NHS
Hertfordshire and
West Essex
Integrated Care Board

Governance Handbook
Version 6

Version Number	**V6.0**
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Author/s	Multiple authors including relevant leads, collated by Simone Surgenor – Deputy Chief of Staff, Governance & Policies.

VERSION CONTROL

Version	Page	Initials	Date	Details of amendment
V2.0	8	IK	18/11/2022	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	22/09/2023	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.
V5.3	5.1 8.1	IK/SS	28/03/25	Revision to term date – for CD, Partner Member -NHS Trusts and Foundation Trusts, and ENH HCP SRO. Revision of PCCC reporting where approval reaches threshold limit.
V5.4	5.1	SS	23/06/25	Section 4 Amended governance structure to include Transition Committee, and host arrangements for HCPs Section 5.1 Second term of office for ICB Chair Second terms noted for three NEMs Revised VCSFE Alliance representative
V.6	Full revision	SS/SF/ME-R	17/10/25	Full revision of document in support of NHS Model Blueprint and pre-transition to new ICB models. 17th October 2025 - Revised document approved by HWE Board meeting in-Common with NHS Cambridgeshire and Peterborough ICB, and Bedfordshire, Luton and Milton Keynes ICB 4th November 2025 – non material change in updating Chair tenure.

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(a) Hertfordshire and West Essex ICB Standing Financial Instructions

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https://www.hertsandwestessex.ics.nhs.uk/documents/standards-of-business-conduct-and-conflicts-of-interest-policy/

6(b) Peoples and Communities Strategy
https://www.hertsandwestessex.ics.nhs.uk/documents/hertfordshire-and-west-essex-ics-people-strategy/

6(c) Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England (Published by the Professional Standards Authority):
www.professionalstandards.org.uk/docs/default-source/publications/standards/standards-for-members-of-nhs-boards-and-ccgs-2013.pdf?sfvrsn=2

1. Introduction

1.1 From 1 October 2025, the Central East Cluster (Cluster) will work collaboratively, bringing together Bedfordshire Luton & Milton Keynes ICB, Cambridgeshire & Peterborough ICB, and Hertfordshire and West Essex (Herts) ICB. The Cluster will work within the context of the NHS Model Blueprint published in May 2025. Subject to legislative change, anticipated to come into force from 1 April 2026, the three ICBs will be dissolved and a new Central East ICB will be established, covering the areas of Bedfordshire Luton & Milton Keynes, Cambridgeshire & Peterborough, and Hertfordshire.

1.2 Due to the NHS Hertfordshire and West Essex having a different board composition - with the Essex geography of its ICB aligning with NHS Mid and South Essex ICB alongside NHS Suffolk and North East Essex ICB, there will be a distinction in the documentation held within this Governance Handbook.

1.3 To support the transition, our governance framework has been designed to:

- To keep the three organisations safe in terms of ensuring each ICB fulfils its statutory duties until a new statutory organisation is formed;
- That is ambitious and supports innovation, and the provider landscape.
- Will ensure the resident and patient voice and experience comes through – linking with neighbourhood/local structures.
- Provides clear, effective and agile governance and clear leadership and decision-making structures during a period of significant change.
- Signals the creation of a new organisation to establish a new culture and ways of working across the current 3 ICBs.
- Provides clear lines of assurance and decision making with the Essex cluster ICBs – as Hertfordshire and West Essex ICB will continue to sit across two clusters in its current entity form.

1.4 Our approach to future governance is in two phases:

Pre-transition - To ensure we provide a pragmatic and streamlined approach to ensure an effective transition and safe delivery of business as usual.

Post- transition - To consider the future governance framework that we will need in place to deliver the 10-year plan and 3 shifts.

- The requirements of the ICB Model Blueprint published in May 2025;
- Aligns the clustering structures with the governance structure of the new ICB established in April 2026; and
- That provides sufficient flexibility to adapt to the changing landscape whilst maintaining a simplistic but effective form.

1.5 The Central East Cluster Governance Handbook (Handbook) aligns the Governance Frameworks of the NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board (ICB), NHS Cambridgeshire and Peterborough ICB, and Herts and West Essex ICB (excluding Essex) and brings together key documents which support the ICBs' Constitutions and good governance.

1.6 In streamlining our governance structures bringing the ICB Boards and Committees together to meet, we will maintain the statutory obligations as independent legal entities. It is proposed that where possible, we operate Board and Committees in Common or as Joint Committees until the establishment of the new ICB. For clarity:

- A **committee in common** is two or more organisations holding their individual meetings in the same place at the same time, having separate agendas although the content may mirror each other's. The sovereign Chair would turn to each sovereign group of members and confirm approval to relevant individual items.

- A **joint committee** is made up of representatives from two or more organisations, who work together to oversee, manage, or resolve specific matters. Joint Committees or the identified individual attending on behalf of their organisation will have documented (e.g. via the Scheme of Reservation and Delegation (SoRD) delegated authority from the host organisations Board or identified individual to make decisions on its behalf.

  Note: statutory Boards and Committees cannot be Joint Committees.

1.7 In respect of statutory committees of each ICB Board - these will operate in-Common with no Constitutional change being required. With both forms of committee and their practical application, care will be taken to utilise hybrid options, with organisations or identified individuals attending meetings at appropriate times i.e. with relevant agenda items. For example, the external auditors would only attend the items on the Audit and Risk Management Committee that are relevant to the current ICB they are contracted to. This mitigates against experiences remembered pre-ICB days, when large groups attended in person and factors in ICB such as HWE pragmatically operating across two clusters (Central East and Essex).

1.8 The arrangements to work in-Common or Joint Committee arrangements are included in this Handbook and agreed by each ICB Board. HWE ICB will take particular care in ensuring its SoRD clearly documents linking assurance and scope. Each ICB would also need to acknowledge Part 2 agendas where statutory organisations need to consider business pertinent to legal entities and also consider the impacts of the Essex governance arrangements.

1.9 The Handbook should be read in conjunction with the three ICBs Constitutions (and Standing Orders). These are published on the website of each ICB.

1.10 Governance is the means by which the Board leads and directs the ICBs, so decision making is effective, and that evidence-based assurance can be provided against the execution of those decisions. Good governance is essential to the work of the ICBs and to its management structure and organisation. The implementation of this handbook is mandatory for all staff, board and members of its committees.

1.11 The Handbook provides further detail on how the ICBs will work collaboratively. In this respect it is a 'living document' and will be updated periodically as new structures and processes are implemented and new policies are approved. During the transition period this includes:

- An overview of the governance framework, including the composition of the Central East and Board Committees' Terms of Reference;
- The roles and responsibilities of Board Members;

- Scheme of Reservation and Delegation, which sets out those decisions that are reserved for the ICB and those decisions that have been delegated;
- Functions and Decisions Map which will develop further throughout the transition period;
- Standing Financial Instructions and Prime Financial Policies, setting out the arrangements for managing the ICB's financial affairs.
- Standards of Business Conduct and Managing Conflicts of Interest policies for each organisation – which includes the arrangements the ICBs have made for the management of conflicts of interest.

1.12 Amendments to the documents that make up the Governance Handbook are approved by the Board of the ICB (the Board) subject to any exceptions set out in the Scheme of Reservation and Delegation.

1.13 Central to good governance is ensuring that the highest standards of public service management are observed within the ICB, including adherence to the Seven Principles of Public Life set out by the Committee on Standards in Public Life (also known as the Nolan Principles) set out below:

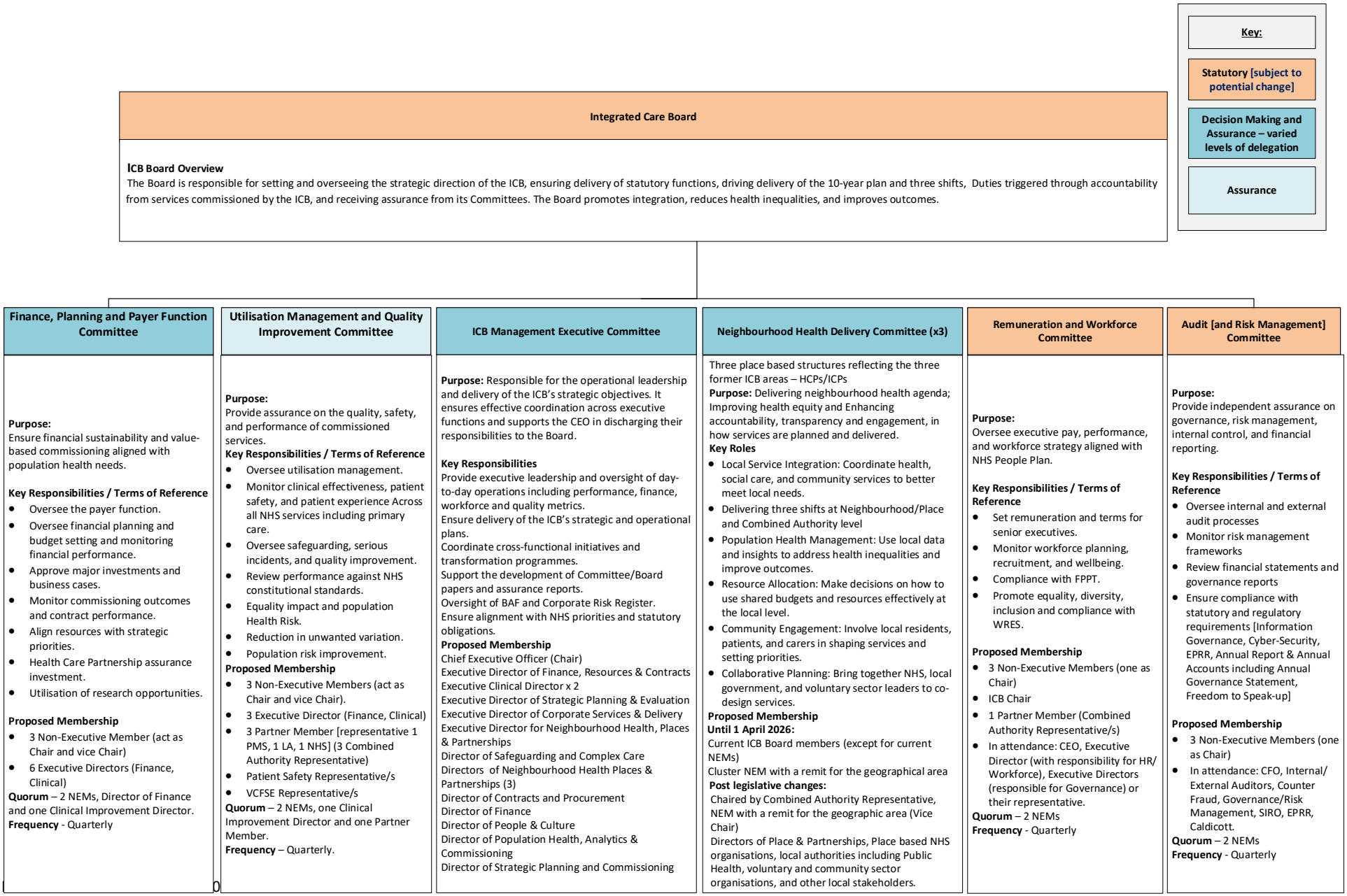
1. **Selflessness -** Holders of public office should act solely in terms of the public interest.
2. **Integrity -** Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.
3. **Objectivity -** Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.
4. **Accountability -** Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.
5. **Openness -** Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.
6. **Honesty -** Holders of public office should be truthful.
7. **Leadership -** Holders of public office should exhibit these principles in their own behaviour and treat others with respect. They should actively promote and robustly support the principles and challenge poor behaviour wherever it occurs.

2. Central East Cluster Governance Framework

2.1 Overview

The Central East Cluster brings together three ICB statutory bodies - Bedfordshire Luton & Milton Keynes ICB, Cambridgeshire & Peterborough ICB, and Hertfordshire and West Essex (Herts) ICB to work collaboratively. The Cluster's high-level governance framework operates as follows:

Governance Structure_v.1.4(14)



2.2 Role of the ICB Board

2.2.1 The board of each ICB comprises all of the board members acting collectively as a unitary board and is collectively accountable for the performance of the ICB's functions. As such all board members are jointly responsible for the decisions of the board. For our cluster arrangements, the Boards of the three ICBs will meet "in Common".

2.2.2 Generally all meetings of the board in common, which are comprised of entirely board members, at which public functions are exercised will be open to the public; however the board may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings.

2.2.3 Meetings of the board in common will be held at regular intervals at such times and places as the board may determine, as set out in the annual cycle of business published on the website.

2.2.4 Agendas and papers for board and committee meetings open to the public, including details about meeting dates, times, and venues, will be published on the ICB's website. At the Chair's discretion, meetings held in public may include a Questions & Answers session at the end of each agenda where members of the public are able to ask questions, which have been submitted in writing ahead of the Board meeting.

2.3 Committees of the Board

2.3.1 The ICB may appoint committees and arrange for its functions to be exercised by such committees. Each committee may appoint sub-committees and arrange for the functions exercisable by the committee to be exercised by those sub-committees. All committees and sub-committees are listed in the Scheme of Reservation and Delegation.

2.3.2 The terms of reference of the Board committees, all of which are chaired by Non-Executive Members of the Board, with the exception of the Management Executive Committee, can be found at Appendix 1 (a) to (f).

- Audit and Risk Committee
- Remuneration & Workforce Committee
- Finance Planning and Payer Function Committee – Joint Committee with NHS Hertfordshire and West Essex ICB sitting in-Common via its Strategic Finance and Commissioning Committee.
- Utilisation Management & Quality Improvement Committee – Joint Committee with NHS Hertfordshire and West Essex ICB sitting in-Common via its System Transformation and Quality Improvement Committee.
- BLMK Neighbourhood Health Delivery Committee – Joint Committee
- C&P Neighbourhood Health Delivery Committees – Joint Committee
- HWE(H) Neighbourhood Health Delivery Committee – Joint Committee
- Management Executive Committee
- Additional committees linking to NHS Hertfordshire and West Essex ICB:
  - Joint Transition Committee

- Quality Committee – sitting as a Joint Committee
- Finance and Performance Committee – sitting as a Joint Committee

2.3.3 A number of enabling and delivery groups will feed into the ICB board, its committees, and sub-committees to support assurance, delivery, decision-making and provide advice where appropriate.

2.4 Statutory Committees in Common

2.4.1 Audit & Risk Committee - (Statutory) - to meet across each ICB as Committees in-Common pre-transition and a new ICB entity being formed
Purpose: Provide independent assurance on governance, risk management, internal control, and financial reporting.

Key Responsibilities

- Oversee internal and external audit processes
- Monitor risk management frameworks including deep dives on system-wide risks
- Review financial statements and governance reports
- Ensure compliance with statutory and regulatory requirements [Information Governance, Cyber Security, EPRR, Annual Report & Annual Accounts including Annual Governance Statement, Freedom to Speak Up].
- Integrated Care Partnership assurance

Terms of Reference are set out at Appendix 1 (a).

2.4.2 Remuneration & Workforce Committee – (Statutory [Remuneration]) - to meet across each ICB as Committees in-Common pre-transition and a new ICB entity being formed.

Purpose: Oversee Executive and Director (VSM) pay, performance, and workforce strategy aligned with NHS People Plan.

Key Responsibilities

- Set remuneration and terms for senior executives
- Monitor workforce planning, recruitment, and wellbeing
- Compliance with the Fit and Proper Persons Test (FPPT)
- Promote equality, diversity and, inclusion and compliance with Workforce Race Equality Standards (WRES)/Workforce Disability Equality Standard (WDES).

Terms of Reference are set out at Appendix 1 (b).

2.5 Non-Statutory Committees – Joint Committees

- 2.5.1 **Finance Planning and Payer Function Committee** - to meet as Joint Committees pre-transition and a new ICB entity being formed. This Committee will be joined in-Common by NHS Hertfordshire and West Essex ICBs Strategic Finance and Commissioning Committee.

Purpose: Ensure financial sustainability and value-based commissioning aligned with population health needs.

Key Responsibilities

- Oversee financial planning, budget setting and monitoring financial performance
- Approve major investments and business cases
- Monitor commissioning outcomes and contract performance
- Align resources with strategic priorities
- Integrated Care Partnership assurance investment

Terms of Reference are set out at Appendix 1 (c).

2.5.2 Utilisation Management & Quality Improvement Committee – to meet as Joint Committees pre-transition and a new ICB entity being formed. This committee will be joined in-Common by NHS Hertfordshire and West Essex ICBs System Transformation and Quality Improvement Committee.

Purpose: Provide assurance on the quality, safety, and performance of commissioned services.

Key Responsibilities

- Monitor clinical effectiveness, patient safety, and patient experience across all NHS services including primary care
- Oversee safeguarding, serious incidents, and quality improvement
- Review outcomes against NHS constitutional standards
- Assure Equality impact and population health risk of ICB commissioned services.
- To review and monitor those risks on the Board Assurance Framework and Corporate Risk Register which relate to quality, safety, effectiveness, access, equity, acceptability and relevance.

Terms of Reference are set out at Appendix 1 (d).

2.5.3 BLMK, C&P and HWE(H) Neighbourhood Health Delivery Committee (one for each current ICB geography with the majority of members from current ICB Boards)– Joint Committees. Three place-based structures reflecting the three former ICB areas. Proposed that existing ICP Committees* become the Neighbourhood Health Delivery Boards until 1 April 2026.

Purpose: Delivering care closer to home; Responding to local priorities; Improving health equity and Enhancing accountability and transparency in how services are planned and delivered

Key Responsibilities

- Delegated responsibility for place-based finance and delivery at neighbourhood and Place
- Local Service Integration: Coordinate health, social care, and community services to better meet local needs
- Population Health Management: Use local data and insights to address health inequalities and improve outcomes
- Make decisions on how to use shared budgets and resources effectively at the local level
- Community Engagement: Involve local residents, patients, and carers in shaping services and setting priorities and informing decisions at Place and ICB.

- Collaborative Planning: Bring together NHS, local government, and voluntary sector leaders to co-design services to meet the needs of the local population.
- Market Management – oversight of providers ensuring services are high quality and value for money

BLMK Neighbourhood Health Delivery Committee Appendix 1 (e)
C&P Neighbourhood Health Delivery Committee Appendix 1 (f)
HWE(H) Neighbourhood Health Delivery Committee Appendix 1(g)

* Integrated Care Partnerships

Each integrated care system, works with an Integrated Care Partnership (ICP) committee formed jointly between health and care organisations, local government, and voluntary sector partners. ICPs are ICS statutory committees and will remain in place until legislative change. Until this time it is proposed that the Neighbourhood Health Delivery Committees act as the ICP for their specific system.

The role of the ICP is to ensure that, within the resources available, our citizens experience the best possible care and are supported to access the services that best meet their needs. The ICP will seek to use its position to influence the decisions of the ICBs in endeavour to ensure that decisions are made in the best interests of the populations living in each system within the Central East cluster. The ICP will focus on the citizen, rather than organisation and work with the ICB to protect those interests and promote coproduction and collaboration as a core values.

The ICPs aims to support the improvement of the health and wellbeing of the whole population and will highlight where further integration of services may be needed in health and care services.

- Together, the ICPs will seek to support the ICBs in its effort to: help people live more independent, healthier lives for longer
- addresses inequalities in health and wellbeing outcomes, experiences, and access to health services
- improve the wider social determinants that drive these inequalities, including employment, housing, education, environment and reducing offending; and
- improve the life chances of our population and actively addresses the population health needs
- take a holistic view of people's interactions with services across the system

8.2 The terms of reference for the ICPs mirror those of the Neighbourhood Health Committee Terms of Reference set out at Appendix € a-c

2.5.4 Management Executive Committee – **-** to meet as a Joint Committee pre-transition and a new entity ICB being formed.

Purpose: Responsible for the operational leadership and delivery of the ICB's strategic objectives. It ensures effective coordination across executive functions and supports the CEO in discharging their responsibilities to the Board.

Key Responsibilities

- Provide executive leadership and oversight of day-to-day operations including performance, finance, workforce, and quality metrics.
- Ensure delivery of the ICB's strategic and operational plans
- Coordinate cross-functional initiatives and transformation programmes
- Support the development of Committee/Board papers and assurance reports
- Oversight of the Board Assurance Framework and Corporate Risk Register
- Ensure alignment with NHS priorities and statutory obligations.

Terms of Reference are set out at Appendix 1 (h).

2.6 Chairs, Executive Leads and Secretariat Functions for each Committee

2.6.1 The Chairs and Executive Leads function for each of Committees described in section 2.5 above are set out below:

Committee	Chair	Executive Lead (s)
Audit & Risk Committee	Non-Executive Member	Executive Director of Finance, Resources & Contracts Executive Director Corporate Services & ICB Development
Remuneration & Workforce Committee	Non-Executive Member	Executive Director Corporate Services & ICB Development
Finance Planning and Payer Function Committee	Non-Executive Member	Executive Director of Finance, Resources & Contracts Executive Director Strategy, Planning & Evaluation
Utilisation Management & Quality Improvement Committee	Non-Executive Member	Executive Director Strategy, Planning & Evaluation Executive Clinical Director Total Quality Management Executive Clinical Director Utilisation Management
Three Neighbourhood Health Delivery Committees (one for each current ICB geography with the majority of members from current ICB Boards)– Joint Committees	Local Authority Member – agreed by the Committee Non-Executive Member (Vice Chair)	Executive Director Neighbourhood Health Places & Partnerships
Management Executive Committees – In Common	Chief Executive Officer	Chief Executive Officer

2.8 Specialised Commissioning Joint Commissioning Consortium

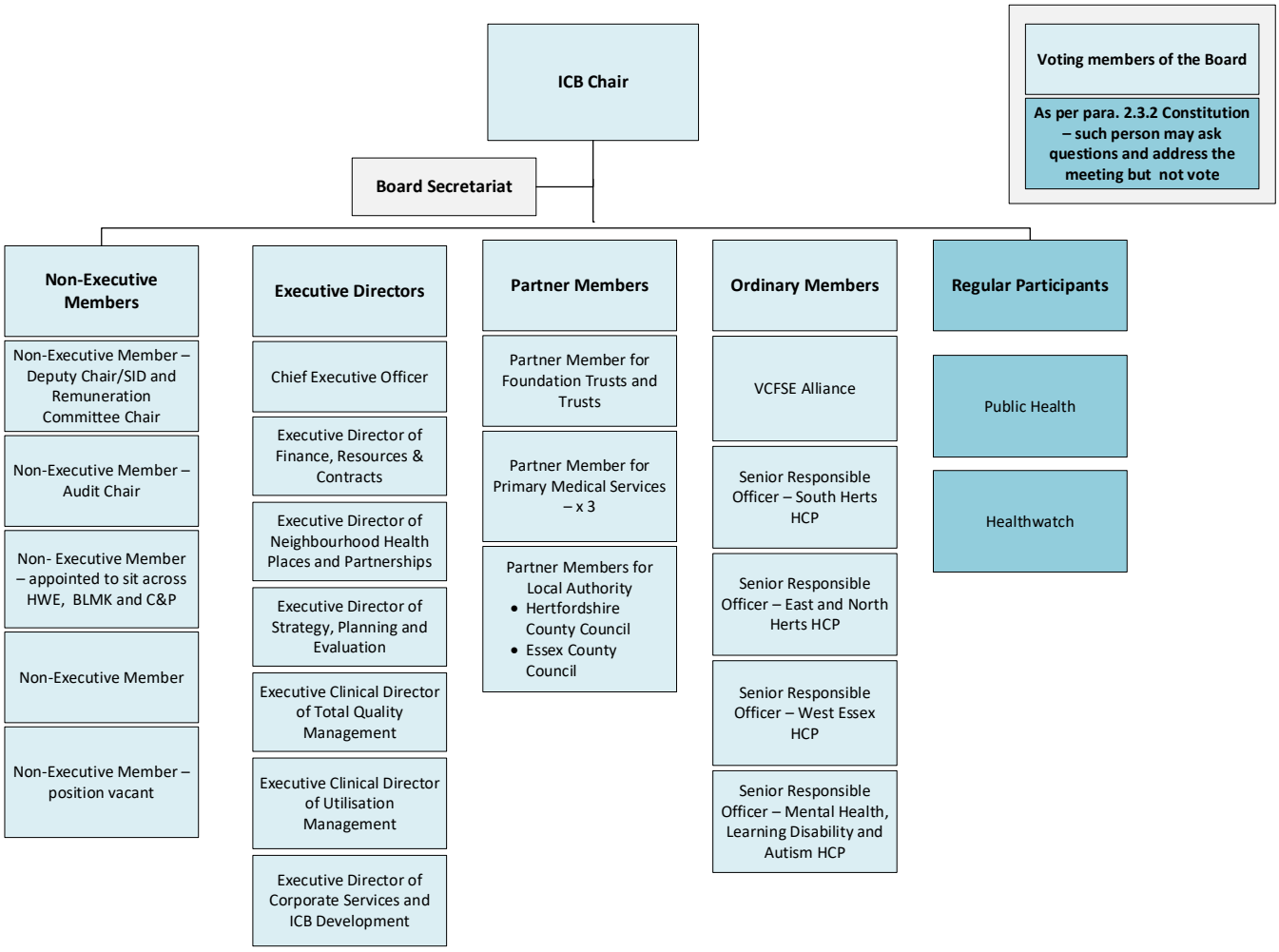
2.8.1 NHS England has delegated the commissioning of some specialised services to the ICB. In collaboration with the other five ICBs in the East of England, the ICB will exercise this responsibility through a Joint Commissioning Consortium. The Joint Commissioning Consortium (JCC) is the mechanism through which an officer authorised by the ICB (Authorised Officer) will collaborate with authorised officers from the other ICBs and NHSE East of England regional office to direct and oversee the delivery of the delegated commissioning functions. The JCC will also act in an advisory capacity to NHSE for those specialised services not being delegated.

2.8.2 Decision making at the JCC will be through the exercise of the existing delegated authority of the Authorised Officer. Where decisions are required above the level of this delegated authority, the Authorised Officer will refer to the appropriate person or body in the ICB for any necessary authorisation or to seek changes to the delegated limits."

3. Roles and responsibilities of Board members

3.1 Overview

The board of the ICB exclusively comprises its members who have voting rights; however, the Chair may invite specified individuals to be regular Participants or Observers at board meetings in order to inform decision-making and discharge of the board's functions, but they may not vote. This is illustrated as follows:


ICB Chair
Board Secretariat
Voting members of the Board
As per para. 2.3.2 Constitution – such person may ask questions and address the meeting but not vote
Non-Executive Members
Non-Executive Member – Deputy Chair/SID and Remuneration Committee Chair
Non-Executive Member – Audit Chair
Non- Executive Member – appointed to sit across HWE, BLMK and C&P
Non-Executive Member
Non-Executive Member – position vacant
Executive Directors
Chief Executive Officer
Executive Director of Finance, Resources & Contracts
Executive Director of Neighbourhood Health Places and Partnerships
Executive Director of Strategy, Planning and Evaluation
Executive Clinical Director of Total Quality Management
Executive Clinical Director of Utilisation Management
Executive Director of Corporate Services and ICB Development
Partner Members
Partner Member for Foundation Trusts and Trusts
Partner Member for Primary Medical Services – x 3
Partner Members for Local Authority
Hertfordshire County Council
Essex County Council
Ordinary Members
VCFSE Alliance
Senior Responsible Officer – South Herts HCP
Senior Responsible Officer – East and North Herts HCP
Senior Responsible Officer – West Essex HCP
Senior Responsible Officer – Mental Health, Learning Disability and Autism HCP
Regular Participants
Public Health
Healthwatch

3.2 Chair

3.2.1 The Chair of the ICB is appointed by NHS England with the approval of the Secretary of State for Health and Social Care. He/ she is responsible for the leadership and conduct the ICB board.

3.2.2 He/ she appoints and reviews the performance of the Chief Executive and has a veto over the appointment of other Board Members enabling him/ her to ensure the ICB board is properly equipped and through its membership collectively has the right skills, experience, and attributes to be effective.

3.2.3 The Chair is accountable for ensuring there is a long-term, viable strategy in place for the delivery of the functions, duties, and objectives of the ICS / ICB and for the stewardship of public money. The Chair champions action to help meet the four core purposes of ICS; to improve outcomes in population health and healthcare; tackle inequalities in outcomes, experience, and access; enhance productivity and value for money and help the NHS support broader social and economic development. The Chair is an ambassador for and champion of effective partnership working with local government and NHS bodies, collaborative leadership, and new governance arrangements across the Integrated Care System. The Chair will lead the board in setting a vision, strategy, and clear objectives for the ICS/ICB in delivering on the four core purposes of the ICS, the triple aim and the body's regulatory responsibilities. The Chair will hold the ICB Chief Executive to account for delivery of the strategy of the ICS/ ICB, the plan for the delivery of health services for the population and effective stewardship of public money.

3.2.4 The Chair appoints and reviews the performance of the Non-Executive Members.

3.2.5 The ICB Chair will appoint a Deputy Chair from amongst the Non-Executive Members. The Chair of Audit and Risk Committee is not eligible to be appointed. The Deputy Chair will deputise as required for the ICB Chair.

3.2.6 The ICB Chair will also appoint a Senior Independent Non-Executive Member.

3.3 Chief Executive Officer

3.3.1 The Chief Executive is appointed by the Chair of the ICB in accordance with any guidance issued by NHS England. The Chief Executive is the accountable officer for the ICB and is personally accountable to NHS England for the stewardship of ICB's allocated resources.

3.3.2 They are responsible for leading the Executive Members and staff of the ICB in the delivery of services and development of the ICB's strategic direction.

3.3.3 The Chief Executive will lead action to drive improved health outcomes for the people and communities living within their Integrated Care System area, bringing together all those involved in planning and providing NHS services to agree and deliver their ambitions for improving the health of their population. They will work in partnership with local government colleagues and other partners to ensure the effective operation of the ICS Integrated Care Partnership and development and delivery of its integrated care strategy.

The Chief Executive will be accountable for the development of the long-term plan for the ICB, delivering the related NHS commissioning and performance arrangements for their entire system and, through this, securing the provision of a comprehensive health service for people in the ICS area. They will be accountable for delivering improvements in the quality of patient care, patient safety, health inequality, workforce productivity and financial health across the ICS. They will establish performance oversight arrangements and lead on the identification of performance risks and issues related to the quality of patient care and work with relevant providers and partners to enable solutions. They will ensure effective governance systems are in place throughout the ICS to do this, to secure the ICS plan and ensure the highest quality and safety of care is delivered. They will ensure their ICB is 'Well Led' and lead the development of a system-wide workforce strategy securing workforce supply and productivity. They will lead the Emergency, Preparedness, Prevention response and hold civil contingency responsibility for the ICB reporting through to the Regional NHSE/I team. The Chief Executive is accountable to the ICB Chair and Board for the delivery of the ICB plan.

3.4 Executive Members

3.4.1 In addition to the Chief Executive, the ICB has six Executive Directors who are voting members of the Board.

3.4.2 Three of these voting Executive Director Members, are required to fulfil three statutory roles set out in the ICB's Constitutions.

- Director of Finance known as the Executive Director of Finance, Resources & Contracts
- Director of Nursing known as the Executive Clinical Director Total Quality Management
- Medical Director known as the Executive Clinical Director Utilisation Management

3.4.3 The other three Executive Directors with accountabilities to the Board are:

- Executive Director Neighbourhood Health Places & Partnerships
- Executive Director Strategy, Planning & Evaluation
- Executive Director Corporate Services & ICB Development

3.4.2 Executive Directors are appointed by the Board subject to the approval of the Chair.

3.4.3 Their appointment is through an open appointment process for which any suitably experienced individual meeting the role specification and eligibility criteria may apply.

3.4.4 They have certain responsibilities set out in their job descriptions and may be delegated other specific responsibilities by the Board and/ or the Chief Executive. In addition, the Director of Finance has delegated responsibilities related to the financial arrangements of the ICB that are described in the Standing Financial Instructions. Their roles are summarised below in 3.4.5 to 3.4.10 below.

3.4.5 **The Executive Clinical Director – Total Quality Management** - Leads the organisation's approach to quality management, ensuring services commissioned are safe, effective, and focused on continuous improvement. Embeds robust governance, performance monitoring, and improvement methodologies. They are accountable for:

- Develop and deliver the Total Quality Management (TQM) strategy aligned with organisational priorities.

- Oversee quality assurance, control, and improvement across all services.
- Ensure contracts deliver high quality at the best possible value.
- Embed continuous improvement methods such as Lean, Six Sigma, and PDSA cycles.
- Manage quality-related risks and ensure learning from incidents is embedded in practice.
- Represent the organisation in quality-related system forums and regulatory engagements.
- Improvement in outcomes.
- Lead and manage the TQM team to deliver the strategy effectively
- Maintain professional accountability to the relevant regional director.

- The Executive Clinical Director – Total Quality Management – will act as the Executive Director responsibility for SEND, Mental Health, Learning Disabilities & Autism and Downs Syndrome, Safeguarding (all age) including looked after children and care leavers.

3.4.6 **The Executive Clinical Director – Utilisation Management** provides executive clinical leadership, ensuring that clinical insights improve the utilisation of healthcare within the ICB and that professional standards are maximised. They are accountable for

- Provide expert clinical advice to inform strategy, decision-making, and service development.
- Reduce unwarranted variation and provision inequalities that lead to variation in outcomes or performance innovative, system-wide approaches.
- Improvement of medicines optimisation, and all-age continuing healthcare functions.
- Promote digitally enabled clinical transformation, population health management, innovation, and research.
- Build partnerships with provider collaboratives, public health, local government, and community organisations.
- Maintain professional accountability to the relevant regional director.
- Acts as the Caldicott Guardian.

3.4.7 **The Executive Director of Finance, Resources & Contracts** reports directly to the Chief Executive and is professionally accountable to the NHS England Regional Finance Director. They are accountable for:

- Develop and deliver the organisation's financial strategy, ensuring revenue, capital, and cost limits are met.
- Lead contracting, procurement, and estates planning to align with strategic objectives and deliver best value.
- Ensure resources are used effectively to improve outcomes, reduce inequalities, and support service sustainability.
- Provide clear financial governance, risk management, and performance monitoring.
- Build partnerships with system leaders and partners to support integrated financial planning.
- EPRR. Accountable Emergency Officer.

3.4.8 **The Executive Director Neighbourhood Health Places & Partnerships** provides system leadership for neighbourhood health and place-based partnerships, ensuring resources are targeted to deliver the best possible care and outcomes for local populations. Builds strong relationships with partners across the integrated care system (ICS). They are accountable for

- Lead the development and delivery of strategies for neighbourhood health and place-based working.
- Ensure resources are effectively deployed to meet the needs of local populations.
- Hold accountability for a broad and evolving portfolio aligned to ICB priorities.

- Contribute to the ICB's long-term strategy, integrating partner organisation priorities.
- Build partnerships and an active provider market across provider collaboratives, public health, primary care, local government, voluntary and community sectors, and local people.

3.4.9 **The Executive Director Strategy, Planning & Evaluation**

- Drives strategic planning, capacity and demand, market analysis, and health economics.
- Oversees care model, service specifications innovation, service change, and joint commissioning & contracting strategy.
- Supports actuarial analysis, utilisation trends, and value-based contracting.
- Responsible for building and maintaining data infrastructure, including engineering, architecture, and integration across partner organisations.
- It ensures that high-quality, timely, and interoperable data is available to support population health management, performance monitoring, and strategic decision-making.
- It the underpins the ability to manage clinical and financial risk effectively.

They are accountable for:

- Lead the implementation of the Model ICB Blueprint and NHS 10-Year Plan priorities, shifting care from treatment to prevention, hospital to community, and analogue to digital models.
- Embed advanced analytics and population health insights into commissioning, planning, and evaluation.
- Ensure optimal allocation of resources through evidence-based prioritisation, cost control, and measurable return on investment.
- Oversee the safe transition and integration of teams during organisational redesign, maintaining critical commissioning and evaluation capabilities.
- Create the environment for population-level improvements.
- Acts as the Senior Independent Risk Owner.

3.4.10 **The Executive Director Corporate Services & ICB Development** oversees corporate governance, programme delivery, and organisational effectiveness. Ensures the ICB operates to high standards, transitions successfully through structural change, and delivers on corporate priorities. They are accountable for:

- Manage corporate governance, board relations, and delivery of corporate priorities.
- Lead the transition and formal merger from multiple ICBs to a single organisation, ensuring continuity and performance.
- Support the development and delivery of the ICB's vision, values, and strategy.
- Oversee internal and external communications to protect and enhance the ICB's reputation.
- Foster a positive, inclusive, and innovative organisational culture.
- Coordinate compliance and assurance reporting to the board, partners, and regulators.
- Build strategic relationships with national and regional bodies, representing organisational priorities.
- Executive Lead for Conflicts of Interest, Complaints and Health and Fire Safety.

3.6 Non-Executive Members

3.6.1 The ICB has five Non-Executive Members who are appointed by the Board subject to the approval of the Chair. A NEM will be expected to take on the role of Vice chairing one of the 3

Neighbourhood Health Delivery Committees, and providing visible leadership within each of the local authority systems.

3.6.2 Their appointment is through an open appointment process for which any suitably experienced individual meeting the role specification and eligibility criteria may apply.

3.6.3 They are responsible for bringing independent scrutiny to the Board and have a shared responsibility to ensure that the ICB exercises its functions effectively, efficiently, economically, with good governance and in accordance with the terms of the ICB's Constitution. Non-Executive Members will bring independent oversight and constructive challenge to the priorities, plans and performance of the ICB, and promote open and transparent decision-making that facilitates consensus. They will operate beyond traditional organisational boundaries, driving forward the vision of integration, collaboration and system-working, by forging productive relationships across local health, social care, and voluntary partners. They have a key role in ensuring that the voice and needs of patients and communities are central to ICB discussions and decisions, so that strategies and services are inclusive and accessible to the whole population and deliver the best possible health outcomes for all. They will be responsible for specific areas relating to board governance and oversight.

3.7 Partner Members (until Legislative Change)

3.7.1 The ICB has six Partner Members, one of whom has been jointly nominated from each of the following three groups in BLMK, C&P and HWE ICBs area and appointed by the Board subject to the approval of the Chair:

- One NHS trusts and foundation trusts;
- Three primary medical services;
- Two local authorities

One of these Partner Members must have knowledge and experience in connection with services relating to the prevention, diagnosis, and treatment of mental illness.

3.7.2 They will provide the ICB board with knowledge and experience of their relevant sectors. While they will be expected to bring knowledge and experience from this sector and will contribute the perspective of this sector to the decisions of the ICB, they are not to act as delegates of this sector.

3.7.3 The nomination and selection process for each partner member is described within Section 3.5 to 3.7 of the ICB Constitution.

3.7.4 In respect of the Primary Medical Services Partner Member, this Member is jointly nominated by providers of primary medical services for the purposes of the health service within the ICB's area, and that are primary medical services contract holders responsible for the provision of essential services, within core hours to a list of registered persons for whom the ICB has core responsibility. The list of relevant providers of primary medical services for this purpose is included as part of this Governance Handbook. The list will be kept up to date and is attached at Appendix 2.

3.8 Ordinary Members:

3.8.1 **VCFSE Representative**

- The ICB also has a member nominated and appointed in accordance with the ICBs Constitution at paragraph 13.3.1.

3.8.2 Health Care Partnerships

- In accordance with paragraph 13.3.2 – four ordinary members will be appointed representing each of the Health Care Partnerships operating in this ICBs geographical area.

3.9 Participants and Observers

The ICB board may invite specified individuals to be Participants or Observers at its meetings in order to inform its decision-making and the discharge of its functions as it sees fit. This includes a Healthwatch representative and a Director of Public Health representative.

3.10 Confidentiality

3.10.1 All members and attendees of the Board, its committees and sub-committees, including joint committees and consultative forums are required to follow the NHS information governance rules on confidentiality. These principles must be observed by all who work within the Integrated Care Board and have access to its person information or confidential information.

3.10.2 All members and attendees are also obliged to follow the common law duty of confidentiality. Common law requires there to be a lawful basis for the use or disclosure of personal information that is held in confidence, for example:

- Where the individual has capacity and has given valid informed consent.
- Where disclosure is in the overriding public interest.
- Where there is a statutory basis or legal duty to disclose, e.g., by court order.

3.11 NHSE Fit and Proper Person Test

The ICB complies with the NHSE Fit and Proper Person Test (FPPT) Framework for all Board members in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT (the Kark Review). This also considers the requirements of the Care Quality Commission (CQC) in relation to directors being fit and proper for their roles. This process is led by the ICB Chair supported by the Executive Director for Corporate Services and ICB Development, and is overseen by the Remuneration and Workforce Committee,

3.12 Removal from Office

3.12.1 Arrangements for the removal from office of Board Members are subject to the Constitution and their individual terms of appointment, and application of the relevant ICB policies and procedures.

3.13 Board Tenures

Name	Role	Start Date	Completion of Terms of Office
Paul Burstow	Chair	01 July 2022	30 June 2025
		01 July 2025	17 October 2025
Gurch Randhawa*	Acting Chair	17 October 2025	04 November 2025
Robin Porter	Chair	04 November 2025	03 November 2028
Dr Jane Halpin	Chief Executive Officer	01 July 2022	01 October 2025
Jan Thomas	Chief Executive Officer	01 October 2025	*Not Applicable*
Alan Pond	Chief Finance Officer	01 July 2022	18 July 2025
Jonathan Wilson	Chief Finance Officer	01 August 2025	01 October 2025
Sarah Griffiths	Finance Director - hereafter referred to as the Executive Director of Finance, Resources & Contracts	01 October 2025	*Not Applicable*
Natalie Hammond	Director of Nursing and Quality	31 July 2023	01 October 2025
Sarah Stanley	Director of Nursing – hereafter referred to as the Clinical Director of Total Quality Management.	01 October 2025	*Not Applicable*
Dr Rachel Joyce	Medical Director	01 July 2022	01 October 2025
Dr Fiona Head	Medical Director – hereafter referred to as the Executive Clinical Director of Utilisation Management.	01 October 2025	*Not Applicable*
Louis Kamfer	Executive Director of Strategy, Planning & Commissioning	01 October 2025	*Not Applicable*
Kate Vaughton	Executive Director of Neighbourhood Health Places & Partnerships	01 October 2025	*Not Applicable*
Matthew Coats	Senior Responsible Officer South West Herts HCP	01 July 2024	30 June 2026

Elliot Howard-Jones	Board Partner Member – NHS Trusts and Foundation Trusts Senior Responsible Officer East and North Herts HCP	01 July 2024 01 July 2025	30 June 2025 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
Adam Sewell-Jones	Joint Senior Responsible Officer East and North Herts HCP Board Partner Member – NHS Trusts and Foundation Trusts	01 July 2024 01 July 2025	30 June 2025 01 July 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
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*	Deputy Chair/Non-Executive Member	01 July 2022 01 July 2025	30 June 2025 30 June 2028
Ruth Bailey	Non-Executive Member	01 July 2022 01 July 2025	30 June 2025 30 June 2028
Thelma Stober	Non-Executive Member	01 July 2022 01 July 2025	30 June 2025 30 June 2028
Nick Moberly	Non-Executive Member	01 December 2023	30 November 2026
Joanna Marovitch	VCFSE Alliance Board Member	04 January 2023	22 May 2025
Mark Hanna	VCFSE Alliance Board Member	23 May 2025	22 May 2027

4. Scheme of Reservation and Delegation

4.1 The Scheme of Reservation and Delegation (the SoRD) sets out those decisions that are reserved to the Board of the ICB and those decisions that have been delegated in accordance with the powers of the Board of the ICB and which must be agreed in accordance with and be consistent with the Constitution. The SoRD identifies where, or to whom, functions and decisions have been delegated.

4.2 Delegation arrangements for:

- all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act; and anything in the Memorandum of Understanding regarding Pharmacy, Optometry and Dental (POD) services;
- any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority, or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act;

must be identified in the Handbook and described in the SoRD, to the extent that they exist.

4.3 Decisions are based on a tiering system which is described in Section 5.2 below.

4.4 The SoRD can be found at Appendix 3.

5. Functions and Decisions Map

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

5.2 The Functions and Decisions Map can be found at Appendix 4. The Map is based on the following tiers of delegated decision-making:

- Tier 1 – Decisions reserved to the Board.
- Tier 2 - Decisions reserved to the Board Committees (delegated from the Board)
- Tier 3 – Decisions delegated to the Programme Board or Sub-Committee (via a Committee or Director Delegation).
- Tier 4 – Decisions delegated to Working Groups / Steering Groups / Task & Finish Group (via a Committee, Sub-Committee or Director Delegation)

6. Standing Financial Instructions and Prime Financial Policies

6.1 The Standing Financial Instructions (the SFIs) and the Prime Financial Policies (the PFPs) set out the arrangements for managing the ICB's financial affairs.

6.2 The SFIs and PFPs can be found at Appendix 5 and Appendix 5.1, respectively.

6.3 Detailed financial limits are managed separately by the Management Executive Committee, and are approved by the ICB Board.

7. Supporting Policies

7.1 The following supporting documents are available on the ICBs website:

- Conflicts of Interest Policy and Standards of Business Conduct Policy https://www.hertsandwestessex.ics.nhs.uk/documents/standards-of-business-conduct-and-conflicts-of-interest-policy/
- People and Communities Strategy https://www.hertsandwestessex.ics.nhs.uk/documents/hertfordshire-and-west-essex-ics-people-strategy/
- Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England (Published by the Professional Standards Authority): www.professionalstandards.org.uk/docs/default-source/publications/standards/standards-for-members-of-nhs-boards-and-ccgs-2013.pdf?sfvrsn=2

8. Business Cycle Approach

8.1 The current Business Cycle can be found on the ICB website https://www.hertsandwestessex.ics.nhs.uk/events/

9. Review

9.1 In compliance with the ICB Constitution - this Governance Handbook will be reviewed on an annual basis or more frequently, as required, by any changes to legislation, statutory guidance, or best practice.

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 v2

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.

To ensure internal audit actions are progressed against the agreed deadlines or risks escalated to responsible decision makers for response before the next committee.

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
V2	Friday 27 June 2025	HWE ICB Board	Annually	Paragraph 4.10

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

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

NHS
Hertfordshire and
West Essex
Integrated Care Board

NHS Hertfordshire and West Essex (ICB)
Neighbourhood Health Delivery Committee

Terms of Reference

1.0 Constitution

1.1 The HWE Neighbourhood Health Delivery Committee (the Committee) is established by the Integrated Care Board (ICB) as a committee of the Board of the ICB (the Board) in accordance with its Constitution. It will act as the Integrated Care Partnership Committee of the HWE ICB Board during the transitional arrangements and be responsible for delivering care closer to home; Responding to local priorities; Improving health equity and Enhancing accountability and transparency in how services are planned and delivered. It is also responsible for overseeing the HWE Health and Care strategy implementation

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 HWE Neighbourhood Health Delivery Committee is a committee Chaired by a local authority representative of HWE on the Board, and its members are bound by the Standing Orders and other policies of the ICB.

2.0 Authority

2.1 The Committee is authorised by the Board to:

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

3.0 Purpose

3.1 The HWE Neighbourhood Health Delivery Committee has been established to take responsibility for the operational leadership and delivery of the ICB's strategic objectives. It ensures effective coordination across executive functions and supports the CEO in discharging their responsibilities to the Board.

3.2 The HWE Neighbourhood Health Delivery Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and system performance management that supports it to effectively deliver its strategic objectives in HWE and ensure that sustainable, high quality care is provided to its population.

3.3 The HWE Neighbourhood Health Delivery Committee will provide regular assurance updates to the ICB in relation to the implementation of HWE operational and financial plan activities and items within its remit.

4.0 Membership and attendance

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

4.2 The Board will appoint HWE representatives as the members of the Committee.

Membership

- Four Local Authority Representatives (One to be Chair)
- One NEM responsible for HWE (Vice-Chair)
- NHS Trust representation
- Two Primary Medical Services Representatives
- Executive Director Neighbourhood Health Places & Partnerships
- Director of Neighbourhood Health Places & Partnerships (HWE)

Regular Attendees

- To be added.

4.2.1 The HWE Neighbourhood Health Delivery Committee may also have regular attendees who are not drawn from the Integrated Care Board. Attendees will receive advanced copies of the notice, agenda, and papers for meetings. They may be invited to attend any or all the meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair, to ask questions and address the meeting but may not vote. The following will be invited to be regular attendees:

Governance Lead
Others to be added

4.3 When determining the membership of the HWE Neighbourhood Health Delivery Committee, active consideration will be made to equality, diversity and inclusion.

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

Chair and Deputy Chair

4.5 The HWE Neighbourhood Health Delivery 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.

4.6 If a Chair has a conflict of interest, then the Deputy Chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

Attendees

4.7 The HWE Neighbourhood Health Delivery Committee may also invite other system colleagues to attend any or all the meetings, or part(s) of a meeting for specific agenda items. Any such person may be invited, at the discretion of the Chair, to ask questions and address the meeting but may not vote.

5.0 Meeting Quoracy and Decisions

5.1 The HWE Neighbourhood Health Delivery 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.

Quorum

There will be a minimum of the Chair and at least 50% of membership including the Executive Director or Director of Neighbourhood Health Place and Partnerships (HWE)

5.3 Where members are required for quoracy but unable to attend, they should ensure that a named and briefed deputy is in attendance who is able to participate and vote on their behalf. No other deputies are permissible.

Decision making and voting

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

5.5 Only members of the HWE Neighbourhood Health Delivery Committee or a nominated deputy as specified in paragraph 5.3 may vote. Each member is allowed one vote and a simple majority will be conclusive on any matter.

5.6 Where there is no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

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

6.0 Responsibilities of the Committee

6.1 The responsibilities of the HWE Neighbourhood Health Delivery Committee will be authorised by the Board of the ICB.

- Delegated responsibility for place-based finance and delivery at neighbourhood and Place
- Local Service Integration: Coordinate health, social care, and community services to better meet local needs
- Population Health Management: Use local data and insights to address health inequalities and improve outcomes
- Make decisions on how to use shared budgets and resources effectively at the local level
- Community Engagement: Involve local residents, patients, and carers in shaping services and setting priorities and informing decisions at Place and ICB.
- Collaborative Planning: Bring together NHS, local government, and voluntary sector leaders to co-design services to meet the needs of the local population.
- Market Management – oversight of providers ensuring services are high quality and value for money. Responsible for the delivery of the HWE operational and financial plan.
- Responsible for the oversight of the HWE Mental Health Learning Disability and Autism collaborative and receive assurance reports from the collaborative.
- Responsible for the oversight of the delivery of Primary Care in HWE and receive assurance reports at each meeting from the Primary Care Commissioning Assurance Programme Board.
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7.0 Behaviours and Conduct

7.1 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 Conflicts of Interest Management and Standards of Business Conduct Policy.

7.2 Equality and Diversity - Members must promote and consider the equality and diversity implications of decisions they make.

7.3 Declarations of Interest - 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.

8.0 Accountability and reporting

8.1 The HWE Neighbourhood Health Delivery Committee is directly accountable to the Board of 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.

8.2 The HWE Neighbourhood Health Delivery Committee will advise the Audit and Risk Committee on the adequacy of assurances available and contribute to the Governance Statement.

8.3 The HWE Neighbourhood Health Delivery Committee will receive scheduled assurance reports from its delegated groups and partners with statutory responsibilities for health and social care provision in the Central East cluster. Any delegated groups would need to be agreed by the Board of the ICB.

9.0 Secretariat and Administration

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

- The agenda and papers are prepared and distributed at least five working days before each meeting in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant Executive lead.
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not attend at least 75% of meetings.
- Records of members' appointments and renewal dates are reviewed and the Board is prompted to renew membership and identify new members where necessary.
- Good quality minutes are taken in accordance with the Standing Orders and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept.
- The Chair is supported to prepare and deliver reports to the Board.
- The Committee is updated on pertinent issues / areas of interest / policy developments.
- Action points are taken forward between meetings and progress against those actions is proactively monitored.

10.0 Review

10.1 The HWE Neighbourhood Health Delivery Committee will review its effectiveness at least annually.

10.2 These Terms of Reference will be reviewed at least every two years and more frequently if required. Any proposed amendments to the Terms of Reference will be submitted to the Board for approval.

Date of Approval: Add Date
Review Date: By Add Date

Management Executive Committee Terms of Reference

1.0 Constitution

1.1 The Management Executive Committee (the Committee) is established by the Integrated Care Board (ICB) as a committee of the Board of the ICB (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 an Executive Committee of the Board, and its members are bound by the Standing Orders and other policies of the ICB.

2.0 Authority

2.1 The Committee is authorised by the Board to:

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

3.0 Purpose

3.1 The Management Executive Committee has been established to take responsibility for the operational leadership and delivery of the ICB's strategic objectives. It ensures effective

coordination across executive functions and supports the CEO in discharging their responsibilities to the Board.

3.2 The Management Executive Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and system performance management that supports it to effectively deliver its strategic objectives and ensure that sustainable, high quality care is provided to its population.

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

4.0 Membership and attendance

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

4.2 The Board will appoint the Executive Directors and Directors of the ICB Management Team as the members of the Committee.

Members (Executive Directors and Directors)

Chief Executive Officer (Chair)
Executive Director of Finance, Resources & Contracts
Executive Clinical Director of Total Quality Management
Executive Clinical Director Utilisation Management
Executive Director Neighbourhood Health Places & Partnerships
Executive Director Strategy, Planning & Evaluation
Executive Director Corporate Services & ICB Development
Director High Cost Patient Management and Safeguarding
Directors of Neighbourhood Health Places & Partnerships (3)
Director of Contracts and Procurement
Director of Finance
Director of People and Culture
Director of Population Health, Analytics and Evaluation
Director of Strategic Planning and Commissioning

Regular Attendees

4.2.1 The Committee may also have regular attendees who are not drawn from the Integrated Care Board. Attendees will receive advanced copies of the notice, agenda, and papers for meetings. They may be invited to attend any or all the meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair, to ask questions and address the meeting but may not vote. The following will be invited to be regular attendees:

Governance Lead
Others to be added

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

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

Chair and Deputy Chair

4.5 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.

4.6 If a Chair has a conflict of interest, then the Deputy Chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

Attendees

4.7 The Committee may also invite other system colleagues to attend any or all the meetings, or part(s) of a meeting for specific agenda items. Any such person may be invited, at the discretion of the Chair, to ask questions and address the meeting but may not vote.

5.0 Meeting Quoracy and Decisions

5.1 The 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.

Quorum

There will be a minimum of the Chief Executive or nominated Deputy, plus 3 other Executive Directors

5.3 Where members are required for quoracy but unable to attend, they should ensure that a named and briefed deputy is in attendance who is able to participate and vote on their behalf. No other deputies are permissible.

<u>Decision making and voting</u>

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

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

5.6 Where there is no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

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

6.0 Responsibilities of the Committee

6.1 The responsibilities of Management Executive Committee will be authorised by the Board of the ICB.

- Provide executive leadership and oversight of day-to-day operations including performance, finance, workforce, and quality metrics.
- Ensure delivery of the ICB's strategic and operational plans
- Coordinate cross-functional initiatives and transformation programmes
- Support the development of Committee/Board papers and assurance reports
- Oversight of the Board Assurance Framework and Corporate Risk Register
- Ensure alignment with NHS priorities and statutory obligations

7.0 Behaviours and Conduct

7.1 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 Conflicts of Interest Management and Standards of Business Conduct Policy.

7.2 Equality and Diversity - Members must promote and consider the equality and diversity implications of decisions they make.

7.3 Declarations of Interest - 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.

8.0 Accountability and reporting

8.1 The Executive Management Committee is directly accountable to the Board of 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.

8.2 The Executive Management Committee will advise the Audit and Risk Assurance Committee on the adequacy of assurances available and contribute to the Governance Statement.

8.3 The Executive Management Committee will receive scheduled assurance reports from its delegated groups and partners with statutory responsibilities for health and social care provision in the Central East cluster. Any delegated groups would need to be agreed by the Board of the ICB.

9.0 Secretariat and Administration

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

- The agenda and papers are prepared and distributed at least five working days before each meeting in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant Executive lead.
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not attend at least 75% of meetings.
- Records of members' appointments and renewal dates are reviewed and the Board is prompted to renew membership and identify new members where necessary.
- Good quality minutes are taken in accordance with the Standing Orders and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept.
- The Chair is supported to prepare and deliver reports to the Board.
- The Committee is updated on pertinent issues / areas of interest / policy developments.
- Action points are taken forward between meetings and progress against those actions is proactively monitored.

10.0 Review

10.1 The Executive Management Committee will review its effectiveness at least annually.

10.2 These Terms of Reference will be reviewed at least every two years and more frequently if required. Any proposed amendments to the Terms of Reference will be submitted to the Board for approval.

Date of Approval: Add Date – 17th October 2025
Review Date: By Add Date

Appendix 2 – Relevant providers of primary medical services:

Practice Name	Address	Postcode
Epping Locality		
Abridge Surgery	37 Ongar Road, Abridge, Essex	RM4 1UH
Chigwell Medical Centre	300 Fencepiece Road, Hainault, Essex	1G62TA
The Forest Practice	26 Pyrles Lane, Loughton, Essex	IG10 2NH
The Loughton Surgery	25 Traps Hill, Loughton, Essex	IG10 1SZ
High Street Surgery	301 High Street, Epping, Essex	CM16 4DA
Kings Medical Centre	23 Kings Avenue, Buckhurst Hill, Essex	IG9 5LP
The Limes Medical Centre	The Plain, Epping, Essex	CM16 6TL
Loughton Health Centre	The Drive, Loughton, Essex	IG10 1HW
Market Square Surgery	Sewardstone Road, Waltham Abbey, Essex	EN9 1NP
Maynard Court Surgery	17/18 Maynard Court, Waltham Abbey, Essex	EN9 3DN
Ongar Health Centre	Ongar War Memorial Medical Centre, 57 Fyfield Road, Ongar, Essex	CM5 0AL
The River Surgery	16 Rous Road, Buckhurst Hill, Essex	IG9 6BN
Palmerston Road Surgery	18 Palmerston Road, Buckhurst Hill, Essex	IG9 5LT
Harlow Locality		
Addison House Surgery	Hamstel Road, Harlow, Essex	CM20 1EW
Church Langley Medical Centre	Minton Way, Church Langley, Harlow, Essex	CM17 9TG
Hamilton Practice	Keats House Health Centre, Bush Fair, Harlow, Essex	CM18 6LY
Lister Medical Centre	Abercrombie Way, Harlow, Essex,	CM18 6YJ
Nuffield House Surgery	The Stow, Harlow, Essex	CM20 3AX
Old Harlow Health Centre	Jenner House, Garden Terrace Road, Old Harlow, Essex	CM17 0AX
The Ross Practice	Keats House, The Fairway, Harlow, Essex	CM18 6LY
Sydenham House Surgery	Monkswick Road, Harlow, Essex	CM20 3NT
Uttlesford Locality		
Angel Lane Surgery	Angel Lane, Great Dunmow, Essex	CM6 1AQ
Eden Surgery	Broomfields, Hatfield Heath, Herts	CM22 7EH
John Tasker House Surgery	56 New Street, Great Dunmow, Essex	CM6 1BH
Newport Surgery	Frambury Lane, Newport, Essex	CB11 3PY
The Crocus Practice	Saffron Walden Community Hospital, Radwinter Road, Saffron Walden, Essex	CVB11 3HY
Peacock Surgery	Castle Maltings, 2 Lower Street, Stansted, Essex	CM24 8XG
Thaxted Surgery	Margaret Street, Thaxted, Essex	CM6 2QN
The Gold Street Surgery	Gold Street, Saffron Walden, Essex	CB10 1EJ

NHS
Hertfordshire and
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Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board

Scheme of Reservation and Delegation

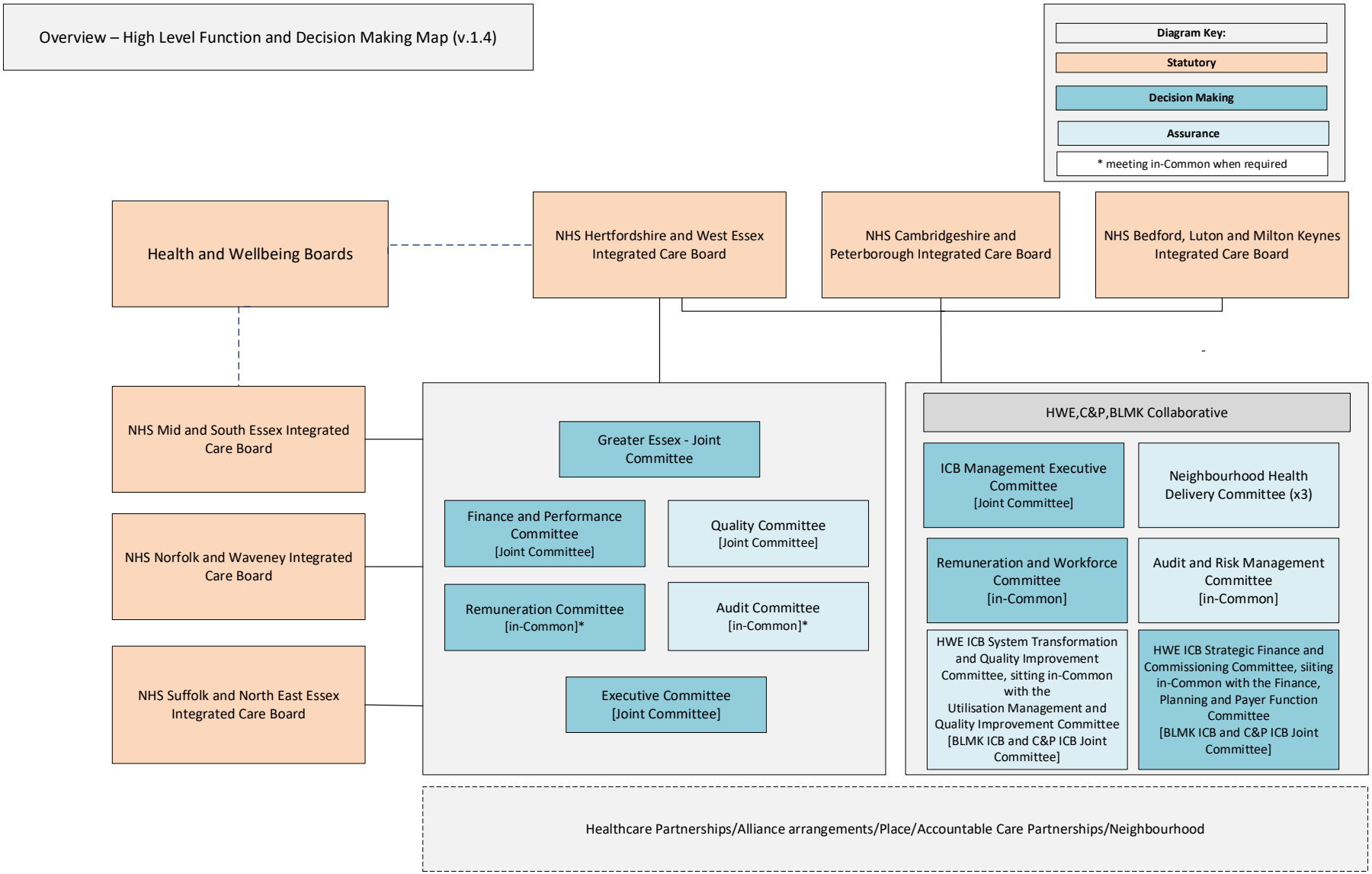
This Scheme of Reservation and Delegation (SoRD), in support of the ICB Model Blueprint and 10-year plan, sets out:

- Those functions that are reserved to each sovereign ICB Board cited above
- Those functions, authority and financials level that have been delegated to an individual or to Committees and Sub-Committees
- Those functions whilst the cited sovereign boards are operating in a cluster arrangement – will be delivered through Boards/Committees meeting in-Common or through a formal Joint Committee arrangements.
- Those functions delegated to another body or to be exercised jointly with another body, under sections 65Z5 and 65Z6 of the 2006 Act.

In compliance with section 4.4.4 mirrored in each ICBs Constitution, sovereign ICB Boards will remain *accountable for all of its functions, including those that it has delegated. All those with delegated authority are accountable to* each of the cited ICB Boards *for the exercise of their delegated functions*.

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.

Overview – High Level Function and Decision Making Map (v.1.4)



Definitions and Abbreviations:

Term	Description
Cluster	For the purpose of this document - the collaboration of ICBs as detailed in the NHS Blueprint
In-Common	A committee in common is two or more organisations meeting in the same place at the same time, has separate agendas but the same items on them and it may reach the same conclusions. But the individual organisations remain distinct and (if the committee is decision-making) take their own decisions. It is understood, this form will have to be used for Boards or Committees triggered by statute i.e. the ICB Board, Remuneration Committee, Audit Committee. Meetings will be triggered in-Common when required and not by default.
Joint Committee	A joint committee is made up of representatives from two or more organisations, who work together to oversee, manage, or resolve specific matters. Joint Committees often have delegated authority from the host organisations to make decisions on its behalf.
2006 Act	National Health Service Act (as amended)
SFI	Standing Financial Instructions
SoRD	Scheme of Reservation and Delegation
EPRR	Emergency Preparedness, Resilience and Response
FPPT	Fit and Proper Person Test
ICP	Integrated Care Partnership
PDSA	Pan-Do-Study-Act
ICS	Integrated Care System

Index:

Version Control:

Version Number	Changes	Date of Approval
v.1	New Document	17 October 2025

	Decisions and functions reserved to the Board – sitting in-Common when required and not by default	Reference Document
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 – sitting in-Common when required and not by default	Reference Document
The Board	**Regulations and Control** Consider and approve proposed amendments to the ICB Constitution by the Chief Executive prior to making an application to vary the constitution to NHSE.	Constitution 1.6.2, Standing Orders 2.1.3, 2.1.4
	Approve Standing Orders (SOs), a schedule of matters reserved to the Board (Scheme of Reservation and Delegation (SoRD) of powers delegated from the Board to the Executive Team and other Committees, Functions and Decisions Map, Standing Financial Instructions (SFIs) and the Governance Handbook for the regulation of its proceedings and business.	Constitution 1.6.2, 1.7.2, 4.4.2, Standing Orders 2.1, 2.3
	Approve to vary or amend the Standing Orders in accordance with the procedures for amending the Constitution as described above.	Constitution 1.6.2; Standing Orders 2.3
	Approve delegation arrangements to ICB Committees, Joint Committees, to other Statutory Bodies, individual Board Members and employees is reserved to the Board. Including approval of committee terms of reference.	Constitution 4.6.1, 4.6.3, 4.6.6, 4.7.1
	The power to approve arrangements for Pooled Funds is reserved to the Board.	Constitution 4.7.3
	Approve arrangements for the management of conflicts of Interest defined within the Conflicts of Interest Policy, including publication of registers of interest.	Constitution 6.1.1, 6.3.2. Standards of Business Conduct and Conflicts of Interest Policy.
	Require and receive the declaration of Board members' (and others as required) interests to discharge its duty to manage conflicts of interest.	Constitution 6.1.3, 6.1.4, 6.1.5, 6.3.1, 6.3.2, 6.3.7
	Approve arrangements for dealing with complaints and ensure a clear complaints process is published.	Constitution 7.3.4
	Ensure the ICB Complies with the Freedom of Information Act 2000 and Information Commissioner Office requirements.	Constitution 7.3.5

	Decisions and functions reserved to the Board – sitting in-Common when required and not by default	Reference Document
	Ensure systems and processes exist to comply with the requirements of the NHS Provider Selection Regime.	Constitution 7.4.2, 7.4.3. Procurement Policy
	Comply with Local Authority Health Overview and Scrutiny Requirements.	Constitution 7.4.4
	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 2.2
The Board	**<u>Appointments/Dismissal</u>** 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 – sitting in-Common when required and not by default	Reference Document
	Appointment of Internal or External Auditors and the Counter Fraud officer following recommendations from the Audit Committee.	Constitution 4.6.8
The Board	**Strategy, Annual Operational Plan and Budgets** Approve a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years. 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 – sitting in-Common when required and not by default	Reference Document
	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 – sitting in-Common when required and not by default	Reference Document
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 Management Committee - sitting in-Common	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: • **Purpose** – in addition to those functions cited in the ICB Constitution, to provide oversight and assurance to the ICB Board on the adequacy of the governance, risk management and internal control processes, and financial reporting. • **Key Responsibilities** - - 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

Committee	Decisions and functions reserved to the Committee	Reference
Remuneration and Workforce Committee - sitting in-Common	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: • **Purpose** – in addition to those functions cited in the ICB Constitution, to oversee executive pay, performance, and workforce strategy aligned to the NHS People Plan. • **Key Responsibilities** - - 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. - Monitor workforce planning, recruitment and wellbeing. - Compliance with Fit and Proper Person Test. - Promote equality, diversity, inclusion and compliance with WRES. • The 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
HWE ICB Strategic Finance and Commissioning Committee – sitting in-Common	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:	

Committee	Decisions and functions reserved to the Committee	Reference

with the BLMK and C&P Finance, Planning and Payer Function 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 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.	

Committee	Decisions and functions reserved to the Committee	Reference

	• 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**:
	
	  • 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:	

Committee	Decisions and functions reserved to the Committee	Reference

	• 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.
	• 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).	

Committee	Decisions and functions reserved to the Committee	Reference
	• 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 • 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.	

Committee	Decisions and functions reserved to the Committee	Reference
	• 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.	
HWE ICB System Transformation and Quality Improvement Committee – sitting in-Common with the BMLK and C&P Utilisation Management and Quality Improvement 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: 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.	Constitution 1.4.5, 1.4.7

Committee	Decisions and functions reserved to the Committee	Reference
	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 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	

Committee	Decisions and functions reserved to the Committee	Reference
	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: • 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	

Committee	Decisions and functions reserved to the Committee	Reference
	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.	

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
For the following posts - where the discharge of functions relates to the west Essex area of NHS Hertfordshire and West Essex ICB - the function will be delivered in consultation with the relevant HWE, BLMK, C&P ICBs Executive Director and through the Essex Joint Committee or the relevant sub-committee of the sovereign ICB Board.			
In collaboration with those ICBs falling within the Central East geography (BLMK and, C&P)			
Neighbourhood Health Delivery Committee (x3)	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: Three place-based structures reflecting the three former ICB areas. These committee will also hold the statutory functions falling under Integrated Care Partnerships. **Purpose -** Delivering neighbourhood health agenda; Improving health equity and Enhancing accountability, transparency and engagement, in how services are planned and delivered. **Key Responsibilities –** • Local Service Integration: Coordinate health, social care, and community services to better meet local needs. • Delivering three shifts at Neighbourhood/Place and Combined Authority level • Population Health Management: Use local data and insights to address health inequalities and improve outcomes. • Resource Allocation: Make decisions on how to use shared budgets and resources effectively at the local level.	Constitution 1.4.5., 1.4.7.	

	• Community Engagement: Involve local residents, patients, and carers in shaping services and setting priorities. • Collaborative Planning: Bring together NHS, local government, and voluntary sector leaders to co-design services.		
Management Executive Committee sitting as a joint 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: **Purpose –** Responsible for the operational leadership and delivery of the ICB's strategic objectives. It ensures effective coordination across executive functions and supports the CEO in discharging their responsibilities to the Board. **Key Responsibilities –** • Provide executive leadership and oversight of day-to-day operations including performance, finance, workforce and quality metrics. • Ensure delivery of the ICB's strategic and operational plans. • Coordinate cross-functional initiatives and transformation programmes. • Support the development of Committee/Board papers and assurance reports. • Oversight of BAF and Corporate Risk Register. • Ensure alignment with NHS priorities and statutory obligations.	Constitution 1.4, 2.3, 3.5, 3.9, 3.10, 3.11.	
Transition Committee sitting as a joint 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 The Transition Committee provides coordinated oversight and governance of the clustering and then subsequent merger between the different clusters. The Committee ensures that key decisions and risks are managed collectively and transparently, and that the transition is delivered safely, legally, and in line with NHS England requirements.		

In collaboration with Essex geography ICBs (NHS Mid and South Essex ICB, and NHS Suffolk and North East Essex ICB)			
Essex Joint Committee	This is a pre-transition Committee. Noted whilst in development. Scope to be defined in this Scheme of Reservation and Delegation for next iteration with Board approval.		
Finance and Performance Joint Committee	This is a pre-transition Committee. Noted whilst in development. Scope to be defined in this Scheme of Reservation and Delegation for next iteration with Board approval.		
Quality Joint Committee	This is a pre-transition Committee. Noted whilst in development. Scope to be defined in this Scheme of Reservation and Delegation for next iteration with Board approval.		

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. • Approve the appointments of the Partner Members of the Board. • Approve the appointment of Executive Members of the Board.	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 Constitution 3.4.1 Constitution 2.2.1, 3.5.4, 3.6.5, 3.7.4

Board Member / employee	Decisions and functions delegated by the Board	Reference
	• 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 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
For the following posts - where the discharge of functions relates to the west Essex area of NHS Hertfordshire and West Essex ICB - the function will be delivered in consultation with the relevant HWE, BLMK, C&P ICBs Executive Director and through the Essex Joint Committee or the relevant sub-committee.		

Chief Executive (Deputy Chief Executive)	**<u>Regulations and Control</u>**
	• 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

Board Member / employee	Decisions and functions delegated by the Board	Reference
	• During the initial period of pre-transition, authority is delegated to the CEO to approve financial delegation approve financial delegation limits for Executive Directors and sub-committees of the ICB Board, supported by recommendations from the Direct of Finance known as The Executive Director of Finance, Resources and Contracts. These approvals will be reported to the next Board for ratification. **<u>Appointments/Dismissal</u>** • 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) **<u>Statutory Functions / Duty</u>** • 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. **<u>NHS England Delegated Specialised Commissioning</u>** • 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 3.5.4, 3.6.5, 3.7.4 Constitution 3.8.2, 3.9.3, 3.10.3, 3.12.3 Constitution 3.11.2, 3.11.7

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

The Executive Clinical Director – Total Quality Management	**<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.
	
	<u>Regulations and Control</u>
	
	• HWE ICB Signatory
	
	<u>Operational Responsibilities</u>
	• Leads the organisation's approach to quality management, ensuring services commissioned are safe, effective, and focused on continuous improvement. Embeds robust governance, performance monitoring, and improvement methodologies. They are accountable for:
	  • Develop and deliver the Total Quality Management strategy aligned with organisational priorities.
	  • Oversee quality assurance, control, and improvement across all services.
	  • Ensure contracts deliver high quality at the best possible value.
	  • Embed continuous improvement methods such as Lean, Six Sigma, and PDSA cycles.	

Board Member / employee	Decisions and functions delegated by the Board	Reference
	• Manage quality-related risks and ensure learning from incidents is embedded in practice. • Represent the organisation in quality-related system forums and regulatory engagements. • Improvement in outcomes. • Lead and manage the TQM team to deliver the strategy effectively • Maintain professional accountability to the relevant regional director. • To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	
The Executive Clinical Director – Utilisation Management	**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** • Provides executive clinical leadership, ensuring that clinical insights improve the utilisation of healthcare within the ICB and that professional standards are maximised. They are accountable for • Provide expert clinical advice to inform strategy, decision-making, and service development. • Reduce unwarranted variation and provision inequalities that lead to variation in outcomes or performance innovative, system-wide approaches. • Improvement of medicines optimisation, and all-age continuing healthcare functions.	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
	• Promote digitally enabled clinical transformation, population health management, innovation, and research. • Build partnerships with provider collaboratives, public health, local government, and community organisations. • Maintain professional accountability to the relevant regional director. • To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	
The Executive Director of Finance, Resources and Contracts	**<u>Regulations and Control</u>** • HWE ICB Signatory • Authenticate use of the seal. • Develop systems and processes to comply with the requirements of the NHS Provider Selection Regime. • Establish processes to ensure compliance with all relevant procurement regulations. **<u>Annual Reports and Accounts</u>** • Preparation of the annual accounts and accounting tables within the Annual Report in accordance with relevant guidance and regulations, including those for funds held on trust. • Arrange for annual accounts to be externally audited and published. **<u>Statutory Functions / Duty</u>** • Ensure systems are in place to deliver the financial duties of the ICB (Sections 223GB, 223N, 223H and 223 J). Including establishing the annual budget and budget management processes.	Standing Order 6 Standing Orders 6.1.3 Constitution 7.3.2, 7.3.3 Constitution 7.3.5 Constitution 7.2.3 Constitution 1.4.7, 7.2.8

Board Member / employee	Decisions and functions delegated by the Board	Reference
	• Establish adequate arrangements to discharge ICB duties in relation to the Freedom of Information Act 2000 and Information Commissioner Office requirements. • Develop the Capital Resource Use Plan for approval by the Board and report how the ICB has exercised its functions in accordance with the Plan within the Annual Report. **<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. **<u>Operational Responsibilities</u>** • Reports directly to the Chief Executive and is professionally accountable to the NHS England Regional Finance Director. They are accountable for: • Develop and deliver the organisation's financial strategy, ensuring revenue, capital, and cost limits are met. • Lead contracting, procurement, and estates planning to align with strategic objectives and deliver best value. • Ensure resources are used effectively to improve outcomes, reduce inequalities, and support service sustainability. • Provide clear financial governance, risk management, and performance monitoring.	Constitution 7.2.5 Constitution 7.4.2

Board Member / employee	Decisions and functions delegated by the Board	Reference
	• Build partnerships with system leaders and partners to support integrated financial planning. • To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	
The Executive Director of Neighbourhood Health Places and Partnerships	**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** • Provides system leadership for neighbourhood health and place-based partnerships, ensuring resources are targeted to deliver the best possible care and outcomes for local populations. Builds strong relationships with partners across the integrated care system (ICS). They are accountable for • Lead the development and delivery of strategies for neighbourhood health and place-based working. • Ensure resources are effectively deployed to meet the needs of local populations. • Hold accountability for a broad and evolving portfolio aligned to ICB priorities. • Contribute to the ICB's long-term strategy, integrating partner organisation priorities. • Build partnerships and an active provider market across provider collaboratives, public health, primary care, local government, voluntary and community sectors, and local people. • To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	

Board Member / employee	Decisions and functions delegated by the Board	Reference
The Executive Director of Strategy, Planning and Evaluation	**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** • Oversees corporate governance, programme delivery, and organisational effectiveness. Ensures the ICB operates to high standards, transitions successfully through structural change, and delivers on corporate priorities. They are accountable for: • Lead the implementation of the Model ICB Blueprint and NHS 10-Year Plan priorities, shifting care from treatment to prevention, hospital to community, and analogue to digital models. • Embed advanced analytics and population health insights into commissioning, planning, and evaluation. • Ensure optimal allocation of resources through evidence-based prioritisation, cost control, and measurable return on investment. • Oversee the safe transition and integration of teams during organisational redesign, maintaining critical commissioning and evaluation capabilities. • Create the environment for population-level improvements. • To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	

Board Member / employee	Decisions and functions delegated by the Board	Reference
The Executive Director of Corporate Services and ICB Development	**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** • Oversees corporate governance, programme delivery, and organisational effectiveness. Ensures the ICB operates to high standards, transitions successfully through structural change, and delivers on corporate priorities. They are accountable for: • Manage corporate governance, board relations, and delivery of corporate priorities. • Lead the transition and formal merger from multiple ICBs to a single organisation, ensuring continuity and performance. • Support the development and delivery of the ICB's vision, values, and strategy. • Oversee internal and external communications to protect and enhance the ICB's reputation. • Foster a positive, inclusive, and innovative organisational culture. • Coordinate compliance and assurance reporting to the board, partners, and regulators. • Build strategic relationships with national and regional bodies, representing organisational priorities. • To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	

Board Member / employee	Decisions and functions delegated by the Board	Reference
Audit and Risk Management 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>
</table>
</td><td></td></tr>
</table>

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	

Delegated Limits assigned by the Board:

- During the initial period of pre-transition, authority is delegated to the CEO to approve financial delegation limits for Executive Directors and sub-committees of the ICB Board, supported by recommendations from the Direct of Finance known as The Executive Director of Finance, Resources and Contracts. These approvals will be reported to the next Board for ratification.

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board

NHS Cambridgeshire and Peterborough

NHS Hertfordshire and West Essex Integrated Care Board

Working in partnership as Central East

Transition Governance – Transition to Central East Cluster (Bedfordshire Luton & Milton Keynes ICB, Cambridgeshire & Peterborough ICB, and Herts and West Essex ICB working in partnership)

Function and Decision Mapping

Version 0.4 - 13 October 2025

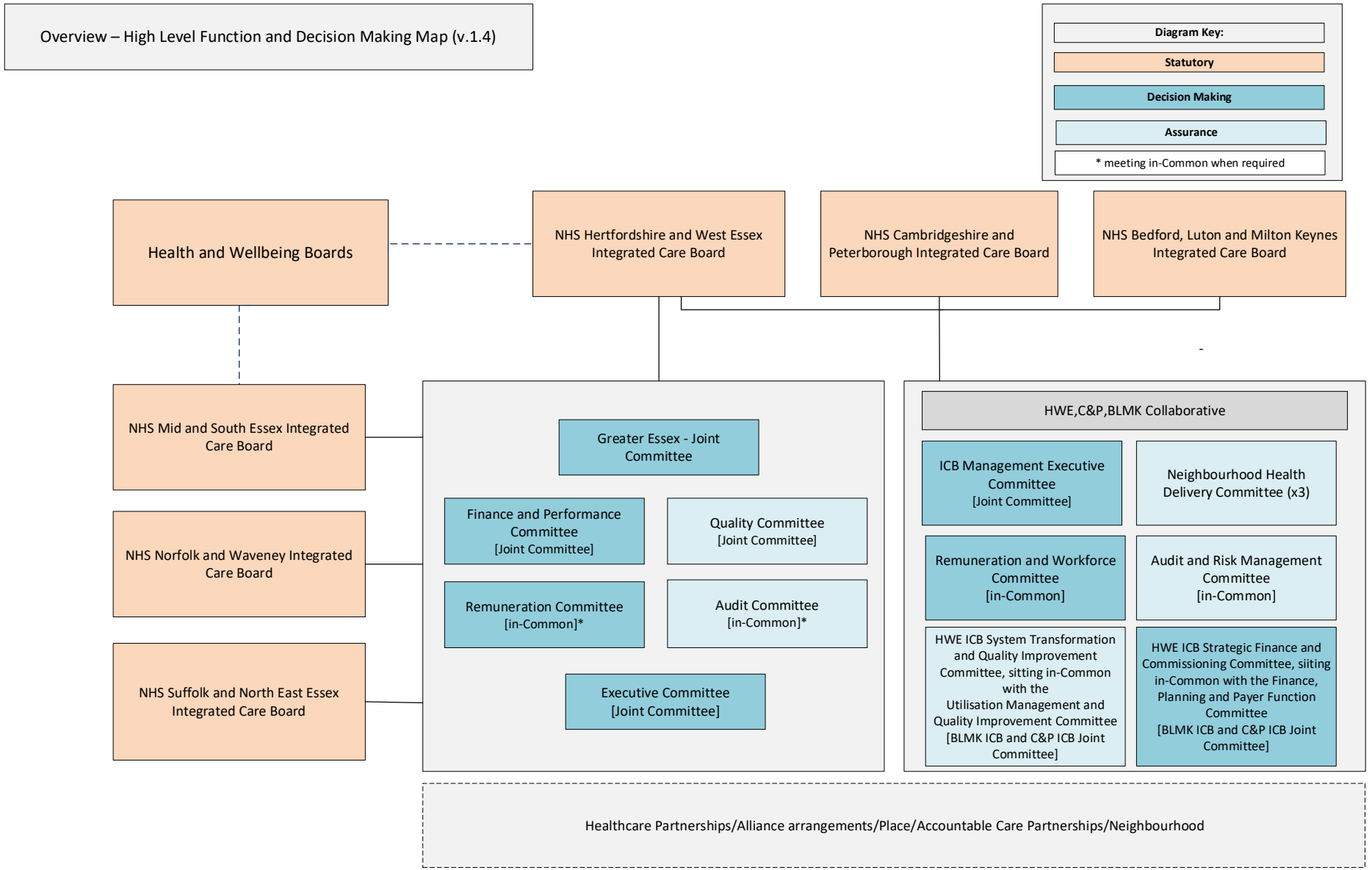
Purpose

The Central East cluster Functions and Decisions Map sets out the governance arrangements that support collective accountability between partner organisations for whole-system delivery and performance. The purpose of this Functions and Decisions Map is to facilitate transparent decision-making and foster the culture and behaviours that enable system working.

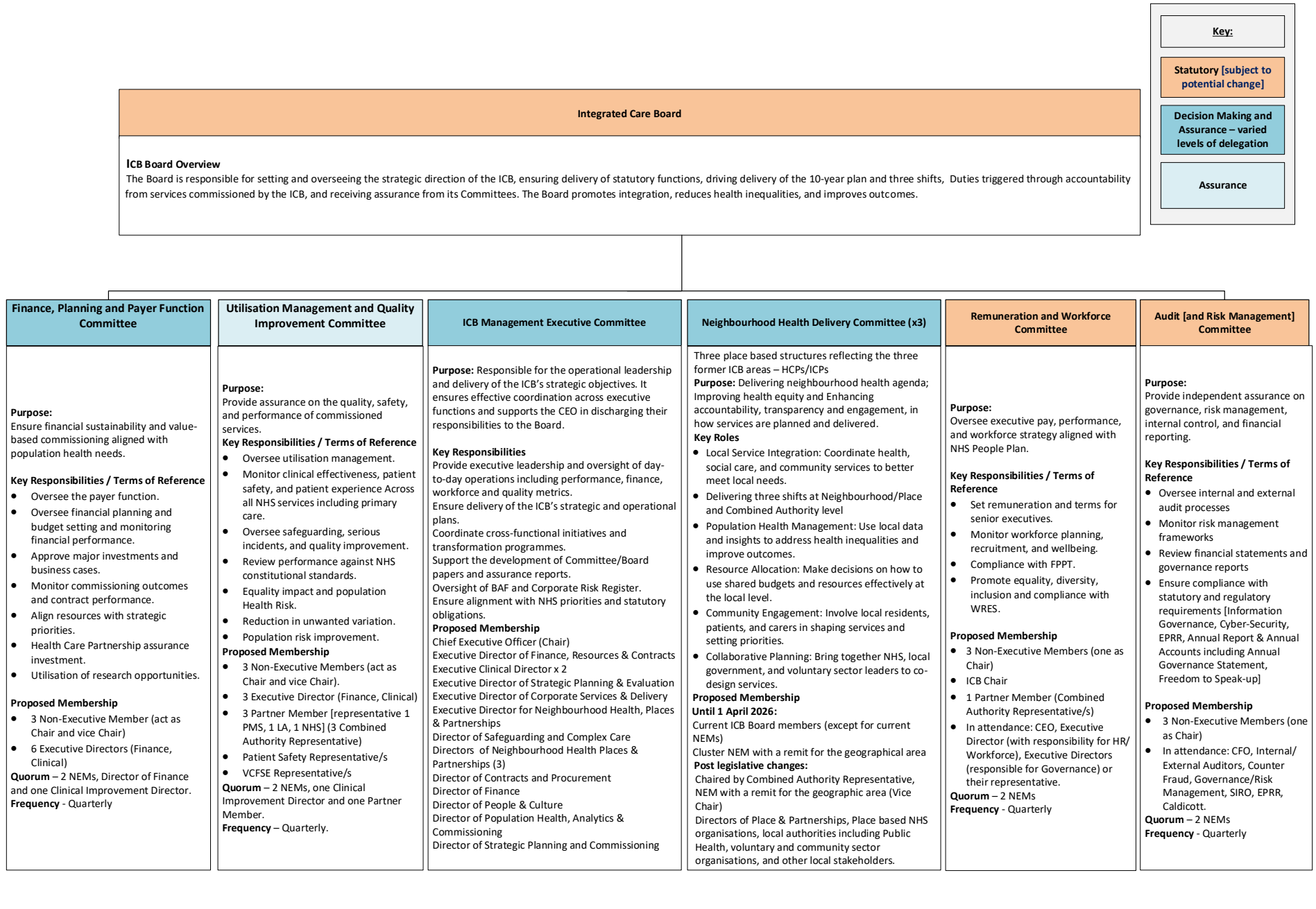
This document details the health commissioning duties of the three Integrated Care Board (ICB)s within the Cluster. It does not detail the wider system duties of the Integrated Care Partnership (ICP). It has been reviewed to reflect the governance arrangements that have developed since establishment, and reflects changes made to assure delivery of our statutory duties, the NHS elements of the Joint Forward Plan delivery and the ICS Outcomes Framework.

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

Overview – Central East High Level Function Map



Governance Structure_v.1.4(14)



Central East Decision-Making Tiers

Tier 1 – Decisions reserved to the Board

Tier 2 – Decisions reserved to the Board Committees (delegated from the Board)

Tier 3 - Programme Board or Sub-Committee similar (Committee or Director delegation)

Tier 4 - Working Groups or Steering Group or Task and Finish Group

ICB Sub-Board Structures – Audit and Risk Committee

Purpose: Provide independent assurance on governance, risk management, internal control, and financial reporting.

Key Responsibilities

- Oversee internal and external audit processes
- Monitor risk management frameworks including deep dives on system-wide risks
- Review financial statements and governance reports
- Ensure compliance with statutory and regulatory requirements [Information Governance, Cyber Security, EPRR, Annual Report & Annual Accounts including Annual Governance Statement, Freedom to Speak Up].
- Health Care Partnership assurance

Tier 3	Information Governance & Cyber Security	Emergency Preparedness Resilience and Response	Local Health Resilience Partnership	Risk Oversight via Management Executive Committee	
Tier 4	Digital Platform Programme Board (ICS) ?				
Other	ICB Auditor Panel				

Statutory Committee

ICB Sub-Board Structures – Remuneration & Workforce Committee

Purpose: Oversee executive pay, performance, and workforce strategy aligned with NHS People Plan.

Key Responsibilities

- Set remuneration and terms for senior executives
- Monitor workforce planning, recruitment, and wellbeing
- Compliance with FPPT
- Promote equality, diversity and, inclusion and compliance with WRES.

Tier 3

- Equality Diversity & Inclusion
- Education, Training
- Staff, Health Wellbeing & Experience
- Workforce Planning / Sustainability
- Organisational Development
- HR Policies
- Recruitment & Retention

Tier 4

- Staff Side Group

All supporting forums

Statutory Committee

ICB Sub-Board Structures – Finance Planning & Payer Function Committee

Purpose: Ensure financial sustainability and value-based commissioning aligned with population health needs.

Key Responsibilities

- Oversee financial planning, budget setting and monitoring financial performance
- Approve major investments and business cases
- Monitor commissioning outcomes and contract performance
- Align resources with strategic priorities
- Neighbourhood Health Delivery Committee assurance investment

Tier 3

- Primary Care Commissioning (Finance)
- Estates Groups
- Medicines Optimisation (Finance)
- Complex Cases (Finance)
- ICS System Financial Planning / Oversight
- System Investment Oversight
- HBL ICT Stakeholder Board
- Hosted Research & Development
- Specialised Commissioning (feeding into Joint Committee)
- Contract Management?
- Planned Care/Unplanned/Cancer etc (Finance)

Tier 4

- Procurement Oversight/PSR
- Investment Oversight Group (exp over £5k BLMK)
- Financial Scrutiny Panel?

Non-Statutory Committee

ICB Sub-Board Structures – Utilisation Management & Quality Improvement Committee

Purpose: Provide assurance on the quality, safety, and performance of commissioned services.

Key Responsibilities

- Monitor clinical effectiveness, patient safety, and patient experience across all NHS services including primary care
- Oversee safeguarding, serious incidents, and quality improvement
- Review outcomes against NHS constitutional standards
- Equality impact and population health risk

Tier 3

- Health Inequalities
- Clinical & Professional Group ? Medical Oversight
- Primary Care Transformation
- Medicines Optimisation
- Local Maternity & Neonatal System Group
- Neighbourhood Health Delivery Committee
- Safeguarding Board
- Infection Prevention and Control
- Provider Assurance & Triangulation
- System Quality Group
- Complex Cases (Quality)
- Mortality Committee ?
- Planned Care/Unplanned/Cancer etc (Quality)

Tier 4

Non Statutory Committee

ICB Sub-Board Structures – BLMK Neighbourhood Health Delivery Committees (transition – current ICP)

Purpose: Ensure financial sustainability and value-based commissioning aligned with population health needs.

Key Responsibilities

- Oversee financial planning, budget setting and monitoring financial performance
- Approve major investments and business cases
- Monitor commissioning outcomes and contract performance
- Align resources with strategic priorities
- Health Care Partnership assurance investment

Tier 3

- Primary Care Commissioning (Delivery)
- BLMK MHLDA Collaborative
- Place Boards
- VCSE Strategy Group
- System Insight Network

Tier 4

All supporting forums

Statutory Committee

ICB Sub-Board Structures - C&P Neighbourhood Health Delivery Committee (transition – current ICP/Joint Health and Wellbeing Board)

Purpose: Ensure financial sustainability and value-based commissioning aligned with population health needs.

Key Responsibilities

- Oversee financial planning, budget setting and monitoring financial performance
- Approve major investments and business cases
- Monitor commissioning outcomes and contract performance
- Align resources with strategic priorities
- Health Care Partnership assurance investment

Tier 3

- Primary Care Commissioning (Delivery)
- Community Board
- C&P MHLD&A Board
- Children
- Place Boards (North & South)
- Patient Group

Tier 4

All supporting forums

Statutory Committee

ICB Sub-Board Structures – HWE(H) Neighbourhood Health Delivery Committee (transition ICP)

Purpose: Ensure financial sustainability and value-based commissioning aligned with population health needs.

Key Responsibilities

- Oversee financial planning, budget setting and monitoring financial performance
- Approve major investments and business cases
- Monitor commissioning outcomes and contract performance
- Align resources with strategic priorities
- Health Care Partnership assurance investment

Tier 3

- Primary Care Commissioning (Delivery)
- HWE Mental Health, Learning Disability &Autism (HCP
- HWE Host Provider Boards x 4
- Patient Engagement Forum

Tier 4

All supporting forums

Statutory Committee

ICB Sub-Board Structures – Management Executive Committee

Purpose: Responsible for the operational leadership and delivery of the ICB's strategic objectives. It ensures effective coordination across executive functions and supports the CEO in discharging their responsibilities to the Board.

Key Responsibilities

- Provide executive leadership and oversight of day-to-day operations including performance, finance, workforce, and quality metrics.
- Ensure delivery of the ICB's strategic and operational plans
- Coordinate cross-functional initiatives and transformation programmes
- Support the development of Committee/Board papers and assurance reports
- Oversight of the Board Assurance Framework and Corporate Risk Register
- Ensure alignment with NHS priorities and statutory obligations.

Tier 3

Risk Oversight	Operational Planning	ICB Policy		
Transformation	Population Health?	ICB workforce		

Tier 4

Green Plan Delivery		

All supporting forums

Statutory Committee

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.

Contents

1.Purpose and statutory framework

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

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

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

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

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

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

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

1.1.8 Should any difficulties arise regarding the interpretation or application of any of these SFIs, the advice of the Chief Executive or the 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.

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

STANDARDS OF BUSINESS CONDUCT & CONFLICTS OF INTEREST POLICY

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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	
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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
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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

CONTENT

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