisational or committee structure supported by a Scheme of Delegation and accountability framework, policies, procedures, guidelines, training, and regular management actions, to facilitate the achievement of desired outcomes.
Senior Information Risk Owner	The Chief Finance Officer (CFO) of the ICB serves as the designated "Senior Information Risk Owner" (SIRO), specifically responsible for information risk management. The SIRO is accountable for information risks and is concerned with the management of all information assets. The SIRO has responsibility for: • Taking overall ownership and accountability for information risk management within the organisation. • Establishing and maintaining an effective information risk management framework • Reviewing and agreeing actions to address identified information risks • Establishing and maintaining robust Counter Fraud arrangements. • Promoting a culture of risk awareness and information security throughout the organisation.

	• Collaborating with relevant stakeholders, such as IT teams and senior management, to address information risks effectively. • Monitoring and reviewing the effectiveness of information risk management practices and making necessary improvements. • Reporting on information risk management activities and outcomes to senior management or the board of directors • Ensuring compliance with applicable laws, regulations, and industry standards related to information security and risk management. • Participating in relevant forums or committees related to information risk management.
Managers	• Coordinate the use of resources to reduce, manage, and control the possibility and/or effect of recognised risks in their respective fields of expertise. • Identify, manage and report risks appropriately ensuring the necessary actions are taken on risks within their sphere of influence. • Implement agreed actions to manage risks. • Report activities or circumstances that may give rise to new or changed risks.
Project Manager	• Capture risks that could potentially impact the project's delivery in Project Initiation Documents. • Include project risks in the Project Highlight Report updates and review them with each stakeholder group and lead Director. • Escalate any project risks that cannot be managed at the project team level to the relevant director for inclusion in the corporate risk register.
Governance Team	• Consolidate, challenge, and report all risk management information. • Facilitate risk management activities, including identification and assessment across the ICB. • Proactively raise risk and risk management awareness and understanding at all levels. • Provide regular and ad-hoc reporting on key business risks, control strength, risk environment, progress of critical actions, and risk process effectiveness. • Attend the Executive Team meetings to provide an ongoing view of risk management performance. • Provide ongoing risk management advice and training to all parts of the organisation. • Develop, implement, maintain, and evolve the policy, considering evolving good industry/regulatory practice. • Monitor the overall level of risk assumed by the ICB and the strength of the control environment.
All staff	All staff must comply with this Risk Management Policy and assisting in the risk management process by:

	• Proactively and promptly identifying risks within their area of work and at meetings and adding risks to the relevant Risk Registers on the ICB's web-based risk management system – Datix (at the time of policy review), • ensuring that identified risks have been assigned to an agreed risk owner and risk lead, to estimate the severity of the risk with regards to the likelihood and impact on objectives at any level. • participating in reviewing existing controls and where there is a gap, agreeing on planned actions to strengthen the controls. • describing risks relating to their work using the best practice provided in this risk management policy. • attending required risk management training and development events to ensure a full understanding of their risk management responsibilities and expectations.
Audit and Risk Committee	The Committee's core responsibilities in relation to risk management involves overseeing strategic and system risks related to achieving the ICB's objectives, scrutinising assurances on the adequacy of risk management and internal control, identifying weaknesses, and seeking reports to assess integrated governance effectiveness. The Audit and Risk Committee plays a crucial role in overseeing the effectiveness of internal and external auditors concerning risk management. The Committee: • Ensures qualified individuals are appointed as auditors, regularly evaluating their performance to uphold effective risk assessment. • Assesses audit findings and recommendations, ensuring adequacy of risk mitigation measures and overseeing necessary improvements. • Ensures auditors maintain independence and objectivity, reviewing potential conflicts of interest and ensuring unrestricted access to relevant information. • Encourages a culture of continuous improvement in risk management practices, providing guidance to auditors for enhanced effectiveness and staying current with emerging risks and best practices.
Risk Review Group	As a subcommittee to the Audit and Risk Committee, the Risk Review Group plays a crucial role in evaluating and monitoring the effectiveness of risk management practices, identifying potential areas of concern, and providing regular reports and recommendations to the Audit and Risk Committee to improve risk management processes. The Risk Review Group provides assurance to the Audit and Risk Committee by fulfilling the following responsibilities: • Reviewing and assessing the organisation's internal risk management framework and policies and ensuring they embed mechanisms to drive risk culture, and the use of risk appetite statement and tolerance in decision-making. • Challenging risk management practises to enhance the quality of Board discussions on significant risks to strategic objectives and escalated risks.

	• Monitoring and reviewing the implementation of risk mitigation strategies and evaluating the effectiveness of our processes. • Conducting regular assessments of emerging risks and changes in the business environment to ensure ongoing risk management relevance.

6 Implementation

6.1 This policy will be made available via the HWE ICB intranet.

6.2 The Risk Management Policy will be implemented primarily through the Executive Team and the Governance Team, however, a number of other roles also hold responsibilities for implementation, as outlined in the roles and responsibilities section above.

6.3 The Governance Team will arrange periodic training on risk management to all staff involved in HWE ICB's risk management processes.

7 Monitoring compliance with this policy

7.1 The Governance Team and the Audit and Risk Committee will take an active approach to monitor compliance with this policy through regular reporting and highlighting of areas of improvement.

7.2 Internal and external auditors also play a role in supporting the ICB to monitor the effective compliance of this policy. They support the ICB by independently providing assurance of compliance with the policy (and wider risk management framework), making recommendations as is appropriate to further improve compliance levels.

8 Risk Management Policy Statement

8.1 Risk management is a fundamental part of governance and leadership at all levels and is driven by identification and assessment of risks. All staff must consider risk and accept responsibility for risks associated with their area of authority.

8.2 Risk management should be integrated into the organisation's overall governance, planning, decision-making, and operational processes. It should be embedded in the ICB's culture and become an integral part of day-to-day activities. The Board Directors and senior leadership of the ICB are required to actively identify risks to achieving the ICB objectives and ensure adequate resources to manage risks are in place.

8.3 To assist with the fulfilment of the above point, Risk Owners are expected to meet at least monthly with the Risk leads and appropriate managers to review current risks and receive updates on further actions as and when they arise.

8.4 Risk management processes should be conducted objectively, without bias or personal interests. Information regarding risks, their assessment, and management should be transparently communicated to relevant stakeholders to facilitate informed decision-making.

8.5 Effective risk management involves engaging all relevant stakeholders, including employees, management, customers, suppliers, and regulators. Different perspectives and expertise contribute to a more comprehensive understanding of risks and better risk response strategies.

8.6 Risk management should result in the implementation of appropriate risk response measures within an appropriate timeframe. Decisions and actions should be based on a thorough analysis of risks and their potential impacts.

8.7 All significant risks to the ICB's strategic objectives and their associated controls and assurances must be added to the Risk Register.

8.8 It is the responsibility of Risk Owners and Risk Leads to ensure that their risk entries on the Risk Register are regularly reviewed and updated in line with the Risk Management Policy

8.9 Primary and principal risks should be reduced to an acceptable level, within an appropriate range in accordance with the ICB's risk appetite statement.

8.10 The risk register produced will include assurance mapping to assist Directors in discussions at the Board, Committees or with their teams to analyse any risks connected to objectives, new projects, or areas of work and to identify any assurance gaps where action is needed to strengthen the existing controls.

8.11 All identified risks must initially be discussed at Team level. After consideration of the nature and scoring of the risk, further discussion and reporting to the Executive Team, Risk Review Group, Committees, and Board meetings should be considered as is appropriate. For proper supervision, risk management should be a standing item on the agenda of each meeting.

8.12 Risk management is a continuous and iterative process, adapting to changes in the ICB's internal and external environments. Regular monitoring, review, and updating of the risk management framework and practices help ensure their relevance and effectiveness over time.

9 Risk Management Process

Source: Adapted from the ISO31000:2018 Risk Management – Guidelines

9.1 Objectives

9.1.1 The process for setting objectives is described on three levels, namely, strategic, corporate, and operational objectives. Objectives set the scope, context, and criteria or risk appetite, against which risks are identified and managed.

9.1.2 Risks should be identified based on a threat to the successful delivery of one or more ICB objective. Therefore, the ICB's objectives provide the landscape and starting point for the assessment of risks.

9.1.3 The ICB has agreed the following strategic objectives for the next 3-5 years:

- Increase healthy life expectancy, and reduce inequality.
- Give every child the best start in life.
- Improve access to health and care services.
- Increase the number of citizens taking steps to improve their wellbeing.
- Achieve a balanced financial position annually.

9.2 Risk Assessment

9.2.1 Risk Identification & Articulation

9.2.1.1 Risk identification involves finding, recognising, and describing risks. It is important to understand the anatomy of risks. As already defined, risk is an uncertainty that something impacting on objectives is likely to happen:

- **NOT** something that ***has*** happened (incident)
- **NOT** something that ***will*** happen or is already happening (issue)

9.2.1.2 Risk consists of a combination of three elements, including cause, event, and effect. The risk description should follow the best practice model: **IF** (cause), **THEN** (risk event), and **RESULTING IN** (effect/impact), to help determine risk severity and how risks can best be mitigated.

Cause	**Event**	**Effect**
What might trigger the event to occur e.g., "IF" our financial performance is incomplete	An unplanned/unintended variation from an objective, e.g., "THEN" we may be unable to demonstrate value for money in all areas	How the organisation could be impacted should the event occur, e.g., "RESULTING IN" (1) a threat to future funding and (2) damage to the ICB's reputation

Source: adapted from Amberwing Ltd

9.2.1.3 The above example would therefore be described using this format as:

*"**If** our financial performance is incomplete, **then** we may be unable to demonstrate value for money in all areas **resulting in** (1) a threat to future funding and (2) damage to the ICB's reputation."*

9.2.2 Risk Analysis and Scoring

9.2.2.1 Risk analysis involves a detailed consideration of uncertainties, risk sources, consequences, likelihood, events, scenarios, time-related factors and volatility, the effectiveness of existing controls, sensitivity and confidence levels.

9.2.2.2 Risk scoring is a method used in risk assessment to estimate and rank risks based on their likelihood (probability) and consequence (impact). Risk scoring involves assigning numerical values or scores to the likelihood and consequence of a risk, and then combining these scores to determine an overall risk score.

9.2.2.3 Likelihood: refers to the probability or chance of a risk event occurring. It is assessed using the numerical values 1 to 5 provided in the table below. The higher the likelihood, the greater the chance of the risk event occurring.

9.2.2.4 Consequence: represents the potential impact or severity of a risk event if it were to occur. The impact can be assessed based on various factors specific to the risk, such as financial loss, reputation damage, or harm to individuals. Similar to likelihood, consequence is assessed using the numerical values in table below. A more detailed description of each of the scoring categories can be found in *Appendix 1 – Risk matrix descriptors*:

		Consequence (Impact)				
		1. Negligible	2. Minor	3. Moderate	4. Major	5. Catastrophic
Likelihood	5. Almost Certain	5	10	15	20	25
	4. Highly Likely	4	8	12	16	20
	3. Possibly	3	6	9	12	15
	2. Unlikely	2	4	6	8	10
	1. Rare/	1	2	3	4	5

Risk Matrix table

Risk Zones and Descriptors	
Green Zone:	Review – no action required. Risks in this zone should be reviewed every quarter or as required.
Yellow Zone:	Continue to watch. Action is discretionary. Risks in this zone which are scored below 12 should be reviewed quarterly, but if rated above 12 then review monthly.
Amber Zone:	Action should be taken and / or continued monitoring by the ICB. Risks in this zone which are scored below 12 should be review quarterly, but if rated above 12 then review monthly.
Red Zone:	Immediate actions required / or continued monitoring by the ICB; review every month.

Action triggers matrix

9.2.2.5 It is not the intention of this Policy to remove all risks or to manage risks to a low assessment. To be successful, the ICB needs to take informed risks:

9.2.3 Risk Evaluation

9.2.3.1 The purpose of risk evaluation is to support decisions. This compares the results of the risk analysis with the established risk criteria to determine where additional action is required, leading to a decision to:

- do nothing further;

- consider risk treatment options;
- undertake further analysis to better understand the risk;
- maintain existing controls; or
- reconsider objectives.

9.3 Controls and Risk Treatment or Action Plans

9.3.1 Existing controls should be identified and recorded on the Datix Risk Register against each risk. Documenting the current controls ensures that there is a clear indication of what is being relied upon to prevent the risk event from materialising. In addition, the team or individual that provides primary oversight over the control should document the key sources of assurance in relation to the control that are in place.

9.3.2 Risk treatment can be described as the process by which key controls are identified to mitigate a risk. The purpose of risk treatment is to select and implement the best options for addressing the risk.

9.3.3 There are four types of risk response that should be considered in determining the required action:

a) **Terminate.** Terminating or avoiding the activity or circumstance that gives rise to the risk or choosing another approach with a lower risk.

b) **Tolerate.** Accepting the consequences of the risk should it occur. This may be appropriate when the resources required to reduce the risk in other ways exceed the consequences of the risk occurring. If a risk is accepted, a contingency plan will be of increased importance.

c) **Transfer.** Transferring the risk by sharing it with or passing it onto suppliers, customers, or contractors, including the use of insurance and defined liability contracts. In practice, it is more likely that only some elements of a risk can be passed on: financial implications may pass down to a provider, but reputational risk relating to a service is more likely to be retained by the commissioning organisation.

d) **Treat.** Implementing controls and other mitigation actions (including contingency plans) that will reduce the likelihood and consequence of risks identified.

10 Risk Appetite or Tolerance Statement

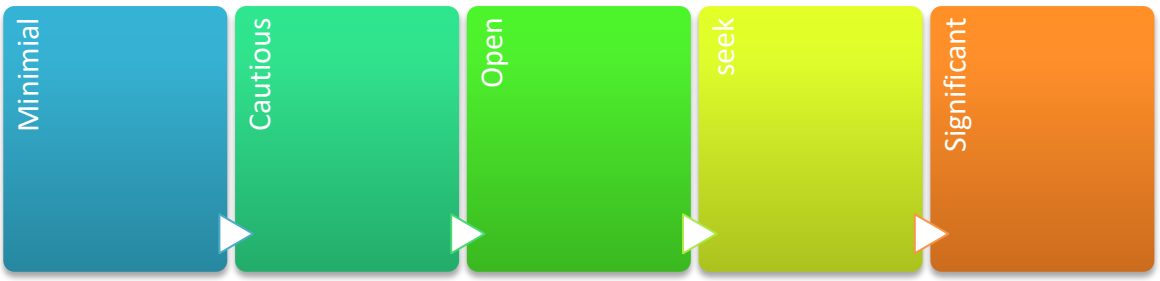
10.1 Risk appetite is the art of taking risks and exercising control while considering differing views at a strategic, tactical, and operational level. It provides consistency in the decision-making process, which will enable the ICB to take well-calculated risks when opportunities arise that will improve delivery, and conversely, to also identify when a more cautious approach should be taken to mitigate a threat.

10.2 Effective risk appetite framework generally includes the following three key principles:

- "Risk appetite should be aligned to the strategic objectives and considered a forward-looking view of an organisation"
- "Board and senior management should be actively involved, and strong accountability structures and clear incentives and constraints should be in place."
- "Risk appetite statements should be operationalised through use of the right level and type of information, fostering strong internal relationships, and establishing risk limits with actionable input for risk and business managers."

10.3 The Board are responsible for making the risk appetite statements for each risk domain, specifying the appetite level the ICB may or may not take, relative to objectives.

10.4 The Board have used the following risk appetite levels to produce the risk appetite statement for each domain. A full description of each risk appetite level for the listed risk domains can be found in *Appendix 2 – Risk Appetite Framework*.



Risk Appetite levels

10.5 The ICB have adopted the risk appetite statements listed in the table below on 24 May 2023. The risk appetite statements outline the level of risk the organisation is willing to accept in each risk domain. These statements enable the ICB to foster innovation and make decisions that may have higher rewards but also carry greater inherent risk compared to other options.

Risk Domains	Risk Appetite	Risk Score Matrix	Appetite statement
FINANCIAL How will we use our resources?	Seek	4	Consistently seek to use available funding to develop and sustain the greatest benefit to health and healthcare for our population and partners, accepting the possibility that not every programme will achieve its desired goals, on the basis that controls are in place.
COMPLIANCE AND REGULATORY How will we be perceived by our regulator?	Open	3	Conform with regulatory expectations but challenge them where we feel that to do so would be to improve outcomes for our residents.
INNOVATIONS, QUALITY AND OUTCOMES	Seek	4	• Pursue innovation and challenge existing working practices, seeking out and adopting new ways of working and new technologies to the benefit of the residents of Hertfordshire and West Essex • Operate with a high level of devolved responsibility • Accept that innovation can be disruptive and to use that as a catalyst to drive positive change
REPUTATION How will we be perceived by the public and our partners?	Seek	4	• We will be willing to take decisions that are likely to bring scrutiny to the organisation but where potential benefits outweigh the risks.

10.6 In recognising the evolving nature of their risk management processes due to the recent establishment of the organisation, the ICB sets an ambition to increase their risk appetite in the future as their control measures, forward scanning, and responsive systems mature.

10.7 The defined risk appetite will provide the Executive Leads (risk owners) and risk leads with relevant information with which they may evaluate significance of risks to ICB objectives and thus support decision-making processes.

11 Recording and Reporting

11.1 The focus of the ICB's Risk Management Policy is continuous proactive engagement on key risk issues as part of everyday business management. One output of this is the on-going process of reporting risks and controls. Reporting of risk and control information is not a one-way process as it promotes oversight, challenge and business engagement that seeks to improve risk and performance.

12 Monitoring and Reviewing of Risks

12.1 The management of risk must be reviewed by the Board, Audit and Risk Committee and Executive Team (in addition to risk owners' with their respective leads) in order to:

- monitor whether the risk profile is changing;
- gain assurance that risk management is effective, or identify that further action is necessary if it is not effective;
- receive assurances available about risk management that deliver an overall opinion about risk management effectiveness; and
- comment on appropriateness of the risk management and assurance processes which are in place.

13 Risk Reporting Arrangements

Risk reporting flow diagram with reporting responsibilities is presented on the next page.

Discussion Forum:	Reporting requirements:
	Risk Report: • Assurance Framework, • Corporate Risk Register - 'Primary Risks' only (rating 16+).
	Assurance Report: • Assurance Framework, • Corporate Risk Register - 'Principal Risks' only (rating Amber 12+), • Provided summary of decisions made at Executive Meeting (including new risks and mitigated risks). • Risk 'deep dives'
	Reporting updates with regards to: • Assurance Framework, • Corporate Risk Register • Decisions about new risks and closure of mitigated risks.
	Risk Update Report: • Review of strategic and operational risks of the ICB against the risk appetite statement and tolerance levels. • Reviewing development of and compliance with the Risk Policy. • Proposing matters for escalation to the Executive and/or the Audit Committee, including risks from the health and care partnership.
	Identified risks within a Team should be discussed at an appropriate forum within Teams or Directorates monthly for appropriate review. Discussions should focus on: • Any new risks identified and agreement on their articulation and scoring. • Review of existing risks and changes in the mitigations or scoring. • Risks or matters for escalation/discussion the Executive Team or Risk Review Group as is appropriate.
	Risks are identified and reported to the risk owner through the ICB's web-based Risk Management system, currently Datix.
	Risks can be identified by a number of different parties including staff from Teams and Directorates. Risks are entered into the ICB's web-based Risk Management System (currently Datix) for formal reporting through the above chain.

14 Corporate Risk Register

14.1 The Corporate Risk Register contains risks that have a total risk score of 12+. The main aim of the Corporate Risk Register is to ensure that risks are actively and collectively managed by the Executive Team and reported to the Audit and Risk Committee. The objectives of the Corporate Risk Register and its review by the above is to:

- use a systematic approach to provide an overall understanding of the ICB's risk exposure and level of assurance over the effectiveness of the control environment in the ICB's key functions.
- Ensure consistency across the ICB in our risk management approach and provide opportunity for discussion and challenge.
- provide a basis for early warnings; and
- identify actions for improvement (above and beyond those already identified / being pursued).

14.2 This process is reliant upon those who have been assigned ownership of risks acknowledging and taking professional responsibility for the management of those risk. Ensuring that risks are aligned with the ICB's strategic objectives and recognising that one risk may impact on the achievement of several objectives.

15 Directorate Risk Registers

15.1 Each directorate and, where deemed appropriate, distinct functions within a directorate, should maintain and review its own register of risks on Datix with all scoring risks present for review. These risks should be discussed at least monthly at team meetings.

15.2 Risks that have been assessed to have a rating of 12 or above must be reviewed by the Executive Director for the directorate and will be included in the Corporate risk Register for wider awareness and discussion.

16 Risk closure

16.1 Risks can be considered for closure if the risk no longer applies (i.e., the process that gave rise to the risk no longer exists) or the risk has reached its target level and no outstanding actions remain. Risk closure is decided by the Risk Owner (Executive Director) after the appropriate evidence and update is recorded on Datix to ensure an appropriate audit trail is maintained.

16.2 There are two categories for closed risk which determine the level of ongoing review:

- Risk still exists but is within target level. These risks will be reviewed once a year to ensure they remain at the target level.
- Risk no longer applies. These risks will not be subject to further review.

17 Assurance Framework

17.1 Assurance is about providing evidence of adequate levels of confidence that risks to objectives are controlled. However, it is acknowledged that it is never possible to provide complete and absolute assurance, and as such the concept of positive or negative assurance is adopted.

17.2 The assurance framework is an integral part of an ICB's risk management strategy rather than a stand-alone activity and is an integral part of the risk management framework used to effectively achieve the ICB's objectives and outcomes. The Audit and Risk Committee is delegated regular assurance monitoring by the Board.

17.3 A diagram that outlines the ICB's full assurance process can be found in *Appendix 3 - Assurance Process Diagram.*

18 Levels of Assurance

18.1 The aim of obtaining assurance is to ensure sufficient and appropriate evidence, to support confidence that a risk is well mitigated. The higher the level of assurance provided, the greater the confidence in the risk management. The Risk Owners and Leads will achieve this by conducting a more in-depth assessment of the assurance. The following are the two common levels of assurance that can be obtained.

- **Positive assurance (+).** This could mean that either a 'reasonable' or 'substantial' level of assurance is evidenced, not that there is an absolute level of assurance.
- **Negative assurance (-).** This could mean that there is either 'no assurance' or only a 'partial/limited' level of assurance.

18.2 Assurance mapping ensures alignment between assurance activities, controls, and the HWE ICB's objectives and risks. The Risk Lead in Datix maps the sources of assurance within the 'three lines of defence' to the risk controls to rate the levels of assurance. There are four levels, including Substantial, Reasonable, limited and None identified. This structure is already integrated into Datix, with Risk Leads responsible for updating relevant fields when reviewing risks.

19 Three Lines of Defence

19.1 To ensure the effectiveness of the ICB's risk management framework, the board and senior management have adopted the 'Three Lines of Defence' model, which is a way of explaining the relationship between the oversight functions within the assurance process.

19.2 First Line of Defence

The internal control framework that enforces required behaviours and working practices throughout the ICB's day-to-day activities. For example: policies, processes, systems, procedures, protocols, professional standards, codes of conduct, etc. Operational management

has ownership, responsibility, and accountability for assessing, controlling, and mitigating risks together with maintaining effective internal controls.

19.3 Second Line of Defence

Oversight functions that: undertake scrutiny; facilitate and implement effective risk management practices by operational management; assist the risk owners in defining the target risk exposure; and report adequate risk related information through the organisation.

For example: governance, compliance framework, financial control, quality, external performance, and commissioning responsibilities, reported to the board.

19.4 Third Line of Defence

Functions providing independent and objective challenge and assurance with regard to the ICB's governance arrangements. For example, Internal Audit, External and other independent assurance providers and regulators.

20 Training

20.1 Embedding of the Risk Management Policy will be supported by a range of training options for all staff delivered by the Governance team and external consultants.

20.2 It is essential that all staff are aware of the Risk Management Policy and their role in implementing it. Embedding of this Risk Management Policy across the ICB is essential to facilitate delivery of effective governance arrangements.

21 Appendices

Please see next page.

Appendix 1 – Risk Matrix Descriptors

Consequence (C) levels descriptors

Risk domains	1. Negligible	2. Minor	3. Moderate	4. Major	5. Catastrophic
Data Protection and Information Security	No adverse effect There is absolute certainty that no adverse effect can arise from the breach	Potentially some minor adverse effect or any incident involving vulnerable groups even if no adverse effect occurred A minor adverse effect must be selected where there is no absolute certainty. A minor adverse effect may be the cancellation of a procedure but does not involve any additional suffering. It may also include possible inconvenience to those who need the data to do their job	Potentially Some adverse effect An adverse effect may be release of confidential information into the public domain leading to embarrassment or it prevents someone from doing their job such as a cancelled procedure that has the potential of prolonging suffering but does not lead to a decline in health.	Potentially Pain and suffering/ financial loss There has been reported suffering and decline in health arising from the breach or there has been some financial detriment occurred. Loss of bank details leading to loss of funds. There is a loss of employment.	Death/ catastrophic event
Clinical Quality and Patient Safety (Including equipment)	No risk of negative impact to ICB	Small risk of delay in patient receiving the required care Small risk of negative impact to ICB Guidance not regularly reviewed.	High risk of delay in patient receiving the required care High risk of negative impact to ICB, and possibly consequences to commissioned services. Guidance insufficient / poor training.	Serious risk of delay in patient receiving the required care Serious risk of harm to patients due to poor commissioning. Investigation resulting in identification of serious omission on the part of the part of the ICB to consider quality and safety in commissioning decisions.	Potential to cause one or a number of fatalities. Compliance breach, causing serious fine, investigation, legal action.
Strategy, Innovation/ Performance/ Outcomes	Minimal impact upon productivity, costs or quality	Small risk of impact upon productivity, e.g., waiting times, patient outcomes. Small risk of impact upon delivery of QIPP schemes (if applicable)	High risk of impact upon productivity e.g., waiting times, patient outcomes High risk of impact upon delivery of QIPP schemes (if applicable)	Significant risk of impact upon productivity e.g., waiting times, patient outcomes. High risk of impact upon delivery of QIPP schemes (if applicable).	Significant risk of negative impact upon patients, providers and/or the ICB i.e., non- delivery of key objectives; loss of percentage of budget
Reputational	Rumours Potential for public concern	Local media coverage and discussions on social media short- term reduction in public confidence Elements of public expectation not being met	Local negative and critical media coverage and discussions on social media leading to medium-term reduction in public confidence MPs and stakeholders raise concerns with ICB	Sustained negative and critical local media coverage and discussions on social media National negative media coverage for less than 3 days MPs and stakeholders raise concerns with ICB NHS England and Improvement or DHSC raises concerns with ICB.	National negative media coverage for more than 3 days MPs and stakeholders raise concerns in public fora (e.g. questions in the House of Commons or critical media articles) Total loss of public confidence

Risk domains	1. Negligible	2. Minor	3. Moderate	4. Major	5. Catastrophic
Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections / Regulatory Action/Legal	No or minimal impact or Breach of guidance/ statutory duty	Breach of statutory Legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Governance/ Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of percentage of budget Claim less than £10,000 Up to 0.05%	Loss of percentage of budget Claim(s) between £10,000 and £100,000 Up to 0.15%	Key objectives not met Uncertain delivery of key objective/Loss of per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time Up to 0.5%	Non-delivery of key objective/ Loss of per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million Over 0.5%
Health and Safety	Minimal effect on staff	Potential for minor harm or intruding into normal non-working time	Incident requiring hospital treatment for more than one member of staff. Intrusion into normal non-working time	Significant injuries, potential death. Major intrusion into staff's time	Deaths and / or major effect on staff lives
Technology/- Service/ Business interruption/ Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood (L) levels descriptors

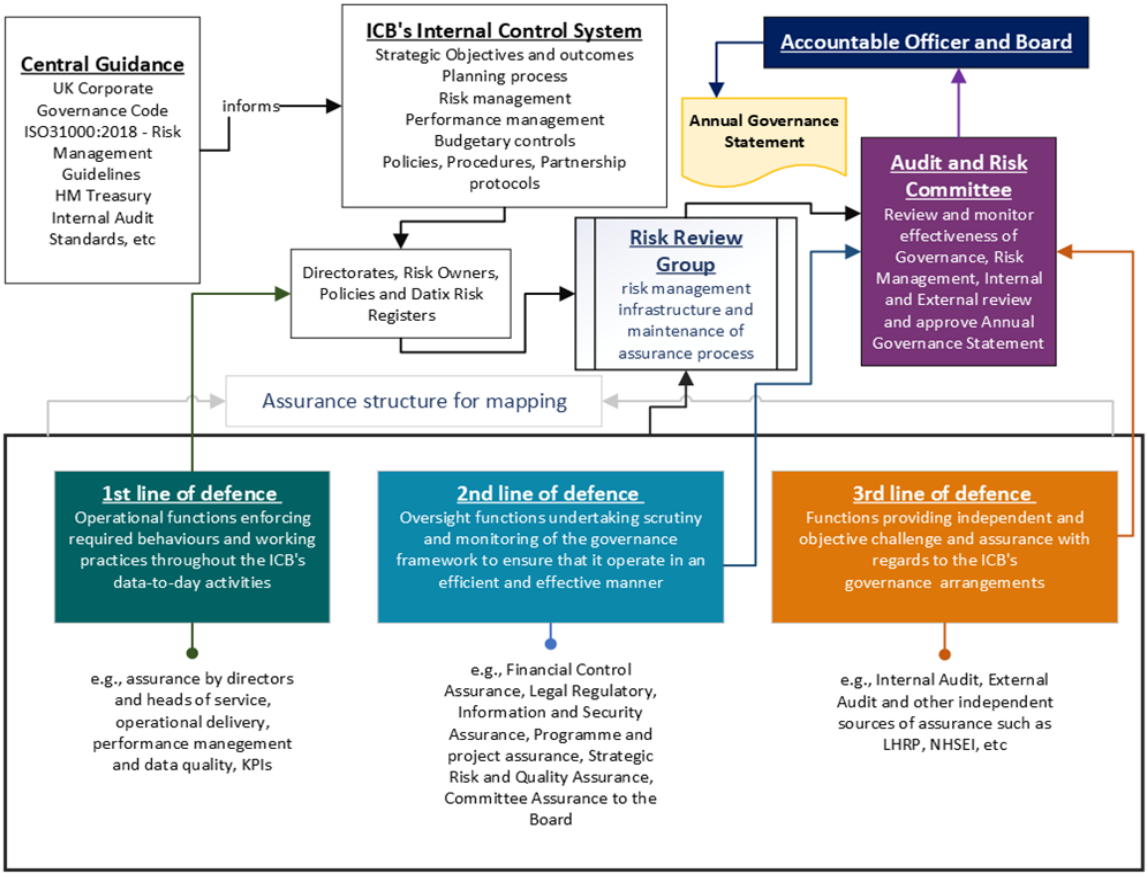
Descriptor	1. Rare	2. Unlikely/	3. Possible	4. Highly Likely	5. Almost certain
Frequency How often might it/does it happen	This will probably never happen/recur or There is absolute certainty that there can be no adverse effect. This may involve a reputable audit trail or forensic evidence	Do not expect it to happen/recur but it is possible it may do so or In cases where there is no evidence that can prove that no adverse effect has occurred this must be selected	Might happen or recur occasionally or It is likely that there will be an occurrence of an adverse effect arising from the breach	Will probably happen/recur but it is not a persisting issue or There is almost certainty that at some point in the future an adverse effect will happen	Will undoubtedly happen/recur, possibly frequently or There is a reported occurrence of an adverse effect arising from the breach.

Appendix 2 – Risk Appetite Framework

RISK APPETITE LEVEL ▶ / RISK TYPES ▼	0 NONE Avoidance of risk is a key organisational objective.	1 MINIMAL Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	2 CAUTIOUS Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	3 OPEN Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	4 SEEK Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).	5 SIGNIFICANT Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
FINANCIAL **How will we use our resources?**	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
REGULATORY **How will we be perceived by our regulator?**	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
QUALITY **How will we deliver safe services?**	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
REPUTATIONAL **How will we be perceived by the public and our partners?**	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
PEOPLE **How will we be perceived by the public and our partners?**	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive chan.

WWW.GOOD-GOVERNANCE.ORG.UK

Appendix 3 – Assurance Process Diagram



Appendix 4 – Equality and Health Inequalities Analysis

Equality Analysis

Title of policy, service, proposal etc being assessed:
Risk Management Policy

What are the intended outcomes of this work? The Risk Management policy will support the HWEICB's strategic direction and objectives, as well as staff duties and responsibilities in understanding and creating an effective risk profile, management's controls to reduce risks, and the mapping of assurances to ensure the Board is aware of known and new risks.
How will these outcomes be achieved? The Risk Management Policy v1.3 will be published and distributed to all employees. This policy will guide ICB's risk management activities. It will replace version 1.0, adopted on 1 July 2022.
Who will be affected by this work? There is no scope for differential impact based on a person's characteristic.

Evidence
Impact Assessment Not Required This is a risk management policy at the highest level. It has no impact on those who have or share a protected characteristic. It specifies critical and/or priority actions as actions that ensure there is no impact on people.

Having considered the proposal and sufficient evidence to reach a reasonable decision on actual and/or likely current and/or future impact I have decided that a full equality impact assessment is not required.	
Assessor's name and job title Date	Paul Curry, Equality and Diversity Lead 30 November 2022

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

STANDARDS OF BUSINESS CONDUCT & CONFLICTS OF INTEREST POLICY

DOCUMENT CONTROL

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Document Owner:	Chief of Staff	
Document Author(s):	Deputy Chief of Staff – Governance & Policies Governance Manager – Conflicts & Policy	
Version:	3.1 FINAL	
Approved By:	HWE ICB Executive Team	
Date of Approval:	02 December 2024 (v3.0)	
Date of Review:	December 2026	
Link to Strategic Objective(s):	*Increase healthy, life expectancy, and reduce inequality*	☒
	Improve access to health and care services	☒
	Increase the numbers of citizens taking steps to improve their wellbeing	☒
	Achieve a balance financial position annually	☒
	Give every child the best start in life	☒

Change and Approval History:

Version	Revision Description	Reviewer(s) / Approval Group	Date
0.1	Draft - Approved by CCG Executive (April 2022). Ratified by HWE CCG Boards sitting in Common (May 2022). (subject to final adoption by HWE ICB on 01 July 2022)	Head of Corporate Governance	April 2022 May 2022
1.0	Final - Approved and adoption by HWE ICB on 01 July 2022.	Board	July 2022
1.1	Final - Declarations contact email address updated.	Governance Manager	September 2023
1.2	Draft – Policy review, updates including: • Formatting into corporate template, • Processes reviewed and streamlined to remove duplication, • Training section updated to include new NHSE training module requirements, • Procurement section reviewed and confirmed by Deputy Director of Contracting & Procurement • Donations section clarified • Appendix added – Example Declarations of Interest, • EqIA updated.	Governance Manager – Conflicts & Policy IG and Governance Officer Deputy Chief of Staff – Governance & Policies	March 2024
1.3	Draft – Minor clarifications following feedback from Chief of Staff and Deputy Chief of Staff	Governance Manager – Conflicts & Policy	March 2024
1.4	Draft - Minor clarifications following Executive Team Review (prior to approval): • training requirement for new starters clarified, • Local Counter Fraud Specialist contact email updated.	Governance Manager – Conflicts & Policy	April 2024
2.0	Final - Updated policy formally approved by ICB executive Team	HWE ICB Executive Team	April 2024
2.1	Final - Minor update to declaration of interest template (Appendix 2).	Governance Manager – Conflicts & Policy	May 2024
2.2	Final - Minor amendment to paragraph 3.3, regarding gifts from suppliers/contractors, to clarify point and remove duplication.	Governance Manager – Conflicts & Policy	June 2024
2.3	Draft - Policy updated taking into consideration the new NHS England Managing of Conflicts guidance for ICB's: • Para 1.6 – definitions for 'conflict of interest' and 'decision making role' added • Para 3.2.3 – details within categories of interest updated	Governance Manager – Conflicts & Policy Deputy Chief of Staff – Governance & Policies	26 September 2024

	• Para 3.2.17 – clarity regarding published register and parameters for redaction • Para 3.2.25 – added to provide general management actions for managing conflicts of interests • Para 3.3.27 – additional clarification added to the 'donations' section • Para 3.3.30 – loyalty interest updated to include roles with advisory groups/other decision making forums. • Para 3.3.52 – amendment from 'secondary' to 'outside' employment and clarification added to subsequent points • Para 3.3.60 – detailed what the G&H declarations should include • Appendix 2 DOI form – clarification of notes regarding publication of interests		
	Draft and the amendments shared with the ICBs Counter Fraud Specialist for comments	Counter Fraud Specialist	September 2024
2.4	Draft – further clarifications and feedback from Internal Audit/ Counter Fraud incorporated: • Para 1.3 expanded to include bullet for associated policies • Para 2.3.2 – expanded to include annual review by Counter Fraud • Para 3.2.6 – reference to checks against publicly accessible sites. • Para 3.3 – guidance for offers of gifts/hospitality clarified • Para 3.6 – section on breaches clarified with signposting to Appendix 5 • Para. 3.6.13 and 3.6.14 – new paragraphs to reference support during the investigation and support to the individuals supporting the investigation. • Additional sections added: - Para 3.3.41 – Sponsored Research - Para 3.3.43 – Sponsored Posts - Para 3.3.45 – Clinical Private Practise - Appendix 5 Potential Sanctions (Breaches) – new appendix	Governance Manager – Conflicts & Policy	17 October 2024
	Shared with Executive Team for comments and approval	Executive Team	October 2024
3.0	Final - Approved	Executive Team	02 December 2024
3.1	Final – Reformat and minor clarification to para 3.2.18 prior to publication	Deputy Chief of Staff – Governance & Policies	12 December 2024

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1.0 Introduction

1.1 The Standards of Business Conduct policy describes the standards and public service values which underpin the work of the NHS and reflects current guidance. Effective handling of conflicts of interest is crucial to give confidence to patients, taxpayers, healthcare providers and Parliament that ICB commissioning decisions are robust, fair, transparent, and offer value for money. ICBs are also required under the NHS Act 2006 (as amended by the Health and Care Act 2022) to manage conflicts of interest.

1.2 The major focus of this policy is conflicts of interest and is intended to ensure that Hertfordshire and West Essex Integrated Care Board ("the ICB") compliance with NHS England's 'Managing Conflicts of Interest in the NHS' guidance (September 2024). which takes into account of changes introduced by the Health and Care Act 2022, specifically the establishment of Integrated Care Boards and the introduction of the Provider Selection Regime.

1.3 ICB Conflicts of Interests Principles

1.3.1 Decision-making must be geared towards meeting the statutory duties of ICBs at all times, including the triple aim. Any individual involved in decisions relating to ICB functions must be acting clearly in the interests of the ICB and of the public, rather than furthering direct or indirect financial, personal, professional or organisational interests.

1.3.2 ICBs have been created to give statutory NHS providers, local authority and primary medical services nominees a role in decision-making. These individuals will be expected to act in accordance with the first principle (as described in paragraph 1.2.1 above), and whilst it should not be automatically assumed that they are personally or professionally conflicted just by virtue of being an employee, director, partner or otherwise holding a position with one of these organisations, the possibility of actual and perceived conflicts of interests arising will remain. For all decisions, ICBs will need to carefully consider whether an individual's role in another organisation could result in actual or perceived conflicts of interest and whether or not that outweighs the value of the knowledge they bring to the process.

1.3.3 The personal and professional interests of all ICB board members, ICB committee members and ICB staff who are involved in the marking of decisions within this ICB need to be declared, recorded and managed appropriately. Declarations must be made as soon as practicable after the person becomes aware of the conflict or potential conflict and, in any event, within 28 days of the person becoming aware. This includes being clear and specific about the nature of any interest, and about the nature of any conflict that may arise regarding a particular decision.

1.3.4 If an interest is declared but there is no risk of a conflict arising, then no further action need be taken (although this will still need to be recorded). However, if a material interest is declared, then it should be considered to what extent this material interest affects the balance of the discussion and decision-making process. In doing so the ICB should ensure conflicts of interest (and potential conflicts of interest) do not, (and do not appear), to affect the integrity of the ICB's decision making processes.

1.3.5 ICBs should consider the composition of decision-making forums and should clearly distinguish between those individuals who should be involved in formal decision taking, and those whose input informs decisions. In particular ICBs should consider the perspective the individual brings and the value they add to both discussions around particular decisions and in actually taking part in the decision including the ability to shape the ICB's understanding of how best to meet patients' needs and deliver care for their populations. The way Conflicts of Interests are managed should reflect this distinction. For example, where independent providers (including the VCFSE sector) hold contracts for services it would be appropriate and reasonable for the body to involve them in discussions, for example about pathway design and service delivery, particularly at place-level. However, this would be clearly distinct from any considerations around contracting and commissioning, from which they would be excluded.

1.3.6 Actions to mitigate a conflicts of interest should be proportionate and should seek to preserve the spirit of collective decision-making wherever possible. Mitigation should take account of a range of factors including the perception of any conflicts and how a decision may be received if an individual with a perceived conflict is involved in that decision, and the risks and benefits of having a particular individual involved in making the decision. Potential options in relation to mitigation could include:

i. Including a conflicted person in the discussion but not in decision making;
ii. Excluding a conflicted person from both the discussion and the decision making;
iii. Including a conflicted person in the discussion and decision where there is a clear benefit to them being included in both – however, including the conflicted person in the actual decision should be done after careful consideration of the risk and with proper mitigation in place. The rationale for inclusion should also be properly documented and included in minutes.
iv. Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source

1.3.7 The way conflicts of interest are declared and managed should contribute to a culture of transparency about how decisions are made. In particular when adopting a specific approach to mitigate any conflicts of interest (including perceived conflicts) ICBs should ensure that the reason for the chosen action is documented in minutes or records.

1.3.8 These factors should be read in conjunction with other relevant NHSE statutory guidance, including guidance on the Provider Selection Regime and guidance on joint working and delegation arrangements. In relation to the Provider Selection Regime, as is already established practice in the NHS, where decisions are being taken as part of a formal competitive procurement of services, any individual who is associated with an organisation that has a vested interest in the procurement should recuse themselves from the process.

1.3.9 This policy, in conjunction with the ICBs Procurement Policy, elaborates on these principles, explaining the processes to be followed in order to maintain them.

1.3.10 Associated ICB policies include:

- Procurement Policy
- Counter-Fraud, Bribery and Corruption Policy
- Freedom to Speak Up (Whistleblowing) Policy
- Disciplinary Policy
- Fit and Proper Person Test Policy

1.4 Guidance and legal framework

1.4.1 This policy is intended to protect patients, taxpayers and staff covering health services in which there is a direct state interest in accordance with the NHS England 'Managing Conflicts of Interest in the NHS' guidance (September 2024).

1.4.2 It is applicable to the following NHS bodies:

- Integrated Care Boards
- NHS Trusts (all or most of whose hospitals establishments and facilities are situated in England) and NHS Foundation Trusts - which include secondary care trusts, mental health trusts, community trusts, and ambulance trusts;
- NHS England (NHSE).

1.4.3 The guidance describes:

- the standards of conduct expected of all NHS staff where their private interests may conflict with their public duties; and the steps which NHS employers should take to safeguard themselves and the NHS against conflicts of interest.
- specifically, it makes it clear that it is the responsibility of staff to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests and their NHS duties.

1.4.4 NHSE's Standards for Business Conduct Policy 2017 (updated 2022) provides further guidance on core standards of conduct expected of NHS staff and boards to act in the best interests of the public and patients / clients to ensure that decisions are not improperly influenced by gifts or inducements.

1.4.5 Professional Codes of Conduct governing health care professionals are also pertinent. The General Medical Council's guidance, "Leadership and management for all doctors" (March 2012), details the standards and expectations required of clinicians in leadership and management positions.

1.4.6 The Professional Standards Authority has also published Standards for members of NHS Boards in England.

1.4.7 NHS England published its revised 'Managing conflicts of interest in the NHS' guidance in September 2024 which applies to ICBs.

1.5 Purpose

1.5.1 The purpose of this policy is to ensure that the ICB maintains the highest standards of probity and that all business relationships lead to clear benefits for patients, and intends to:

(a) Enable the ICB to deliver its statutory duty to manage conflicts of interest
(b) Enable individuals to demonstrate that they are acting fairly and transparently and in the best interest of patients and the local population
(c) Uphold confidence and trust in the NHS
(d) Safeguard commissioning, whilst ensuring objective decision- making
(e) Support individuals to understand when conflicts of interest (whether actual or potential) may arise and how to manage them if they do
(f) Ensure that the ICB operates within the legal framework.
(g) Uphold the reputation of the ICB and its staff in the way it conducts business.

1.6 Scope

1.6.1 This policy applies to, including and without limitation, whether permanent, temporary or contracted-in (either as an individual or through a third party supplier).,:

(a) all ICB staff members and those of hosted organisations,

(b) members of the Board, Sub-Committees and Practice Representatives, involved in the ICB's policy-making processes,

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

- Board and sub-committee members
- Place Based Directors
- Executive and Senior Managers as outlined in the Scheme of Reservation and Delegation and Standing Financial Instructions
- Level 4 Patient and Public Voice partners

1.7 Definitions

1.7.1 The following definitions apply in the context of this policy:

Term	Definition
Commercial Sponsorship	An arrangement where the ICB receives financial support or support in kind for staff, research, training, equipment, premises or conferences.
Conflict of Interest	A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold.
Decision Making Role	Examples of decision-making staff: • executive and non-executive directors who have decision-making roles which involve the spending of

	taxpayers' money (equivalent roles in different organisations carry different titles and these should be considered on a case-by-case basis) • members of advisory groups which contribute to direct or delegated decision-making on the commissioning or provision of taxpayer-funded services. • those at Agenda for Change band 8D and above (reflecting guidance issued by the Information Commissioner's Office with regard to freedom of information legislation) • administrative and clinical staff who have the power to enter into contracts on behalf of their organisation. • administrative and clerical staff involved in decision-making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment and formulary decisions.
Gifts	Any item of cash or goods, or any service, which is provided for personal benefit, free of charge or less than its commercial value.
Hospitality	Food, drink, travel, accommodation, or entertainment offered or provided in the nature of the organisation's business by anyone other than the employer.
Pharmaceutical Industry	Includes: • Companies, partnerships or individuals involved in the manufacturing, sale, promotion or supply of medicinal products subject to the licensing provision of the Medicines Act 1968[16]. • Companies, partnerships or individuals involved in the manufacture, sale, promotion or supply of medical devices, appliances, dressings, and nutritional supplements which are used in the treatment of patients within the NHS. • Trade associations and agencies representing companies involved with such products. • Companies, partnerships or individuals who are directly concerned with research, development or marketing of a medicinal product, device, appliance, dressing or supplement that is being considered by, or would be influenced by, decisions taken by the ICB. • Pharmaceutical industry related industries, including companies, partnerships or individuals directly concerned with enterprises that may be positively or adversely affected by decisions taken by the ICB. •
Joint Working	Situations where, for the benefit of patients, organisations pool skills, experience and/or resources for the joint development and implementation of patient centred projects and share a commitment to successful delivery.

	Joint working agreements and management arrangements are conducted in an open and transparent manner. Joint working differs from sponsorship, where pharmaceutical companies simply provide funds for a specific event or work programme.
VCFSE	Means voluntary, community, faith and social enterprise.

2.0 Roles and Responsibilities

2.1 The following definitions apply in the context of this policy:

Role	Responsibilities
Board	• Required to comply with all relevant elements of this policy. • Ensure that the ICB's policies and procedures reflect best practice particularly in relation to the procurement of services; • Ensure that arrangements for audit and reporting are open, robust and effective.
Audit and Risk Committee	• Oversee the arrangements for the management of conflict of interest, gifts, hospitality and commercial sponsorship, and advise the Board as required. • Receive a Decision Register report on a quarterly basis which will include all decisions made by the Board and Board Committees inclusive of any declaration of interests made against each decision and how those conflicts were managed. • Ensure that the registers of interests and gifts, hospitality and sponsorship are reviewed regularly, and updated as necessary. • Ensure that for every interest declared, arrangements are in place to manage the conflict of interests or potential conflict of interests, to ensure the integrity of the ICB's decision making process. • The arrangements will confirm the following: - When an individual should withdraw from a specified activity, on a temporary or permanent basis. - Monitoring of the specified activity undertaken by the individual, either by a line manager, colleague or other designated individual.
Chief Executive Officer	Overall accountability for the ICB's management of conflicts of interest, responsible for: • ensuring that the ICB has processes in place to enable individuals to declare and manage conflicts of interest. • creating a culture in which ICB employees feel able and supported to report any conflicts of interest concerns.
Chief of Staff	Chief of Staff or their nominated representative will: • Ensure the ICB has a conflicts of interest policy in place which is accessible to staff • Provide advice, support and guidance on how conflicts of interest should be managed.

	• Ensure that appropriate administrative processes are put in place. • Maintain the registers of interests based on the Declaration of Interest Forms completed and ensures that registers are published on the ICB public website. • Maintain the registers of gifts, hospitality and sponsorship and ensure they are published on the ICB public website. • Maintain the Decision Register of all decisions made by the Board and Board Committees inclusive of any declarations made against each action, provide to Audit and Risk Committee meetings on a quarterly basis and subsequently published on the ICB public website, unless exempt due to reasons of commercial sensitivity or personal confidentiality. • Support the Conflicts of Interest Guardian to enable them to carry out the role effectively.
Conflicts of Interest Guardian	The ICB has appointed the Audit Chair to be the Conflicts of Interest Guardian. In collaboration with the Chief of Staff, their role is to: • Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest • Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest • Support the rigorous application of conflict of interest principles and policies • Provide independent advice and judgement to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation • Provide advice on minimising the risks of conflicts of interest.
Members of Staff, Committee Members, Contractors	Required to comply with all relevant elements of this policy, and responsible for: • Declaring any interests promptly. • Speaking up if you have any concerns about how conflicts of interest are being managed. • Acting with honesty, transparency and integrity. • Supporting others to identify and manage conflicts of interest. • Managing conflicts of interest in accordance with the ICB's conflicts of interest policy. • Undertaking mandatory online conflicts of interest training annually. • Being proactive in the management of conflicts of interest and seeking advice as required. • Acting in accordance with the ICB's bribery and counter fraud policy.
NHS Counter Fraud Authority	The ICB Local Counter Fraud Specialist should be contacted in the first instance if you have any genuine suspicions or concerns over fraud or bribery, in accordance with the ICB Counter Fraud Policy.

2.2 Implementation

2.2.1 Training will be provided to all employees as part of the staff induction programme, Board members and members of ICB committees and sub-committees on the management of conflicts of interest. This is to ensure staff and others within the ICB understand what conflicts are and how to manage them effectively.

2.2.2 Induction training will cover the following:

- What is a conflict of interest?
- Why is conflict of interest management important?
- What are the responsibilities of the organisation you work for in relation to conflicts of interest?
- What should you do if you have a conflict of interest relating to your role, the work you do or the organisation you work for (who to tell, where it should be recorded, what actions you may need to take and what implications it may have for your role).
- How conflicts of interest can be managed.
- What to do if you have concerns that a conflict of interest is not being declared or managed appropriately.
- What are the potential implications of a breach of the ICB's rules and policies for managing conflicts of interest?
- Other areas monitored: Gifts, Hospitality, Commercial Sponsorship, Pharmaceutical Industry, Joint Working.

2.2.3 All employees and ICB Board Members will be required to undergo annual training via the NHS England online module available on ESR.

2.2.4 Module 1 of the annual training explains how NHS-wide conflicts of interest rules should be applied within ICBs and will guide and support you in identifying and managing real and perceived conflicts of interest, and will cover the following:

- what conflicts of interest are and why they need to be managed.
- roles and responsibilities in relation to identifying and managing conflicts of interest.
- what to do if you have a conflict of interest, or suspect someone else may have a conflict of interest.
- how you can manage conflicts of interest.
- how to report concerns.
- the potential implications of a breach of conflicts of interest policy.

2.2.5 The online module ends with a brief assessment, which you must be passed to complete the training.

2.2.6 Further Conflicts of Interest modules are pending release by NHS England and therefore colleagues are asked to check required training modules via their ESR login.

2.3 Monitoring

2.3.1 The Audit and Risk Committee will monitor compliance with this policy and the declaration of interest process via reporting as identified in the Committee's annual workplan.

2.3.2 The ICB will commission an annual internal audit to assess compliance with this policy, which will include an annual review by Counter Fraud as part of requirement 12 Government Functional Standards.

2.3.3 The ICB will maintain a minimum of 90% compliance of ICB staff who have completed the mandatory conflicts of interest online training as of 31 March each year. All staff must undertake this training on an annual basis and new starters must complete the training in line with the induction programme, which forms part of mandatory training requirements.

3.0 Standards of Business Conduct – Policy Content

3.1 Principles of good business conduct

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

- The Seven Principles of Public Life (Appendix 1)
- The Good Governance Standards for Public Services (CIPFA 2004)[1]
- The seven key principles of the NHS in England[2]
- The Equality Act 2010[3]
- The UK Corporate Governance Code[4]
- Standards for members of NHS boards and CCG governing bodies in England[5]

3.1.2 In addition, as an ICB we will:

- Do business appropriately: conflicts of interest become much easier to identify, avoid and/or manage when the processes for needs assessments, consultation mechanisms, commissioning strategies and procurement procedures are right from the outset, because the rationale for all decision-making will be clear and transparent and should withstand scrutiny.
- Be proactive, not reactive: commissioners should seek to identify and minimise the risk of conflicts of interest at the earliest possible opportunity.
- Be balanced and proportionate: rules should be clear and robust but not overly prescriptive or restrictive. They should ensure that decision-making is transparent and fair whilst not being overly constraining, complex or cumbersome.

[1] https://www.cipfa.org/policy-and-guidance/reports/good-governance-standard-for-public-services

[2] https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england

[3] https://www.legislation.gov.uk/ukpga/2010/15/contents

[4] https://www.frc.org.uk/getattachment/88bd8c45-50ea-4841-95b0-d2f4f48069a2/2018-UK-Corporate-Governance-Code-FINAL.PDF

[5] https://www.professionalstandards.org.uk/docs/default-source/publications/standards/standards-for-members-of-nhs-boards-and-ccgs-2013.pdf?sfvrsn=2

- Be transparent: document clearly the approach and decisions taken at every stage in the commissioning cycle so that a clear audit trail is evident.
- Create an environment and culture where individuals feel supported and confident in declaring relevant information and raising any concerns.

3.1.3 The ICB recognises that:

- A perception of wrongdoing, impaired judgement or undue influence can be as detrimental as them actually occurring.
- If in doubt, it is better to assume the existence of a conflict of interest and manage it appropriately rather than ignore it.
- For a conflict of interest to exist, financial gain is not necessary.

3.1.4 The ICB understands the requirement to consult upon major changes before decisions are reached and will be open with the public, patients and staff. Information supporting decisions will be made available in a way that is understandable and responses to requests for information in accordance with the Freedom of Information Act 2000 will be provided in this spirit.

3.1.5 Our business will be conducted in a way that is socially responsible, forging an open and positive relationship with the local community and in consideration of the impact of the organisation's activities on the environment.

3.2 Conflicts of Interest

3.2.1 A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship. In some circumstances, it could be reasonably considered that a conflict exists even when there is no actual conflict. In such cases it is important to still manage these perceived conflicts in order to maintain public trust.

- Actual - There is a material conflict between one or more interests
- Potential - There is the possibility of a material conflict between one or more interests in the future.

3.2.2 Staff may hold interests for which they cannot see any potential conflict. However, caution is always advisable because others may see it differently. It will be important to exercise judgement and to declare such interests where there is otherwise a risk of imputation of improper conduct.

3.2.3 Conflicts of interest can arise in many situations, environments and forms of commissioning, with an increased risk in primary care commissioning, out-of-hours commissioning and involvement with integrated care organisations, as clinical commissioners may here find themselves in a position of being at once commissioner and provider of services. Conflicts of interest can arise throughout the whole commissioning cycle: from needs assessment, to procurement exercises, to contract monitoring.

3.2.3 Categories of interest:

'Interests' can arise in a number of different contexts. A material interest is one which a reasonable person would take into account when making a decision regarding the use of taxpayers' money because the interest has relevance to that decision.

Financial interests: Where an individual may get direct financial benefits (a benefit may arise from the making of gain or avoiding a loss) from the consequences of a decision their organisation makes. This could include:

- A director (including a non-executive director) or senior employee in another organisation which is doing or is likely to do business with an organisation in receipt of NHS funding.
- A shareholder, a partner or owner of an organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding.
- Someone in outside employment.
- Somone in receipt of secondary income.
- Someone in receipt of a grant.
- Someone in receipt of other payments (e.g. honoraria, day allowances, travel or subsistence)

Someone in receipt of research sponsorship. funding,

Non-financial professional interests: Where an individual may obtain a non-financial professional benefit (a benefit may arise from the making or gain or avoiding loss) from the consequences of a decision their organisation makes, such as increasing their professional reputation or status or promoting their professional career. This could include situations where the individual is:

- An advocate for a particular group of patients
- A clinician with a special interest
- An active member of a particular specialist body
- An advisor for the Care Quality Commission (CQC) or the National Institute for Health and Care Excellence (NICE)
- Undertaking a research role, particularly sponsored research.

Non-financial personal interests: This is where an individual may benefit (a benefit may arise from the making or gain or avoiding loss) personally from a decision their organisation makes 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 member of a voluntary sector board or has a position of authority with a voluntary sector organisation
- A member of a lobbing or pressure group with an interest in health and care.

Indirect interests: This is where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit ((a benefit may arise from the making or gain or avoiding loss) from a decision they are involved in making. This would include:

- Close family member and relative
- Close friends and associates.
- Business partner(s).

A common-sense approach should be applied to these terms. It would be unrealistic to expect staff to know of all the interests that people in these classes might hold. However, if staff do know of material interests (or could be reasonably expected to know about them) then these should be declared.

3.2.4 Declaring interests

3.2.5 It is a statutory requirement for ICBs to make arrangements to ensure individuals declare any conflict or potential conflict in relation to a decision to be made by the organisation as soon as they become aware of it, and in any event within 28 days. ICBs must record the interest in the registers as soon as they become aware of it.

3.2.6 Declarations of interest must be made using the form (Appendix 2) as soon as possible and by law within 28 days after the interest arises. The ICB also expects individuals to declare interests they are pursuing. Declarations received will be checked against publicly accessible sites including hosted by Companies House, and Disclosure UK - with particular focus being directed to individuals holding decision making roles within this ICB:

- Declarations must be made **on appointment** to the ICB, the Board or any committees. When an appointment is made, a formal declaration of interests should be made using the Declarations of Interest Form.

- Individuals will be asked to confirm **annually** that declarations are accurate and up to date. Where there are no interests to declare, a "nil return" should be recorded.

- All board or committee members are required to declare any interests in agenda items in advance of the meeting. All **meeting attendees** are required to declare their interests as a standing agenda item for every board, committee, sub-committee or working group meeting, before the item is discussed. Even if an interest has been recorded in the register of interests, it should still be declared in meetings where matters relating to that interest are discussed. Declarations of interest and how they were managed should be recorded in minutes of meetings.

- Additionally, if a specialist or expert is invited to comment on a meeting paper in order to help the committee or group with their discussions, then that individual must be asked to complete a declaration of interest.

- **Whenever an individual's role, responsibility or circumstances change** in a way that affects the individual's interests (e.g., where an individual takes on a new role outside the ICB or enters into a new business or relationship), a further declaration should be made to reflect the change in circumstances as soon as possible, and in any event within 28 days. This could involve a conflict of interest ceasing to exist or a new one materialising. If an individual's circumstances change, it is their

responsibility to make a further declaration as soon as possible and in any event within 28 days, rather than waiting to be asked

- **Development of a new service or contract** - Conflicts of interest should be managed appropriately throughout the whole commissioning cycle and then within the ongoing management of existing contracts.

  You should complete a conflict of interest form at the outset of any commissioning process, even if you have nothing to declare, and a record of this should be made available to relevant stakeholders as per the ICB policy around register of interests.

  Where a potential conflict of interest has been identified, you are expected to take steps to declare this as soon as possible and work with the commissioning lead and/or ICB Chief of Staff C to agree the extent to which it's appropriate for you to be involved in the ongoing process and in some circumstances whether it's appropriate to be involved at all.

  Similarly, this includes if your circumstances change at any point during the commissioning cycle, you should declare any potential conflict of interest as soon as possible and follow steps identified in your ICB's conflict of interest policy.

3.2.7 The appointment of board members, committee members and senior employees.

3.2.8 On appointment of board members, committee members and senior employees, the ICB will consider whether conflicts of interest should exclude individuals from being appointed to the relevant role. This will be considered on a case-by-case basis, with advice being sought from the Conflicts of Interest Guardian. In relation to any committees or sub-committees exercising ICB commissioning functions, and in compliance with the ICB Constitution - approval and appointment of members to such committees or sub-committees will be made by the ICB chair.

3.2.9 The ICB will assess the materiality of the interest, in particular whether the individual (or any person with whom they have a close association) could benefit (whether financially or otherwise) from any decision the ICB might make.

3.2.10 The ICB will determine the extent of the interest and the nature of the appointee's proposed role within the ICB. If the interest is related to an area of business significant enough that the individual would be unable to operate effectively and make a full and proper contribution in the proposed role, then that individual will not be appointed to the role.

3.2.11 Any individual who has a material interest in an organisation which provides, or is likely to provide, substantial services to an ICB should recognise the inherent conflict of interest risk that may arise and should not be a member of the Board or of a committee or sub-committee of the ICB. This is applicable if the nature and extent of their interest and the nature of their proposed role is such that they are likely to need to exclude themselves from decision-making on so regular a basis that it significantly limits their ability to effectively perform that role.

3.2.12 Additionally, the ICB constitution specifically prohibits appointment of individuals to the ICB board, committees or sub-committees if the appointment could reasonably be regarded as undermining the independence of the health services because of the candidate's involvement with the private healthcare sector or otherwise.

3.2.13 This would prevent, for example, directors of private healthcare companies or significant stakeholders of private healthcare companies from sitting on any board, committee or sub-committee exercising ICB commissioning functions.

3.2.14 However, employees/directors of voluntary organisations, social enterprises, and GPs and other clinicians may be appointed as members of the ICB board, committees or sub-committees provided they are not regarded as undermining the independence of the health services.

3.2.15 Register of Interest

3.2.16 It is a statutory requirement that ICBs must maintain one or more registers of interest of: the members of its board, members of its committees or sub-committees of its board, and its employees. ICBs must publish interests of decision-making staff and make arrangements to ensure that members of the public have access to these registers on request.

3.2.17 **In exceptional circumstances**, **an individual's name and/or other information can be redacted** from any publicly available registers where the public disclosure of information could give **rise to a real risk of harm or is prohibited by law**. Application of this exemption will be subject to Chief of Staff approval.

3.2.18 Declarations must be made by, and registers of interest will be created and maintained for the following staff:

- all full and part time staff;
- any staff on sessional or short-term contracts;
- any students and trainees (including apprentices);
- agency staff;
- seconded staff.

3.2.19 In addition, any self-employed consultants or other individuals working for the ICB under a contract for services should make a declaration of interest in accordance with this guidance, as if they were ICB employees.

3.2.20 **Members of the Board** and all members of the ICB's committees, sub-committees/sub-groups, including:

- co-opted members;
- appointed deputies;
- temporary appointments;
- any members of committees/groups from other organisations.

3.2.21 The ICB Chair may wish to require completion also by "participants", that is individuals who regularly attend and speak at board meetings but unlike board members do not have a vote and are not accountable for board decisions.

3.2.21 Where the ICB is participating in a joint committee, any interests which are declared by the committee members should be recorded on the register(s) of interest of each participating organisation.

3.2.22 All interests declared must be transferred to the relevant ICB register by the Corporate Governance team within 10 working days.

3.2.23 An interest should remain on the public register for a minimum of 6 months.

3.2.24 The ICB will retain a private record of historic interests for a minimum of 6 years after the date on which it expired. The ICB's published register of interests will state that historic interests are retained by the ICB for the specified timeframe, with details of whom to contact to submit a request for this information.

3.2.5 General management actions for managing conflicts of interests

The ICB should manage interests sensibly and proportionately. If an interest presents an actual or potential conflict of interest then management action is required, such as;

- requiring staff to comply with this guidance
- requiring staff to proactively declare interests at the point they become involved in decision-making
- considering a range of actions, which may include:
  - deciding that no action is warranted
  - restricting an individual's involvement in discussions and excluding them from decision-making
  - removing an individual from the whole decision-making process
  - removing an individual's responsibility for a whole area of work
  - removing an individual from their role altogether if the conflict is so significant that they are unable to operate effectively in the role
- keeping an audit trail of actions taken

Each case will be different. The general management actions, along with relevant industry/professional guidance should complement the exercise of good judgement. It will always be appropriate to clarify circumstances with individuals involved to assess issues and risks.

3.2.26 Managing conflicts of interests at meetings

3.2.27 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.

3.2.28 The chair, with support of the ICB's Chief of Staff or their representative should proactively consider ahead of meetings what conflicts are likely to arise and how they should be managed, including taking steps to ensure that supporting papers for particular agenda items of private sessions/meetings are not sent to conflicted individuals in advance of the meeting where relevant.

3.2.29 On circulation of the meeting agenda, delegates should be asked to confirm in writing prior to the meeting whether they believe themselves to be conflicted or

potentially conflicted regarding one or more of the agenda items.

3.2.30 The chair should ask at the beginning of each meeting if anyone has any conflicts of interest to declare in relation to the business to be transacted at the meeting. Each member of the group should declare any interests which are relevant to the business of the meeting, whether or not those interests have previously been declared. Any new interests which are declared at a meeting must be included on the ICB's relevant register of interests to ensure it is up-to-date.

3.2.31 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.

3.2.32 It is the responsibility of each individual member of the meeting to declare any relevant interests which they may have. However, should the chair or any other member of the meeting be aware of facts or circumstances which may give rise to a conflict of interests, but which have not been declared, then they should bring this to the attention of the chair who will decide whether there is a conflict of interest and the appropriate course of action to take in order to manage the conflict of interest.

- Declarations of interest in respect to board and committee meeting agenda items should be declared at the time the agenda and papers are circulated to enable the chair to plan how any conflicts should be managed at the meeting.

- Perceptions of conflicts of interests should be considered even if an actual conflict does not exist: if there is a perception of a conflict of interest, the individual should consider recusing themselves from the meeting.

- On reviewing the committee or board agenda and accompanying papers, members should inform the chair and secretariat of details on the specific agenda items and the type of conflict

3.2.33 Interests that have previously been declared should also be included in the pre-meeting declaration. There is no need for partner members to make a general statement regarding the fact that they are practicing local clinicians or professionals. However, if their status in that role places them in conflict regarding a specific agenda item then they should state this, along with the type of interest, as listed above.

3.2.34 Managing conflicts when making joint decisions with other partners.

3.2.35 Conflicts of interest management is important in the context of joint decision-making processes, especially working with local partners, other ICBs or NHSE to jointly commission services. promising the ICB's ability to make robust commissioning decisions.

3.2.36 Appropriate governance arrangements must be put in place that ensure that conflicts of interest are identified and managed. Where independent providers (including the voluntary sector) hold contracts for services (for example, community services) it would be appropriate and reasonable for the body to

involve them in discussions (for example, about pathway design and service delivery, particularly at place-level). However, this would be clearly distinct from any considerations around contracting and commissioning, from which they would be excluded.

3.2.37 The chair of the meeting has ultimate responsibility for deciding whether there is a conflict of interest and for taking the appropriate course of action, in order to manage the conflict of interest.

3.2.38 When a member of the meeting (including the chair or deputy chair) has a conflict of interest in relation to one or more items of business to be transacted at the meeting, the chair (or deputy chair or remaining non-conflicted members where relevant as described above) must decide how to manage the conflict. The appropriate course of action will depend on the particular circumstances but could include one or more of the following:

- Chairing by non-conflicted member - Where the chair has a conflict of interest, deciding that the deputy chair (or another non-conflicted member of the meeting if the deputy chair is also conflicted) should chair all or part of the meeting;

- Not attend - Requiring the individual who has a conflict of interest (including the chair or deputy chair if necessary) not to attend the meeting.

- Not receive papers or minutes - Ensuring that the individual concerned does not receive the supporting papers or minutes of the meeting which relate to the matter(s) which give rise to the conflict.

- Leave discussion - Requiring the individual to leave the discussion when the relevant matter(s) are being discussed and when any decisions are being taken in relation to those matter(s). In private meetings, this could include requiring the individual to leave the room and in public meetings to either leave the room or join the audience in the public gallery.

- Partial attendance - Allowing the individual to participate in some, or all, of the discussion when the relevant matter(s) are being discussed but requiring them to leave the meeting when any decisions are being taken in relation to those matter(s). This may be appropriate where, for example, the conflicted individual has important relevant knowledge and experience of the matter(s) under discussion, which it would be of benefit for the meeting to hear, but this will depend on the nature and extent of the interest which has been declared.

- Remain and participate - Noting the interest and ensuring that all attendees are aware of the nature and extent of the interest but allowing the individual to remain and participate in both the discussion and in any decisions. This is only likely to be the appropriate course of action where it is decided that the interest which has been declared is either immaterial or not relevant to the matter(s) under discussion. The conflicts of interest case studies include examples of material and immaterial conflicts of interest.

3.2.39 At the start of meetings, the chair should summarise all interests received prior to the meeting and call for any other interests in respect of the agenda items. Just prior to individual agenda items being discussed, the chair should confirm

any declarations of interest referred to earlier in the meeting. The chair, in discussion with meeting attendees if appropriate, should agree on a course of action to manage those conflicts. This very much depends on an assessment of the facts at the time but a number of options are available to the chair of the meeting:

- Ask the individual to leave the meeting when the agenda item on which an individual is conflicted is discussed.
- Allow the individual to take part in the discussion but leave the meeting when the decision is made.
- Note the interest but allow them to take part in the discussion and the decision making.

3.2.40 Details on how individual conflicts of interest were managed should be reflected in the minutes of the meeting. Examples of where it may be appropriate to exclude the public include:

- Information about individual patients or other individuals which includes sensitive personal data is to be discussed.
- Commercially confidential information is to be discussed, for example the detailed contents of a provider's tender submission.
- Information in respect of which a claim to legal professional privilege could be maintained in legal proceedings is to be discussed.
- To allow the meeting to proceed without interruption and disruption.

3.2.41 The chair of the meeting has ultimate responsibility for deciding whether there is a conflict of interest and for taking the appropriate course of action, in order to manage the conflict of interest.

3.2.42 Minutes taking at meetings

3.2.43 If any conflicts of interest are declared or otherwise arise in a meeting, the chair must ensure the following information is recorded in the minutes:

- Who has the interest?
- The nature of the interest and why it gives rise to a conflict, including the magnitude of any interest.
- The items on the agenda to which the interest relates.
- How the conflict was agreed to be managed.
- Evidence that the conflict was managed as intended (for example recording the points during the meeting when individuals left or returned to the meeting).

3.3 Gifts, Hospitality and Sponsorship

This policy prohibits the offer or receipt of gifts, hospitality, payment or expenses whenever these could affect or be perceived to affect the outcome of business transactions and are not reasonable and bona fide expenditure.

All staff should be aware that gifts and hospitality can be used as a subterfuge for bribery and, if this is suspected it should be reported immediately to the Local Counter Fraud Specialist.

3.3.1 Gifts

3.3.2 A gift means any item of cash or goods, or any service, which is provided for personal benefit, free of charge, or at less than its commercial value. In all circumstances, staff should not accept gifts that may affect, or be seen to affect, their professional judgement.

3.3.3 Gifts offered to ICB staff, Board members or committee members by providers or contractors linked (currently or prospectively) to the ICB's business should be **declined**. The person to whom the gifts were offered should also declare the offer so the offer which has been declined can be recorded on the register.

Gifts from suppliers or contractors –

- Gifts from suppliers or contractors doing business (or likely to do business) with an organisation should be declined, whatever their value.
- Subject to this, low-cost branded promotional aids may be accepted where they are under the value of a common industry standard of £6 in total and need not be declared, such as promotional 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. The £6 value has been selected with reference to existing industry guidance issued by the ABPI.

Gifts from other sources (i.e. patients, families, service users) –

- Gifts of cash and vouchers should always be declined.
- Staff should not ask for any gifts.
- Gifts valued at over £50 should be treated with caution and only be accepted on behalf of an organisation (i.e. to an organisation's charitable funds), not in a personal capacity. These should be declared by staff.
- Modest gifts under a value of £50 do not need to be declared.
- 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).
- 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.

3.3.4 Gifts under £50 can be accepted from non-suppliers and non-contractors (please note the clear guidance referenced above concerning suppliers and contractors*), and do not need to be declared. Gifts with a value of over £50 can be accepted on behalf of the organisation, but not in a personal capacity and must be declared. 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.

3.3.5 If you are in any doubt as to whether to accept a gift, it is better to politely decline the offer.

3.3.6 Any personal gift of cash or cash equivalents (e.g. vouchers, tokens, offers of remuneration to attend meetings whilst in a capacity working for or representing the ICB) must always be **declined**, whatever their value and whatever their source, and the offer which has been declined must be declared and recorded on the register.

3.3.8 Hospitality

3.3.9 Delivery of services across the NHS relies on working with a wide range of partners (including industry and academia) in different places and, sometimes, outside of 'traditional' working hours. As a result, staff will sometimes appropriately receive hospitality. Staff receiving hospitality should always be prepared to justify why it has been accepted and be mindful that even hospitality of a small value may give rise to perceptions of impropriety and might influence behaviour.

3.3.10 Hospitality means offers of meals, refreshments, travel, accommodation, and other expenses in relation to attendance at meetings, conferences, education and training events, etc.

3.3.11 The ICB does not wish to prevent people from accepting appropriate hospitality. However, individuals should be able to demonstrate that the acceptance or provision of hospitality would be of benefit to patients.

In all circumstances:

- Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement.
- Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event.
- Particular caution should be exercised 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.

Meals and refreshments:

- Under a value of £25 – may be accepted and need not be declared.
- Of a value between £25 and £75 – may be accepted and must be declared. The £75 value has been selected with reference to existing industry guidance issued by the ABPI.
- Over a value of £75 – should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on an organisation's register(s) of interest as to why it was permissible to accept.
- A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).

Travel and accommodation:

- Modest offers to pay some or all of the travel and accommodation costs related to attendance may be accepted and must be declared.
- Offers which go beyond modest, or are of a type that the organisation might not usually offer, need approval by senior staff, should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on an organisation's register(s) of interest as to why it was permissible to accept travel and accommodation of this type.
- A non-exhaustive list of examples includes: Offers of business class or first class travel and accommodation (including domestic travel).
  Offers of foreign travel and accommodation.

3.3.12 Modest hospitality provided in normal and reasonable circumstances is 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. Hospitality of this nature does not need to be declared to the Chief of Staff, nor recorded on the register, unless it is offered by suppliers or contractors linked (currently or prospectively) to the ICB's business in which case all such offers (whether or not accepted) should be declared and recorded.

3.3.13 In the case of modest hospitality offered by pharmaceutical companies, the ICB requires clarity on what products are to be promoted. If the product(s) has been rejected for use in the Hertfordshire and West Essex ICB area, the offer should be declined. Advice should be sought from the Pharmacy and Medicines Optimisation Team where appropriate.

3.3.14 Offers of hospitality which go beyond modest, or are of a type that the ICB itself would not offer, should be politely **refused**. A non-exhaustive list of examples includes:

- hospitality of a value of above £75 per attendee;
- in particular, offers of overseas travel and accommodation.

3.3.15 There may be some limited and exceptional circumstances where accepting the types of hospitality referred to in this paragraph may be contemplated. Hospitality of between £25 and £75 can be accepted, but must be declared to the Chief of Staff, and recorded on the register, whether accepted or not. Hospitality under £25 can be accepted and does not need to be declared. If the value of the hospitality is over £75, it must be declared and prior approval should be sought from the appropriate Director or the Chief of Staff before accepting such offers, and the reasons for acceptance should be recorded in the ICB's register of gifts and hospitality. Otherwise, such offers must be **refused**.

3.3.16 In addition, particular caution should be exercised where hospitality is offered by suppliers or contractors linked (currently or prospectively) to the ICB's business. Offers of this nature can be accepted if they are modest and reasonable but advice should always be sought from the Chief of Staff as there may be particular sensitivities, for example if a contract re-tender is imminent. All offers of hospitality from actual or prospective suppliers or contractors (whether or not accepted) should be declared and recorded.

3.3.17 The total value of hospitality provided by any specific company to the ICB must not exceed £1,000 in one financial year.

3.3.18 With regard to the provision of hospitality by the Integrated Care Board, The Code of Conduct: Code of Accountability in the NHS[6] advises that the use of NHS monies for hospitality and entertainment, including hospitality at conferences or seminars, should be carefully considered. It advises that all expenditure on these items should be capable of justification, as reasonable in the light of general practice in the public sector. It reminds NHS

[6] chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/viewer.html?pdfurl=https%3A%2F%2Fwww.nhsbsa.nhs.uk%2Fsites%2Fdefault%2Ffiles%2F2017-02%2FSect_1_-_D_-_Codes_of_Conduct_Acc.pdf&clen=125735&chunk=true

organisations that hospitality or entertainment is open to challenge by auditors and that ill- considered actions can damage respect for the NHS in the eyes of the community.

3.3.19 Shareholding and Other Ownership Interests

3.3.20 Holding shares or other ownership interests can be a common way for staff to invest their personal time and money to seek a return on investment. However, conflicts of interest can arise when staff personally benefit from this investment because of their role with the ICB. For instance, if they are involved in their organisation's procurement of products or services which are offered by a company they have shares in then this could give rise to a conflict of interest.

3.3.21 Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the ICB. If these shareholdings or other ownership give rise to risk of conflicts of interest they need to be considered and actions to mitigate risks need to be put in place.

3.3.22 There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

3.3.23 Patents

3.3.24 The development and holding of patents and other intellectual property rights allows staff to protect something that they create, preventing unauthorised use of products or the copying of protected ideas. However, conflicts of interest can arise when staff that hold patents and other intellectual property rights are involved in decision making and procurement.

3.3.25 Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation).

3.3.26 Employees should seek prior permission from the ICB before entering into any agreement with bodies regarding product development, research, work on pathways, etc., where this impacts on the ICB's own time, or uses its equipment, resources or intellectual property. Where this gives rise to a conflict of interest then this risk needs to be mitigated.

3.3.26 Donations

3.3.27 A donation is a charitable financial payment, which can be in the form of direct cash payment or through the application of a will or similar directive. Charitable giving and other donations are often used to support the provision of health and care services. As a major public sector employer the NHS holds formal and informal partnerships with national and local charities. However, conflicts of interest can arise and the following applies:

- Acceptance of donations made by suppliers or bodies seeking to do business with the ICB should be treated with caution and not routinely accepted. In exceptional circumstances a donation from a supplier may be

accepted but should receive prior written approval from the Chief of Staff or the projects lead executive director and always be declared.

- Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the ICB or is being pursued on behalf of the ICB's registered charity (if it has one) or other charitable body and is not for their own personal gain

- Staff must obtain permission if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign.

- Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued

- Staff wishing to make a donation to a charitable fund in lieu of a professional fee they receive may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for

3.3.28 Further, the ICB will not recommend alternative organisations or charities as recipients of the donation where it has deemed the offer as something the ICB will not accept. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.

3.3.29 Loyalty interests

3.3.30 Conflicts of interest can arise when decision making is influenced through association with colleagues or organisations out of loyalty to the relationship they have, rather than through an objective process. Loyalty interests should be declared by staff involved in decision making where they:

- hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role;
- sit on advisory groups or other paid or unpaid decision-making forums that can influence how the ICB spends taxpayers' money,
- are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.

3.3.31 Where holding loyalty interests gives rise to a conflict of interest then they need to be considered and the risks mitigated.

3.3.32 Commercial Sponsorship

3.3.33 This section should be read in conjunction with section 3.5 "Joint working with the pharmaceutical industry."

3.3.34 ICB staff, the Board and committee members may be offered commercial sponsorship for events such as courses, conferences, post/project funding, meetings and publications in connection with the activities which they carry out

for or on behalf of the ICB. All such offers (whether accepted or declined) must be declared so that they can be included on the ICB's register of gifts, hospitality and commercial sponsorship, and the Chief of Staff should provide advice on whether or not it would be appropriate to accept any such offers. If such offers are reasonably justifiable then they may be accepted, with the written approval of a director or the Chief of Staff.

3.3.35 Acceptance of commercial sponsorship should not in any way compromise commissioning decisions of the ICB or be dependent on the purchase or supply of goods or services. Any payment that is received for speaking at events in organisation time should be paid to the NHS organisation.

3.3.36 Sponsors should not have any influence over the content of an event, meeting, seminar, publication or training event. The ICB should not endorse individual companies or their products. It should be made clear that the fact of sponsorship does not mean that the ICB endorses a company's products or services. Sponsorship of ICB events by appropriate external bodies should only be approved if a reasonable person would conclude that the event will result in clear benefit for the ICB and the NHS.

3.3.37 During dealings with sponsors there must be no breach of patient or individual confidentiality or data.

3.3.38 No information should be supplied to a company for their commercial gain and information which is not in the public domain should not normally be supplied unless there is a clear benefit to the NHS or patients.

3.3.39 At the ICB's discretion, sponsors or their representatives may attend or take part in the event, but they should not have a dominant influence over the content or the main purpose of the event. The involvement of a sponsor in an event should always be clearly identified in the interest of transparency.

3.3.40 For further information on what to do if offered sponsorship, see Appendix 3.

3.3.41 Sponsored research

3.3.42 Research is vital in helping the NHS to transform services and improve outcomes, however there is potential for conflicts of interest to occur, particularly when research funding by external bodies does or could lead to a real or perceived commercial advantage. There needs to be transparency and any conflicts of interest should be well managed, the following principles apply:

- funding sources for research must be transparent,
- any proposed research must go through the relevant health research authority or other approvals process,
- there must be a written protocol and written contract between staff, the ICB, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services,
- the study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service,
- staff should declare involvement with sponsored research to the ICB.

3.3.43 Sponsored posts

3.3.44 Sponsored posts can offer benefits to the delivery of care, providing expertise, extra capacity and capability that might not otherwise exist if funding was required to be used from the NHS budget, however, safeguards are required to ensure that the deployment of sponsored posts does not cause a conflict of interest between the aims of the sponsor and the aims of the ICB, particularly in relation to procurement, the following principles apply:

- staff who are establishing the external sponsorship of a post should seek formal prior approval from the ICB,
- rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and confirm the appropriateness of arrangements continuing,
- sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. For the duration of the sponsorship, auditing arrangements should be established to ensure this is the case. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise,
- sponsored post holders must not promote or favour the sponsor's specific products, and information about alternative products and suppliers should be provided,
- sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

3.3.45 Clinical private practice

3.3.46 Service delivery in the NHS is done by a mix of public, private and not-for-profit organisations. The expertise of clinicians in the NHS is in high demand across all sectors and the NHS relies on the flexibility that the public, private and not-for-profit sectors can provide. It is therefore not uncommon for clinical staff to provide NHS funded care and undertake private practice work either for an external company, or through a corporate vehicle established by themselves.

3.3.47 Existing provisions in contractual arrangements make allowances for this to happen and professional conduct rules apply. However, these arrangements do create the possibility for conflicts of interest arising. Therefore, these provisions are designed to ensure the existence of private practice is known so that potential conflicts of interest can be managed. These provisions around declarations of activities are equivalent to what is asked of all staff in the section on outside employment.

3.3.48 Clinical staff should declare all private practice on appointment, and/or any new private practice when it arises including:

- where they practise (name of private facility)
- what they practise (specialty, major procedures)
- when they practise (identified sessions/time commitment)
- hospital consultants are already required to provide their employer with this information by virtue of paragraph 3, schedule. 9 of Terms and conditions – consultants (England)

3.3.49 Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

- seek prior approval of their organisation before taking up private practice
- ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work (these provisions already apply to hospital consultants by virtue of paragraphs 5 and 20, schedule 9 of the Terms and conditions – consultants (England)
- not accept direct or indirect financial incentives from private providers

3.3.50 Hospital consultants should not initiate discussions about providing their private professional services for NHS patients, nor should they ask other staff to initiate such discussions on their behalf (these provisions already apply to hospital consultants by virtue of paragraphs 5 and 20, schedule 9 of the Terms and conditions – consultants (England)).

3.3.51 Where clinical private practice gives rise to a conflict of interest then the general management actions outlined in this guidance should be considered and applied to mitigate risks.

3.3.52 Outside employment

3.3.53 The NHS relies on staff with good skills, broad knowledge and diverse experience. Many staff bring expertise from sectors outside the NHS, such as industry, business, education, government and beyond. The involvement of staff in these outside roles alongside their NHS role can therefore be of benefit, but the existence of these should be well known so that conflicts can be either managed or avoided.

3.3.54 Outside employment means employment and other engagements, outside of formal employment arrangements. This can include directorships, non-executive roles, self-employment, consultancy work, charitable trustee roles, political roles and roles within not-for-profit organisations, paid advisory positions and paid honorariums which relate to bodies likely to do business with an organisation.

3.3.55 It is the responsibility of all staff, board and committee members, contractors and others engaged under contract to make the ICB aware if they are employed or engaged in, or wish to be employed or engage in, any employment or consultancy work in addition to their work with the ICB:

- staff should declare any existing outside employment on appointment, and any new outside employment when it arises, the declaration should include:
    - staff name and their role with the organisation
    - a description of the nature of the outside employment (eg who it is with, a description of duties, time commitment)
    - relevant dates
    - any other relevant information (eg action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance)

- where a risk of conflict of interest is identified, the general management

actions should be considered and applied to mitigate risks.

3.3.56 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:

- employment with another NHS body;
- employment with another organisation which might be in a position to supply goods/services to the ICB;
- directorship of a GP federation or primary care network;
- self-employment 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.

3.3.57 The ICB requires that individuals obtain prior written permission from a director to engage in outside employment and reserves the right to refuse permission where it believes a conflict will arise which cannot be effectively managed. ICBs should ensure that they have clear, and robust organisational policies in place to manage issues arising from outside employment.

3.3.58 In particular, it is unacceptable for pharmacy advisers or other advisers, employees or consultants to the ICB on matters of procurement to themselves to be in receipt of payments from the pharmaceutical or devices sector.

3.3.59 Declarations of offers of gifts, hospitality and sponsorship

3.3.60 Declarations of offers of gifts, hospitality and sponsorship should be made by completing the appropriate form (Appendix 3) and should include:

- staff name and their role with the organisation
- a description of the nature and value of the gift
- date of receipt
- any other relevant information (eg circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance)

3.3.61 All declarations must be made promptly and will be transferred to a gifts and hospitality register.

3.3.62 The gifts and hospitality register will be published on the ICB public website.

3.3.63 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 removed from the publicly available registers. 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 hweicbwe.declarations@nhs.net .

3.3.64 Decisions not to publish information must be made by the Conflicts of Interest Guardian for the ICB, who should seek appropriate legal advice where required. The ICB should retain a confidential un-redacted version of the registers.

3.3.65 All individuals who are required to make a declaration of interests or a declaration of gifts or hospitality should be made aware that the registers will be published, prior to their publication. This should be done by the provision of a fair processing notice that details: the identity of the data controller; the purposes for which the registers are held and published; and contact details for the data protection officer. This information should additionally be provided to any individuals who have been named in the registers because they have a relationship with the person making the declaration.

3.3.66 The registers of interests (including the register of gifts and hospitality) will be published via a web link as part of the ICB's Annual Report and Annual Governance Statement and periodically updated, following review by the Audit and Risk Committee. Up to date copies of registers can be requested via a Freedom of Information request to the ICB.

3.3.67 Register of gifts, hospitality and sponsorship

3.3.68 The ICB will maintain registers of gifts, hospitality and sponsorship

3.3.69 All the 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. 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.

3.4 Procurement

3.4.1 "Procurement" relates to any purchase of goods, services or works and the term "procurement decision" should be understood in a wide sense to ensure transparency of decision-making on spending public funds. The Public Contracts Regulations 2015 ('PCR 2015'), as amended, remains the key legislation for non-healthcare procurements.

3.4.2 The ICB will ensure that there are decision-making structures within the ICB that will allow for decisions around arranging healthcare services to be made in line with the NHS Provider Selection Regime. This includes ensuring that there are appropriate governance structures that will deal with any challenges that may follow decisions about provider selection. ICBs will need to evidence that they have properly exercised their responsibilities for arranging healthcare services set out in the NHS Provider Selection Regime. This will include publishing their intentions for arranging services in advance, publishing contracts awarded and keeping records of decision making. The ICB will ensure that local audit arrangements will be capable of auditing the decisions made under the NHS Provider Selection Regime[7]. The ICB will ensure that local audit arrangements will be capable of auditing the decisions made under the NHS Provider Selection Regime[8].

3.4.3 The ICBs Procurement Policy applies to both the Public Contracts Regulations and Provider Selection Regime. The Procurement Policy sets out the specific

[7] https://www.gov.uk/government/consultations/provider-selection-regime-supplementary-consultation-on-the-detail-of-proposals-for-regulations

[8] https://www.gov.uk/government/consultations/provider-selection-regime-supplementary-consultation-on-the-detail-of-proposals-for-regulations

COI requirements for each of the regulations in relation to procurement of services and awarding contracts.

3.4.4 Conflicts of interest need to be managed appropriately through the whole procurement process. At the outset of any process, the relevant interests of individuals involved should be identified and clear arrangements put in place to manage any conflicts. This includes consideration as to which stages of the process a conflicted individual should not participate in, and in some circumstances, whether the individual should be involved in the process at all. Further guidance is provided in the ICB's Standing Financial Instructions, and the ICB's Procurement Policy.

3.4.5 Contract management

3.4.6 Any contract monitoring meeting needs to consider conflicts of interest as part of the process. The chair of a contract management meeting should: invite declarations of interests; record any declared interests in the minutes of the meeting; and manage any conflicts appropriately and in line with this policy. This equally applies where a contract is held jointly with another organisation or with other ICBs under lead commissioner arrangements.

3.4.7 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.

3.4.8 The ICB will consider any potential conflicts of interest when circulating any contract or performance information/reports on providers and manage the risks appropriately.

3.5 Joint working with the pharmaceutical industry

3.5.1 This section should be read in conjunction with section 3.3.31 "Commercial sponsorship".

3.5.2 The Department of Health (DH) and the Association for British Pharmaceutical Industry (ABPI) seek to encourage collaborative working for the benefit of the local healthcare economy and ultimately the patient.

3.5.3 Pharmaceutical companies that are members of the ABPI are required to comply with the ABPI Code of Practice for the Pharmaceutical Industry 2016 , which regulates the promotion of prescription medicines and certain other non-promotional activities.

3.5.4 The ABPI guidance seeks to provide a framework and greater clarity for pharmaceutical companies about various aspects of Joint Working and Sponsorship.

3.5.5 This section of the policy is intended to:

- Ensure transparency for all our stakeholders on our approach to joint

working with the pharmaceutical industry.

- Promote ethical working relationships between the pharmaceutical industry and the NHS and should be used in conjunction with the DH/ABPI document "Moving beyond sponsorship: Interactive toolkit for joint working between the NHS and the pharmaceutical industry"

3.5.6 Joint working can be defined as "situations where, for the benefit of patients, one or more pharmaceutical companies and the NHS pool skills, experience and/or resources for the joint development and implementation of patient centred projects and share a commitment to successful delivery".

3.5.7 The key requirements from this definition are:

- Any joint working project must be focused on benefits to patients
- There must be a "pooling" of resources between the pharmaceutical company or companies and the NHS organisation(s) involved. Each party must, therefore, make a significant contribution to the Joint Working project to avoid the arrangement being construed as merely a gift, benefit in kind, donation or some other non- promotional/commercial practice. Resources may come in various forms, including people, expertise, equipment, communication channels, information technology and finance.

3.5.8 Other principles to be applied to any instances of joint working and sponsorship are:

- All joint working and sponsorship will support projects that address local and national priorities and will maintain the freedom of clinicians to prescribe the most clinically appropriate and effective treatment for individual patients.
- Joint working and sponsorship will be conducted in an ethical, open and transparent manner.
- Joint working will take place at a corporate (organisational) level, and not with individual healthcare professionals or NHS administrative staff.
- Joint working contracts will be negotiated on fair and reasonable terms, in line with NHS values.
- Confidentiality of information received in the course of the joint working arrangement will be respected and never used outside the scope of the project. All patient identifiers will be removed from data to preserve and respect patient confidentiality in line with the Data Protection Act 2018.
- In the interests of transparency, the overall arrangements for joint working and sponsorship must be made public via the ICB website.
- Joint working and sponsorship is based on mutual trust and respect. Pharmaceutical companies must comply with the ABPI Code at all times. All NHS employed staff should comply with NHS, the ICB and relevant professional body codes of conduct at all times.
- Clinical and prescribing policies or guidelines must be based upon principles of evidence-based medicine and cost effectiveness. They will be consistent with national recommendations including the National Institute for Health and Clinical Excellence (NICE), expert bodies such as the Royal College of General Practitioners (RCGP) and local guidance.
- The Pharmaceutical industry should not have undue influence.
- Sponsorship must not provide personal benefit.

3.5.9 Any Joint Working/Sponsorship must ensure that all arrangements are neutral, free from preference regarding the use of the company's product over other more clinically appropriate or cost-effective products or services. In addition, arrangements must be in keeping with local guidelines and formularies.

3.5.10 The ICB will act in a transparent, objective manner, never endorsing any individual company or product through such agreements.

3.5.11 Where joint working is being contemplated, full consideration of the proposal must be given before any agreement is made. Advice should be sought from the Pharmacy and Medicines Optimisation Team and the Chief of Staff. Legal advice may also be necessary.

3.5.12 There must be a specific agreement for each joint working project which contains information on:

- The name of the joint working project, the parties to the agreement, the date and the term of the agreement.
- The expected benefits for patients, the NHS and the pharmaceutical company.
- How the success of the project will be measured, when and by whom. A set of baseline measurements must be established at the outset of the project to track and measure the success of the project aims, particularly patient outcomes. For longer term projects (>1 year) patient outcomes should be analysed at least every six months as a minimum to ensure that anticipated patient benefits are being delivered.
- An outline of the financial arrangements.
- The roles and responsibilities of the ICB and the pharmaceutical company. All aspects of input from the company should be included such as training, support for service redesign, business planning, data analysis etc.
- The agreement should specify criteria that result in high certainty that both parties can meet their commitments. For example, both parties should be able to demonstrate that they have the capability, resource or track record to deliver on the commitments they are making.
- The planned publication of any data or outcomes.
- Procedures for dealing with Freedom of Information Act requests.
- If a pharmaceutical company enters into a joint working agreement on the basis that its product is already included in an appropriate place on the local formulary, a clear reference to this should be included in the joint working agreement so that all the parties are clear as to what has been agreed.
- The agreement should include contingency arrangements to cover possible unforeseen circumstances such as changes to summaries of product characteristics and updated clinical guidance. Agreements should include a dispute resolution clause and disengagement/exit criteria including an acknowledgement by the parties that the project might need to be amended or stopped if a breach of the ABPI Code is ruled.

3.5.13 Approval must be obtained from the Commissioning Committee or relevant sub-group before the project proceeds. This will allow a full evaluation of the joint working agreement including governance issues and the overall impact of the joint working to be assessed in relation to healthcare priorities.

3.5.14 Joint Working offers of any kind from pharmaceutical companies must be

declared and registered whether refused or accepted and be available for public scrutiny on request.

3.5.15 The ICB will encourage competitor companies to collaborate on any such ventures. If several companies are able to provide the same arrangements they should all – or at least a selection – be approached to ascertain their willingness to undertake joint working. If willing to do so, they could then share a joint working arrangement.

3.5.17 Any joint working arrangements will be reported to the Audit and Risk Committee.

3.5.18 A primary care rebate scheme (PCRS) is an agreement between an ICB and a pharmaceutical company that provides an economic benefit to the commissioner and, in theory, may increase the volume sales of a company's product. These are different to national patient access schemes which are negotiated nationally by the Department of Health to enable patient access for very high-cost drugs that have clear clinical benefits. PCRS could be seen to undermine national pricing agreements between the Department of Health and Industry.

- The ICB believes that the pharmaceutical industry should supply medicines to the NHS using transparent pricing mechanisms, wherever possible.
- The ICB does accept rebates from pharmaceutical companies. The decision as to whether to accept a rebate is made by the Pharmacy & Medicines Optimisation Team based on the PrescQIPP[9] operating model.

3.6 Raising concerns and breaches

3.6.1 It is the duty of every ICB employee, Board member, committee, sub-committee or group member 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 raise their concerns with the Conflicts of Interest Guardian, in line with the ICB's Whistleblowing Policy.

3.6.2 Any suspicions or concerns of acts of fraud or bribery can be reported to HWE ICB Local Counter Fraud Specialist (natalie.nelson@rsmuk.com) or the National Fraud and Corruption Line 0800 028 4060 for any concerns about fraud, Bribery and Corruption. For more information, please see the Counter Fraud Bribery and Corruption Policy

3.6.3 If conflicts of interest are not effectively managed, the ICB could face civil challenges to decisions made. For instance, if breaches occur during a service re-design or procurement exercise, the ICB risks a legal challenge from providers that could potentially overturn the award of a contract, lead to damages claims against the ICB, and necessitate a repeat of the procurement process. This could delay the development of better services and care for

[9] https://www.prescqipp.info/umbraco/surface/authorisedmediasurface/index?url=%2fmedia%2f4228%2fpisgrb-operating-model-v44.pdf

patients, waste public money and damage the ICB's reputation. In extreme cases, staff and other individuals could face personal civil liability.

3.6.4 Failure to manage conflicts of interest could lead to criminal proceedings including for offences such as fraud, bribery, and corruption. Under the Bribery Act 2010 it is an offence to:

- promise, offer or give a bribe;
- request, agree to receive or accept a bribe;
- bribe a foreign official;

It is also an offence for the organisation to fail to prevent bribery by not having adequate preventative procedures in place.

3.6.5 The ICB will ensure that individuals who fail to disclose any relevant interests or who otherwise breach the ICB's rules and policies relating to the management of conflicts of interest are subject to investigation and, where appropriate, to disciplinary action. ICB staff, Board and committee members in particular should be aware that the outcomes of such action may, if appropriate, result in the termination of their employment or position with the ICB.

3.6.6 Statutorily regulated healthcare professionals who work for, or are engaged by, the ICB are under professional duties imposed by their relevant regulator to act appropriately with regard to conflicts of interest. The ICB will report statutorily regulated healthcare professionals to their regulator if they believe that they have acted improperly, so that these concerns can be investigated. Statutorily regulated healthcare professionals should be made aware that the consequences for inappropriate action could include fitness to practise proceedings being brought against them, and that they could, if appropriate, be struck off by their professional regulator as a result.

3.6.7 Investigation of potential breaches

3.6.8 Any potential breach of the conflicts of interest elements of this policy will be investigated and actual breaches published on the ICB website. This includes the treatment of service contracts where a breach of conflicts of interest was identified.

3.6.9 Potential breaches highlighted during the course of ICB business, reported to the Conflicts of Interest Guardian or identified in any other way, will be documented by the Chief of Staff and investigated.

3.6.10 Each breach needs to be investigated and judged on its own merits and this should start with those involved having the opportunity to explain and clarify any relevant circumstances.

3.6.11 A conflicts of interest panel will be assembled by the Chief of Staff. The panel will be chaired by a non-executive board member and a minimum of two other non-executive board members will be members of the panel.

3.6.12 All documented evidence will be compiled by the Chief of Staff or their representative and circulated to panel members at least five working days prior to the panel meeting.

3.6.13 There is an expectation that the individual being investigated will respond to questions and provide evidence sought in a timely manner to reduce possible delay.

3.6.14 The ICB recognises that receiving requests as part of the investigative process could be distressing for the individuals, and therefore HR will be approached to provide or sign-post relevant support.

3.6.15 Witnesses and the individual being investigated may be invited to the meeting if appropriate.

3.6.16 The panel meeting will be minuted by the Chief of Staff, or their representative. and minutes will be kept on file for a minimum of six years.

3.6.17 The role of the panel is to assess whether an actual breach has occurred and to decide on a course of action to reflect the consequences of that breach.

3.6.18 Legal or other appropriate advice may be sought prior to imposing sanctions which could have serious consequences for those involved, Appendix 5 outlines the 'Potential Sanctions' (as per NHS England Managing Conflicts of Interest Guidance 2024).

3.6.19 The potential courses of action available to the panel include:

- Stipulating how the risk of future similar breaches can be mitigated against;
- Recommendation of disciplinary action;
- Seek advice from local counter fraud services;
- If appropriate, referral of the matter to the Counter Fraud Authority (CFA);
- Referral to professional regulatory body.

3.6.20 In the case of a potential beach not being ruled as an actual breach, the panel may make recommendations to mitigate the risk of an actual breach occurring in the future.

3.6.21 Reports of any actual breaches will be anonymised and reported on the ICB website. If the matter has been reported to the CFA, the report will not be published until at a time advised by the CFA.

Appendix 1
The Seven Principles of Public Life (Nolan Principles)

Our management of conflicts of interest should be underpinned by principles set out by the Committee on Standards in Public Life, and sets out seven principles, which apply to everyone who works as a public office holder, including all staff who work for the NHS. They're also known as the Nolan principles. These seven principles underpin all aspects of public life, including our management of conflicts of interest.

Selflessness	Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends
Integrity	Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties
Objectivity	In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit
Accountability	Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office
Openness	Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands
Honesty	Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest
Leadership	Holders of public office should promote and support these principles by leadership and example.

As well as upholding the Standards of Public Life, you should also apply the following key principles.

- **Be aware** – A perception of wrongdoing, impaired judgement or undue influence can be as significant as any of them actually occurring.
- **Be proactive** – Be proactive, not reactive in the management of conflicts of interest. Think about where and how conflicts might arise in your work and ensure that you take action to declare and manage them. If in doubt, it is better to assume the existence of a conflict of interest and manage it appropriately rather than ignore it.
- **Be transparent** – Be transparent at every stage of the commissioning cycle. Ensure any conflicts are declared and managed throughout the commissioning cycle. Ensure that any actions to manage conflicts are clearly recorded.
- **Be informed** – Financial gain is not necessary for a conflict of interest to exist.
- **Be supportive** – Make sure individuals feel supported when they declare relevant information and raise legitimate concerns.
- **Be proportionate** - Actions to mitigate conflicts of interest should seek to preserve the spirit of collective decision-making wherever possible.

Appendix 2 – Declarations of Interest

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

DECLARTIONS OF INTEREST FORM

Name:	
Position within, or relationship with, the ICB (or NHS England in the event of joint committees):	

Detail of interests held (complete all that are applicable):

Type of Interest*	Description of Interest (including for indirect interests, details of the relationship with the person who has the interest)	Date interest relates		Actions to be taken to mitigate ~~risk~~ (to be agreed with line manager or a senior ICB manager)
		From	To	

Please note:

1. 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 will be held in electronic form in accordance with GDPR/Data Protection Act 2018. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that the ICB holds.

2. By completing and submitting this form you:

   - Confirm that the information provided above is complete and correct.
   - 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.
   - Are aware that civil, criminal or internal disciplinary action may result from a failure to make full, accurate or timely declarations.

3. If you do declare interests, we are required to publish the information on the ICB website and/or make arrangements to ensure that members of the public have access to the registers on request.

4. In exceptional circumstances, an individual's name and/or other information can be redacted from any publicly available registers where the public disclosure of information could give rise to a real risk of harm or is prohibited by law. Application of this exemption will be subject to Chief of Staff approval. Please provide further information below if you feel this exemption applies to any part of this declaration.

5. Please note that ICB staff need this form to be signed by their line manager before submitting.

Signed: **Date:**

Signed (Manager): **Date:** **Position:**

PLEASE RETURN THIS FORM TO: hweicbwe.declarations@nhs.net

***Types of Interest**

Types of Interest	Description
Financial Interests	Where an individual may get direct financial benefits (a benefit may arise from the making of gain or avoiding a loss) from the consequences of a decision their organisation makes. This could include: • a director (including a non-executive director) or senior employee in another organisation which is doing or is likely to do business with an organisation in receipt of NHS funding • a shareholder, partner or owner of an organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding • someone in outside employment • someone in receipt of secondary income • someone in receipt of a grant • someone in receipt of other payments (e.g. honoraria, day allowances, travel or subsistence) • someone in receipt of research sponsorship
Non-Financial Profession-al Interests	Where an individual may obtain a non-financial professional benefit (a benefit may arise from the making of gain or avoiding a loss) from the consequences of a decision their organisation makes, such an increasing their professional reputation or status or promoting their professional career. This could include situations where the individual is: • an advocate for a particular group of patients • a clinician with a special interest • an active member of a particular specialist body • undertaking a research role, particularly sponsored research • an advisor for the Care Quality Commission or National Institute of Health and Care Excellence
Non-Financial Personal Interests	This is where an individual may benefit (a benefit may arise from the making of gain or avoiding a loss) personally from a decision their organisation makes in ways which are not directly linked to their professional career and do not give risk to a direct financial benefit. This could include, for example, where the individual is: • a member of a voluntary sector board or has a position of authority within a voluntary sector organisation • a member of a lobbying or pressure group with an interest in health and care
Indirect Interests	This is where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit (a benefit may arise from the making of gain or avoiding a loss) from a decision they are involved in making. This would include: • close family member and relatives • close friends and associates • business partners

Example Conflicts of Interest

Example	Category	To be declared?	Conditions / action required
I am a pharmacist and sit on the ICB's medicines optimisation group, which makes decisions about the medicines and devices we recommend. What are my responsibilities relating to conflicts of interest?	Financial Interest	**Yes**	• Any group making key strategic decisions like this is subject to the guidance. Other examples would be groups making decisions around contracts, procurement or grants. You should make sure that all interests, or potential conflicts, are declared in accordance with local arrangements within 28 days of any changes. In meetings, you have a personal responsibility for declaring any material interests at the beginning of each meeting and as they arise, which will be added to the organisation's register if not already included. If the chair considers that your interest might create the risk of conflict with an item of the group's business, they might take a range of management actions relating to your participation in the group to make sure that this risk is properly managed
I am a GP Clinical Lead for the ICB. As well as declaring that I am a partner of a GP practice, do I need to declare that my practice is part of a wider PCN?	Financial	**Yes**	• Yes, you should declare the details of the PCN as a separate interest. • GPs could be both commissioners and providers of services. They could be responsible for selecting providers and deciding on spending, while potentially being involved in delivering some of those services.
I am employed by the ICB as a prescribing support dietician and am also a member of the British Diabetic Association. Do I need to declare my membership?	Non-Financial Professional Direct Interest	**Yes**	• You should declare this interest for transparency and flag at any meetings you attend where this topic comes up for discussion.
I am a contracts officer for the ICB. A close relative is an employee of a provider that the ICB commissions services from. I attend contract, performance and quality meetings where matters pertaining to this provider are discussed but I am not part of the contract management process for this provider and do not influence or discuss commissions decisions relating to this contract.	Non-Financial Personal Indirect Interest	**Yes**	• You should declare this interest for transparency
My husband is a director of a company which has supplied equipment to a provider commissioned by the ICB. Do I need to declare this?	Indirect Interest	**Yes**	• As your husband has decision making responsibilities in the company, then yes, you should declare it.

Template Register for Declarations of Interests:

Surname	Forename	Current Position(s) held within HWE ICB	Team/Directorate	Interest Declared (Name of the organisation and nature of business)	Financial	Non-financial Professional	Non-financial personal	Direct Interest	Indirect Interest	Date of Interest From	Date of interest To	Action taken to mitigate risk	Date signed and confirmed

Template Register for Declarations of Interest raised at meetings:

Surname	Forename	Current Position within organisation	Role within the HWE ICB [*insert committee*]	Interest Declared	Financial	Non-financial Professional	Non-financial personal	Direct Interest	Indirect Interest	Date of Interest From	Date of interest To	Action taken to mitigate risk	Date signed and confirmed

Appendix 3 – Gifts, Hospitality and Sponsorship

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

DECLARATION OF HOSPITALITY/GIFTS/SPONSORSHIP

Name: **Position:**

Date: **Directorate and Division:**

PLEASE RETURN THIS FORM TO: hweicbwe.declarations@nhs.net

Link to the ICB policy: hwe-integrated-governance-handbook (icb.nhs.uk)
For further questions: hweicbwe.declarations@nhs.net

ALL QUESTIONS TO BE COMPLETED

NATURE of the hospitality/ sponsorship/ gift offered to you	
Was the gift accepted or declined? **REASON** *(for declining)*	
TOTAL *value* *(if you are unsure please ask the donor for an estimated cost)*	£
NUMBER of items?	
REASON hospitality/sponsorship/gift was offered to you	
DONOR of hospitality/sponsorship/gift	
DATE of the hospitality/sponsorship/gift	

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APPROVAL considered by *(Refer to policy for authority levels)*	**Approval given: *Yes** **Name:** **Role:** *"I confirm that, to the best of my knowledge, 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."* **Signature:**
Reason for non-approval *(If applicable)*	

Please return this form to the Governance Team at hweicbwe.declarations@nhs.net

Examples of Gifts, Hospitality, Commercial Sponsorship and Secondary Employment

Example	Category	Acceptable?	Conditions / action required
Chocolates or small gifts from members of public, patients or staff	Gifts/Offer	Yes	• Must not exceed the value of £6. There is no need to declare or enter on the register.
Diaries, calendars, stationery, or other inexpensive office items	Gifts/Offer	Yes	• Must not exceed the value of £6. • Only acceptable if received at a conference, meeting or other organised event. • There is no need to declare or enter on the register.
Gift offered by a current or prospective supplier / contractor	Gifts/Offer	No	• Must be declined, declared and entered on the register
Personal gift of cash or cash equivalents (e.g. vouchers, tokens, offers of remuneration to attend meetings whilst in a capacity working for or representing the ICB)	Gifts/Offer	No	• Must be declined, declared and entered on the register
Modest hospitality such as a working lunch in the course of working meetings, trade fairs or conferences	Hospitality	Yes	• Must not exceed the value of £75. • If received from a current or prospective supplier / contractor, must be declared and entered on the register
Dinner offered at high quality restaurant / hotel	Hospitality	No	• If the value of hospitality is over £75, it must be declined, declared and entered on the register
Working lunch provided by a pharmaceutical company for a locality meeting.	Hospitality	Yes	• A written agreement must be in place and the sponsorship disclosed in any papers relating to the meeting, including any minutes taken, as well as entered into the register. • Advice should be sought from the Pharmacy and Medicines Optimisation Team as to the local status of the product(s) being promoted. • The total value of hospitality provided by any specific company to the ICB must not exceed £1,000 in one financial year.
Entertainment from an existing supplier to mark a special occasion, e.g. the opening of new premises	Hospitality	Yes	• Must be approved by a director in advance, declared and entered into the register • All such special occasions must be discussed first with the Communications Team and approved by a director
Sponsorship for training courses, conferences, post/project funding, meetings and publications	Commercial sponsorship	Yes	• Must be approved in advance by a director, declared and enter on the register
Sponsorship for attending conferences abroad	Commercial sponsorship	No	• In general, all such offers should be declined. There may be exceptional circumstances in which an offer might be acceptable; the advice of the Chief of Staff should be sought. • All offers must be declared and entered on the register.
Payment for advisory work for a pharmaceutical company	Secondary employment	No	• Must be declined, declared and entered on the register
Offer of part-time employment with an existing or prospective supplier/contractor	Secondary employment	Yes	• Must be approved by a director. The ICB may refuse permission if it is believed that an unacceptable conflict of interest arises as a result. • All secondary employment must be declared and entered onto the register of declarations of interest.

Template Register for Declarations of Gifts, Hospitality and Sponsorship:

Position	Date of Offer	Declined or Accepted	Date of Receipt (if applicable)	Details of Gift/Hospitality Sponsorship	Estimated Value	Supplier/Offeror (or provider / giver's) Name and Nature of Business	Reason for Accepting or Declining

Appendix 4 - Procurement

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

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?[1]	

[1]Taking into account all relevant regulations (e.g. the NHS (Procurement, patient choice and competition) (No 2) Regulations 2013 and guidance (e.g. that of Monitor).

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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?	

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

DECLARATION OF CONFLICT OF INTERESTS FORM FOR BIDDERS/CONTRACTORS

Name of Relevant Person	*[complete for all Relevant Persons]*	
Details of interests held:		
Type of Interest	**Details**	**Personal interest or that of a family member, close friend or other acquaintance?**
Provision of services or other work for the ICB or NHSE/I		
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 NHSE/I, whether personal or professional, which the public could perceive may impair or otherwise influence the ICB's or any of its board or committee members' or employees' judgements, decisions or actions		

Name of Organisation:	
Details of interests held:	
Type of Interest	**Details**
Provision of services or other work for the ICB or NHS England and Improvement(NHSE/I)	
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 NHSE/I, whether personal or professional, which the public could perceive may impair or otherwise influence the ICB's or any of its board or committee 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:

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Template Register for Procurement

Ref No.	Contract/ Service Title	Service commencement date / Planned service commencement date:	Procurement description	Existing Contract or New Procurement (if existing include details)	Procurement type – ICB procurement, collaborative procurement with other ICBs/ organisations/ partners	*For internal noting, not to be published* ICB Clinical Lead / Service Lead (Name)	ICB Contract Manager (Name)	Decision making process and name of decision making committee	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)	Subcontractor (if applicable)	Type	Total Contract Cost (exc VAT)	Contract value (£) (Total):	Contract value (£) (Total) and value to ICB	Duration	Comments to note

Appendix 5
Potential Sanctions (Breaches)

(Extract from NHSE Managing Conflicts of Interest Guidance 2024)

Disciplinary sanctions

Staff who fail to disclose any relevant interests or who otherwise breach an organisation's rules and policies relating to the management of conflicts of interest are subject to investigation and, where appropriate, to disciplinary action. This may include:

- employment law action such as:
  - informal action – such as reprimand or signposting to training and/or guidance
  - formal action – such as formal warning, the requirement for additional training, re-arrangement of duties, redeployment, demotion or dismissal
  - referring incidents to regulators
  - contractual action against organisations or staff
- where the staff member is not a direct employee, review of their appointment to the role that has given rise to the conflict

Professional regulatory sanctions

Statutorily regulated healthcare professionals who work for, or are engaged by, organisations are under professional duties imposed by their relevant regulator to act appropriately with regard to conflicts of interest. Organisations should consider reporting statutorily regulated healthcare professionals to their regulator if they believe that they have acted improperly, so that these concerns can be investigated. These healthcare professionals should be made aware that the consequences for inappropriate action could include fitness to practise proceedings being brought against them, and that they could, if appropriate be struck off by their professional regulator as a result.

Information and contact details for the healthcare professional regulators are accessible from the Professional Standards Authority for Health and Social Care's website.

Civil sanctions

If conflicts of interest are not effectively managed, organisations could face civil challenges to decisions they make – for instance if interests were not disclosed that were relevant to the bidding for, or performance of contracts. If a decision-maker has a conflict of interest, then the decision is also potentially vulnerable and could be overturned on judicial review. In extreme cases, staff and other individuals could face personal civil liability, for example a claim for misfeasance in public office.

Criminal sanctions

Failure to manage conflicts of interest could lead to criminal proceedings including for offences such as fraud, bribery and corruption. This could have implications for the

organisation concerned and linked organisations, and the individuals who are engaged by them.

The Fraud Act 2006 created a criminal offence of fraud and defines 3 ways of committing it:

- fraud by false representation
- fraud by failing to disclose information
- fraud by abuse of position.

In these cases, an offender's conduct must be dishonest and their intention must be to make a gain, or a cause a loss (or the risk of a loss) to another. Fraud carries a maximum sentence of 10 years imprisonment and/or a fine and can be committed by a body corporate.

The Bribery Act 2010 makes it easier to tackle this offence in public and private sectors. Bribery is generally defined as giving or offering someone a financial or other advantage to encourage a person to perform certain activities and can be committed by a body corporate.

Commercial organisations (including NHS bodies) will be exposed to criminal liability, punishable by an unlimited fine, for failing to prevent bribery.

The offences of bribing another person or accepting a bribe carry a maximum sentence of 10 years imprisonment and/or a fine. In relation to a body corporate the penalty for these offences is a fine.

Reputational consequences

A failure to manage conflicts of interest (including the perception of such a failure) can lead to reputational damage and undermine confidence in the integrity of the decision-making process and give the impression that the organisation or individual has not acted in the public interest.

Appendix 6
Equality Impact Assessment

Title of policy, service, proposal etc being assessed:
Standards of Business Conduct & Conflicts of Interest Policy

What are the intended outcomes of this work?
This policy is intended to: • Enable the ICB to deliver its statutory duty to manage conflicts of interest. • Enable individuals to demonstrate that they are acting fairly and transparently and in the best interest of patients and the local population. • Uphold confidence and trust in the NHS. • Safeguard commissioning, whilst ensuring objective decision making. • Support individuals to understand when conflicts of interest (whether actual or potential) may arise and how to manage them if they do. • Ensure that the ICB operates within the legal framework. • Uphold the reputation of the ICB and its staff in the way in conducts business.
How will these outcomes be achieved? Reporting to the Audit and Risk Committee as outlined within in the policy, and the monitoring compliance with training and annual declaration refresh.
Who will be affected by this work? The policy relates to internal stakeholders.

Evidence - Impact Assessment Not Required
The purpose of this document is to ensure that the ICB maintains the highest standards of probity and that all business relationships lead to clear benefits for patients, therefore this policy will have no impact (positive or negative) on people from the equality and health inequality groups.

For your records **Name of person(s) who carried out these analyses:** Governance Manager
Date analyses were completed: March 2024

Equality and Diversity Lead Sign off
Agreed. Paul Curry, Equality and Diversity Lead, 22 March 2024

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board

Scheme of Reservation and Delegation

Decisions and functions reserved to the Board

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

	Decisions and functions reserved to the Board	Reference
The Board	**General Enabling Provision** The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers. The Board will establish the necessary systems and processes to comply with relevant law and regulations, directions issued by the Secretary of State, directions issued by NHS England, statutory guidance and advice issued by NHS England and relevant authorities and respond to reports and recommendations made by Healthwatch organisations in the ICB area.	Constitution 4.2.2

	Decisions and functions reserved to the Board	Reference
The Board	**Regulations and Control** Consider and approve proposed amendments to the ICB Constitution by the Chief Executive prior to making an application to vary the constitution to NHSE. Approve Standing Orders (SOs), a schedule of matters reserved to the Board (Scheme of Reservation and Delegation (SoRD) of powers delegated from the Board to the Executive Team and other Committees, Functions and Decisions Map, Standing Financial Instructions (SFIs) and the Governance Handbook for the regulation of its proceedings and business. Approve to vary or amend the Standing Orders in accordance with the procedures for amending the Constitution as described above. Approve delegation arrangements to ICB Committees, Joint Committees, to other Statutory Bodies, individual Board Members and employees is reserved to the Board. Including approval of committee terms of reference. The power to approve arrangements for Pooled Funds is reserved to the Board. Approve arrangements for the management of conflicts of Interest defined within the Conflicts of Interest Policy, including publication of registers of interest. Require and receive the declaration of Board members' (and others as required) interests to discharge its duty to manage conflicts of interest. Approve arrangements for dealing with complaints and ensure a clear complaints process is published. Ensure the ICB Complies with the Freedom of Information Act 2000 and Information Commissioner Office requirements. Ensure systems and processes exist to comply with the requirements of the NHS Provider Selection Regime.	Constitution 1.6.2, Standing Orders 2.1.3, 2.1.4 Constitution 1.6.2, 1.7.2, 4.4.2, Standing Orders 2.1, 2.3 Constitution 1.6.2; Standing Orders 2.3 Constitution 4.6.1, 4.6.3, 4.6.6, 4.7.1 Constitution 4.7.3 Constitution 6.1.1, 6.3.2 Constitution 6.1.3, 6.1.4, 6.1.5, 6.3.1, 6.3.2, 6.3.7 Constitution 7.3.4 Constitution 7.3.5

	Decisions and functions reserved to the Board	Reference
	Comply with Local Authority Health Overview and Scrutiny Requirements. Adopt the Executive structure to facilitate the discharge of business by the ICB and to agree modifications thereto except where these functions have been delegated to a Joint Committee. Receive reports from committees including those that the ICB is required by the Secretary of State or other regulation to establish and to action appropriately. Confirm the recommendations of the ICB's committees where the committees do not have executive powers. Approve arrangements relating to the discharge of the ICB's responsibilities as a corporate trustee for funds held on trust. Discipline members of the Board who are in breach of statutory requirements or SOs.	Constitution 7.4.2, 7.4.3 Constitution 7.4.4 Constitution 2.2
The Board	**Appointments/Dismissal** Appoint each Ordinary Member of the Board, exercised by the Chair. Approve dismissal of members of the Board at the recommendation of the Chair, to be executed by the Chair. The Chair of the ICB will be appointed by NHS England as set out within legislation. Appoint and dismiss other committees (and individual members) that are directly accountable to the Board.	Constitution 2.1.5, 2.2.2, 2.2.4 Constitution section 3

	Decisions and functions reserved to the Board	Reference
	Appointment of Internal or External Auditors and the Counter Fraud officer following recommendations from the Audit Committee.	Constitution 4.6.8
The Board	**<u>Strategy, Annual Operational Plan and Budgets</u>** Approve a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years. Approve and publish an Integrated Care System Plan and Capital Resource use Plan. Oversee and maintain accountability for the management of key strategic risks, evaluate them and ensure adequate responses are in place and are monitored, including the approval of the ICB Risk Management Policy. Approve plans in respect of the application of available financial resources to support the agreed Annual Operational Plan (Financial Framework and Annual Budgets), except where these functions have been delegated to a Joint Committee. Approve proposals for ensuring quality and developing clinical governance in services provided by the ICB or its constituent practices (ICB Quality Strategy), having regard to any guidance issued by the Secretary of State, except where these functions have been delegated to a Joint Committee. Approve annually (with any necessary appropriate modification) the annual refresh of system plan, except where these functions have been delegated to a Joint Committee. Approve annually and publish the ICB Engagement Framework setting out how the ICB complies with and delivers its duties to engage with the public. Approve Outline and Final Business Cases for Commissioning Investment if this represents a variation from the Plan, in line with the ICB SFIs and Schedule of Detailed Delegated Financial Limits.	Constitution 4.3, Constitution 1.4.10, 7.3.8 Constitution 9.1.1

	Decisions and functions reserved to the Board	Reference
	Approve the ICB's organisational development proposals. Approve Executive Team proposals on individual contracts (other than NHS contracts) of a revenue, except where these functions have been delegated in line with the ICB Schedule of Detailed Delegated Financial Limits. Approve Executive Team proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Director of Resources (for losses and special payments) as per the ICB SFIs and detailed scheme of delegated limits.	
The Board	**Policy Determination** Approve ICB Policies (including HR policies incorporating the arrangements for the appointment, removal and remuneration of staff), except where delegated to specific committees (set out below) for the approval of minor changes and updates.	
The Board	**Audit and Counter Fraud** Receive the annual management letter from the External Auditor and agreement of the Executive Team's proposed action, taking account of the advice, where appropriate, of the Audit Committee. Receive an annual report (and Head of Internal Audit Opinion) from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee. Receive an annual report from the Counter Fraud officer and agree action on recommendations where appropriate of the Audit Committee.	
The Board	**Annual Reports and Accounts** Receive and approve the ICB's Annual Report and Annual Accounts, to be externally audited and published. Receive and approve the Annual Report and Accounts for funds held on trust.	Constitution 7.5

	Decisions and functions reserved to the Board	Reference
The Board	**Monitoring** Receipt of such reports as the Board sees fit from the Executive Team and other committees in respect of its exercise of powers delegated.	

Decisions and functions delegated by the Board to the ICB committees

Committee	Decisions and functions reserved to the Committee	Reference
Audit & Risk Committee	• The Committee will, in accordance with the terms of reference of the Committee as approved by the Board as if written into the Scheme of Reservation and Delegation and ICB Constitution, provide oversight and assurance to the ICB Board on the adequacy of the governance, risk management and internal control processes within the ICB including: - Integrated governance, risk management and internal control - Internal Audit, External Audit and Counter Fraud - Freedom to Speak Up - Information Governance - Financial Reporting - Conflicts of Interest - Security (including Cyber Security) - Governance - Emergency Planning, Preparedness and Resilience - Sustainability • The Audit Committee shall review instances of non-compliance with Standing Orders.	Constitution 4.6.4, 4.6.8 Standing Orders 3.6
Remuneration Committee	• The Committee will, in accordance with the terms of reference of the Committee as approved by the Board as if written into the Scheme of Reservation and Delegation and ICB Constitution, exercise the functions of the ICB relating to	

Committee	Decisions and functions reserved to the Committee	Reference
	paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006 and implement NHSE guidance, including: - Determining the remuneration of the Chief Executive, Directors and other Very Senior Managers and Board members (other than non-executive members). - Determining arrangements for the termination of employment and other contractual and non-contractual terms of the Chief Executive, Directors and other Very Senior Managers and Board members (other than non-executive members). - Agreeing the pay framework for clinical staff working within the ICB but outside of Agenda for Changes Terms and Conditions. - Determining the arrangements for termination payments and any special payments for all staff. • The Remuneration Committee shall establish a Non-Executive Remuneration Panel to consider and agree arrangements for remuneration of Non-Executive Members.	Constitution 4.6.8, 8.1.6 Constitution 3.13.1
Strategic Finance & Commissioning Committee	The Strategic Finance and Commissioning Committees is delegated by the Board to focus its purpose on improving the health and wellbeing outcomes of the ICBs population taking into account financial resource alongside national and local evidence to support affordability. It will do this through: • Oversight and development of strategic finance management: • Consider Commissioning and investment proposals based on their contribution to the overall delivery of the ICB objectives • Oversee the development and delivery of a robust, viable and sustainable system financial plan. This will include: • financial performance of the ICB • financial performance of NHS organisations within the ICB footprint; • To seek assurance that an effective system financial framework and operating model (for capital and revenue funding) is in place for collectively distributing and	

Committee	Decisions and functions reserved to the Committee	Reference

	managing resources, and that they can be used in accordance with the ICB's Integrated Care Strategy.
	
	• Oversight and accountability of strategic commissioning:
	  • Oversee procurement and contracting processes.
	  • Make decisions about proceeding with commissioning changes including commissioning of new services, significant commissioning changes, decommissioning, and redesign of health services with proposals supported by completed or proposed evaluation.
	  • Identify opportunities for commissioning services at scale, including sharing of best practice and innovation across the ICS, and identifying opportunities for improvement, cost efficiency and sustainability.
	
	• Oversight and assurance in the delivery of ICB strategic priorities by HWE Health Care Partnerships:
	  • To ensure an assurance framework is effectively in place to proactively oversee system productivity and efficiency programmes to meet agreed priorities.
	  • To monitor financial performance against approved budgets, ensuring alignment with ICB strategic priorities.
	  • Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation but may not delegate any decisions to such groups.
	
	  • **This Committee has delegated authority to approve ICB policies in respect of the following**:	

Committee	Decisions and functions reserved to the Committee	Reference
	• Policies concerning dispute resolution for Primary Care, Community Pharmacy, Optometry and Dentistry contract holders will be referred to the Primary Care Commissioning Committee for approval. • Evidence Based Interventions (EBI) policies which describe procedures that are not routinely commissioned or are only routinely commissioned when certain clinical criteria (or thresholds) are met will be referred to the Clinical Policies Group for approval. The Clinical Policies Group will not make recommendations or decisions about funding for individual patients; this is the responsibility of the Individual Funding Request panels. The group will not make recommendations or decisions about interventions which are the commissioning responsibility of NHSE. • **This Commissioning Committee has delegated authority for the following to the ICBs Primary Care Commissioning Committee.** With that authority will come approval for expenditure, business cases and contract awards as specified in the ICBs Standing Financial Instructions: • To oversee implementation of the delivery of quality commissioning and contracting within Primary Care inclusive of Primary Medical services, Dental, Community Pharmacy and Optometry across Herts and West Essex. • To provide assurance that action plans and risks relating to primary care quality are being addressed and that practices are being supported to improve quality. • To approve bids or returns on behalf of the ICB e.g. estates/capital submissions. • To liaise directly with the regional and national teams of NHSE on matters relating to Primary Care.	

Committee	Decisions and functions reserved to the Committee	Reference

	• To take an overview of the financial position for primary care in Herts and West Essex, including tracking investment against the agreed financial plan. Financial position to include the delegated budget, system development funding and other resource received, or utilised, for investment in primary care, ensuring value for money.
	• To monitor and review risks within the Committee's remit and identify any additional risks.
	• To oversee the robustness of the arrangements for and assure compliance with the ICB's responsibilities around primary care prescribing and medicines optimisation
	• To exercise the ICB's delegated primary care commissioning decisions in relation to:
	  • GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract).
	  • Newly designed Local Enhanced Services and Directed Enhanced Services.
	  • Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF).
	  • Decision making on whether to establish new GP practices in an area,
	  • Delegation of Pharmacy, Optometry and Dental Commissioning, Section 7A Public health functions and Health and Justice Commissioning – oversight of future model, governance and financial impacts.
	• Working closely with the Primary Care Board to agree the primary care priorities that are included in the ICB strategy/annual plan including priorities to address variations and inequalities	

Committee	Decisions and functions reserved to the Committee	Reference
	• To review primary care provider performance through quantitative and qualitative information across system and place and neighbourhood to continuously improve outcomes • To evaluate primary care commissioned services and provide assurance as appropriate to the Commissioning Committee and others. • Primary Care Commissioning Committee will provide regular assurance update to the Commissioning Committee. • **This Commissioning Committee has delegated authority for the following to the ICBs Provider Selection Regime (PSR) Review Group**: • The Group will review of formal representations – in compliance with the Health Care Services (Provider Selection Regime) Regulations 2023 (the Regulations). • **ICB Commissioning Committee grants the following delegated authority to the Hertfordshire and West Essex Area Prescribing Committee (HWE APC):** • HWE APC recommendations can be made and implemented in advance of formal ratification by Commissioning Committee if recommendations are: • both drug and activity cost neutral or cost saving. • implementation resources, developed to support a recommendation previously made and not associated with an additional separate cost-pressure. • for a mandatory NICE Technology Appraisal (drugs may be added to formulary in advance of formal ratification to allow for implementation within the mandated time scales) • Where a non-NICE TA recommendation has a cost pressure this must be reported for consideration before implementation. The recommendation will then be reviewed for prioritisation and consideration for affordability and formal ratification by the HWE ICB Commissioning Committee or other agreed mechanism.	

Committee	Decisions and functions reserved to the Committee	Reference
System Transformation and Quality Improvement Committee	The responsibilities of the System Transformation and Quality Improvement Committee will be authorised by the ICB Board. It is expected that the Committee will: Quality: • Be assured that there are robust processes in place for the effective management of quality. • Scrutinise structures in place to support quality planning, control and improvement, to be assured that the structures operate effectively, and timely action is taken to address areas of concern. • Agree and submit to ICB put forward the key quality priorities that are included within the ICB strategy/ annual plan. • Oversee and monitor delivery of the ICB key statutory requirements (e.g. Continuing Health Care) as applicable to quality. • Review and monitor those risks on the Strategic and Corporate Risk Register which relate to quality, and high-risk operational risks which could impact on care. Ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner. • Oversee and scrutinise the ICB's response to all relevant (as applicable to quality) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the Department of Health and Social Care (DHSC), NHS England & Improvement (NHSEI) and other regulatory bodies / external agencies (e.g. Care Quality Committee (CQC), National Institute for Health and Care Excellence (NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained. Maintain an overview of changes in the methodology employed by regulators and changes in	Constitution 1.4.7

Committee	Decisions and functions reserved to the Committee	Reference
	legislation/regulation as applicable to quality and assure the ICB that these are disseminated and implemented across all sites. • Oversee and seek assurance on the effective and sustained delivery of the ICB Quality Improvement Programmes. • Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place. • 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. • Receive assurance that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from death (including coronial inquests and Prevention of Future Death (PFD) report). • To be assured that service users are systematically and effectively involved as equal partners in quality activities. • Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children. • Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for infection prevention and control. • Clinical or Quality related policies should come through the Quality committee for oversight, scrutiny and comment prior to approval and adoption by the ICB. Policy approval will be met through compliance with the ICBs Scheme of Reservation and Delegation. • Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety. • Have oversight of the Terms of Reference and work programmes for the groups reporting into the Quality Committee (e.g., System Quality Groups, Infection Prevention and Control, Safeguarding Boards / Hubs etc). Performance:	

Committee	Decisions and functions reserved to the Committee	Reference
	• The Terms of Reference sets out how Hertfordshire and West Essex ICB will work in partnership with the regional and national NHS England teams to provide effective, streamlined oversight for quality, performance, collective use of resources, and delivery of the 2021/22 Operational Planning requirements. • These requirements include: Covid-19 restoration and recovery, a greater emphasis on population health management, and improving health inequalities, outcomes, and access. The Committee is the primary governance forum to oversee the Partnership's mutual accountability arrangements. Its primary function is to monitor system performance and provide assurance relating to quality, finance, workforce and operational performance against constitutional standards, national priorities, and local strategic plans. • The TOR describe the scope, function, and ways of working for the Committee. They should be read in conjunction with the Hertfordshire and West Essex (HWE) Partnership Memorandum of Understanding. Primary Care Transformation: • Propose the strategic direction for local primary care services and identify the key priority areas needing change. • Enable local clinical perspectives to inform strategic decision-making. • Set the strategic context for transformation and take oversight of its implementation. Enable codesign/co-production across areas of primary care transformation and redesign in partnership with patients/citizens and all partners across the wider system. • Set out the principles and methodology for transformation in the strategic delivery plan. Lead the development of the primary care strategy and make recommendations to the Integrated Care Board. • Oversee the implementation and delivery of the primary care strategic delivery plan. • Drive quality and reduce unwarranted variation in outcomes for patients in primary care across HWE.	

Committee	Decisions and functions reserved to the Committee	Reference
People Committee	The People Committee will be responsible for: • Strategic workforce leadership supporting care and health service delivery and transformation and developing innovative new working practices and meeting workforce challenges within the system and the emerging Integrated Care Partnership. • Provide workforce leadership and support for emerging ICPs and oversight of system wide strategic workforce challenges and solutions. • Play a key role in future proofing workforce challenges and ensuring plans are developed to minimise future stresses. • Supporting the development of the health and social care sector as anchor institutions, supporting the economic and social development of our community. • Effective workforce planning at an ICS and ICP level. • Ensuring a truly equal, diverse and inclusive approach to attracting, supporting and developing the health and care workforce across the system. • Fostering effective cross-organisational, multi-disciplinary working is enabled across the health and social care system, and incorporates wider stakeholders such as Education, Housing, and the Voluntary, Community and Social Enterprise sectors. • Overseeing the workforce transformation programme with specific responsibility for effective delivery of system wide initiatives and the broader People Strategy, including the six identified workstreams: integrated workforce planning; innovation and new ways of working; sustainable workforce supply; equality and inclusion; staff wellbeing and experience; and education, training and leadership development.	
Strategy Committee	The Strategy Committee is authorised by the Board to: • Provide assurance and oversight to the Integrated Care Board; and • Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee members. The Committee shall determine the membership and terms of reference of any such task and finish sub-	

Committee	Decisions and functions reserved to the Committee	Reference

	groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation but may not delegate any decisions to such groups.
	• Having oversight, assurance and providing constructive challenge to ensure that NHS Herts & West Essex ICB and partner organisations are delivering on its strategic priorities:
	  • Increasing healthy life expectancy and reduce inequality o Give every child the best start in life
	  • Improving Access to Health and Care Services o Increasing the number of citizens taking steps to improve their wellbeing
	  • Successfully delivering our financial plan each year
	• Consider the progress of the organisation in implementation of the Integrated Care Boards Medium Term Plan, and amend that plan as needed.
	• Advise the Integrated Care Board on the alignment of plans and strategies across the ICB.
	• Promoting the adoption of Population Health Management across the ICS and provide regular updates to the board on progress in this area.
	• Promote and facilitate the use of research and evidence generated by research.	

Health Care Partnership (HCP) Board – applicable to each HCP within the geographical area of HWE ICB	Each Health Care Partnership (HCP) Board within the geographical area of this ICB shall be responsible for transacting the HCP's core business and leading strategic thinking on behalf of the HCP. In discharging these key responsibilities the HCP Board will: **Core Business** • To take accountability for the development and delivery of the overall financial plan for the [specified HCP] within the specified delegated budgets of the HCP. • To scrutinise and approve recommendations proposed by the HCP Strategic Finance & Commissioning Committee and the HCP System Transformation and Quality Improvement Committee, or through whatever model of managing these responsibilities the HCP agrees. This will include investment and spending decisions within the specified delegated budgets of the HCP.	

Committee	Decisions and functions reserved to the Committee	Reference
	• To approve recommendations for activity/interventions arising from the HCP's Clinical Transformation workstreams, the enabling workstreams and the task and finish groups. • Receive updates from the HCP Finance & Commissioning Committee and the HCP System Transformation and Quality Improvement Committee (or equivalent) and to review the HCP's risk register • To assure and drive the performance and delivery of Integrated Neighbourhood Team transformation work in [the specified HCP]. **Strategic Leadership** • To participate in the development of strategy across the Integrated Care System • To take joint accountability for the development and implementation of plans to transform the delivery of health and care in [the specified HCP]. • To maintain oversight, understanding and alignment of individual organisation strategies and plans. • To bring together activity, finance, operations, and quality intelligence from NHS providers in order to drive whole-system planning and prioritisation. • To lead the resolution of strategic challenges, issues and risks between partners.	

Decisions and functions delegated to be exercised jointly

Committee/entity that will exercise the function/decision	Decisions and functions delegated by the Board	Legal power	Governing arrangements
ICB/Essex County Council	Better Care Fund funding as set out in and in accordance with: • Our final approved plan. • The national conditions (the "National Conditions") set out in the Better Care Fund Policy Framework for 2023-25 and further detailed in the Better Care fund Planning Requirements for 2023-25. • Satisfactory progress being made towards meeting the performance objectives specified in our Better Care Fund Plan. In respect of Better Care Fund funding – • The ICB and Council have entered into arrangements to established pooled budgets for the purpose of discharging the duties set out within the Act. All governance arrangements are defined within Section 75 Agreements as if written into the SORD Reports on our area's progress and performance: • Will be provided to NHS England in accordance with relevant guidance and any requests made by NHS England and governmental departments. This includes quarterly reporting on the Better Care Fund overall and fortnightly reporting on use of the Additional Discharge Funding, as set out in the Planning Requirements document.		
ICB/Hertfordshire Council	Better Care Fund funding as set out in and in accordance with: • Our final approved plan. • The national conditions (the "National Conditions") set out in the Better Care Fund Policy Framework for 2023-25 and further detailed in the Better Care fund Planning Requirements for 2023-25.		

	• Satisfactory progress being made towards meeting the performance objectives specified in our Better Care Fund Plan. In respect of Better Care Fund funding – • The ICB and Council have entered into arrangements to established pooled budgets for the purpose of discharging the duties set out within the Act. All governance arrangements are defined within Section 75 Agreements as if written into the SORD Reports on our area's progress and performance: • Will be provided to NHS England in accordance with relevant guidance and any requests made by NHS England and governmental departments. This includes quarterly reporting on the Better Care Fund overall and fortnightly reporting on use of the Additional Discharge Funding, as set out in the Planning Requirements document.		

Decisions and functions delegated by the Board to other statutory bodies

Body	Decisions and functions delegated by the Board	Legal power	Governing arrangements
Essex County Council	• s.75 – Partnership Agreement Relating to Specialist Healthcare Tasks - Essex Wide • s.75 – Partnership Agreement Relating to the Provision of Mediation and Disagreement Resolution Services for Children and Young People with Special Education Needs or Disabilities – Essex Wide • s.256 - Mental Health accommodation - Essex wide • s.256 – Street Triage - Essex wide • s.75 – Supported Employment Services, Essex wide • s.75 – Learning Disabilities services, Essex wide • Better Care Fund – and services falling within that	Section 75, section 65Z5	Delegation agreement, MOU, etc

Hertfordshire County Council	• s.75 – Agreement covering a number of services including Mental Health • s.256 – Agreement covers voluntary and community transport • MoU – Contribution towards costs of adult wright management Programme • Collaboration Agreement – for the provision of children and young people services in the QEII. • Alliance Agreement – for the provision of Stroke Services.		

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

Board Member / employee	Decisions and functions delegated by the Board	Reference
Chair	**Regulations and Control** • Authenticate use of the seal. • Suspend Standing Orders in conjunction with 2 other Board members. • In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from the relevant Director, will provide a settled view which shall be final. • To call meetings of the Board and preside over Board meetings. • In conjunction with the Chief Executive (or relevant lead Director in the case of committees) and one other member, make an urgent decision on behalf of the Board/Committee. **Appointments/Dismissal** • Appoint the Chief Executive of the ICB subject to the approval of NHS England.	Standing Order 6 Standing Order 6 Standing Orders 5.1.1 Standing Orders 3.4 Standing Orders 4.1.2, 4.2.1 Standing Order 4.9.5

Board Member / employee	Decisions and functions delegated by the Board	Reference
	• Approve the appointments of the Partner Members of the Board. • Approve the appointment of Executive Members of the Board. • Approve the appointment or re-appointment of Non-Executive Members of the Board. • Appoint the Vice Chair of the Board. • Approve appointment of members of any committee. • Suspend or terminate members of the Board, as approved by the Board.	Constitution 3.4.1 Constitution 2.2.1, 3.5.4, 3.6.5, 3.7.4 Constitution 2.1.5, 2.2.2, 3.8.2, 3.9.3, 3.10.3, 3.12.3 Constitution 3.11.2 Constitution 3.11.8 Constitution 4.6.6; Standing Orders 4.2.3 Constitution 3.13.3

Chief Executive (Deputy Chief Executive)	**Regulations and Control**
	• Propose amendments to the Constitution to be considered and approved by the ICB prior to making an application to vary the Constitution to NHS England.
	• Establish a procedure for the use of the seal and keep (or nominate a manager to keep) the seal secure.
	  • Authenticate use of the seal
	  • HWE ICB Signatory
	• Propose to the Board the adoption of the Executive structure to facilitate discharge of ICB business.
		Constitution 1.6.2, Standing Orders 2.1.3, 2.1.4
		Standing Orders 6.1.1, 6.1.3
		Constitution 3.5.4, 3.6.5, 3.7.4

Board Member / employee	Decisions and functions delegated by the Board	Reference
	Appointments/Dismissal • Subject to the approval of the ICB Chair, appoint the Partner Members of the Board. • Subject to the approval of the ICB Chair, appoint the Executive Members of the Board. • Subject to the recommendation of the selection panel, approve the appointment of the Non-Executive Members and their re-appointment (within the limit of terms of office) **Statutory Functions / Duty** • In accordance with section 252A of the 2006 Act (as amended) act as the Accountable Emergency Officer (AEO) and Gold Commander for responding to Emergency Planning Resilience and Response events and declared incidents. **NHS England Delegated Specialised Commissioning** • ICB Authorised Officer – for the Joint Commissioning Consortium. Responsibilities include those detailed in the Joint Commissioning Consortium Terms of Reference and cover the services as cited in Decisions and functions delegated to the Board by other organisations below. • ICB Authorised Officer – to oversee revisions to the supporting Delegation Agreement.	Constitution 3.8.2, 3.9.3, 3.10.3, 3.12.3 Constitution 3.11.2, 3.11.7
Chief Financial Officer	**Regulations and Control** • HWE ICB Signatory • Authenticate use of the seal.	Standing Order 6 Standing Orders 6.1.3

Board Member / employee	Decisions and functions delegated by the Board	Reference
	• Develop systems and processes to comply with the requirements of the NHS Provider Selection Regime.	Constitution 7.3.2, 7.3.3
	• Establish processes to ensure compliance with all relevant procurement regulations.	Constitution 7.3.5
	Annual Reports and Accounts • Preparation of the annual accounts and accounting tables within the Annual Report in accordance with relevant guidance and regulations, including those for funds held on trust.	Constitution 7.2.3
	• Arrange for annual accounts to be externally audited and published.	
	Statutory Functions / Duty • Ensure systems are in place to deliver the financial duties of the ICB (Sections 223GB, 223N, 223H and 223 J). Including establishing the annual budget and budget management processes.	Constitution 1.4.7, 7.2.8 Constitution 7.2.5
	• Establish adequate arrangements to discharge ICB duties in relation to the Freedom of Information Act 2000 and Information Commissioner Office requirements.	Constitution 7.4.2
	• Develop the Capital Resource Use Plan for approval by the Board and report how the ICB has exercised its functions in accordance with the Plan within the Annual Report.	
	Operational Responsibilities	

Board Member / employee	Decisions and functions delegated by the Board	Reference
	• To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation, and best practice: Financial Strategy; Financial Operations; Planning and Reporting; Estates; Purchase of Healthcare; Digital Technology; Data and System Technology. • To be the lead Executive Officer ensuring appropriate advice and explanations are provided to the Finance & Investment Committee. • To be the Senior Information Risk Owner (SIRO) for the ICB. • Maintain and refresh (where appropriate and subject to approval of the Board) the Schedule of Detailed Delegated Financial Limits. • Establish and maintain the financial framework of the ICB as defined within Standing Financial Instructions. • Respond to the annual management letter from External Audit preparing proposed actions for to present to the Board after review by the Audit Committee. • To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	
Medical Director	**Regulations and Control** • HWE ICB Signatory **Operational Responsibilities** • To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice: Development (Clinical and Professional Leadership, Primary Care and Primary Care Networks Development); Stewardship;	

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

Board Member / employee	Decisions and functions delegated by the Board	Reference
	• To be the lead Executive Officer ensuring appropriate advice and explanations are provided to the Quality & Safety Committee. • To act as the Caldicott Guardian and the Designated Safeguarding Lead. • To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	
Chief People Officer	**Strategy, Annual Operational Plan and Budgets** • Develop and present to the Board for approval, proposals for organisational development. **Operational Responsibilities** • To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice: Human Resources (ICB internal function); System Workforce. • To be the lead Executive Officer ensuring appropriate advice and explanations are provided to the Remuneration Committee. • To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	
Chief of Staff	**Regulations and Control** • Ensure processes are in place to comply with Local Authority Health Overview and Scrutiny Requirements. • Report urgent decisions to the Board for ratification. **Annual Reports and Accounts**	Constitution 7.3.4 Standing Order 4.9 Constitution 7.4.1

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

Board Member / employee	Decisions and functions delegated by the Board	Reference
	• Establish a robust system for the management of risk (including defining the strategic aims and objectives; identify, evaluate and report on risks, establishment of a risk management policy). • Management the policy framework of the ICB ensuring that policies are reviewed, updated and approved in a cyclical manner. • To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	
Director of Strategy	**Strategy, Annual Operational Plan and Budgets** • Develop and publish a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years. • Develop the Integrated Care System Plan for approval by the Board reviewing, within the annual report, the extent to which the ICB has exercised its functions. **Statutory Functions / Duties** • In accordance with section 14Z44 of the Act establish processes for public involvement and consultation in relation to commissioning arrangements and report on the discharge of these duties within the Annual Report; ensuring the ICB meets the ten principles set out by NHSE for working with people and communities. • In accordance with section 116B(1) of the Local Government and Public Involvement in Health Act 2007 ensure that due regard is given to assessments and strategies.	Constitution 7.2.8 Constitution 7.2.8, 7.4.2 Constitution 1.4.7, 7.2.8, 7.4.1, 9.1.1, 9.1.2, 9.1.3 Constitution 1.4.7

Board Member / employee	Decisions and functions delegated by the Board	Reference
	• Ensure systems are in place to reduce inequalities (Section 14Z35) and report on the discharge of these duties within the Annual Report. **<u>Operational Responsibilities</u>** • To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice: ICB Strategy: Community Resilience and Mobilisation; ICP Development and Strategic Partnerships; System Development Plan; MSE Partners; Communications and Engagement. • To be the lead Executive Officer ensuring appropriate advice and explanations are provided to the Integrated Care Partnership. • Ensure the ICB discharges its responsibilities to lead the ICS Engagement Framework. • To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	Constitution 1.4.7, 7.2.8, 7.4.1 Constitution 9.1.7
Director of Performance	**<u>Statutory Functions / Duties</u>** • In accordance with section 14Z38 of the Act establish arrangements for obtaining appropriate advice. • In accordance with section 14Z43 of the Act meet the duty to have regard to wider effect of decisions and report of the discharge of this duty within the Annual Report. • In accordance with section 116B(1) of the Local Government and Public Involvement in Health Act 2007 ensure that due regard is given to assessments and strategies.	Constitution 1.4.7 Constitution 1.4.7, 7.2.8, 7.4.1 Constitution 1.4.7

Board Member / employee	Decisions and functions delegated by the Board	Reference
	Operational Responsibilities • To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice: System Performance Management and Oversight, Co-ordination/oversight of performance Improvement, Annual Business Cycle, Business Intelligence, Including PHM Analysis, Planned Care, Elective Care and Cancer, Digital Transformation. • To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	
Director of Operations	**Statutory Functions / Duties** • In accordance with section 14Z38 of the Act establish arrangements for obtaining appropriate advice. • In accordance with section 14Z43 of the Act meet the duty to have regard to wider effect of decisions and report of the discharge of this duty within the Annual Report. • In accordance with section 116B(1) of the Local Government and Public Involvement in Health Act 2007 ensure that due regard is given to assessments and strategies. **Operational Responsibilities** • To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice: Day-to-day system/place operational delivery, Co-ordination of Place Based Development and Leadership, Local Pathway design and implementation, EPRR, Urgent and Emergency Care, HBL ICT Shared Services.	Constitution 1.4.7 Constitution 1.4.7, 7.2.8, 7.4.1 Constitution 1.4.7

Board Member / employee	Decisions and functions delegated by the Board	Reference
Audit Committee Chair	To act as the Conflicts of Interest Guardian.	Constitution 6.1.6
On Call Director	To fulfil the duties required as set out by the Emergency Planning Team for managing escalations, incidents and out of hours cover as set out within associated ICB Policies.	

Decisions and functions delegated to the Board by other organisations

Body making the delegation	Decisions and functions delegated to the Board	Reference
NHS England	In accordance with its statutory powers under section 65Z5 of the NHS Act, NHS England have delegated the exercise of Delegated Functions: For Primary Medical Services - to the ICB to commission a range of services for the people of the area as follows: • Decisions in relation to the commissioning, and management of Primary Medical Services. • Planning Primary Medical Services in the Area, including carrying out needs assessment. • Undertaking review of Primary Medical Services in respect of the Area. • Management of Delegated Funds in the Area. • Co-ordinating a common approach to the commissioning and delivery of Primary Medical Services with other health and social care bodies in respect of the Area where appropriate; and • Such other ancillary activities that are necessary in order to exercise the Delegated Functions. Specific obligations also include: • Primary Medical Services Contract Management. • Enhanced Services. • Design of Local incentive Schemes. • Making decisions on discretionary payments or support. • Making decisions about commissioning urgent care for out of areas registered patients. • Transparency and Freedom of Information. • Planning the Provider Landscape. • Primary Care Networks. • Approving Primary medical Services Provider Mergers and Closures. • Making decisions in relation to management of poorly performing Primary Medical Services Providers.	Delegation Agreement.

Body making the delegation	Decisions and functions delegated to the Board	Reference
	• Premises Costs Directions Functions. • Maintaining the Performers List. • Procurement and New Contracts. • Complaints. • Commissioning ancillary support services. • Finance • Workforce For Primary and Secondary Dental Care Services - to the ICB to commission a range of services for the people of the area as follows: • Decisions in relation to the commissioning and management of Primary Dental Services; • Planning Primary Dental Services in the Area, including carrying out needs assessments; • Undertaking reviews of Primary Dental Services in the Area; • Management of the Delegated Funds in the Area; • 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 • such other ancillary activities that are necessary in order to exercise the Delegated Functions. Specific Obligations – Primary Dental Services only: • Dental Services Contract Management. • Transparency and Freedom of Information. • Planning the Provider Landscape. • Finance. • Staffing and Workforce.	

Body making the delegation	Decisions and functions delegated to the Board	Reference
	• Integrated dentistry into communication at Primary Care Network level. • Making Decisions in relation to Management of Poorly Performing Dental Services Providers. • Maintaining the Performers List. • Procurement and New Contracts. • Complaints. • Commissioning Ancillary Support Services. For Primary Ophthalmic Services - to the ICB to commission a range of services for the people of the area as follows: • Decisions in relation to the management of Primary Ophthalmic Services; • Undertaking reviews of Primary Ophthalmic Services in the Area; • Management of the Delegated Funds in the Area; • Co-ordinating a common approach to the commissioning of Primary Ophthalmic Services with other commissioners in the Area where appropriate; and • Such other ancillary activities that are necessary in order to exercise the Delegated Functions. Specific Obligations – Primary Ophthalmic Services: • Primary Ophthalmic Services Contract Management. • Transparency and Freedom of Information. • Maintaining the Performers List. • Finance. • Workforce. • Integrated optometry into communities at Primary Care Network Level. • Complaints. • Commissioning ancillary support services.	

<table>
<tr><th>Body making the delegation</th><th>Decisions and functions delegated to the Board</th><th>Reference</th></tr>
<tr><td></td><td>
For Pharmaceutical Services - to the ICB to commission a range of services for the people of the area as follows:

Delegated Pharmaceutical Functions – as cited in the NHS England to HWE ICB Delegation Agreement – with terms as referenced in March 2023.
Prescribed Support.
Local Pharmaceutical Services Schemes.
Barred Persons.
Other Services.
Payments.
Flu vaccinations.
Integration.
Integrating Pharmacy into Communities at Primary Care Network Level.
Complaints.
Commissioning ancillary support services.
Finance.
Workforce.

Such arrangements as have been set out in the ‘delegation agreement’ and shall prevail as if written into the SORD.

Specialist Commissioning:

The following Specialised Services were delegated to the ICB on 1 April 2024.
<table>
<tr><th>PSS Manual Line</th><th>PSS Manual Line Description</th><th>Service Line Code</th><th>Service Line Description</th></tr>
<tr><td rowspan="2">2</td><td rowspan="2">Adult congenital heart disease services</td><td>13X</td><td>Adult congenital heart disease services (non-surgical)</td></tr>
<tr><td>13Y</td><td>Adult congenital heart disease services (surgical)</td></tr>
<tr><td>3</td><td>Adult specialist pain management services</td><td>31Z</td><td>Adult specialist pain management services</td></tr>
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Body making the delegation	Decisions and functions delegated to the Board				Reference
	4	Adult specialist respiratory services	29M	Interstitial lung disease (adults)	
			29S	Severe asthma (adults)	
			29L	Lung volume reduction (adults)	
	5	Adult specialist rheumatology services	26Z	Adult specialist rheumatology services	
	7	Adult Specialist Cardiac Services	13A	Complex device therapy	
			13B	Cardiac electrophysiology & ablation	
			13C	Inherited cardiac conditions	
			13E	Cardiac surgery (inpatient)	
			13F	PPCI for ST- elevation myocardial infarction	
			13H	Cardiac magnetic resonance imaging	
			13T	Complex interventional cardiology (adults)	
			13Z	Cardiac surgery (outpatient)	
	9	Adult specialist endocrinology services	27E	Adrenal Cancer (adults)	
			27Z	Adult specialist endocrinology services	
	11	Adult specialist neurosciences services	08O	Neurology (adults)	
			08P	Neurophysiology (adults)	
			08R	Neuroradiology (adults)	
			08S	Neurosurgery (adults)	
			08T	Mechanical Thrombectomy	
			58A	Neurosurgery LVHC national: surgical removal of clival chordoma and chondrosarcoma	
			58B	Neurosurgery LVHC national: EC-IC bypass (complex/high flow)	
			58C	Neurosurgery LVHC national: transoral excision of dens	
			58D	Neurosurgery LVHC regional: anterior skull based tumours	
			58E	Neurosurgery LVHC regional: lateral skull based tumours	
			58F	Neurosurgery LVHC regional: surgical removal of brainstem lesions	
			58G	Neurosurgery LVHC regional: deep brain stimulation	
			58H	Neurosurgery LVHC regional: pineal tumour surgeries - resection	
			58I	Neurosurgery LVHC regional: removal of arteriovenous malformations of the nervous system	
			58J	Neurosurgery LVHC regional: epilepsy	

Body making the delegation	Decisions and functions delegated to the Board				Reference
		Adult specialist neurosciences services (continued)	58K	Neurosurgery LVHC regional: insula glioma's/ complex low grade glioma's	
			58L	Neurosurgery LVHC local: anterior lumbar fusion	
			58M	Neurosurgery LVHC local: removal of intramedullary spinal tumours	
			58N	Neurosurgery LVHC local: intraventricular tumours resection	
			58O	Neurosurgery LVHC local: surgical repair of aneurysms (surgical clipping)	
			58P	Neurosurgery LVHC local: thoracic discectomy	
			58Q	Neurosurgery LVHC local: microvascular decompression for trigeminal neuralgia	
			58R	Neurosurgery LVHC local: awake surgery for removal of brain tumours	
			58S	Neurosurgery LVHC local: removal of pituitary tumours including for Cushing's and acromegaly	
	12	Adult specialist ophthalmology services	37C	Artificial Eye Service	
			37Z	Adult specialist ophthalmology services	
	13	Adult specialist orthopaedic services	34A	Orthopaedic surgery (adults)	
			34R	Orthopaedic revision (adults)	
	15	Adult specialist renal services	11B	Renal dialysis	
			11C	Access for renal dialysis	
	16	Adult specialist services for people living with HIV	14A	Adult specialised services for people living with HIV	
	17	Adult specialist vascular services	30Z	Adult specialist vascular services	
	18	Adult thoracic surgery services	29B	Complex thoracic surgery (adults)	
			29Z	Adult thoracic surgery services: outpatients	
	30	Bone conduction hearing implant services (adults and children)	32B	Bone anchored hearing aids service	
			32D	Middle ear implantable hearing aids service	
	35	Cleft lip and palate services (adults and children)	15Z	Cleft lip and palate services (adults and children)	

Body making the delegation	Decisions and functions delegated to the Board				Reference
	36	Cochlear implantation services (adults and children)	32A	Cochlear implantation services (adults and children)	
	40	Complex spinal surgery services (adults and children)	06Z	Complex spinal surgery services (adults and children)	
			08Z	Complex neuro-spinal surgery services (adults and children)	
	54	Fetal medicine services (adults and adolescents)	04C	Fetal medicine services (adults and adolescents)	
	58	Specialist adult gynaecological surgery and urinary surgery services for females	04A	Severe Endometriosis	
			04D	Complex urinary incontinence and genital prolapse	
	58A	Specialist adult urological surgery services for men	41P	Penile implants	
			41S	Surgical sperm removal	
			41U	Urethral reconstruction	
	59	Specialist allergy services (adults and children)	17Z	Specialist allergy services (adults and children)	
	61	Specialist dermatology services (adults and children)	24Z	Specialist dermatology services (adults and children)	
	62	Specialist metabolic disorder services (adults and children)	36Z	Specialist metabolic disorder services (adults and children)	
	63	Specialist pain management services for children	23Y	Specialist pain management services for children	
	64	Specialist palliative care services for children and young adults	E23	Specialist palliative care services for children and young adults	
	65	Specialist services for adults with infectious diseases	18A	Specialist services for adults with infectious diseases	
			18E	Specialist Bone and Joint Infection (adults)	
	72	Major trauma services (adults and children)	34T	Major trauma services (adults and children)	
	78	Neuropsychiatry services (adults and children)	08Y	Neuropsychiatry services (adults and children)	
	83	Paediatric cardiac services	23B	Paediatric cardiac services	

Body making the delegation	Decisions and functions delegated to the Board				Reference
	94	Radiotherapy services (adults and children)	01R	Radiotherapy services (Adults)	
			51R	Radiotherapy services (Children)	
			01S	Stereotactic Radiosurgery / radiotherapy	
	105	Specialist cancer services (adults)	01C	Chemotherapy	
			01J	Anal cancer (adults)	
			01K	Malignant mesothelioma (adults)	
			01M	Head and neck cancer (adults)	
			01N	Kidney, bladder and prostate cancer (adults)	
			01Q	Rare brain and CNS cancer (adults)	
			01U	Oesophageal and gastric cancer (adults)	
			01V	Biliary tract cancer (adults)	
			01W	Liver cancer (adults)	
			01Y	Cancer Outpatients (adults)	
			01Z	Testicular cancer (adults)	
			04F	Gynaecological cancer (adults)	
			19V	Pancreatic cancer (adults)	
			24Y	Skin cancer (adults)	
			19C	Biliary tract cancer surgery (adults)	
			19M	Liver cancer surgery (adults)	
			19Q	Pancreatic cancer surgery (adults)	
			51A	Interventional oncology (adults)	
			51B	Brachytherapy (adults)	
			51C	Molecular oncology (adults)	
			61M	Head and neck cancer surgery (adults)	
			61Q	Ophthalmic cancer surgery (adults)	
			61U	Oesophageal and gastric cancer surgery (adults)	
			61Z	Testicular cancer surgery (adults)	
			33C	Transanal endoscopic microsurgery (adults)	
			33D	Distal sacrectomy for advanced and recurrent rectal cancer (adults)	
	106	Specialist cancer services for children and young adults	01T	Teenage and young adult cancer	
			23A	Children's cancer	

Body making the delegation	Decisions and functions delegated to the Board				Reference
	106A	Specialist colorectal surgery services (adults)	33A	Complex surgery for faecal incontinence (adults)	
			33B	Complex inflammatory bowel disease (adults)	
	107	Specialist dentistry services for children	23P	Specialist dentistry services for children	
	108	Specialist ear, nose and throat services for children	23D	Specialist ear, nose and throat services for children	
	109	Specialist endocrinology services for children	23E	Specialist endocrinology and diabetes services for children	
	110	Specialist gastroenterology, hepatology and nutritional support services for children	23F	Specialist gastroenterology, hepatology and nutritional support services for children	
	112	Specialist gynaecology services for children	73X	Specialist paediatric surgery services - gynaecology	
	113	Specialist haematology services for children	23H	Specialist haematology services for children	
	115B	Specialist maternity care for adults diagnosed with abnormally invasive placenta	04G	Specialist maternity care for women diagnosed with abnormally invasive placenta	
	118	Neonatal critical care services	NIC	Specialist neonatal care services	
	119	Specialist neuroscience services for children	23M	Specialist neuroscience services for children	
			07Y	Paediatric neurorehabilitation	
			08J	Selective dorsal rhizotomy	
	120	Specialist ophthalmology services for children	23N	Specialist ophthalmology services for children	
	121	Specialist orthopaedic services for children	23Q	Specialist orthopaedic services for children	
	122	Paediatric critical care services	PIC	Specialist paediatric intensive care services	
	125	Specialist plastic surgery services for children	23R	Specialist plastic surgery services for children	
	126	Specialist rehabilitation services for patients with highly complex needs (adults and children)	07Z	Specialist rehabilitation services for patients with highly complex needs (adults and children)	

Body making the delegation	Decisions and functions delegated to the Board				Reference
	127	Specialist renal services for children	23S	Specialist renal services for children	
	128	Specialist respiratory services for children	23T	Specialist respiratory services for children	
	129	Specialist rheumatology services for children	23W	Specialist rheumatology services for children	
	130	Specialist services for children with infectious diseases	18C	Specialist services for children with infectious diseases	
	131	Specialist services for complex liver, biliary and pancreatic diseases in adults	19L	Specialist services for complex liver diseases in adults	
			19P	Specialist services for complex pancreatic diseases in adults	
			19Z	Specialist services for complex liver, biliary and pancreatic diseases in adults	
			19B	Specialist services for complex biliary diseases in adults	
	132	Specialist services for haemophilia and other related bleeding disorders (adults and children)	03X	Specialist services for haemophilia and other related bleeding disorders (Adults)	
			03Y	Specialist services for haemophilia and other related bleeding disorders (Children)	
	134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	05P	Prosthetics (adults and children)	
	135	Specialist paediatric surgery services	23X	Specialist paediatric surgery services - general surgery	
	136	Specialist paediatric urology services	23Z	Specialist paediatric urology services	
	139A	Specialist morbid obesity services for children	35Z	Specialist morbid obesity services for children	
	139AA	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital	04P	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital	
	ACC	Adult Critical Care	ACC	Adult critical care	

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Hertfordshire and West Essex Integrated Care Board

Standing Financial Instructions

ICS implementation guidance

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

They exist to achieve four aims:

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

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

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

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

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

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

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1.Purpose and statutory framework

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

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

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

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

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

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

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

1.1.8 Should any difficulties arise regarding the interpretation or application of any of these SFIs, the advice of the Chief Executive or the Chief Financial Officer must be sought before acting.

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

1.2.0 The Audit and Risk Committee is responsible for approving all detailed financial policies.

1.2.1 These SFIs will be published and maintained on the ICB's website at.

1.2.2 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Chief Financial Officer must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the ICB's constitution, standing orders and scheme of reservation and delegation.

2. Scope

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

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

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

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

3. Roles and Responsibilities

3.1 Staff

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

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

The roles and responsibilities of the ICBs members, employees, members of the Governing Body, members of the Governing Body's Committees and Sub-Committees and persons working on behalf of the ICB are set out in paragraph 2.2 of the ICB constitution.

3.2 Accountable Officer

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

3.2.2 The Chief Financial Officer reports directly to the ICB Chief Executive Officer and is professionally accountable to the NHS England regional finance director

3.2.3 The Chief Executive will delegate to the chief financial officer the following responsibilities in relation to the ICB:

- preparation and audit of annual accounts.
- adherence to the directions from NHS England in relation to accounts preparation.
- ensuring that the allocated annual revenue and capital resource limits are not exceeded, jointly, with system partners.
- ensuring that there is an effective financial control framework in place to support accurate financial reporting, safeguard assets and minimise risk of financial loss.

- meeting statutory requirements relating to taxation.
- ensuring that there are suitable financial systems in place (see Section 6)
- meets the financial targets set for it by NHS England.
- use of incidental powers such as management of ICB assets, entering commercial agreements.
- the Governance statement and annual accounts & reports are signed.
- planned budgets are approved by the relevant Board; developing the funding strategy for the ICB to support the board in achieving ICB objectives, including consideration of place-based budgets.
- making use of benchmarking to make sure that funds are deployed as effectively as possible.
- executive members (partner members and non-executive members) and other officers are notified of and understand their responsibilities within the SFIs.
- specific responsibilities and delegation of authority to specific job titles are confirmed.
- financial leadership and financial performance of the ICB.
- identification of key financial risks and issues relating to robust financial performance and leadership and working with relevant providers and partners to enable solutions; and
- the Chief Financial Officer will support a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and process are in place to minimise risk.

3.3 Audit and risk committee

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

- the management of key risks

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

4. Management accounting and business management

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

4.1.2 The chief financial officer will delegate the budgetary control responsibilities to budget holders through a formal documented process.

4.1.3 The chief financial officer will ensure:

- the promotion of compliance to the SFIs through an assurance certification process.
- the promotion of long-term financial heath for the NHS system (including ICS).

- budget holders are accountable for obtaining the necessary approvals and oversight of all expenditure incurred on the cost centres they are responsible for.

- the improvement of financial literacy of budget holders with the appropriate level of expertise and systems training.

- that the budget holders are supported in proportion to the operational risk; and

- the implementation of financial and resources plans that support the NHS Long term plan objectives.

- advise the Governing Body on 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 the scheme of reservation and delegation. (**Section 16 appendix 1**)

- set out the list of managers who are authorised to place requisitions for the supply of goods and services, the maximum level of each requisition and the system for authorisation above that level.

- be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable.

- be responsible for the prompt payment of all properly authorised accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

- Any requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the ICB. In so doing, the advice of the ICB's adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Financial Officer (and/or the Accountable Officer) shall be consulted.

- Prepayments are only permitted where exceptional circumstances apply. In such instances:

- Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%).

    - The appropriate officer member of the Senior Management Team 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 prepayment agreement unable to meet his commitments.

    - The Chief Financial Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed.

    - The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Accountable Officer if problems are encountered.

- No contract or other form of order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors, employees, or agents of the ICB, other than isolated gifts of a trivial character or inexpensive seasonal gifts such as calendars or conventional hospitality such as lunches in the course of working visits.

- No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Financial Officer on behalf of the Accountable Officer.

- Orders must not be split or otherwise placed in a manner devised so as to avoid the financial thresholds set out in these SFIs.

- Goods are not to be taken on trial or loan in circumstances that could commit the ICB to a future uncompetitive purchase.

4.1.4 In addition, the Chief Financial Officer should have financial leadership responsibility for the following statutory duties:

- the of the ICB, in conjunction with its partner NHS trusts and NHS foundation trusts, to exercise its functions with a view to ensuring that, in respect of each financial year.

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

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

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

- the duty of the ICB, in conjunction with its partner trusts, to seek to achieve any joint financial objectives set by NHS England for the ICB and its partner trusts. The Chief Financial Officer and *any senior officer responsible* for finance within the ICB should also promote a culture where budget holders and decision makers consult their finance business partners in key strategic decisions that carry a financial impact.

5. Income, banking arrangements and debt recovery

5.1 Income

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

5.1.2 The Chief Financial Officer is responsible for:

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

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

5.2 Banking

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

5.2.2 The Chief Financial Officer will ensure that:

- the ICB holds the minimum number of bank accounts required to run the organisation effectively. These should be raised through the government banking services contract; and
- the ICB has effective cash management policies and procedures in place.
- ensuring payments made from bank or (GBS) accounts do not exceed the amount credited to the account except where arrangements have been made.
- reporting to the Governance and Audit Committee all arrangements made with the ICB's bankers for accounts to be overdrawn.
- monitoring compliance with any NHS England guidance on the level of cleared funds.

5.3 Debt management

5.3.1 The Chief Financial Officer is responsible for the ICB debt management strategy.

5.3.2 This includes:

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

- the appropriate recovery action on all outstanding debts, with income not received dealt with in accordance with losses procedures. Overpayments should be detected (or preferably prevented) and recovery initiated.

- establishing and maintaining systems and procedures for the secure handling and prompt banking of cash and other negotiable instruments.

- designing, maintaining, and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.

- developing effective arrangements for making grants or loans.

6. Financial systems and processes

6.1 Provision of finance systems

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

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

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

6.1.4 The Chief Financial Officer will, in relation to financial systems:

- promote awareness and understanding of financial systems, value for money and commercial issues.

- ensure that transacting is carried out efficiently in line with current best practice – e.g., e-invoicing
- ensure that the ICB meets the required financial and governance reporting requirements as a statutory body by the effective use of finance systems.

- enable the prevention and the detection of inaccuracies and fraud, and the reconstitution of any lost records.
- ensure that the financial transactions of the authority are recorded as soon as, and as accurately as, reasonably practicable.
- ensure publication and implementation of all ICB business rules and ensure that the internal finance team is appropriately resourced to deliver all statutory functions of the ICB.
- ensure that risk is appropriately managed.
- ensure identification of the duties of officers dealing with financial transactions and division of responsibilities of those officers.
- ensure the ICB has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of the ICB.
- ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes; and
- where another health organisation or any other agency provides a computer service for financial applications, the Chief Financial Officer shall periodically seek assurances that adequate controls are in operation.

7. Procurement, purchasing, tendering & Contracting

7.1 Principles

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

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

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

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

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

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

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

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

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

7.1 Tendering and Contracting Procedure

This procedure will ensure that all procurement activities are legally compliant to ensure we incur only budgeted, approved, and necessary spending. The ICB will seek value for money proposals for all goods and services ensuring that competitive tenders are invited for supplies, works and services (other than specialised services sought from or provided by the Department of Health); and for

the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens) for disposals.

The Public Contract Regulations 2015 (as amended by The Public Procurement (Amendment etc.) (EU Exit) Regulations 2020) applies to all public authorities, including the NHS. Where the contracted services are captured by the Regulations and the expected value of a contract exceeds the relevant threshold, the procurement will be undertaken in accordance with the Regulations. This includes:

publicising their intention to seek offers in relation to the contract by publishing a call for competition notice in the governments Find a Tender website and the Contracts Finder website

the process and timescales for evaluating and selecting the successful bidder.

the process for contract award and notification of contract award.

Where The Public Contracts Regulations 2015 (as amended by The Public Procurement (Amendment etc.) (EU Exit) Regulations 2020) is not applicable, but the ICB elects to invite tenders for the supply of services, the ICBs Standing Orders and Standing Financial Instructions shall apply, and:

The Governing Body may only negotiate contracts on behalf of the ICB, and the ICB may only enter into contracts, within the statutory framework set up by the 2006 Act, as amended by the 2012 Act. Such contracts shall comply with:

- the ICB's Standing Orders.
- the Public Contracts Regulation 2015, any successor legislation and any other applicable law; and
- consider as appropriate any applicable NHS England or NHS Improvement guidance that does not conflict with (b) above.

When entering into contracts with providers or suppliers of healthcare services, the standard NHS contract or short form contract must be used unless the value of the contract is less than £100,000 when a locally agreed contract can be utilised. Locally agreed contract forms can also be agreed for non-healthcare services.

In all contracts entered into, the group shall endeavour to obtain best value for money. The Accountable Officer shall nominate an individual who shall oversee and manage each contract on behalf of the ICB.

Unless the exceptions set out in 7.2.13 or 7.2.14 apply, the ICB shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than three

firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

Formal tendering procedures need not be applied where the estimated expenditure or income does not, or is not reasonably expected to, exceed

- £213,477 (inclusive of VAT) for services which fall under the non-light touch regime

- £663,540 (inclusive of VAT) for services which fall under the light touch regime; or

- Where the supply is proposed under special arrangements negotiated by NHS England in which event the said special arrangements must be complied with.

Formal tendering procedures may be waived in the circumstances set out in (a) to (j) below. 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 signed by the Accountable Officer and Chief Financial Officer and reported to the next Governance and Audit Committee meeting.

a) in very exceptional circumstances where the Accountable 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.

b) where the requirement is covered by an existing contract and there is an agreed and signed record of a contestability and value for money assessment

c) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of consortium members

d) where the timescale genuinely precludes competitive tendering (failure to plan the work properly would not be regarded as a justification for a single tender)

e) where specialist expertise is required and is available from only one source and this has been evidenced by market consultation

f) 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

g) there is a clear benefit 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

h) 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 Chief Financial Officer will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work, where allowed and provided for in the Capital Investment Manual. Written quotations should be obtained from at least three firms/individuals based on a written specification and detailed options appraisal following procurement best practice where the intended expenditure or income exceeds or is reasonably expected to exceed £25,000.

The Accountable Officer or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. The reasons for this choice should be recorded in a permanent record.

No quotation 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 Standing Financial Instructions except with the authorisation of either the Accountable Officer or Chief Financial Officer.

Items estimated to be below the limits set in these SFI for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Accountable Officer and be recorded in an appropriate ICB record.

Where tenders have been invited:

An e-Procurement portal must be used to keep a formal record of all actions undertaken, when electronic "opening" of the tenders shall be by the authorised individual.

A record shall be kept showing for each set of competitive tender invitations dispatched:

a) the name of all firms' individuals invited.

b) the names of firm's individuals from which tenders have been received.

c) the date the tenders were received and opened.

d) the price shown on each tender.

e) a note where price alterations, if any, have been made on the tender and suitably initialled.

If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Accountable Officer.

Where only one tender is received and a contract is to be awarded, the Accountable Officer and Chief Financial Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money.

Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Accountable Officer or his/her nominated officer decides that there are exceptional circumstances e.g., dispatched in good time but delayed through no fault of the tenderer. Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Accountable Officer or his/her nominated officer or if the process of evaluation and adjudication has not started. 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 by the Accountable Officer or his/her nominated officer. Accepted late tenders will be reported to the Governance and Audit Committee.

Contracts will be awarded based on the best value for money, inclusive of other factors affecting the success of a project should be considered. Where other factors are considered in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) clearly stated.

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 Accountable Officer.

All Tenders should be treated as confidential and should be retained for inspection.

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by the following staff to the value of the contract as follows: Section 16 **Appendix 1** For further guidance please see

Hertfordshire and West Essex Integrated Care Board Procurement Policy

8. Commissioning

Working in partnership with relevant national and local stakeholders, the ICB will commission certain health services to meet the reasonable requirements of the persons for whom it has responsibility

The ICB will coordinate its work with NHS England, other ICB's, local providers of services, Local Authority(ies), including through the Integrated Care System, the Health and Wellbeing Board, patients and their careers, the voluntary sector and others as appropriate to develop robust operating plans.

In considering its approach to the commissioning of and contracting for healthcare services the ICB will comply with legislation and nationally published guidance by NHS England, NHS Improvement and other equivalent bodies. Where the ICB decides not to open a new service to the market by way of tender, the reason for this will be reported to the Governing Body. Where the ICB decides to tender services, section 7 of these SFI's will apply.

The Accountable Officer will establish arrangements to ensure that regular reports are provided to the Governing Body detailing actual and forecast expenditure and activity for each contract.

The Chief Financial Officer will ensure there is a system of financial monitoring to ensure the effective accounting of expenditure under contracts. This should provide a suitable audit trail for all payments made under the contracts whilst maintaining patient confidentiality.

Agreements with providers of NHS commissioned healthcare services shall be drawn up in accordance with the relevant Health and Social Care Act and administered by the ICB. Agreements with NHS Trusts are not contracts in law and are not enforceable by the courts. However, a contract with a Foundation Trust is a legal document and is enforceable in law.

The Accountable Officer is responsible for ensuring the ICB enters into suitable contracts for healthcare services. The Accountable Officer shall nominate officers to commission standard contract agreements with providers of healthcare in line with a commissioning plan approved by the Governing Body. All funding should aim to implement the agreed priorities contained within the Operating Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Accountable Officer should take into account:

- the standards of service quality expected.
- the relevant national outcome frameworks.

- the provision of reliable information on cost and volume of services.
- that contracts build where appropriate on existing Joint Operating Commissioning Plans.

9. Staff costs and staff related non pay expenditure

9.1 Chief People Officer

9.1.1 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.

9.1.2 Operationally the CPO will be responsible for.

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

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

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

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

10. Annual reporting and Accounts

10.1.1 The Chief Financial Officer will ensure, on behalf of the Accountable Officer and ICB board, that:

- the ICB is in a position to produce its required monthly reporting, annual report, and accounts, as part of the setup of the new organisation; and
- the ICB, in each financial year, prepares a report on how it has discharged its functions in the previous financial year.
- the ICB prepares the accounts in accordance with the accounting policies and guidance given by NHS England and HM Treasury, the ICBs accounting policies and generally accepted accounting practice
- the ICB considers the external auditor's management letter and fully address all issues within agreed timescales; and
- the ICB publishes the external auditor's management letter on the ICBs website.

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

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

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

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

10.2 Internal audit

The Chief Executive, as the Accountable Officer, is responsible for ensuring there is appropriate internal audit provision in the ICB. For operational purposes, this responsibility is delegated to the Chief Financial Officer to ensure that:

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

10.3 External Audit

The Chief Financial Officer is responsible for:

- liaising with external audit colleagues to ensure timely delivery of financial statements for audit and publication in accordance with statutory, regulatory requirements.
- ensuring that the ICB appoints an auditor in accordance with the Local Audit and Accountability Act 2014; in particular, the ICB must appoint a local

auditor to audit its accounts for a financial year not later than 31 December in the preceding financial year; the ICB must appoint a local auditor at least once every 5 years (ICBs will be informed of the transitional arrangements at a later date); and

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

11. Losses and special payments

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

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

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

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

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

11.1.5 All losses and special payments (including special severance payments) must be reported to the ICB Audit and Risk Assurance Committee and NHS England noting that ICBs do not have a delegated limit to approve losses or special payments.

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

12. Fraud, bribery and corruption (Economic crime)

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

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

13. Capital Investments & security of assets and Grants

13.1.1 The Chief Financial Officer is responsible for:

- ensuring that at the commencement of each financial year, the ICB and its partner NHS trusts and NHS foundation trusts prepare a plan setting out their planned capital resource use;
- ensuring that the ICB and its partner NHS trusts and NHS foundation trusts exercise their functions with a view to ensuring that, in respect of each financial year local capital resource use does not exceed the limit specified in a direction by NHS England;
- ensuring the ICB has a documented property transfer scheme for the transfer of property, rights or liabilities from ICB's predecessor clinical commissioning group(s);
- ensuring that there is an effective appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans.
- ensuring that there are processes in place for the management of all stages of capital schemes, that will ensure that schemes are delivered on time and to cost.
- ensuring that capital investment is not authorised without evidence of availability of resources to finance all revenue consequences; and
- for every capital expenditure proposal, the Chief Financial Officer is responsible for ensuring there are processes in place to ensure that a business case is produced.

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

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

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

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

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

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

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

14. Grants

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

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

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

15. Legal and insurance

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

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

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

16. Appendix 1(Delegated limits)

Commitment of Healthcare, non-healthcare contracts and expenditure			
Committee	Role	Approval expenditure, business cases and contract award All expenditure must be authorised against known and agreed budget and cannot be exceeded All figures cited below include individual contracts or services where a perceived monetary value has been calculated – e.g., where a service is being offered to the ICB for free or at a reduced market rate. In such cases, and in support of full transparency a cost figure will be identified alongside an anticipated market value.	Authorisation for payment of prior approved expenditure
ICB Board / Governing Body		Unlimited	n/a
Strategic Finance and Commissioning Committee		**Approve** proposals on individual contracts or services of a capital or revenue nature amounting to, or likely to amount to £7.5m (or up to £15m if contract exceeds 12 months): **With delegated approval for the above sums to the ICBs Primary Care Commissioning Committee** in respect: • GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract). • Newly designed Local Enhanced Services and Directed Enhanced Services. • Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF). • Decision making on whether to establish new GP practices in an area, • Delegation of Pharmacy, Optometry and Dental Commissioning, Section 7A Public health functions and Health and Justice Commissioning – oversight of future model, governance and financial impacts. **For Primary Care Commissioning Committee - Recommend** to the Strategic Finance and Commissioning Committee for approval all proposals on individual contracts or services of a capital or revenue nature amounting to, or likely to amount to	**n/a**

		over £2.5m (or £5m if contract exceeds 12 months.	
Remuneration Committee		up £100k, for clinical and non-clinical	**n/a**
Health Care Partnership/Place		**Approve** – • Authority to approve where the source of funds and its use is determined nationally • Proposals on individual contracts or services of a capital or revenue nature amount to, or likely to amount to £1m (or up to £2m if contract exceeds 12 months). **Recommend** to the Commissioning Committee for approval all proposals on individual contracts or services of a capital or revenue nature amount to, or likely to amount to £2.5, (or up to £5m if the contract exceeds 12 months)	
	CEO	up to £2.5m	Unlimited
	CFO	up to £1000k	Unlimited
	Deputy CFO	up to £50k	£29,999.999
	Other Directors	up to £100k	£ 999,999
	Deputy/Assistant/Associate Directors	up to £50k	£49,999
	Other budget holders*	Up to £25k	£24,999
	Senior Finance Manager	Up to £5k	£1,499,000
	Other Managers*		£4,999
	Continuing Health Care Placements (Operational leads)*	Approve care packages > £1.5K per week	£9,999
	Continuing Health Care Placements (Senior leads)*	Approve care packages < £2.5K per week	£24,999
	Continuing Health Care Placements (Assistant Director)	Approve care packages < £5K per week	£99,999
	Continuing Health Care Placements (Director Nursing)	Approve care packages > £5K per week	£ 999,999
	Financial Services (T10s) For urgent payments	up to £5k	£99.999

Tenders and quotations for non-clinical services			
	1 written quote with evidence to be obtained for contracts	£0 to £24,999	
	3 written quotes – Competitive invitation to quote supported by a specification and evaluation or the use of an appropriate framework	£25,000 to £216,446	
	Formal procedure in line with the Public Contract regulations	£213,447	
Tenders and quotations for clinical services			
	1 written quote with evidence to be obtained for contracts	Up to £24,999	
	3 written quotes – Competitive invitation to quote supported by a specification and evaluation or the use of an appropriate framework	£25,001 to £299,999	
	4 written quotes – Competitive invitation to quote supported by a specification and evaluation or the use of an appropriate framework	£300,000 to £663,539	
	Formal process in line with the Public Contract Regulations	£663,539 & above	

Procurement thresholds in line with Public Contract Regulations 2015 thresholds – note that all values are inclusive of VAT. The £25k threshold is the point at which we need to advertise on Contracts Finder, anything underneath that is outside of a formal process.
*Director confirmation will be sought by finance leads – of colleagues within their teams provided with delegated authority to approve sums to this level. A register will be held documenting these names and the same or relevant director will notify the finance team of any changes.

Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

Working in partnership with people and communities

17 May 2022

(Updated 21 March 2023)

1. Background

The Health and Care Act 2022 set Hertfordshire and west Essex's Integrated Care System (ICS) onto a statutory footing from 1 July 2022 onwards, building on the proposals for legislative change set out by NHS England and NHS Improvement in its Long Term Plan. Clinical Commissioning Groups (CCGs) ceased to exist from 30 June 2022.

The Act requires our public and voluntary sector health and care organisations to work together to improve health and wellbeing for all, in order to:

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

The Act reflects extensive discussions with NHS England, the Local Government Association and the health and care sector. It incorporates lessons learned from the COVID-19 pandemic, where the positive impact of collaborative working, information sharing and voluntary, community, faith and social enterprise (VCSFE) organisations helped to support our most vulnerable residents.

It introduces an Integrated Care Board (ICB), and an Integrated Care Partnership (ICP) that each Integrated Care Board and its partner local authorities will be required to establish. ICPs bring together health, social care, public health and wider partners to deliver joined-up care for their communities, tackling health inequalities.

Collaborating as an ICS will help health and care organisations in Hertfordshire and west Essex to tackle the complex challenges facing our 1.6m population, including:

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

2. The key role of people and communities

We can only successfully tackle the health inequalities and the health and wellbeing challenges faced by our Hertfordshire and west Essex population if we actively involve and engage people and communities at the heart of our health and care system, so that they can shape and influence the development and commissioning of services.

The creation of our statutory ICS has brought fresh opportunities to strengthen the positive legacy of the area's three former Clinical Commissioning Groups. We can build on the good relationships, networks and activities which exist across the ICS's organisations and embed the positive involvement and engagement practices which have in many cases been strengthened by the COVID-19 pandemic.

3. Guiding principles for our Integrated Care System

Meaningful involvement and engagement should guide all our work, from neighbourhood and community planning to board-level decision making processes. Although the ICS will operate at a strategic level to address challenges facing the overall health and wellbeing of our residents, it will place person-centred care at the heart of a policy making.

The ICB has adopted ten principles set out by NHS England in its guidance on working with people and communities. The principles are embedded in the ICB's constitution and will be used when developing and maintaining arrangements for engaging and communities.

It is hoped that the same ten principles will guide the involvement of people and communities across our ICS area; from the ICP, to our three place-based Health and Care Partnerships, Hertfordshire's Mental Health, Learning Disability and Autism Health and Care Partnership and at neighbourhood level too, leading to a consistent, best-practice approach.

The development of this strategy has involved stakeholders and health and care professionals, patient voice members, representatives from the VCSFE Alliance and Healthwatch Hertfordshire and Healthwatch Essex representatives.

The strategy was first presented to the ICB Board for their review on 1 July 2022. At this stage, the strategy was in draft form, as it was still subject to NHS England's approval process. Since then, it has been reviewed and approved by NHS England, and updates have been made in response to the positive feedback and suggestions received. A supplementary framework document has been added (see Appendix One) which is referenced below under 'Principle One'.

Principle One

Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS

The ICB's constitution requires that arrangements are in place to ensure that individuals, their carers and their representatives are involved in:

- the planning of commissioning arrangements by the ICB
- the development and consideration of proposals by the ICB
- any changes in commissioning arrangements where the implementation of proposals would have an impact on the range of health services available, or the manner in which those services are delivered
- ICB decisions which would affect commissioning arrangements in a way that would have an impact on services or the way they are delivered.

The independent, non-executive members of the ICB will be supported to undertake their roles through training and development. They will be tasked with helping to ensure that the statutory duties of the ICB are met, including those relating to patient and public participation. Non-executive members will be connected with representative organisations including the new ICS-wide VCSFE Alliance, Health Care Partnership-specific citizens panels and the well-established and effective co-production groups in our area, including those run by Essex and Hertfordshire county councils.

The learning from these representative bodies will inform the Board's work and improve decision-making. There will also be an expectation that individuals' views are taken into account, with 'experts by experience' invited to share their insights during Board meetings.

Transparent decision-making supports accountability and responsiveness to communities. Both the ICB and ICP will meet in public, with information published in advance on accessible public-facing websites outlining the agenda. Meeting papers will be available in advance in a timely way, and there will be clear information on how the public can pose questions and observe meetings if they wish to do so.

Information about the membership, roles, accountability, and governance structures of both the ICB and the ICP will be made readily available via the ICS's over-arching website. The responsibilities of independent members/non-executive directors of formal governance bodies, such as providing a lay perspective or particular expertise, will be clearly outlined.

The ICB Involvement and Engagement Framework, developed in alignment with this strategy, and with the involvement of patient representatives from across Hertfordshire and west Essex, sets out:

- a structure to help people and communities see how their views, experiences and expertise can play a part in formal and informal health and care involvement and engagement
- a description of the tools available to the system to involve people, including co-production
- a description of how to resource involvement and engagement so that we can successfully deliver on working with people and communities.

The framework is included for reference as an appendix to this document.

Patient stories

Our ICB Board members hear directly from a patient as part of every Governing Body meeting in public. In September 2022, Mark Seal from Hertfordshire shared his experience of being cared for by the cardiology 'virtual hospital', run by West Hertfordshire Teaching Hospitals NHS Trust and his local community trust. Mr Seal's heart condition was able to be closely monitored by hospital consultants and community nurses using digital health monitoring technology which sent key health information to the expert team caring for him. This meant that he could be looked after from the comfort of his own home.

These patient stories are aligned with a planned 'deep dive' into a particular area of health provision. Other topics already covered include primary care and community health services. The ICB board always encourages patients featured to give full and frank feedback on the services they receive, so that this can be considered when decisions are made, and services planned.

Principle Two

Start engagement early when developing plans and feed back to people and communities how their engagement has influenced activities and decisions

A number of approaches will be employed to ensure the involvement of people and communities in decision making at a 'formative stage' in Hertfordshire and west Essex. These will include:

- having regard to groups with 'protected characteristics' under the Equality Act, such as age, disability, race or sex, and engaging with them when planning services or service changes
- involving 'experts by experience', for example unpaid/family carers, people with long term conditions and service users and their families, including those on existing county council co-production boards. Healthwatch Essex and Healthwatch Hertfordshire will support the recruitment of people whose circumstances or health and social care needs give them valuable personal insights into services
- engaging with representative organisations who advocate on behalf of the people and communities they support
- working with patient, service user, carer and public reference groups
- liaising with clinical transformation programmes and the health and care professional senate to ensure that patients and carers play a key part in treatment pathway and patient information design work.

The ICS will use a range of appropriate and accessible communication channels to feed back the results of engagement and co-production to those involved, taking account of any accessibility requirements of those involved. A 'You said, we did' approach will help to build public confidence in the impact of involvement across our ICS.

Community diagnostics

The development of the ICB's new community diagnostic strategy is being shaped by input from those with recent experiences of diagnostic tests, as well as staff with an interest in these services.

Engagement activities have included surveys, focus group interviews and informal online feedback sessions with GPs, those facing health inequalities, carers, and learning disability social care professionals.

A comprehensive feedback report has been produced which raises issues such as the need to consider patients on low incomes, disabled patients, and digitally excluded patients when planning services. Positive feedback has been received about arranging appointments and hospital experiences, and areas of improvement such as communicating the outcomes of tests and staffing issues have been highlighted. The outcomes of the engagement process will be fed back to participants as the strategy development continues.

Principle Three

Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect

The ICS will use information from a range of sources, including public health surveillance information, information gleaned from the results of residents' surveys, feedback from patient experience and quality sources and input from elected and community representatives to understand the needs of our communities and to assess the impact of its policies.

In line with the requirements of the Equality Act 2010, the ICB will be required to:

- evidence the analysis that has been undertaken to establish whether our policies and practices have (or would) further the aims of the general equality duty.
- provide details of information that we have considered when carrying out an analysis.

- provide details of engagement (consultation / involvement) that we have undertaken with people whom we consider would have an interest in furthering the aims of the general equality duty.

In order to meet the requirements of this duty the ICB will carry out an Equality Impact Assessment process at the primary stages of planning changes, such as:

- organisational change
- considering any new or changing activity
- developing or changing service delivery
- procuring services
- developing projects
- developing a policy / procedure / guidance or changing or updating existing ones.

The Equality Impact Assessment process will be used to assess whether there may be any barriers or difficulties, harassment or exclusion as a result of a planned change, or in fact any positive impact such as the promotion of equality of opportunity, developing good community relationships, encouraging participation and involvement as experienced by service users, patients, carers, relatives, staff, the general public and key stakeholders.

Our Healthier Future strategy

In October and November 2022, the ICB led an engagement process in order to inform the Integrated Care Partnership's strategy – a 10 year plan aimed at tackling the root causes of ill-health in our area. A stakeholder engagement process, literature review, and a number of themed focus groups helped to explore the challenges to healthy living experienced by people facing health inequalities in Hertfordshire and west Essex, including those whose voices are seldom heard.

Relevant findings from this work, which helped to set the ICP's six over-arching priorities for the next 10 years, have been shared with staff developing the delivery plan for this significant policy document.

Principle Four

Build relationships with excluded groups, especially those affected by inequalities

The ICS is committed to ensuring that everybody, irrespective of their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, (including nationality and ethnicity), religion or belief, sex (male/female) or sexual orientation should have equal access to services and that services should, as far as possible, be sensitive to individual needs.

An emerging area of focus during the COVID-19 pandemic response was the way in which the virus had a disproportionate impact on the health of people living in poverty, with noticeable impacts on people who are Black, Asian or from other minority ethnic groups. As a result, health and care organisations have become more closely engaged with community and faith groups, district and borough councils – and our own staff from Black, Asian and minority ethnic backgrounds - who have made it clear that they want to be more involved in shaping health services to ensure they are better tailored to meet the needs of our diverse population.

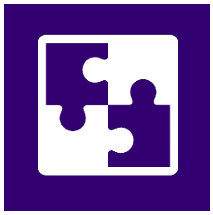
This could be around improving local services to ensure equal access for all, and the way that we help residents to hold us to account for the way that services are provided. ICS partners will take particular care to hear from people who cannot access care and support, and have poor experiences and health outcomes, to understand their needs, barriers and aspirations and opportunities for improvement. This will be either through direct engagement or through linking with representative organisations.

Population health management approaches will help us to better understand local population needs and demonstrate how these impact on future commissioning and service delivery. We will take the opportunities presented by collaboration in the ICS to mobilise the strengths and experience of all partners, build and strengthen relationships with people and communities who experience inequalities, and tackle agreed inequalities targets.

Making every contact count

In Hatfield, the NHS, the University of Hertfordshire and Welwyn Hatfield Borough Council have worked together throughout the vaccine programme to improve the take-up of the COVID-19 jab among students and staff, in an area where vaccination rates were among the lowest in our ICS area. **Pop-up vaccination sessions and engagement events** at the university enabled joint teams to improve vaccine take-up, whilst also helping students to register with a GP practice and connecting them with the support and information available through the borough council's Healthy Hub.

Principle Five



Work with Healthwatch and the voluntary, community and social enterprise (VCFSE) sector as key partners

Healthwatch is the independent body with statutory powers, responsible for understanding the needs, experiences and concerns of patients and the public, and to ensure people's views are put at the heart of health and social care. Funded through public monies, at a national level Healthwatch listens to what people like about services and what could be improved, and shares this insight with a range of commissioners, providers and regulators.

Our ICS is covered by two Healthwatch organisations, Healthwatch Hertfordshire and Healthwatch Essex. They have a broad remit, covering health and social care for both children and adults and provide independent sources of insight gathered outside service delivery, typically through surveys, focus groups, research papers and interaction with the public and local members.

The insight and expertise of our local Healthwatch organisations is already valued in our ICS and they will have an ongoing active involvement in the new statutory Integrated Care Board, the ICP, and our area's Health and Care Partnerships.

Building on the existing strong partnerships with the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector in Hertfordshire and west Essex, a new 'VCFSE Alliance' is in place. This will help to maximise the impact of the sector and its expertise in health creation across the ICS, and ensure that the sector gets the strategic support it needs to be effective. The Alliance will be open to any charitable organisation with a remit to improve health and care in Hertfordshire and west Essex.

Improving GP access

The ICB works closely with our Healthwatch Hertfordshire and Essex partners. As part of our aim to improve access to primary care services, in the summer of 2022 we commissioned both organisations to carry out targeted engagement work with parents, in order to improve satisfaction with access to GP services for young families. Recommendations drawn from this engagement work include improvements to phone lines, better information on practice websites, and improved signposting to alternative sources of help and support. These recommendations have been reported back to the ICB's primary care commissioning committee, where they have shaped improvement and investment plans.

Principle Six

Provide clear and accessible public information about vision, plans and progress, to build understanding and trust

Effective engagement and inclusive communications promote transparency and inclusivity and empower people to shape, understand and access the services and support that are available to help them to lead healthier, happier lives.

The following communications and engagement principles have been developed in recent years as best practice. Our information will:

- **Be clear and accessible:** We will work to ensure that all public-facing ICS communications are written in plain language, avoiding jargon. All acronyms will be spelt out. Complicated language will be avoided, and different formats made available where possible.

- **Be empowering:** Involving our patients, service users the public and stakeholders as joint partners in decisions made about services they use.

- **Be embedded into everyday:** It is everybody's business to 'start with people' and we want to ensure that the public views and experiences influence our ICS organisations' everyday practices. All system colleagues can assist in making this a reality by getting communications and engagement specialists involved at an early stage in conversations about decision making or service changes, for example.

- **Be timely:** Our communications will be delivered at the most effective time for voices to be heard through any engagement process. We will link closely with quality and complaints teams, as well as the newly appointed 'Patient Safety Partners', so that themes that emerge from patient, service user or stakeholder enquiries and complaints can be quickly identified and addressed.

- **Be collaborative:** We will work closely with different organisations in the statutory, voluntary, faith and community sector to ensure that we take a collaborative approach. We will seek to engage with organisations and individuals where they are, rather than expecting them to come to us. The ICP, ICB and Health and Care Partnerships will work to maintain a positive and proactive dialogue with the Hertfordshire and Essex Health 'Overview and Scrutiny Committees', and the district and borough council committees that scrutinise health and care services, to support an open and honest dialogue with elected representatives.

- **Be accurate:** All communications will deliver an accurate picture of the current landscape and all engagement will be clear and realistic in its outcome at the start.

- **Be meaningful:** Engagement with our patients, public and stakeholders will be meaningful and add value to the work of the ICB and ICP, with experience and insight being fed into the decision-making process at a formative stage of the commissioning cycle. We will be clear and honest with the public about the parameters within which policy decisions and service changes can be made.

- **Be innovative:** We will review and adapt our communications and engagement to reflect new tools and methodologies to constantly improve our approach. We will leverage the opportunities available through digital approaches such as social media, online information gathering and webinars.

- **Be representative:** We will open up more opportunities for people to give their views and feedback, to ensure better representation from the communities we serve. We will also continue with targeted work with the 'seldom heard' in our communities such as young carers and people with learning disabilities.

- **Be evidence-based:** We will evaluate the effectiveness of our engagement and communications work so that we can evidence its impact and ensure that the approaches we use are fit for purpose.

Reader Panel

An ICB **volunteer reader panel** has been established, building on best practice from Herts Valleys CCG, which includes members of the public with disabilities that affect their ability to receive information. Made up of volunteer patients, carers, community members and others, panel members review leaflets and other material and feedback on whether information is easy to understand, accessible and free from jargon.

The panel has recently reviewed booklets on winter wellness for older people and on children's minor illnesses, patient letters on changes to prescriptions and a number of leaflets. Its involvement has led to changes in content to make information more relatable for the audience, changes in language to use words that are more familiar to patients, and amendments to layout and font size to make important information clearer and changes to avoid ambiguity. Healthwatch Essex has a disability panel which can also support in sense-checking documents.

Principle Seven

Use community development approaches that empower people and communities, making connections to social action

The Voluntary, Community, Faith and Social Enterprise Sector (VCFSE) is a key provider of services to disadvantaged, under-represented and minority ethnic communities and has an excellent understanding of the health and care issues faced by those communities in our area. VCFSE organisations are often trusted, accessible and skilled at outreach and engagement.

Our statutory ICS partners have well-established partnerships with VCFSE organisations which support the engagement of people and communities in health and care matters. In many cases, the impact of these partnerships have been strengthened during the COVID-19 response.

COVID Information Champions

As part of the pandemic response, representatives from diverse communities in Hertfordshire were recruited to take on the role of information ambassadors, working as part of a network of county-wide **'COVID Information Champions'**. Managed through the voluntary agency 'Communities 1st', these ambassadors have worked to tackle vaccine misinformation and promote the benefits of the vaccine programme in their own local communities – feeding back questions and concerns into communications and engagement planning.

COVID recovery workers

Through funds raised nationally by Captain Sir Tom Moore during the pandemic, Black, Asian and minority ethnic **'COVID recovery workers'** were employed to support digital inclusion during the pandemic, when 'real life' interactions for many people were strictly limited by lockdown requirements and shielding. The workers provided practical help, advice and equipment which has made it possible for digitally excluded people to get online and benefit from the connections this can bring for the first time.

Principle Eight

Use co-production, insight and engagement to achieve accountable health and care services

Co-production describes an approach through which individuals, family members, carers, organisations and commissioners work together in an equal way to design, deliver and monitor services and projects. This way of working is important because people who use social care and health services (and their families) have knowledge, experience and insight that can be used to improve services and tackle inequalities, not only for themselves but for other people who need them.

There are co-production boards at local authority level, such as the Hertfordshire All Age Autism Co-Production Board, and examples of services which have been developed through co-production, such as the Essex Local Offer for families and children with special educational needs and disabilities. Similarly West Hertfordshire Teaching Hospitals NHS Trust has implemented a robust approach to co-production and the South and West Hertfordshire Health and Care Partnership has committed to a co-production approach.

With various interpretations of coproduction and co-design, an ICS-wide shared understanding of these terms and what they mean would benefit transparency and public understanding.

Cancel Out Cancer

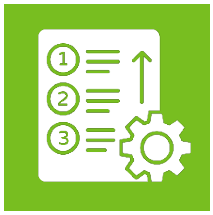
The **'Cancel Out Cancer'** awareness programme is an example of a co-produced health improvement programme in the Hertfordshire and West Essex ICS area. Led by networks of local GP practice patient group representatives with a passion for cancer prevention, the programme was developed with the support of cancer experts and NHS engagement professionals. Through interactive sessions, which can be run face-to-face or online, the programme leads people towards a greater understanding of cancer signs, symptoms and screening programmes through group activities and discussions.

Seeking out feedback to improve services

To address the impact on patients and their families of long waiting lists for some non-urgent treatments, a number of supportive programmes have been put in place. The **'waiting well'** initiative contacts patients to ensure that their health is not deteriorating, and to find out whether targeted support can improve their wellbeing as they wait. A similar approach is now being adopted to supporting patients who have been discharged home from a hospital stay without care packages. Callers check that patients and their families are managing and find out whether any additional help from the voluntary sector is required.

It is important that the learning from these programmes is fed back into the design of services to ensure that they are as patient-centred and effective as they can be.

Principle Nine



Co-produce and redesign services and tackle system priorities in partnership with people and communities

Co-production is one of the ways in which our ICS works with people and communities to ensure that services meet the needs of the people that use them and are not designed around the convenience of the organisations meeting their needs. People with relevant lived experience can put forward ideas that clinicians and managers may not have thought of, leading to changes that better meet the needs of the local population.

As well as giving better outcomes, a co-production approach can help build better relationships. It needs to be based on genuine partnerships, with professionals being comfortable with not having the answers and with sharing resources, responsibility and power.

The ICS approach to co-production will build on the long-standing approach to co-production adopted by our two county councils. There is a commitment to co-production throughout the ICS, from the ICB, ICP, Health and Care Partnerships and Mental Health, Learning Disability and Autism Health and Care Partnership.

Co-production at Essex County Council

Essex County Council works with Collaborate Essex for some of its co-production work. In adult care, there are several steering groups for commissioning joined by people with lived experience who provide input to strategies and also work with the council on service specifications and tender evaluation. The council has also worked with the organisations 'Think Local Act Personal' and the National Co-production Advisory Group to support with the re-commissioning of services.

The council is currently discussing a **co-production strategy** to look at how the council increases the breadth of people they engage with, and how they may be recompensed for working with the council.

A successful forum of over 1,000 people with disabilities complements co-production work, raising topics of importance, gathering evidence and then discussing them with relevant professionals and senior leaders from health and social care to make improvements to services and policies.

Co-production at Hertfordshire County Council

Adult Care Services has eight subject-specific **co-production boards** which meet every three months, covering the following interests: older people, mental health, physical disability and sensory needs, drug & alcohol, learning disabilities, dementia, carers and all age autism. The boards feed into a strategic co-production board which support the Council to make decisions and design services in partnership with the people that use them or support people that use them, such as unpaid carers or friends or family. Most boards meet quarterly but use Task and Finish groups in-between. Boards are co-chaired by a 'professional' representative and someone with lived experience who is supported with training to help them in their role. Co-chairs usually serve a three year term.

The Hertfordshire and West Essex ICS will:

- visibly support and sponsor co-production through culture, behaviour and relationships, including senior leadership role modelling, such as through the ICB's Non-Executive Members

- build on the culture of co-production already in place in parts our system, and nurture, share and spread this way of working

- support organisations and an infrastructure that enables the voice of people and communities to be heard

- invest in people who use care and support, including unpaid carers, to ensure they have the knowledge, skills and confidence to contribute 'on a level playing field'

- work closely with the VCSFE Alliance and our diverse networks of community champions to assess needs in what are referred to as our 'system, places and neighbourhoods' in national guidance documents. Systems are described as covering a population of 1-2 million people, places are described as typically covering populations of 250-500,000 people and neighbourhoods as covering a population of 30-50,000 people.

Principle Ten

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

Our ICS organisations, including the Integrated Care Partnership, the Integrated Care Board, the Hertfordshire Mental Health, Learning Disability and Autism Health and Care Partnership and the three geographically based Health and Care Partnerships, are being established in a way that is designed to ensure that input is captured from a broad range of voices, representing a wide range of interests. The work of the new VCSFE Alliance, as well as that of our Health Care Partnerships, will play a key role in this. In addition, attendees with insights or lived experience will be invited to share their input on relevant agenda items in key decision-making fora. This approach will ensure that our decision-making bodies remain agile and can draw directly from relevant individual experiences, as well as hearing from representative groups.

The ICS will seek to draw from best practice across Hertfordshire and West Essex, such as the community asset mapping approach led by Healthwatch Essex, sharing and nurturing activities and insight which enable the needs and views of people and communities to be heard and understood. This involvement and insight will be particularly important during key points of the commissioning cycle, when there is the greatest opportunity for meaningful input into services commissioned.

Engagement models rooted in GP practices

GP-practice based patient involvement and participation groups, supported by the area's Clinical Commissioning Groups, have played an active role for a number of years in ensuring that registered patients are involved in decisions about the range and quality of services provided and commissioned by their practices, as well as supporting health campaigns in their local communities. These groups are most effective when they have the full support and cooperation of their GP practices. Successful practice-led campaigns have supported people with diabetes, dementia, those experiencing bereavement and people isolating due to the COVID pandemic.

With the support of the National Association for Patient Participation, an incentive scheme was introduced in the south and west of Hertfordshire in 2021, aimed at encouraging and rewarding practices for routinely asking for and acting on the views of their patients, engaging with their practice population and supporting the development of their patient group was. The scheme, developed with input from Healthwatch, GP practice representatives and patient representatives, also encouraged patient group members to engage on wider local health issues.

Practices were incentivised to encourage and reward patient group development, with additional funding available for highly developed and evidenced schemes. The success of this scheme in improving the approach to patient engagement in south and west Herts has led to it being included as part of the ICB's new Enhanced Commissioning Framework for primary care across the ICS area, working with the Patient Association to broaden the range of people involved in their patient participation group by taking a community engagement approach.

GP practice-based social prescribers support approximately 30,000 people per year to improve their health and wellbeing, linking with district and borough council-based 'healthy hubs' and wellbeing offers and signposting people to VCSFE resources in their local communities that can support and empower them.

Appendix One

NHS
Hertfordshire and West Essex
Integrated Care Board

Involvement and engagement framework

The ambition of Hertfordshire and West Essex Integrated Care System (ICS) to tackle health inequalities and improve health and care for residents will only be achieved if we place our people and communities at the heart of the decisions we take.

Developed from the ICB's *Working with People and Communities Strategy,* this involvement and engagement framework outlines how the NHS Hertfordshire and West Essex Integrated Care Board (ICB) will work with partner organisations in our integrated care system to ensure that our diverse people and communities are involved in priority-setting and decision-making forums.

This document includes:

- a structure to help people and communities see how their views, experiences and expertise can play a part in formal and informal health and care involvement and engagement
- a description of the tools available to the system to involve people, including co-production
- a description of how to resource involvement and engagement so that we can successfully deliver on working with people and communities.

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Introduction and context

Involvement and engagement should guide all our work, from neighbourhood and community health and care discussions, to developing and commissioning new services and strategies at our most senior decision-making bodies.

This framework is based on the 10 principles outlined in the ICB's *Working in Partnership with People and Communities Strategy* (Appendix 2), which are set out by NHS England in national guidance to help organisations realise the benefits of working with people and communities. These principles are embedded into the ICB's constitution and have been adopted by the Hertfordshire and West Essex Integrated Care Partnership.

The principles are:

- centre decision-making and governance around the voices of people and communities
- involve people and communities at every stage and feed back to them about how it has influenced activities and decisions
- understand your community's needs, experiences, ideas and aspirations for health and care, using engagement to find out if change is working
- build relationships based on trust, especially with marginalise groups and those affected by health inequalities
- work with Healthwatch and the voluntary, community, faith and social enterprise (VCFSE) sector
- provide clear and accessible public information
- use community-centred approaches that empower people and communities, making connections to what works already
- have a range of ways for people and communities to take part in health and care services
- tackle system priorities and service reconfiguration in partnership with people and communities
- learn from what works and build on the assets of all health and care partners – networks, relationships, and activity in local places.

Developing our approach to public involvement and engagement

Our approach puts what NHS England calls a 'Start With People' focus at the centre. Organisations are encouraged to take this approach across all involvement and engagement activity. This diagram shows how it can be at the centre of planning:

The development of the ICB's *Working with People and Communities Strategy* involved different stakeholders and health and care professionals, patient voice members, representatives from the VCSFE Alliance and Healthwatch Hertfordshire and Healthwatch Essex representatives.

A task and finish group of experienced patient voice volunteers have helped to develop this Involvement and Engagement Framework, taking into account:

- the legacy of the three former clinical commissioning groups and the relationships, networks and activities which exist across the ICS
- the positive involvement and engagement practices which have, in many cases, been strengthened by the COVID-19 pandemic
- health and care inequalities and barriers to community involvement
- how people listen, give feedback and share information with the ICB.

Patient voice volunteer Alan Bellinger, a member of the Healthwatch Hertfordshire Board, has supported the group's work by writing a networking model from a volunteer perspective. This document includes some principles that Alan set out. The group will continue working with the ICB's Communications and Engagement Team to support the next steps and activities described in this document.

Building this framework has also considered:

- the involvement and engagement forums established in our ICB's health and care

partnerships (HCPs)
- how engagement and experience staff work can work effectively with partner organisations to increase efficiency and support innovation.

Thank you to everyone who has been involved in this work before and since the transition to a statutory ICS. This framework is open to review as our integrated care system beds in during 2022/23, to ensure it is fit for purpose and is aligned with the principles of the *Working with People and Communities Strategy*.

Putting involvement and engagement into practice - assurance

- The ICB must ensure legal and mandatory guidance on working with people and communities is adhered to when it carries out its duties, and that good practice is consistent. The ICB has already adopted governance arrangements which enshrine engagement in its constitution
- an agreed approach to working in partnership with people and communities.

The NHS England 'people and communities' guidance is to use a 'System', 'Place' and 'Neighbourhood' approach to turn these commitments into action. This helps to ensure that engagement and involvement influences decision making at the most appropriate level in our ICB and supports the flow of information and learning gained through engagement around the integrated care system.

At System level, there are mechanisms in place to give assurance that involvement and engagement work is ongoing, effective and influences decision-making, and that organisations' responsibilities for working with people and communities are being delivered:

Joint Strategic Needs Assessments are prepared by local authorities through their Health and Wellbeing Boards with local ICBs, with the involvement of local Healthwatch, local people and district councils.

Joint local health and wellbeing strategies are prepared by local authorities, through the Health and Wellbeing Boards with local ICBs, with the involvement of

local Healthwatch and local people.

Integrated care strategies are prepared by Integrated Care Partnerships, with the involvement of local Healthwatch and local people.

Joint forward plans are prepared by ICBs and partner NHS trusts and NHS foundation trusts, with the involvement of local people and Health and Wellbeing Boards.

Based on the committee structure of the ICB, an over-arching Patient Engagement Forum is proposed as an advisory group to the Board, with public participation sub-groups supporting the Primary Care and Nursing and Quality directorates. The communications and engagement team will continue to work with a range of stakeholders and patient and public voice representatives on projects and workstreams and will support a new network of diverse patient voice partners who will feed information and knowledge around the system and encourage very local community engagement champions to link together (see Appendix 4). Former CCG patient voice members would be invited to be part of this network, many of whom have continued to work closely with the ICB since its establishment in June 2022.

The Patient Engagement Forum is an advisory and steering group directly accountable to the ICB Board. It will have:

- one ICB executive and one non-executive member
- a patient voice volunteer chair
- representatives from the ICB's Primary Care and Nursing and Quality public participation sub-groups
- relevant 'experts by experience' – invited to attend the forum on an ad-hoc basis to contribute their views when a topic they have an insight into is being discussed
- Patient and public voice partners from the Health and Care Partnerships
- ICB Equalities Lead(s)
- carer representatives
- Healthwatch representatives.

The forum will meet formally, but will involve activity between meetings (e.g. sense-checking engagement and involvement activity for projects).

The learning from this forum will inform the Board's work and improve decision-making. There will also be an expectation that relevant individual experiences are considered when decisions are made, with 'experts by experience' invited to share their insights during Board meetings.

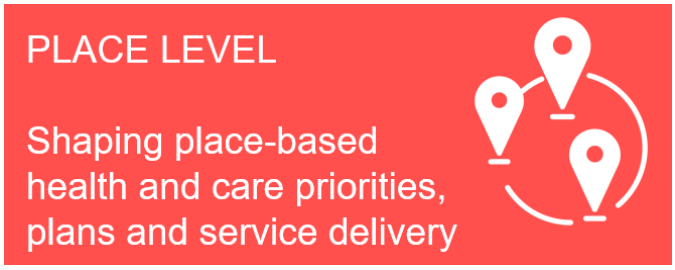
The ICB will also:

- ensure public involvement in and engagement on projects and programmes led by clinicians and health and social care professionals continue to support an advisory 'Readers Panel' to sense-check public-facing documents and ensure that they are accessible
- run a social media-based involvement network for anyone registered with a GP to join, where continuous involvement can be demonstrated, and where ideas can be shared and opportunities shared
- continue to distribute and grow the readership of our regular e-newsletter for the public which includes updates and raises awareness of opportunities to be involved and engaged with local NHS services

- help develop an Engagement Network for ICS staff who run non-ICB patient and carer experience forums (e.g. PALs team coordinators, provider trust public engagement and experience colleagues, etc.).

Both the ICB and ICP meet in public, with information about the meetings including the agenda and papers published in advance on accessible public-facing websites. Meeting papers will be made available in a timely way, and there will be clear information on how the public can pose questions and observe meetings if they want to.

The ICB's independent, non-executive members will be supported to undertake their roles through training and development. They will be tasked with helping to ensure that the statutory duties of the ICB are met, including those relating to patient and public participation, and will be connected with representative organisations including the new ICS-wide VCSFE Alliance, Health Care Partnership-specific citizens panels and the well-established and effective co-production groups in our area, including those run by Essex and Hertfordshire County Councils.



NHS England guidance describes the areas formerly served by Clinical Commissioning Groups as 'Places'. Places typically have populations of between 250,000 - 500,000 residents. We have three in our ICS, these are: south and west Hertfordshire, west Essex and east and north Hertfordshire. Each of these geographies is served by an acute trust – the West Herts Teaching Hospitals Trust in south and west Hertfordshire, Princess Alexandra Hospital in west Essex and the Lister Hospital in east and north Hertfordshire.

Health and care, public sector and voluntary and community organisations should engage with the communities in the places where they provide services, so that they can learn from those communities and start to tackle the health inequalities that affect residents together. These include challenges relating to housing, the built and natural environment, transport, economic opportunities and access to health and care services.

Each of our 'Places' has an established health and care partnerships (HCP), and there is an additional health and care partnership which serves people with mental health needs, learning disabilities and autism living in Hertfordshire.

Three health and care partnerships have involvement groups already in place. Each area has a different name for their main engagement and involvement forum (East and North Hertfordshire HCP has a Community Assembly, West Essex HCP has a Community Voices Group and South West Hertfordshire HCP has a Co-Production Board) and they operate differently in each place. Below are some examples of some of the progress already achieved by the involvement groups:

West Essex HCP Community Voices Group

An extensive engagement exercise in the pandemic built deeper connections with faith and ethnic minority groups to tackle misinformation about the COVID jabs, and regular information was cascaded to the communities around other issues and opportunities, such as flu vaccinations and health inequalities.

Much of this was done collaboratively with volunteer and community groups, councils and the Citizens Advice Bureau and by raising the profile of health initiatives by attending events run by partner organisations.

South west Hertfordshire HCP co-production

SWHHCP's interim co-production board meetings began in September 2022, with the full board due to launch in April 2023.

The board has been reviewing transformation projects the HCP has already been working on, such as the virtual hospital, well-leg service, MSK transformation etc. Project leads outline their work and engagement and coproduction then received feedback from the board about engagement/coproduction to-date and recommendations.

In preparation for April 2023, when the board will be fully launched, elements being considered include appropriate public voice representation. At the moment, there are two patient reps on the interim coproduction board, in addition to representatives from several organisations.

East and North Hertfordshire Community Assembly

The Assembly was launched in 2021 and is an online meeting held four times a year.

It is a forum for patients, carers, groups and members of the public from across the area who want to be informed and engaged and help shape and improve their local health and care services.

The Assembly wants to understand the challenges, needs, and views of residents, enable them to play a crucial role in the development of health and care services in the area, and act as a 'one stop shop' to enable the community to help the partnership achieve their objectives.

Representation from the community includes patient representatives mainly drawn from primary care networks, as well as VCSFE colleagues. Colleagues from ICS organisations also attend, and in 2022 the attendance invite was extended to the general public meaning anyone is able to join an Assembly meeting online.

Over time, these different models are expected to learn from each other and share best practice, developing and evolving.

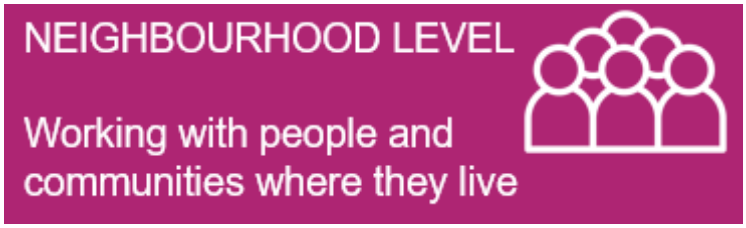
Each provider organisation which is a member of an HCP (HPFT, HCT, GP practices, Hertfordshire or Essex County Council, CLCH etc.) also has their own established, long-running patient and/or public engagement forums.

Involvement and engagement should be joined up, not duplicated. There will be a representative from each place-based forum and the mental health, learning disability and autism HCP on the System level Patient Engagement Forum, ensuring a link between Place

and System.

The ICB's communications and engagement team will work closely with health and care partnerships and Place leads as part of their roles in the newly developed team structure.

Neighbourhood level



Neighbourhoods are smaller areas that make up a Place, with populations between 30,000-50,000 residents. They operate at Primary Care Network level. Primary Care Networks are groups of GP practices which work with other providers and neighbourhood teams to address the health needs in an area.

A great example of how Neighbourhood-driven forums can lead to positive change is the 'hub' run by the community organisation Rainbow Services in Harlow. The hub works in partnership with Mind in West Essex, Harlow Foodbank, Citizens Advice and the Volunteer Centre Harlow. People affected by crisis situations can access a food bank at the hub, as well as information on community and physical activities, access to volunteering and a school uniform service. Staff from the Hub support patients registered with GP practices from the North Harlow Primary Care Network, Citizens Advice staff base themselves in local GP surgeries, and there are regular pop-up sessions throughout the town.

The ICB's communications and engagement team will work to support Neighbourhood-based grass roots activities, such as community events and meetings, in order to hear from local people about their experiences of health and care services, encourage more people onto our forums and groups, and to share information. Examples could include supporting health awareness days run by a GP surgery or community, attending Freshers Fairs and careers events or supporting refugees with settling into the local area.

Neighbourhoods will not be linked directly with the ICB's Patient Engagement Forum. Instead, the work happening in Neighbourhoods will support public engagement with the health service and enable the ICB to reach into communities which might not actively engage with the NHS in more formal settings.

Engagement within Integrated Care Partnerships (ICPs)

Integrated care partnerships are a statutory element of an integrated care system. They are jointly run by the integrated care board - the NHS element - and local authorities.

The Hertfordshire and West Essex ICP is transparent and accountable to our communities, meeting in public with minutes and papers available online.

Healthwatch Hertfordshire and Healthwatch Essex are members of the ICP and bring independent insight, expertise in engagement, and constructive challenge to the partnership.

There is an expectation placed on all ICPs to fully involve people and communities in every system in all aspects of the development of the ICP integrated care strategy. ICPs must say how they have involved, engaged and listened to local people and explain how they have acted in response to these views. Our Hertfordshire and West Essex ICP has adopted the the same approach to involvement and engagement as the ICB.

Developing successful Patient Participation Groups (PPGs) and PCN patient groups

PPGs are an invaluable community of patient advocates and GP surgery ambassadors. Many have enjoyed close relationships with the area's three former CCGs. Some have faced difficulties with their development and effectiveness, particularly during the COVID-19 pandemic.

In 2022, the ICB and the representative group the Patient's Association have run a project supporting practices and PPGs to establish, grow, diversify their membership and develop. The work has been led by a steering group of patient voice members from PPGs, GP practice managers, Engagement and Primary Care leads and Healthwatch representatives.

By encouraging grassroots involvement in these very local groups, the ICB can nurture a more representative generation of patient ambassadors.

Meanwhile, some primary care networks are developing ways to get patient representation to cover a whole network, with examples including setting up a kind of PCN PPG, or at the very least having one person representing the group's PPGs at meetings and within network-focused discussions. There are different approaches being taken, and the ICB communications and Primary Care colleagues are supporting on these when requested to do so. The PPG development work complements the evolution of PCN and Neighbourhood-level representation furthermore.

Resourcing and working with patient and public voice volunteers

Communications and engagement professionals from the ICB and ICP member organisations will support the new involvement and engagement framework, with most of the joint activity at Neighbourhood and Place and Health and Care Partnership level. Some partnership working of this sort happens already, but this is an area of development for our system. By working together on a range of projects as System, Place and Neighbourhood level, involvement and engagement activity can be more effectively coordinated.

ICB communications and engagement leads will oversee the System-level work, meaning they have oversight of the Patient Engagement Forum, and work with Patient Experience and Governance leads.

The ICB's communications and engagement team has restructured with more emphasis on engagement work, which will help ensure that involvement and engagement principles continue to be embedded through workstreams and projects.

Learning from people and communities who don't usually get involved in decision making

Increasing the number of different people who are able, or willing, to be engaged in health and care matters which are important to them is an ongoing challenge.

Those representing patients, carers and communities are often white, literate people with access to the internet, people who have more free time to engage and be involved, people who can drive to meetings or join them online, or people who have a professional background in health and care.

Young people, people with caring responsibilities, people experiencing poverty, those not online, people facing language and communication barriers, refugees seeking asylum and people with physical and learning disabilities are just some groups whose views are under-represented.

The ICB needs to offer options to actively involve and engage them, and be flexible to their needs. It can do this by committing to:

- offering online forums that mirror a group who meet in person and / or arranging more than one meeting about the same topic to increase opportunities for participation.
- tapping into existing networks, such as established community listening events, social groups, or forums run by member organisations of our Integrated Care Partnership, such as community policing priority forums or district council engagement events
- running events at places where there is a bus route, free or cheap parking, hearing loop equipment and so on
- running events at places where people go (e.g. a place of faith, a health and wellness hub, day centre etc.)

Stakeholder groups connected to the system represent different communities, which is evident at Neighbourhood level (with some communities described in more detail in Appendix 3).

Training and development

Equipping people and communities

Taking part in regular involvement and engagement as a patient or service user will require ongoing development so they feel confident to execute their role effectively. To support this, we will:

- provide opportunities for peer-to-peer support between those with experience in involvement and engagement and those who are newer to it
- provide and share training and development opportunities and tools e.g. webinars, workshop days, and courses.

We will also:

- ensure we're meeting the needs of individuals and follow up any challenges for them when they are involved in a piece of work (for example, we will ask people if they sensory and accessibility needs, what pronouns people use, whether we need access to mental health first aiders, safeguarding etc.)
- reimburse out-of-pocket costs in line with policies
- regularly thank people for their time and commitment through celebration events, formal letters, and putting them forward for award schemes to help highlight their

contribution.

Equipping people working in the system

Making engagement relevant, real and meaningful is very important - the ICB needs to be resident-focused, initiating conversations on topics that are important to people and communities and that they will want to join in.

People and communities often appreciate the opportunity to hear directly from experts in their field, such as clinical leads and so that means involvement and engagement activities involve a range of colleagues. We will support other colleagues to help deliver presentations, take part in events, and proactively look for engagement opportunities.

The toolkit for involvement and engagement

There are tried and test involvement and engagement tools which the ICB and ICS already uses widely. We will also use digital and non-digital feedback mechanisms, and ensure we ask people what tools and methods suit their needs.

When designing services and to ensure we 'start with people' to start the engagement process, there needs to be co-production approach wherever possible. Co-production gives the opportunity for people to come together with staff at organisations and commissioners to work in an equal way to design, deliver and monitor services and projects.

There are co-production boards at local authority level, such as the Hertfordshire All Age Autism Co-Production Board and examples of services developed through co-production at place include the Essex Local Offer for families and children with special educational needs and disabilities. Similarly West Herts Hospital Trust has implemented a robust approach to co-production and the South and West Hertfordshire Health and Care Partnership has committed to a co-production approach.

To build on the culture of co-production already in parts our system, and to nurture, share and spread this way of working, we will explore co-production training for all colleagues and people and communities who have not done it before.

Examples of feedback tools:

- Surveys conducted by the ICB and our wider partner organisations, such as Healthwatch and county and district councils
- Health Matters webinars to help get more people interested in health and care topics, learn, and give feedback
- Reader Panel (to review and help develop engagement and communications to ensure they are accessible and inclusive)
- Focus groups
- Events bringing together a range of people
- Informal drop-ins into existing services
- Online 'listening in' to conversations already happening in local areas, such as neighbourhood-specific social media groups
- Online for a such as patient experience groups on Facebook and user reviews on google and trip advisor

- Feedback from annual patient surveys, PALS teams in provider organisations and from the ICB's own patient quality team.

Social media and digital networking will be two fundamental tools. Setting up carefully administered private and open forums on channels such as Facebook can help draw in engagement in different ways – for instance, a Cancel Out Cancer Facebook group helps participants of the campaign sessions keep in touch, and share news they find about cancer.

Using insight and data

The system should use insight from trusted sources to help create a bank so we can what the data is telling us about people and communities using health and care services, with the stories and feedback from those people.

This will rely heavily on regular input from Population Health Management and Public Health data, data held by councils from the engagement they have, national and local survey results, Office of National Statistics data and reports, and more.

A data and insight bank should not duplicate anything already in place but act as one data and insight bank for Hertfordshire and West Essex to inform the activity for involvement and engagement.

The ICB also benefits from roles such as social prescribers, link workers, community champions, carers leads and Macmillan nurses who connect with PCNs. They are gathering data and insight about how people are accessing services.

Next steps

Some of these steps are already happening (such as PCN engagement support), and some will need to take place concurrently with others (such as determining roles and remits of public and patient members at System level and the groups they will be in):

- Establish Key Performance Indicators and an evaluation framework, supported by the Task and Finish group
- Determine the role and remit of the Patient Engagement Forum, with ToRs, and engage exec and non-exec lead for this Forum
- Determine the role and remit of other groups at the System level
- Write a 'how to' for decision makers for service change process (including a Patient and Public Involvement Assessment and Planning Form). Examples from Joined Up Care Derbyshire https://joinedupcarederbyshire.co.uk/involving-people-communities/guide-to-working-with-people-communities/
- Work with Place and HCP directors to explore the scope of HCP-led public forums and joint principles
- Connect with PCNs to develop their PPG representation per network (ongoing PPG development at practice level)
- Launch the Forum and establish connection / role with potentially new patient voice partners by in early 2023 (e.g. those linked into HCP, experts by experience)

- Establish a mechanism for gathering insight within the system from different sources including scoping the resource needed to analyse, interpret, and present insight which informs decision making
- Set up a social media-based involvement network for anyone registered with a GP to join
- Continue to advertise the regular e-newsletter to stakeholders
- Formalise an Engagement Network within the ICS, for colleagues who run patient and carer experience forums (e.g. PALs team coordinators, provider trust public engagement and experience colleagues, etc.).

Appendix 1 Our legal duties

National Health Service Act 2006

Under section 14Z59 of the Act, NHS England assesses the performance of ICBs on various duties, including those under section 14Z45 for public involvement.

This will be included in the new System Oversight Framework, building on the approach that happened for CCGs. The ICB will need to provide evidence that it meets the 10 principles in this guidance of Working with People and Communities and the difference it has made. It will look for evidence of meaningful involvement taking place consistently across the ICB's places and neighbourhoods.

Our involvement of local people and communities should be an ongoing approach that ensures we provide opportunities for people to raise the issues and ideas that matter to them and make decisions with them about their health and care services.

There are also specific legal duties for commissioners and providers of health and care services. Our approach will ensure we meet these.

This sets out the main duties on NHS bodies to make arrangements to involve the public under sections 13Q and 14Z44 (for NHS England and Integrated Care Boards) and section 242 (for NHS trusts and NHS foundation trusts).

Health and Care Act 2022

This makes it a legal requirement for community involvement to include the involvement of carers and representatives (if any), as well as patients and services users themselves.

The Gunning Principles

These four principles relate to formal public consultation and guide what constitutes a fair consultation exercise.

The triple aim duty

NHS England, integrated care boards, and trusts are subject to the new 'triple aim' duty in Health and Care Act 2022 (sections 13NA, 14Z43, 26A and 63A). This requires us to have regard to the 'triple aim' of better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources.

The Equality Act 2010

This prohibits unlawful discrimination in the provision of services on the grounds of protected characteristics – age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation.

The Act requires public sector organisations to eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act, advance equality of opportunity between people who share a protected characteristic and those who do not, and foster good relations between people who share a protected characteristic and those who do not.

In line with the requirements of the Equality Act 2010, the ICB is required to:

- evidence the analysis that has been undertaken to establish whether our policies and practices have (or would) further the aims of the general equality duty
- provide information that we have considered when carrying out an analysis
- provide details of engagement (consultation / involvement) with people whom we consider would have an interest in furthering the aims of the general equality duty.

To meet the requirements of this duty, the ICB will carry out an Equality Impact Assessment process at the primary stages of planning changes, such as:

- organisational change
- considering any new or changing activity
- developing or changing service delivery
- procuring services
- developing projects
- developing a policy / procedure / guidance or changing or updating existing ones.

The Equality Impact Assessment process will be used to assess whether there may be any barriers or difficulties, harassment or exclusion as a result of a planned change, or in fact any positive impact such as the promotion of equality of opportunity, developing good community relationships, encouraging participation and involvement as experienced by service users, patients, carers, relatives, staff, the general public and key stakeholders.

Health inequalities

NHS England and Integrated Care Boards are also under a separate statutory duty to have regard to the need to reduce health inequalities of access to health services and the outcomes achieved (sections 13G and 14T of the NHS Act 2006).

Public Services (Social Value) Act 2012

There are several benefits to local communities in embedding social value in commissioning, including improved service delivery, health creation and an increase in the resilience of communities. This Act requires commissioners to think about how they secure wider social, economic and environmental benefits.

Appendix 2

Draft ICB Working with People and Communities (May 2022 submission)

https://hertsandwestessex.icb.nhs.uk/downloads/file/4/working-in-partnership-with-people-and-communities-pending-approval-by-nhs-england-and-nhs-improvement-

NHS England Working with People and Communities Guidance (updated July 2022)

https://www.england.nhs.uk/publication/working-in-partnership-with-people-and-communities-statutory-guidance/

Appendix 3 Terminology

The term ‘involvement and engagement’ describes the different ways we connect people and communities.

Engagement is ongoing participation and working together on a regular basis. It helps relationships flourish, helps people have an awareness of what is happening with health and care, and means we are always open to feedback.

Involvement is short- to medium-term participation that might look at service changes or design. It might only need to involve one or two communities or patient cohorts such as parents and maternity, those with long term conditions, or a GP practice’s registered patient base.

‘Community’ is everyone of all ages, their representatives, relatives, and unpaid carers whether or not they access health and care services and support. ‘Communities’ are groups or networks of people not just in the geographical sense, but also by how they identify or share interests.

‘Hard to reach’ is an out-moded term for people and communities being hard to reach, Instead, because someone in a marginalised or challenged position might find our system difficult to navigate and engage with, it us in fact which are ‘hard to reach’.. Some communities have a distrust of working with health and care professionals and it can take time to build up that trust, but it is not impossible to find the opinions and feedback.

Therefore, the ICB and ICS should use ‘seldom heard’, ‘underrepresented’, or ‘facing health inequalities’ which is more accurate.

‘Inclusivity’ describes having the Equalities Act 2010 protected characteristics always at the forefront of planning involvement and engagement activity, as well as considering carers, those in poverty, and those who are digital excluded, so they are not overlooked. ‘Inclusion health groups’ is also a term used to described those who experience the worst health inequalities either because they’re at risk of, or living within extremely poor health caused by poverty, marginalisation, multi-morbidity and social exclusion.

A person’s experience can be further impacted on by discrimination and stigmatisation, and not being accounted for in electronic records (such as healthcare databases). These can overlap with protected characteristic groups.

These are any socially excluded population including, but not limited to:

- Gypsies, Roma, Travellers, Showmen and Liveaboard Boaters
- people experiencing homelessness
- people experiencing alcohol and/or drug dependence
- sex workers
- vulnerable migrants and refugees
- young carers
- victims of modern slavery ·
- people in contact with the criminal justice system.

There are other groups that experience barriers to accessing services, like people with a learning disability and autistic people, and people with severe mental illness. They can also belong to inclusion health groups.

Appendix 4

The task and finish group involved in the development of involvement and engagement activity are patient voice volunteers in the local health and care systems. The group members, as well as supporting the delivery of the ambitions in this document, are keen to also focus on:

- what good looks like
- a self-assessment tool to review progress of patient engagement
- how we can develop KPIs.

Current patient voice volunteers have built up a network of people and flow of information and knowledge. This can be built on as the system working matures and to help them explore this further, patient voice champion Alan Bellinger has devised a 'Maturity Model'. It highlights aspects such as:

- the effectiveness of a network which facilitates the flow of information and knowledge
- the origin and scope of the content that flows through the network (such as different health and care topics covered through hosting webinars)
- the extent to which patient voice volunteers are engaged within the governance part of involvement and engagement.

This table shows how factors such as networking and running awareness events with a structure 'content' approach evolves and matures over time:

HWE Patient Engagement Maturity Model

	Initial	Emerging	Engaging	Collaborative	Mature
Networking	Network established	Group Networking developed	Peer-to-Peer established.	Networking is continuous	Network is autonomous
Content	Content developed centrally	Collaborative approach to content development	Schedule is collaborative.	Content both Upward and Downward	Content developed through the Network
Governance	Formal Leadership Group established	Leadership Groups become collaborative.	Leadership fully engaged with ICB	Leadership becomes Networked	Self-governing Network.
Sustainability	Finding Thought Leaders	Emerging Thought Leadership	Groups providing Thought Leadership and Governance	Emergence of Networked Leadership	Self-governing Network
Equality	Finding and establishing Ambassadors	Developing the Ambassador Role	Growing Networks	Selective Engagement & Diversity	Full Engagement & Diversity
Co-Design	Explorative	Start & End Discussion	Formalised Process	Selective Programmes	All Programmes
	Establishing	Engaging	Value-Add	Contribution	Outcomes

Appendix two

Building on our positive legacy

Alison Gardner
Lay Member for Public and Patient Involvement
Herts Valleys Clinical Commissioning Group and
East and North Hertfordshire Clinical Commissioning Group

“In my years working across the two Hertfordshire CCGs, I have been delighted to provide assurance to both governing bodies about the range, breadth and impact of patient involvement activity taking place. Both CCGs have much to be proud of in the way they have fulfilled their public and patient participation obligations in a meaningful way.

Each CCG has developed its own approach to patient and public involvement and engagement, with these functions embedded in their organisations in different ways. However, where opportunities for collaboration have afforded themselves, the two sides of the county have worked together for consistent and unified information sharing. For example, we have brought together both CCGs’ patient engagement networks for webinars about Hertfordshire-wide services and topics, such as updates on the COVID-19 pandemic and the vaccination programme.

East and North Hertfordshire CCG has well-established patient participation groups which are linked together in locality-based networks. There is strong patient attendance at board meetings and committees. There have also been some effective targeted communication and consultation activities which have had strong patient involvement. For example, the public engagement around the opening hours of the Urgent Care Centre at the New QEII Hospital in Welwyn Garden City involved senior clinicians in face-to-face conversations with patients and the public in high streets and shopping centres across the patch. In combination with public meetings, online, paper and social media methods, this engagement process reached a wide cross-section of residents who were able to find out more about urgent and emergency care and put their views to the Governing Body.

The ‘Cancel Out Cancer’ awareness programme was co-produced by East and North Hertfordshire patient volunteers with the support of cancer experts. Through interactive sessions, which were adapted to be held online during the pandemic, the programme leads people towards a greater understanding of cancer signs, symptoms and screening programmes through activities and discussions.

Herts Valleys CCG facilitated a programme to the support the community with a series of virtual events. ‘Let’s get connected’ brings together members of GP practice patient groups with a range of community support groups. Sessions provide an opportunity for patient practice group members to be aware of and link into the diverse community support networks that are available locally. Topics covered include coping with bereavement, a memory event and working with the voluntary and community sector.

The Patient and Public Involvement (PPI) Committee provides assurance to the Herts Valleys board that there is meaningful participation in the business of the organisation from patients, carers, families and members of the public. Its role also includes the review of strategies and proposals to offer views from a patient or public perspective. Recently the PPI committee has had the opportunity to offer views on restoring services after COVID disruption and winter planning, among other areas.

I feel very strongly that there are a great deal of well tested approaches that will leave the NHS in Hertfordshire with a major resource to draw on when building the future arrangements for patient and public involvement and engagement. The ICB will be able to start from a position of strength to develop strategies for involving our public, patients and communities in improved and sometimes new ways.

Finally, as I move from this role and observe the work of the ICB going forward, I am looking forward to seeing strong integration with social care, a commitment to reducing health inequalities and tackling the social determinants of good health, and a focus on the role of personal responsibility in staying well – all with the meaningful participation of, and contributions from the people of Hertfordshire and west Essex.”

Bobbie Graham
Lay Member for Patient and Public Involvement
West Essex Clinical Commissioning Group

“As the Lay Member for Patient and Public Involvement at West Essex CCG, I have been in the privileged position of being able to see the real difference engagement has made to the way patients experience the services they need.

West Essex is incredibly diverse and includes some of the most affluent areas of Essex to among the most deprived. Health inequalities were laid bare during the pandemic in a way we have never seen before, showcasing a stark need for support and engagement in areas including digital access and mental health. I am pleased to say we have risen to that challenge by working in partnership and collaboration across county borders in multi-disciplinary teams to address immediate and longer-term issues.

Looking back, engagement has played a large and constant role in developing mental health services in particular. Our award-winning Adult Mental Health Family Group Conference gave individuals receiving secondary mental health care a space in which to collaborate with service providers to plan and make decisions relating to their own care and wellbeing. Drawing on best practice, this approach brings in the individual’s extended family, friends, neighbours, community members and professionals to support decision making where difficulties extend beyond the individual alone.

This collaborative approach with the individual’s wider support network enables individuals to maintain their recovery through their support network. By working on their terms, involving those most important to them, the individual is no longer stressed and isolated. By the end of the process they have come up with a unique and flexible care plan to follow.

The Integrated Adult Mental Health Transformation Services is another scheme which continues its coproduction on services including dementia and is currently working with a service user living with dementia to coproduce the West Essex Dementia Plan.

We recognise that putting the voices of people who have first-hand experience of our services is vital to their effectiveness. Our 18-25 mental health transformation work involves the local population in the design of inclusive services and delivery models that are accessible to wider groups, including people from diverse ethnic backgrounds and those within the LGBTQ+ communities.

District councils have been key to supporting our engagement, along with local businesses, including Stansted Airport.

Reaching younger people has always been more challenging so a highlight of the CCG's work was with Sixth Form students at St John's School in Epping, who joined our Health Ambassadors Programme within the school to raise awareness of mental health and wellbeing and reduce the stigma of mental health concerns among students and teachers.

With support from the CCG, North East London NHS Foundation Trust (NELFT) and direction from the 'Time to Change' initiative, the CCG guided students on their presentation, offering suggestions for service signposting and ways to get help and advice. A psychologist from NELFT collaborated with the students on the presentation, which was delivered by the students to their peers and teachers.

In more recent years the CCG's engagement with patients and the public has grown and supported the excellent work of the COVID vaccination programme to reach those most vulnerable and in need. Working in partnership with ICS colleagues, local authorities, neighbouring CCGs in Essex, Healthwatch, and voluntary sector colleagues, the CCG was able to reach and engage and build trust with people, sharing correct information to enable more to be protected from COVID.

I am particularly proud to say our engagement doesn't stop end at the end of a programme or project. We want to continue developing relationships and are increasingly inviting public and patients involved in various pieces of work to get involved in wider CCG and ICS-wide engagement programmes. Our dedicated Medicine Champions – including patients from different practices – have been working with us for many years to keep patients informed about the correct use of medication, checking prescriptions and advising against stockpiling. Members were invited to join patients from across the ICS area on a wider engagement network which continues to evolve as the ICB transition draws closer.