NHS
Norfolk and Waveney
Integrated Care Board

Meeting of the Board of NHS Norfolk and Waveney Integrated Care Board (ICB)

Friday, 1 July, 10.30am – 12.30pm, in public

Meeting to be held at The King's Centre, 63-75 King Street, Norwich NR1 1PH

Our mission: To help the people of Norfolk and Waveney live longer, healthier and happier lives.

Our goals:

1. **To make sure that people can live as healthy a life as possible.**
2. **To make sure that you only have to tell your story once.**
3. **To make Norfolk and Waveney the best place to work in health and care.**

Chair: Rt Hon. Patricia Hewitt

Item	Time	Agenda Item	Lead
1.	10.30	**Welcome and introductions**	Chair
2.		**Apologies for absence**	Chair
3.		**Declarations of interest** To declare any interests that board members may have specific to agenda items that could influence the decisions they make. Declarations made by members of the ICB Board are listed in the ICB's Register of Interests. The Register is available via the ICB's website.	Chair
4.		**Action log – things we have said we will do** To make sure the ICB completes all the actions it agrees are needed. To consider any actions which have been transferred from the CCG's Governing Body.	Chair
5.	10.40	**Chair and Chief Executive's Report** To note an update from the Chair and the Chief Executive of the ICB about the work the ICB has done since the last meeting.	Chair and Tracey Bleakley
		Establishment of the Integrated Care Board	
6.		**Establishment of the Board of the ICB- Introduction** A verbal introduction to the following processes to fully establish the Board of the Integrated Care Board	Karen Barker
7.		**NHS Norfolk and Waveney's ICB's Constitution** To note the Constitution of the Integrated Care Board, which is the 'rule book' for how the organisation operates.	Chair

Item	Time	Agenda Item	Lead
		Documents for approval As this is the first meeting of the new organisation, there are a number of documents that need to be approved that will decide how the ICB will work in future:	
8.		**Governance Handbook** The Governance Handbook sets out how the organisation will ensure good governance (being open, honest and effective) through its decision making, in particular through good standards of business conduct and rules relating to conflicts of interest. This document is for discussion and approval.	Chair
9.		**Policy Approval and Transfer** To approve the arrangements for adoption of the Integrated Care Board policies.	Chair
10.		**Confirm responsible officer and arrangements for Emergency Planning Resilience and Response (EPRR)** To approve the arrangements for the Integrated Care Board in an emergency including who will be in charge.	Chair
11.		**Board Assurance Framework** A review of the risks (things that might go wrong and how we can alleviate them) within the Integrated Care system and a handover of risks from the Clinical Commissioning Group.	Chair
12.		**Approval of Board Leads** It is important that is clear which Board member is taking the lead on various functions (areas of work) of the Integrated Care Board.	Chair
13.		**Establishment of the Board of the ICB's committees** The Board will formally establish ("set up") the Committees who will help it with its work. Including appointing the chair and members of the committees. The Board will also appoint the founder member of the Integrated Care Partnership.	Chair
14.		**Agreement of Board dates from 1 July 2022 to 31 March 2023**	Chair
		Learning from people, staff and communities	
15.	11.15	**Learning from people, staff and communities** To hear the lived experience of people in Norfolk and Waveney who are informal family carers about what matters to them, and to discuss and learn.	Tricia D'Orsi
16.	11.45	**Question and answer session** An opportunity for members of the public and our partners in the Integrated Care System (ICS) to ask questions of the Board of the ICB.	Chair
17.	12.25	**Any other business**	Chair

Item	Time	Agenda Item	Lead
Date, time and venue of next meeting: **Tuesday, 27 September 2022, 1.30pm – 3.30pm, venue to be confirmed.**			
Any queries or items for the next agenda please contact: **nwccg.corporateaffairs@nhs.net**			

Some explanations of terms used in this Agenda.

Please see further terms defined on our website www.improvinglivesnw.org.uk
(link live from the 1 July 2022)

Integrated Care System (ICS) - new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.

Integrated Care Board (ICB) - an organisation with responsibility for NHS functions and budgets. Membership of the board includes 'partner' members drawn from local authorities, NHS trusts/foundation trusts and primary care.

Clinical Commissioning Group (CCG) – NHS bodies that will be replaced by ICBs on 1st July 2022.

Integrated Care Partnership (ICP) - a statutory committee bringing together all system partners to produce a health and care strategy. Representatives include voluntary, community and social enterprise (VCSE) organisations and health and care organisations, and representatives from the ICB board.

Health and Wellbeing Partnerships (HWP) - are local place-based partnerships work on addressing the wider determinants of health, reducing health inequalities and aligning NHS and local government services and commissioning.

Lived experience - knowledge gained by people as they live their lives, through direct involvement with everyday events. It is also the impact that social issues can have on people, such as experiences of being ill, accessing care, living with debt etc.

NHS Norfolk and Waveney Integrated Care Board (ICB)
Register of Interests

Declared interests of the Board

Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	
Patricia Hewitt	Chair, Norfolk and Waveney ICB	Getlink Group	X			Direct	Non-executive director, Getlink Group	2010	April 22	Conflict to be removed October 22 Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Director of Corporate Affairs
		FTI Consulting	X			Direct	Senior advisor, FTI Consulting	2015	Present	Since January 2022 I have not undertaken any work on healthcare or life sciences. Will declare at relevant meetings if a risk arises.
		Newnham College Cambridge			X	Direct	Honorary Associate, Newnham College Cambridge	2018	Present	No conflicts have arisen or foreseen
		Oxford India Centre for Sustainable Development			X	Direct	Chair, Oxford India Centre for Sustainable Development	2018	Present	No conflicts have arisen or foreseen
		ORA Choral Ensemble			X	Direct	Chair, trustees, ORA Choral Ensemble	2020	Present	No conflicts have arisen or foreseen
		Age UK Norfolk			X	Direct	Volunteer, Age UK Norfolk	2020	Present	Declaration of interest made in any relevant conversation
		PA Consulting	N/A			Indirect	Daughter is a sub-contractor on a temporary contract for PA Consulting - clients including NHSE/I	2021	Present	Conflict to be removed September 22 Under the terms of her contract she does not disclose details of her work. Will declare at relevant meetings if a risk arises
Catherine Armor	Non-Executive Member, Norfolk and Waveney ICB	Brundall Medical Practice			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		Norwich University of the Arts			X	Direct	Deputy Chair of Council, Norwich University of the Arts	2019	Present	Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		Evolution Academy Trust			X	Direct	Trustee, Evolution Academy Trust	2022	Present	
		Cambridge University Press		X		Direct	Trustee, Cambridge University Press	Ongoing		
		East of England Ambulance Service NHS Trust	N/A			Indirect	Daughter-in-law is Technician for East of England Ambulance Service NHS Trust	Ongoing		
Jon Barber	Partner Member - Acute, Norfolk and Waveney ICB	James Paget university Hospitals Trust		X		Direct	Director of Strategy & Transformation James Paget university Hospitals Trust	Ongoing		In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Broadland St Benedict			X	Direct	Non-executive Director of Broadland St Benedicts – the property development subsidiary of Broadland housing Group	2020	Present	

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			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	
Tracey Bleakley	Chief Executive Officer, Norfolk and Waveney ICB	Nothing to Declare	N/A				N/A	N/A	N/A	N/A
James Bullion	Partner Member - Local Authority (Norfolk), Norfolk and Waveney ICB	Norfolk County Council		X		Direct	Executive Director Adult Social Services, Norfolk County Council	Ongoing		In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
Sue Cook	Partner Member - Local Authority (Suffolk), Norfolk and Waveney ICB	Suffolk County Council		X		Direct	Executive Director Adult Social Services, Norfolk County Council	Ongoing		In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
Steven Course	Director of Finance, Norfolk and Waveney ICB	March Physiotherapy Clinic Limited				Indirect	Wife is a Physiotherapist for March Physiotherapy Clinic Limited	2015	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards March Physiotherapy Clinic Limited
Tricia D'Orsi	Director of Nursing, Norfolk and Waveney ICB	Nothing to Declare	N/A				N/A	N/A		N/A
David Holt	Non-Executive Member, Norfolk and Waveney ICB	Solebay Health Centre			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		Tavistock and Portman NHS Foundation Trust		X		Direct	Senior Independent Director, Tavistock and Portman NHS Foundation Trust	2013	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards Tavistock and Portman NHSFT
		Department of Work and Pensions		X		Direct	Non-Executive Board Member, Department of Work and Pensions. Chair of the Audit Committee and Chair of the Health Transformation Programme Board	2019	Present	Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
Emma Ratzer	Partner Member - VCSE	Access Community Trust	X			Direct	I am the Chief Executive Officer of Access Community Trust, an organisation which holds contracts with NWICB	2009	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards Community Access Trust

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			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	
		VCSE Assembly			X	Direct	I am CEO of a voluntary sector organisation operating in NWCCG and Independent Chair of NWVCSE Assembly	2021	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest
Stuart Richardson	Partner Member - Mental Health and Community, Norfolk and Waveney ICB	Norfolk and Suffolk Foundation Trust	X			Direct	Chief Executive Officer, Norfolk and Suffolk Foundation Trust	Ongoing		In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest
Dr Frankie Swords	Interim Medical Director, Norfolk and Waveney ICB	Norfolk and Norwich University Hospitals NHS FT	X			Direct	Honorary Consultant Physician and Endocrinologist at Norfolk and Norwich University Hospitals NHS FT (1 day a week)	2008	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		N/A			X	Direct	Clinical Advisor of multiple patient charities - Addison Self Help Group - Orchid Testicular Cancer Trust - Pituitary Patient Support Group - Turner syndrome Society	2008	Present	
		Ruby Media	N/A			Indirect	Husband is director of Ruby Media which commissions various professional conferences and other events relating to health and care	2008	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards Ruby Media
Hein van den Wildenberg	Non-Executive Member, Norfolk and Waveney ICB	Lakenham Surgery			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		College of West Anglia			X	Direct	Governor at College of West Anglia (Note: the College hosts the School of Nursing, in partnership with QEHKL and borough council)	2021	Present	Low risk. If there is an issue it will be raised at the time.

NORFOLK & WAVENEY INTEGRATED CARE BOARD - Friday 1 July 2022							
No:	**Date of Meeting**	**ACTIONS**		**RESP**	**Due Date**	**ACTION / UPDATE**	**Status**
1	CCG GB - 26 April 2022	Maternity Report	ICB to receive an update and assurance on the report at a future meeting	Patrica D'Orsi	27-Sep-22	Placed on forward planner.	

Norfolk and Waveney
Integrated Care Board

Agenda item: 5

Subject:	**Chair and Chief Executive's report**
Presented by:	**Rt Hon. Patricia Hewitt, Chair, NHS Norfolk and Waveney ICB** **Tracey Bleakley, Chief Executive, NHS Norfolk and Waveney ICB**
Prepared by:	**Rt Hon. Patricia Hewitt, Chair, NHS Norfolk and Waveney ICB** **Tracey Bleakley, Chief Executive, NHS Norfolk and Waveney ICB**
Submitted to:	**ICB Board**
Date:	**1 July 2022**

Purpose of paper:

To update members of the Board on the work of the ICB.

Executive Summary:

The report covers the following:

A. Our Integrated Care System
B. Mental health services
C. Access to general practice
D. System pressures

Report

A. Our Integrated Care System

There is nothing more important than our own and our family's health. It's why, as a country, we treasure the NHS and its dedicated staff. But vital though it is, the NHS

only accounts for a fraction of our physical and mental health and wellbeing. All the rest depends on other things: genetics, our environment - whether we have decent work, enough money, close family and friends, a warm home, clean air - and our own lifestyles.

The development of our Integrated Care System is a unique opportunity to bring together the many different partners who support the health and wellbeing of Norfolk and Waveney's almost 1.1 million residents: the staff and organisations working in the NHS and social care; local government with its responsibilities for public health, social care, housing, leisure and the environment; the voluntary, community and social enterprise sector; and many others in the public and private sectors.

Milestone is perhaps a word that is overused, but there is absolutely no doubt that this a pivotal moment in our journey towards improving people's health, wellbeing and care. The Health and Care Act 2022 is the most significant health legislation in a decade. However, this is a pivotal moment not because the change in the law will transform people's health and wellbeing overnight, but because of the opportunity it brings. This is a chance to do things differently; we must and will seize it.

Our mission is clear: To help the people of Norfolk and Waveney live longer, healthier and happier lives. But health and care systems are complex, and, like any complex undertaking, we need organisations, structures and committees to support partnership working. Our NHS Integrated Care Board, or ICB, will be a vital part of that governance, along with the wider Integrated Care Partnership, that will agree a strategy focusing on the wider determinants of health and reducing health inequalities.

From July, the ICB will be accountable for the overall performance and finances of the NHS in Norfolk and Waveney. It will take over the functions of the Clinical Commissioning Group (CCG), but it is not going to be the CCG with a new logo. The ICB will have a very different role – helping to bring organisations together, working collaboratively, removing traditional barriers and more.

We want to thank CCG colleagues, including the Governing Body, for their hard work and dedication, not just for their extraordinary efforts during the pandemic, but for all they have done since clinical commissioning groups came into existence in 2013. The CCG era has bought many benefits, particularly greater clinical engagement, and we must build on these.

However, our Integrated Care System is not fundamentally about structures and governance. It is about relationships between people: relationships between each of us when we need care and those who care for us; relationships with our neighbours and wider communities, and between this 'civil society' and statutory organisations; relationships between staff from different teams, professions and organisations; relationships between the many organisations that make up the ICS, and so on.

The COVID-19 vaccination programme showed how our GPs, nurses and other staff in primary, community and acute care could work together with local councils, community and faith groups, mobilising volunteers and drawing on the support of the wider system to create one of the most successful vaccination schemes in the

country. That local approach will be the foundation of our Integrated Care System, supported by health and wellbeing partnerships that bring together local government with the voluntary sector, the NHS and other key partners.

Just as local people know best what their community needs if they are to flourish, each of us is the expert in our own lives. And all of us have a responsibility for our own health and wellbeing. So our Integrated Care System will have at its heart a constant process of listening to people, learning from their experience and acting on what we hear. We will reinforce these insights by bringing together all the data that is already available to local government, the NHS, regulators and many others. By developing and publishing this rich source of evidence, we can create a virtuous circle of constantly learning, innovating and improving.

The Integrated Care System is not, and must not be, yet another layer of hierarchy and regulation. Instead, this partnership must be built on the principle of leadership at every level, mutual accountability between different system partners and an open, transparent relationship with the public. Our new NHS Integrated Care Board will be accountable to NHS England and the Secretary of State for Health and Social Care for the overall performance and finances of the NHS in Norfolk and Waveney: but the real test of our success will be our ability to support front-line staff, teams and leaders across the NHS and social care. And as partners with Norfolk and Suffolk County Councils in establishing the wider Integrated Care Partnership, we will make a vital contribution to improving population health and reducing health inequalities.

By working together, we can create a healthier Norfolk and Waveney.

B. Mental health services

Improving mental health services and supporting people's wellbeing is one of the highest priorities for the new Integrated Care Board. We know that local services are not consistently good enough, and at the same time, many more people need support, both as a result of the pandemic and due to the hardship being experience by people because of the increasing cost of living.

A significant amount of work has and continues to be done by Norfolk and Suffolk NHS Foundation Trust (NSFT), with support from local partners and NHS England, in response to the recent findings of the Care Quality Commission (CQC). The Trust accepts the areas that the CQC identified as needing urgent improvement and they, as well as both integrated care systems, are completely committed to ensuring that people living in Norfolk and Suffolk receive good quality mental health services.

While the CQC rating of NSFT as 'inadequate' is disappointing, it is important to acknowledge the huge efforts of frontline staff at NSFT who have worked tirelessly to respond to the pandemic. Their care has been rated as 'good' by the CQC.

NSFT has been successful at improving some services, for example children and young people's services and learning disability services. This has been achieved by working with and co-producing plans with patients, service users, carers and staff. The Trust is committed to being transparent about the challenges they face, where progress is and is not being made, and to supporting staff to do their job. Taken

together, this is the right approach to improving the experience for people who use their services. However, neither we nor the Trust underestimate the scale of the challenge.

It is also essential to recognise that improving the mental health and wellbeing of people living in Norfolk and Waveney is about much more than improving NSFT services, vital though that is. We all have a part to play - the wider NHS, local government, voluntary and community groups, other parts of the public sector, employers and other groups, alongside individuals, families and communities.

General practice has seen a significant increase in people presenting with mental health conditions, including anxiety, depression and eating disorders over the past two years. Other NHS providers, social services and the voluntary, community and social enterprise sector are all coming into regular contact and caring for people who need support with their mental health and wellbeing.

Having dedicated mental health practitioners and recovery support workers based in primary care networks and GP practices is a positive step forward in making it easier for people to get help and support quickly. The work led by our clinical lead for mental health, Dr Ardyn Ross, in partnership with Primary Care Networks and the voluntary sector, was recently praised by the Health Minister in the House of Commons as part of the national 'No Time to Wait' campaign.

The STEAM House Cafés run by Access Community Trust in King's Lynn, Gorleston and other areas across Norfolk and Waveney are another good example of what we can achieve in partnership with the voluntary, community and social enterprise sector. The cafes provide holistic support and therapies for adults experiencing mental health crisis, with STEAM standing for Support, Transform, Eat, Aspire and Motivate.

C. Access to general practice

GPs and all their colleagues in primary care have played a vital role in the system's response to the pandemic, adapting how it works to meet the changing situation over the past two years. We are very grateful to everyone working in general practice for their dedication; general practice remains the cornerstone of the NHS and the first port of call when people need help or are worried about their health.

There is a lot of discussion again nationally and locally about access to general practice and face-to-face appointments; we know some people are frustrated by their experience of booking an appointment. Here's the latest data about appointments:

- **The total number of appointments with general practice in Norfolk and Waveney is now higher than before the pandemic.** In 2019/20 there were 6.3 million appointments; in 2021/22 there were 6.5 million appointments – on top of this general practice also delivered over 700,000 COVID-19 vaccinations in 2021/22.

- **More patients are being seen face-to-face in Norfolk and Waveney than in other parts of the country.** While 71% of our patients were seen in person in April 2022, the national average was 63%.

We recognise that within this overall data there is some variation between practices and even within some practices, for example due to staff absence on a particular day or staff taking holidays. We are working to support increased resilience across general practice, by supporting networks of practices to work together, investing in more staff, increasing the types of roles that form the general practice team and by doing more to integrate community-based services with general practice.

It's important to remember that practices do have to manage the flow of patients, balancing the need to provide urgent care against the need to proactively care for patients with long term conditions. An important way of doing this is by ensuring that patients are cared for by the most appropriate professional. People don't always need to see GP and can often be better cared for by one of the other professionals that now work in general practice as part of a multi-disciplinary team under the leadership of GPs, such as a physio, social prescriber or a pharmacist. This enables our GPs to use their specialist skills to focus on the patients who really need to see them and that only they can treat.

While remote appointments don't work for all situations or individuals, many people do like and value them, particularly those who work and have children. Even before the pandemic it was national policy to increase remote appointments and to digitise health services. The ICB will continue to support practices with changes to their working practices and the implementation of remote appointments, including providing training to help ensure there is equality of access for all patients.

Finally, following the publication of the 'Next steps for integrating primary care: Fuller Stocktake report', we look forward to working with colleagues to implement the recommendations.

D. System pressures

Health and care services are experiencing high demand for their services; this is true across the board, from general practice, social care and community health services, through to acute care, our ambulance service and mental health services. This is happening everywhere in the country, not just in Norfolk and Waveney.

Before Covid, we were already working together to make it easier for people to get urgent care when they need it without having to go to the hospital Emergency Department (ED). For instance, we expanded 111, ensured they could book patients directly into their GP practice and advertised it more widely; we also made it possible for paramedics in the ambulance service to see vital information from GP records before arriving at a patient's home. Today, compared with the situation before the pandemic, there are fewer ambulances being despatched, fewer people being taken to hospital by ambulance and fewer people being admitted to hospital as an emergency.

Despite that work, ambulances are still having to queue at our hospitals before they can hand over a patient, too many patients are waiting too long in ED and the length of time patients stay in hospital is increasing.

One of the biggest challenges we face is having patients in our hospitals that no longer need to be there (in NHS terms, they have 'no-criteria to reside'). We have seen progress in this area, but it has not been consistent, for example there was a peak again over the Jubilee bank holiday weekend. This is challenging for staff, who are having to make difficult decisions about how patients are treated, and it is not what we want for people and their families.

We are implementing a plan to improve hospital discharge, which aims to:

- **Review and simplify processes for the management of discharge to assess pathways.** (As a principle, long-term placements for patients should only made after a Multi Disciplinary Team assessment, not in an acute hospital.)

- **Model and plan capacity**, to build medium and long-term plans for capacity.

Our priority actions are to:

- **Increase capacity in 'pathway 1'**, which is when patients are discharged to intermediate care and reablement services provided in their own homes (rather than discharged to residential or nursing care).

- **Model demand and capacity**, including financial and activity assumptions.

- **Review and simplify process for assessment and referral to discharge to assess.**

Improving our discharge arrangements will make a significant difference to the care people receive. It is a priority for the health and care system and we will continue to keep the Board informed of progress.

Recommendation to the Board:

This agenda item is for information only.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A

Impact Assessment (environmental and equalities):	N/A
Reputation:	N/A
Legal:	N/A
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	N/A

Norfolk and Waveney
Integrated Care Board

Agenda item: 7

Subject:	**NHS Norfolk and Waveney ICB Constitution**
Presented by:	**Karen Barker, Director of Corporate Affairs and ICS Development, NHS Norfolk and Waveney ICB**
Prepared by:	**Karen Barker, Director of Corporate Affairs and ICS Development, NHS Norfolk and Waveney ICB**
Submitted to:	**ICB Board**
Date:	**1 July 2022**

Purpose of paper:

To note the Norfolk and Waveney ICB Constitution.

Executive Summary:

The final Norfolk and Waveney ICB Constitution is attached for review.

Report

1.1 In line with NHS England Guidance the ICB Constitution has been developed with our system partners and with our ICB designate leaders. We have used the ICB model Constitution produced by NHSE which includes mandated elements (legal or policy requirements) and elements which may be modified locally broadly based on example wording.

1.2 The Transition Oversight Group, comprising the ICB Chair Designate and no-executives and councillors from the system, has overseen the development of the ICB Constitution as well as the wider transition to the ICB.

1.3 In May 2022 the Constitution was submitted to NHS England for approval. This approval was received in June 2022.

1.4 NHS England will bring the proposed ICB Constitution into effect for 1 July 2022 through the ICB Establishment Order.

1.5 There is no requirement for this first meeting of the ICB Board, on 1 July 2022, to approve the Constitution. However, it will be important to ensure that all Board members are familiar with the Constitution and the provisions within it hence its inclusion in the papers today.

Recommendation to the Board:

To note the Constitution.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	N/A
Legal:	The ICB has to have a Constitution to be clear on the rules it follows as an organization.
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	This item has not been discussed at any other Board meeting or committee of the ICB, as the ICB is being established today.

NHS
Norfolk and Waveney
Integrated Care Board

NHS Norfolk and Waveney Integrated Care Board

CONSTITUTION

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

CONTENTS

1. Introduction

1.1 Foreword

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

a) improve outcomes in population health and healthcare
b) tackle inequalities in outcomes, experience and access
c) enhance productivity and value for money
d) help the NHS support broader social and economic development.

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

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible.

Our Integrated Care System

The Norfolk and Waveney Integrated Care System ("the ICS") is made up of a wide range of partner organisations, working together to help people lead longer, healthier and happier lives. The ICS is comprised of an NHS Integrated Care Board working with an Integrated Care Partnership committee formed jointly with local authority partners.

Over and above everything else we want to achieve, we've set ourselves three goals:

1. To make sure that people can live as healthy a life as possible.

This means preventing avoidable illness and tackling the root causes of poor health. We know the health and wellbeing of people living in some parts of Norfolk and Waveney is significantly poorer – how healthy you are should not depend on where you live. This is something we must change.

2. To make sure that you only have to tell your story once.

Too often people have to explain to different health and care professionals what has happened in their lives, why they need help, the health conditions they have and which medication they are on. Services have to work better together.

3. To make Norfolk and Waveney the best place to work in health and care.

Having the best staff, and supporting them to work well together, will improve the working lives of our staff, and mean people get high quality, personalised and compassionate care.

The partners in our ICS work together at 'system' level across Norfolk and Waveney, more locally at 'place' and 'neighbourhood' levels, and through our primary care networks and provider collaboratives.

Our Integrated Care Board

NHS Norfolk and Waveney ICB ("the ICB") was formed on 1 July 2022 and covers the same area as the former Norfolk and Waveney CCG previously did. The ICB brings the local NHS together to improve population health and care. The responsibilities of the ICB include developing a plan to meet the population's health needs and arranging for the provision of health services.

As with all NHS bodies that plan and commission services in England, NHS Norfolk and Waveney ICB and our local NHS trusts and foundation trusts are subject to the triple aim duty, and as such consider the effects of their decisions on:

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

Our Integrated Care Partnership

Our Integrated Care Partnership ("the ICP") brings together the local NHS, local authorities, the voluntary, community and social enterprise sector and other partners that have an impact on the wider determinants of health. The ICP is responsible for agreeing an integrated care strategy for improving the health care, social care and public health across the whole population. The ICB is required to have regard to the ICP's Integrated Care Strategy when making decisions, commissioning and delivering services. The ICP is a statutory committee of the ICB, Norfolk and Suffolk County Councils.

The membership of the ICP is the same as the Norfolk Health and Wellbeing Board and includes representatives from Suffolk County Council and Waveney. The partners involved are the ICB, providers of health and care services, our county, district, borough and city councils, voluntary, community and social enterprise sector organisations, Healthwatch, the Constabulary and the Office of the Police and Crime Commissioner.

This Constitution for the ICB and the terms of reference for the ICP are aligned to ensure that our governance arrangements are clear, and more importantly, that all partner organisations are working toward the same aim and goals.

1.2 Name

1.2.1 The name of this Integrated Care Board is NHS Norfolk and Waveney Integrated Care Board ("the ICB").

1.3 Area Covered by the Integrated Care Board

1.3.1 The area covered by the ICB is set out in the map below. The ICB covers the whole of the area covered by Norfolk County Council. The ICB also covers part of Suffolk but not all of the area covered by Suffolk County Council. The area covered by the ICB also includes the following local government areas: the District of Breckland, District of Broadland, Borough of Great Yarmouth, Borough of King's Lynn and West Norfolk, District of North Norfolk, City of Norwich, District of South Norfolk and also part of the District of East Suffolk.

1.3.2 All of the Lower Super Output Areas in the District of East Suffolk which are covered by the ICB are set out in Appendix 1.

1.4 Statutory Framework

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

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

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

1.4.4 In accordance with section 14Z25(5) of, and paragraph 1 of Schedule 1B to, the 2006 Act the ICB must have a Constitution, which must comply with the requirements set out in that Schedule. The ICB is required to publish its Constitution (section 14Z29). This Constitution is published at www.improvinglivesnw.org.uk.

1.4.5 The ICB must act in a way that is consistent with its statutory functions, both powers and duties. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to ICBs. Examples include, but are not limited to, the Equality Act 2010 and the Children Acts. Some of the

statutory functions that apply to ICBs take the form of general statutory duties, which the ICB must comply with when exercising its functions. These duties include but are not limited to:

a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act);
b) Exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act);
c) Duties in relation to children including safeguarding, promoting welfare etc (including the Children Acts 1989 and 2004, and the Children and Families Act 2014)
d) Adult safeguarding and carers (the Care Act 2014)
e) Equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35);
f) Information law, (for instance, data protection laws, such as the UK General Data Protection Regulation 2016/679 and Data Protection Act 2018, and the Freedom of Information Act 2000); and
g) Provisions of the Civil Contingencies Act 2004

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

1.4.7 The performance assessment will assess how well the ICB has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under:
a) section 14Z34 (improvement in quality of services),
b) section 14Z35 (reducing inequalities),
c) section 14Z38 (obtaining appropriate advice),
d) section 14Z40 (duty in respect of research)
e) section 14Z43 (duty to have regard to effect of decisions)
f) section 14Z44 (public involvement and consultation),
g) sections 223GB to 223N (financial duties), and
h) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

1.4.8 NHS England has powers to obtain information from the ICB (section 14Z60 of the 2006 Act) and to intervene where it is satisfied that the ICB is failing, or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so (section 14Z61).

1.5 Status of this Constitution

1.5.1 The ICB was established on 1 July 2022 by The Integrated Care Boards (Establishment) Order 2022, which made provision for its Constitution by reference to this document.

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

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

1.6 Variation of this Constitution

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

a) where the ICB applies to NHS England in accordance with NHS England's published procedure and that application is approved; and
b) where NHS England varies the Constitution of its own initiative, (other than on application by the ICB).

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

a) The Chief Executive of the ICB can propose a change to the Constitution by notifying the board in writing with at least 7 days' notice.
b) The Chair of the ICB will be consulted on any proposed changes.
c) The board of the ICB must approve any changes to the Constitution in accordance with its standing orders.
d) Proposed amendments to this Constitution will not be implemented until an application to NHS England for variation has been approved.

1.7 Related documents

1.7.1 This Constitution is also supported by a number of documents which provide further details on how governance arrangements in the ICB will operate.

1.7.2 The following are appended to the Constitution and form part of it for the purpose of clause 1.6 and the ICB's legal duty to have a Constitution:

a) Standing Orders– which set out the arrangements and procedures to be used for meetings and the processes to appoint the ICB committees.

1.7.3 The following do not form part of the Constitution but are required to be published.

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

b) Functions and Decision map– a high level structural chart that sets out which key decisions are delegated and taken by which part or parts of the

system. The Functions and Decision map also includes decision making responsibilities that are delegated to the ICB (for example, from NHS England).

c) **Standing Financial Instructions –** which set out the arrangements for managing the ICB's financial affairs.

d) **The ICB Governance Handbook –** This brings together all the ICB's governance documents so it is easy for interested people to navigate. It includes:
   - The above documents a) – c)
   - Terms of reference for all committees and sub-committees of the board that exercise ICB functions.
   - Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act.
   - Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act.
   - The up-to-date list of eligible providers of primary medical services under clause 3.6.2

e) **Key policy documents -** which should also be included in the Governance Handbook or linked to it:
   - Standards of business conduct policy
   - Conflicts of interest policy and procedures
   - Policy for public involvement and engagement

2 Composition of the Board of the ICB

2.1 Background

2.1.1 This part of the Constitution describes the membership of the Integrated Care Board. Further information about the criteria for the roles and how they are appointed is in section 3.

2.1.2 Further information about the individuals who fulfil these roles can be found on our website at www.improvinglivesnw.org.uk.

2.1.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB (referred to in this Constitution as "the board" and members of the ICB are referred to as "board members") consists of:

a) a Chair
b) a Chief Executive
c) at least three Ordinary Members.

The membership of the ICB (the board) shall meet as a unitary board and shall be collectively accountable for the performance of the ICB's functions.

2.1.4 NHS England Policy, requires the ICB to appoint the following additional Ordinary Members:

a) three Executive Members, namely:
   - Director of Finance
   - Medical Director
   - Director of Nursing
b) At least two non-executive members.

2.1.5 The Ordinary Members include at least three members who will bring knowledge and a perspective from their sectors. These members (known as Partner Members) are nominated by the following and appointed in accordance with the procedures set out in Section 3 below**:**

- NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description
- the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description
- the local authorities which are responsible for providing social care and whose area coincides with or includes the whole or any part of the ICB's area.

While the Partner Members will bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the board, they are not to act as delegates of those sectors.

2.2 Board Membership

2.2.1 The ICB has 5 Partner Members:

a) 2 Partner members: NHS trusts and foundation trusts
b) 1 Partner Member: primary medical services
c) 2 Partner Members: local authorities

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

a) 2 Non-executive Members
b) Member from the VCSE Assembly Board
c) Member from the Integrated Care Partnership

2.2.3 The board is therefore composed of the following members:

a) Chair
b) Chief Executive
c) 2 Partner members NHS trusts and foundation trusts
d) 1 Partner member primary medical services
e) 2 Partner members local authorities
f) 4 Non-executive Members
g) Director of Finance
h) Medical Director
i) Director of Nursing
j) Member from the VCSE Assembly Board
k) Member from the Integrated Care Partnership.

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

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

2.3 Regular Participants and Observers at board meetings

2.3.1 The board may invite specified individuals to be Participants or Observers at its meetings in order to inform its decision-making and the discharge of its functions as it sees fit.

2.3.2 Participants will receive advanced copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair to ask questions and address the meeting but may not vote.

a) Director of Performance, Transformation and Strategy
b) Director of People
c) Patients and Communities Director
d) Director of Corporate Affairs and ICS Development
e) Director of Population Health Management
f) Director of Place Development and System Support
g) Director of Digital and Data
h) Director of Public Health for Norfolk County Council (unless they are one of the local authority Partner Members)
i) Director of Public Health for Suffolk County Council (unless they are of the local authority Partner Members)

Further system Directors may be invited to participate as relevant by the Chair.

2.3.3 Observers will receive advanced copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting by the Chair. Any such person may not address the meeting and may not vote.

a) Healthwatch Norfolk
b) Healthwatch Suffolk
c) Norfolk and Waveney Local Medical Committee

2.3.4 Participants and / or observers may be asked to leave the meeting by the Chair in the event that the board passes a resolution to exclude the public as per the Standing Orders

3 Appointments process for the board

3.1 Eligibility Criteria for Board Membership:

3.1.1 Each member of the ICB must:

a) Comply with the criteria of the "fit and proper person test"
b) Be willing to uphold the Seven Principles of Public Life (known as the Nolan Principles)
c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.2 Disqualification criteria for board membership

3.2.1 A Member of Parliament.

3.2.2 A person whose appointment as a board member ("the candidate") is considered by the person making the appointment as one which could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

3.2.3 A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted—

a) in the United Kingdom of any offence, or
b) outside the United Kingdom of an offence which, if committed in any part of the United Kingdom, would constitute a criminal offence in that part, and, in either case, the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.

3.2.4 A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, sections 56A to 56K of the Bankruptcy (Scotland) Act 1985 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).

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

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

a) that it was not in the interests of, or conducive to the good management of, the health service body or of the health service that the person should continue to hold that office
b) that the person failed, without reasonable cause, to attend any meeting of that health service body for three successive meetings,
c) that the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest, or
d) of misbehaviour, misconduct or failure to carry out the person's duties;

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

a) the person's suspension from a register held by the regulatory body, where that suspension has not been terminated
b) the person's erasure from such a register, where the person has not been restored to the register
c) a decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded, or
d) a decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.

3.2.8 A person who is subject to:

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

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

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

a) section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities), or

b) section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).

3.3 Chair

3.3.1 The ICB Chair is to be appointed by NHS England, with the approval of the Secretary of State.

3.3.2 In addition to criteria specified at 3.1, this member must fulfil the following additional eligibility criteria
a) The Chair will be independent.

3.3.3 Individuals will not be eligible if:
a) They hold a role in another health and care organisation within the ICB area.
b) Any of the disqualification criteria set out in 3.2 apply

3.3.4 The term of office for the Chair will be 3 years and the total number of terms a Chair may serve is 3 terms.

3.4 Chief Executive

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

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

3.4.3 The Chief Executive must fulfil the following additional eligibility criteria
a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act

3.4.4 Individuals will not be eligible if
a) Any of the disqualification criteria set out in 3.2 apply
b) Subject to clause 3.4.3(a), they hold any other employment or executive role

3.5 Partner Member(s) - NHS trusts and foundation trusts

3.5.1 These Partner Members are jointly nominated by the NHS trusts and/or FTs which provide services for the purposes of the health service within the ICB's area and meet the forward plan condition or (if the forward plan condition is not met) the level of services provided condition.

- James Paget University Hospitals NHS Foundation Trust
- Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
- Norfolk and Norwich University Hospitals NHS Foundation Trust
- East of England Ambulance Service NHS Trust
- Norfolk and Suffolk NHS Foundation Trust
- Norfolk Community Health and Care NHS Trust

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

a) Be an Executive Director of one of the NHS Trusts or FTs; or
b) Be an Executive Director of East Coast Community Healthcare CIC within the ICB's area; and
c) Any criteria set out in NHS England's guidance from time to time; and
d) One member to have particular knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness, and of community services
e) One member bringing particular knowledge and experience in acute hospital services; and
f) Senior level operational expertise.

3.5.3 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply; and
b) Any exclusion criteria as set out in NHS England guidance applies

3.5.4 These members will be appointed by a panel subject to the approval of the Chair.

3.5.5 The appointment process will be as follows:

a) Joint Nomination:
    - When a vacancy arises, each eligible organisation listed at 3.5.1.a will be invited to make nominations.
    - The nomination of an individual must be seconded by one other eligible organisation.
    - Eligible organisations may nominate individuals from their own organisation or another organisation
    - All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.
b) Assessment, selection, and appointment subject to approval of the Chair under c)
    - The full list of nominees will be considered by a panel convened by the Chief Executive.
    - The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.5.2 and 3.5.3
    - In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.
    - A fit and proper person test will also be undertaken on the preferred candidate before appointment.

c) Chair's approval

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

3.5.6 The term of office for these Partner Member will be 3 or 4 years as agreed with the Chair at the start of the term, and the total number of terms they may serve is 2 terms, in the case of a 3 year term, and 1 term in the case of a 4 year term.

3.6 Partner Member - providers of primary medical services

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

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

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

a) Any criteria set out in NHS England's guidance from time to time;
b) This member must be a Healthcare Professional, either a partner or employee, actively working within a practice in the Norfolk and Waveney ICB area; or
c) A locum that is active for the majority of their time within a practice in Norfolk and Waveney ICB area.
d) Fulfil the requirements relating to the relevant experience, knowledge, skills and attributes set out in a role and person specification.

3.6.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply; and
b) Any criteria as set out in NHS England guidance applies.

3.6.5 This member will be appointed by a panel subject to the approval of the Chair.

3.6.6 The appointment process will be as follows:

a) Joint Nomination:
- When a vacancy arises, each eligible organisation described at 3.6.1 and listed in the Governance Handbook will be invited to make nominations.
- The nomination of an individual must be seconded by three other eligible organisations.
- Eligible organisations may nominate individuals from their own organisation or another organisation.
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 10 working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put

forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c)
   - The full list of nominees will be considered by a panel convened by the Chief Executive.
   - The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.6.3 and 3.6.4
   - In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.
   - A fit and proper person test will also be undertaken on the preferred candidate before appointment

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

3.6.7 The term of office for this Partner Member will be 3 or 4 years as agreed with the Chair at the start of the term, and the total number of terms they may serve is 2 terms in the case of a 3 year term, and 1 term in the case of a 4 year term.

3.7 Partner Member(s) - local authorities

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

a) Norfolk County Council
b) Suffolk County Council

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

a) Be the Chief Executive or hold a relevant Executive level role of one of the bodies listed at 3.7.1; and
b) Any criteria set out in NHS England's guidance from time to time.

3.7.3 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply; and
b) any criteria as set out in NHS E guidance applies.

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

3.7.5 The appointment process will be as follows:

a) Joint Nomination:
   - When a vacancy arises, each eligible organisation listed at 3.7.1.a will be invited to make nominations.
   - Eligible organisations may nominate individuals from their own organisation or another organisation

- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until a consensus is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c)
   - The full list of nominees will be considered by a panel convened by the Chief Executive.
   - The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.7.2 and 3.7.3
   - In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.
   - A fit and proper person test will also be undertaken on the preferred candidate before appointment.

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

3.7.6 The term of office for these Partner Members will be 3 or 4 years as agreed with the Chair at the start of the term, and the total number of terms they may serve is 2 terms, in the case of a 3 year term, and 1 term in the case of a 4 year term.

3.8 Medical Director

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

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Be a registered Medical Practitioner;
c) Any further criteria as set by NHS England from time to time; and
d) Meet the criteria as set out in the person specification for the role.

3.8.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply; and
b) any criteria set out in NHS England guidance applies.

3.8.3 This member will be appointed by the Chief Executive subject to the approval of the Chair. This will be after a recruitment process is undertaken which includes the Chief Executive and Chair on the selection panel.

3.9 Director of Nursing

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

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Be a registered Nurse
c) Any further criteria as set by NHS England from time to time; and
d) Meet the criteria as set out in the person specification for the role.

3.9.2 Individuals will not be eligible if:
a) Any of the disqualification criteria set out in 3.2 apply; and
b) any criteria as set out in NHS England guidance applies.

3.9.3 This member will be appointed by the Chief Executive subject to the approval of the Chair. This will be after a recruitment process is undertaken which includes the Chief Executive and Chair on the selection panel.

3.10 Director of Finance

3.10.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:
a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Any further criteria as set by NHS England from time to time; and
c) Meet the criteria as set out in the person specification for the role.

3.10.2 Individuals will not be eligible if:
a) Any of the disqualification criteria set out in 3.2 apply; and
b) any criteria as set out in NHS England guidance applies.

3.10.3 This member will be appointed by the Chief Executive subject to the approval of the Chair. This will be after a recruitment process is undertaken which includes the Chief Executive and Chair on the selection panel.

3.11 Four Non-executive Members

3.11.1 The ICB will appoint four Non-executive Members.

3.11.2 These members will be appointed by a panel subject to the approval of the Chair.

3.11.3 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:
a) Not be an employee of the ICB or a person seconded to the ICB
b) Not hold a role in another health and care organisation in the ICS area
c) One shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit Committee
d) Another shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration, People and Culture Committee
e) Another shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Finance Committee.

f) Another shall have specific knowledge, skills and experience with regard to the people and the community of Norfolk and Waveney.
g) Any other criteria as set out by NHS England's guidance.

3.11.4 Individuals will not be eligible if
a) Any of the disqualification criteria set out in 3.2 apply
b) They hold a role in another health and care organisation within the ICB area; and
c) any criteria as set out in NHS England's guidance applies.

3.11.5 The term of office for a Non-executive Member will be 3 years and the total number of terms an individual may serve is 3 terms, after which they will no longer be eligible for re-appointment.

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

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

3.12 Other Board Members

VCSE Assembly Board member

3.12.1 This member is nominated by the Norfolk and Waveney VCSE Assembly Board.

3.12.2 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:
a) Be the Chief Executive or hold a relevant Executive level role in one of the VCSE sector legal entities in Norfolk and Waveney; and
b) Any criteria set out in NHS England's guidance from time to time

3.12.3 Individuals will not be eligible if
a) Any of the disqualification criteria set out in 3.2 apply; and
b) any criteria as set out in NHS England guidance applies.

3.12.4 This member will be appointed by a panel subject to the approval of the Chair.

3.12.5 The appointment process will be as follows:
a) Joint Nomination:
- When a vacancy arises, each member of the Norfolk and Waveney VCSE Assembly Board will be invited to make nominations.
- The nomination of an individual must be seconded by one other eligible member of the Norfolk and Waveney VCSE Assembly Board.
- Eligible members may nominate individuals from their own organisation or another organisation
- All eligible members of the Norfolk and Waveney Assembly Board will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days

being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c)
   - The full list of nominees will be considered by a panel convened by the Chief Executive.
   - The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.12.2 and 3.12.3
   - In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.
   - A fit and proper person test will also be undertaken on the preferred candidate before appointment

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

Integrated Care Partnership Board Member

3.12.6 This member is nominated by the Norfolk and Waveney Integrated Care Partnership.

3.12.7 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria
a) Be a member of the Integrated Care Partnership Committee; and
b) Any criteria set out in NHS England's guidance from time to time

3.12.8 Individuals will not be eligible if
a) Any of the disqualification criteria set out in 3.2 apply; and
b) any criteria as set out in NHS England guidance applies.

3.12.9 This member will be appointed by a panel subject to the approval of the Chair.

3.12.10 The appointment process will be as follows:

a) Joint Nomination:
   - When a vacancy arises, each individual member of the Integrated Care Partnership Committee will be invited to make nominations.
   - The nomination of an individual must be seconded by one other member of the Integrated Care Partnership Committee.
   - Eligible members may nominate individuals from their own organisation or another organisation
   - All members will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If

they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c)
   - The full list of nominees will be considered by a panel convened by the Chief Executive.
   - The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.12.7 and 3.12.8
   - In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.
   - A fit and proper person test will also be undertaken on the preferred candidate before appointment.

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

3.13 Board Members: Removal from Office

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

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

a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this Constitution, regulations or guidance.
b) If they fail to attend a minimum of 90% of the meetings to which they are invited including ICB Board and Committee meetings unless agreed with the Chair in extenuating circumstances
c) If they are deemed to not meet the expected standards of performance at their annual appraisal
d) If they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the ICB and is likely to bring the ICB into disrepute. This includes but it is not limited to dishonesty; misrepresentation (either knowingly or fraudulently); defamation of any member of the ICB (being slander or libel); abuse of position; non-declaration of a known conflict of interest; seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise
e) Are deemed to have failed to uphold the Nolan Principles of Public Life
f) Are subject to disciplinary proceedings by a regulator or professional body

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

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

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

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

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

3.14 Terms of appointment of Board Members

3.14.1 With the exception of the Chair and Non-executive members, arrangements for remuneration and any allowances will be agreed by the Remuneration, People and Culture Committee in line with the ICB remuneration policy and any other relevant policies published at www.improvinglivesnw.org.uk.and any guidance issued by NHS England or other relevant body. Remuneration for Chairs will be set by NHS England. Remuneration for Non-executive Members will be set by the Board. Any discussions about remuneration for the Non-executive Members will be held without the Non-executive Members present.

3.14.2 Other terms of appointment will be determined by the Remuneration, People and Culture Committee.

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

3.15 Specific arrangements for appointment of Ordinary Members made at establishment

3.15.1 Individuals may be identified as "designate Ordinary Members" prior to the ICB being established.

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

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

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

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

4 Arrangements for the exercise of our functions

4.1 Good governance

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

4.1.2 The ICB has agreed a standards of business conduct policy which sets out the expected behaviours that members of the board and its committees will uphold whilst undertaking ICB business. It also includes a set of principles that will guide decision making in the ICB. The ICB standards of business conduct policy can be found on our website at www.improvinglivesnw.org.uk.

4.2 General

4.2.1 The ICB will:

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

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

4.3 Authority to Act

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

a) any of its members or employees
b) a committee or sub-committee of the ICB

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

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

4.4 Scheme of Reservation and Delegation

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

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

4.4.3 The SoRD sets out:

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

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

4.5 Functions and Decision Map

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

4.5.2 The Functions and Decision Map is published at www.improvinglivesnw.org.uk.

4.5.3 The map includes:

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

4.6 Committees and sub-committees

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

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

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

4.6.4 The board remains accountable for all functions, including those that it has delegated to committees and subcommittees and therefore, appropriate reporting and assurance arrangements are in place and documented in terms of reference. All committees and sub committees that fulfil delegated functions of the ICB, will be required to:

a) Submit regular decision or assurance reports to the board
b) Comply with any internal audit findings of the ICB
c) Conduct annual committee effectiveness reviews
d) Submit their term of reference for board approval.

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

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

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

4.6.8 The following committees will be maintained:

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

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

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

The Remuneration, People and Culture Committee will be chaired by a non-executive member other than the Chair or the Chair of Audit Committee.

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

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

4.7 Delegations made under section 65Z5 of the 2006 Act

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

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

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

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

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

5 Procedures for Making Decisions

5.1 Standing Orders

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

- conducting the business of the ICB
- the procedures to be followed during meetings; and
- the process to delegate functions.

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

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

5.2 Standing Financial Instructions (SFIs)

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

5.2.2 A copy of the SFIs is published in the Governance Handbook.

6 Arrangements for conflict of interest management and standards of business conduct

6.1 Conflicts of Interest

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

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

6.1.3 All board, committee and sub-committee members, and employees of the ICB, will comply with the ICB policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.

6.1.4 All delegation arrangements made by the ICB under section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures comparable with those of the ICB.

6.1.5 Where an individual, including any individual directly involved with the business or decision-making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Constitution, the Conflicts of interest Policy and the Standards of Business Conduct Policy.

6.1.6 The ICB has appointed the Audit and Risk Committee Chair to be the Conflicts of Interest Guardian. In collaboration with the ICB's governance lead, their role is to:

a) Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest;
b) Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest;
c) Support the rigorous application of conflict of interest principles and policies;
d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation;
e) Provide advice on minimising the risks of conflicts of interest.

6.2 Principles

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

a) The ICB acts in the public interest at all times
b) Avoiding undue influence
c) Transparency and Accountability.

6.3 Declaring and registering interests

6.3.1 The ICB maintains registers of the interests of:
a) Members of the ICB
b) Members of the board's committees and sub-committees
c) Its employees.

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

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

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

6.3.5 All declarations will be entered in the registers as per 6.3.1

6.3.6 The ICB will ensure that, as a matter of course, declarations of interest are made and confirmed, or updated at least annually.

6.3.7 Interests (including gifts and hospitality) of decision-making staff will remain on the public register for a minimum of six months. In addition, the ICB will retain a record of historic interests and offers/receipt of gifts and hospitality for a minimum of six years after the date on which it expired. The ICB's published register of interests states that historic interests are retained by the ICB for the specified timeframe and details of whom to contact to submit a request for this information.

6.3.8 Activities funded in whole or in part by third parties who may have an interest in ICB business such as sponsored events, posts and research will be managed in accordance with the ICB policy to ensure transparency and that any potential for conflicts of interest are well-managed.

6.4 Standards of business conduct

6.4.1 Board members, employees, committee and sub-committee members of the ICB will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should:
a) act in good faith and in the interests of the ICB;
b) follow the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles);
c) comply with the ICB's Standards of Business Conduct Policy, and any requirements set out in the policy for managing conflicts of interest.

6.4.2 Individuals contracted to work on behalf of the ICB or otherwise providing services or facilities to the ICB will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the ICB's Standards of Business Conduct policy.

7 Arrangements for ensuring accountability and transparency

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

7.2 Meetings and publications

7.2.1 Board meetings, and committees composed entirely of board members or which include all board members, will be held in public except where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest.

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

7.2.3 Annual accounts will be externally audited and published.

7.2.4 A clear complaints process will be published.

7.2.5 The ICB will comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the ICB.

7.2.6 Information will be provided to NHS England as required.

7.2.7 The Constitution and Governance Handbook will be published as well as other key documents including but not limited to:

- Conflicts of interest policy and procedures
- Registers of interests
- Key policies

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

- sections 14Z34 to 14Z45 (general duties of integrated care boards), and
- sections 223GB and 223N (financial duties)

and

a) proposed steps to implement the Norfolk and Waveney joint local health and wellbeing strategies

7.3 Scrutiny and decision making

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

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

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

a) Complying with existing procurement rules until the provider selection regime comes into effect.
b) evidencing that it has properly exercised the responsibilities conferred on it by the regime, once this is published, by:
   - publishing the intended selection approach in advance.
   - publishing the outcome of decisions made and the details of contracts awarded.
   - keeping a record of decisions made under the regime, including evidence that all relevant issues and criteria have been considered and that the reasons for any decision are clearly justified.
   - recording how conflicts of interest were managed.
c) monitoring compliance with this regime via an annual internal audit process, the results of which will be published.
d) including in the annual report a summary of contracting activity as specified by the regime.
e) ensuring that appropriate internal governance mechanisms are in place to deal with representations made against provider selection decisions and that any such representations are considered fairly and impartially within the timescales prescribed.

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

7.4 Annual Report

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

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

8 Arrangements for Determining the Terms and Conditions of Employees

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

8.1.2 The board has established a Remuneration, People and Culture Committee which is chaired by a Non-executive Member other than the Chair or Audit Chair.

8.1.3 The membership of the Remuneration, People and Culture Committee is determined by the board. No employees may be a member of the Remuneration People and Culture Committee, but the board ensures that the Remuneration People and Culture Committee has access to appropriate advice by:

a) The Chair may invite relevant staff to the meeting as necessary in accordance with the business of the committee
b) Meetings 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
   - The Director of Finance or their nominated deputy
   - The Chief Executive or their nominated deputy, and
   - Director of Corporate Affairs and ICS Development or their nominated deputy

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

8.1.5 The main purpose of the Remuneration People and Culture Committee is to exercise the functions of the ICB regarding remuneration included in paragraphs 18 to 20 of Schedule 1B to the 2006 Act. The terms of reference agreed by the board are published in the ICB's Governance Handbook.

8.1.6 The duties of the Remuneration People and Culture Committee include for the Chief Executive, Members of the Board and other Very Senior Managers:

a) Determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses, pensions and cars;
b) Determine arrangements for termination of employment and other contractual terms and non-contractual terms.

For all staff:

a) Determine the ICB pay policy, including the adoption of pay frameworks such as Agenda for Change;
b) Oversee contractual arrangements;
c) 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.

For Clinical Advisors:

a) Determine ICB pay policy
b) Oversee contractual arrangements

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

9 Arrangements for Public Involvement

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

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

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

a) All consultation proposals will be formally agreed by the ICB and will be shared with a range of key stakeholder prior to the start of any consultation process to ensure that the proposals are robust and representative.
b) Work with Healthwatch Norfolk and Healthwatch Suffolk to ensure patient and public voice is embedded into the work of the Norfolk and Waveney Integrated Care Board, embracing co-production and co-design wherever possible.

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

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

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

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

9.1.5 These arrangements, include:

a) Working with patients and members of the public across the ICS to ensure patients and members of the public are involved in helping to shape services at a local level.
b) Strengthening Patient Participation Groups, supporting them to embrace new ways of reaching out to local communities and feeding these views into local alliances.
c) Working with the Norfolk and Waveney Communications and Engagement Group (including NHS, local authorities, both Norfolk and Suffolk Heathwatch, and VCSE) to consider as part of Norfolk and Waveney wide campaigns, communication and engagement activities.
d) Working with the Integrated Care Board to include patient stories at their meetings, linked to and focussed on highlighting the importance of patient and public views and voices to help inform decision making.

Appendix 1: Definitions of Terms Used in This Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022
ICB board	Members of the ICB
Area	The geographical area that the ICB has responsibility for, as defined in part 2 of this Constitution
Committee	A committee created and appointed by the ICB board.
Sub-committee	A committee created and appointed by and reporting to a committee.
Integrated Care Partnership	The joint committee for the ICB's area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's area.
Healthcare Professional	A member of a profession that is regulated by one of the following bodies: the General Medical Council (GMC) the General Dental Council (GDC) the General Optical Council the General Osteopathic Council the General Chiropractic Council the General Pharmaceutical Council the Pharmaceutical Society of Northern Ireland the Nursing and Midwifery Council the Health and Care Professions Council any other regulatory body established by an Order in Council under Section 60 of the Health Act 1999
Place-based Partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the Integrated Care Board, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities, as well as primary care provider leadership, represented by Primary Care Network clinical directors or other relevant primary care leaders.
Ordinary Member	The board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the board are referred to as Ordinary Members.

Partner Members	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are and appointed in accordance with the procedures set out in Section 3 having been nominated by the following: • NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description • the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description • the local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.
Health Service Body	Health Service Body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.

Appendix 2: Standing Orders

1. Introduction

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

2. Amendment and review

2.1. The Standing Orders are effective from 1 July 2022

2.2. Standing Orders will be reviewed on an annual basis or sooner if required.

2.3. Amendments to these Standing Orders will be made as per clause 1.6.

2.4. All changes to these Standing Orders will require an application to NHS England for variation to the ICB Constitution and will not be implemented until the Constitution has been approved.

3. Interpretation, application and compliance

3.1. Except as otherwise provided, words and expressions used in these Standing Orders shall have the same meaning as those in the main body of the ICB Constitution and as per the definitions in Appendix 1.

3.2. These Standing Orders apply to all meetings of the board, including its committees and sub-committees unless otherwise stated. All references to board are inclusive of committees and sub-committees unless otherwise stated.

3.3. All members of the board, members of committees and sub-committees and all employees, should be aware of the Standing Orders and comply with them. Failure to comply may be regarded as a disciplinary matter.

3.4. In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from the Director Corporate Affairs and ICS Development, will provide a settled view which shall be final.

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

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

4. Meetings of the Integrated Care Board

4.1. Calling Board Meetings

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

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

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

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

c) In emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.

4.1.3. A public notice of the time and place of meetings to be held in public and how to access the meeting shall be given by posting it at the offices of the ICB body and electronically at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.

4.1.4. The agenda and papers for meetings to be held in public will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting is not likely to be open to the public.

4.2. Chair of a meeting

4.2.1. The Chair of the ICB shall preside over meetings of the board.

4.2.2. If the Chair is absent, or is disqualified from participating by a conflict of interest, then the Deputy Chair of the ICB shall preside over the meeting of the board. The Deputy Chair shall be appointed by the board. If both the Chair and the Deputy Chair are absent, or are disqualified from participating by a conflict of interest, then the board may appoint a temporary deputy to preside over meetings of the board.

4.2.3. The board shall appoint a Chair to all committees and sub-committees that it has established. The appointed committee or sub-committee Chair will preside over the relevant meeting. Terms of reference for committees and sub-committees will specify arrangements for occasions when the appointed Chair is absent.

4.3. Agenda, supporting papers and business to be transacted

4.3.1. The agenda for each meeting will be drawn up and agreed by the Chair of the meeting.

4.3.2. Except where the emergency provisions apply, supporting papers for all items must be submitted at least seven calendar days before the meeting takes place. The

agenda and supporting papers will be circulated to all members of the board at least five calendar days before the meeting.

4.3.3. Agendas and papers for meetings open to the public, including details about meeting dates, times and venues, will be published on the ICB's website at www.improvinglivesnw.org.uk.

4.4. Petitions

4.4.1. Where a valid petition has been received by the ICB it shall be included as an item for the agenda of the next meeting of the Board in accordance with the ICB policy as published in the Governance Handbook.

4.5. Nominated Deputies

4.5.1. With the permission of the person presiding over the meeting, the Executive Directors of the board may nominate a deputy to attend a meeting of the Board that they are unable to attend. For the avoidance of doubt, the deputy may speak but may not vote on their behalf.

4.5.2. Partner Members will not be permitted to send deputies.

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

4.6. Virtual attendance at meetings

4.6.1. The board of the ICB and its committees and sub-committees may meet virtually using telephone, video and other electronic means when necessary, unless the terms of reference prohibit this.

4.7. Quorum

4.7.1. The quorum for meetings of the board will be 10 members, including:

a) Either the Chief Executive or the Director of Finance
b) Either the Medical Director or the Director of Nursing
c) At least one Independent member (which can include the Chair)
d) At least one Partner Member.

4.7.2. For the sake of clarity:

a) No person can act in more than one capacity when determining the quorum.
b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.

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

4.8. Vacancies and defects in appointments

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

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

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

4.9. Decision making

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

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

a) All members of the board who are present at the meeting will be eligible to cast one vote each.
b) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.
c) For the sake of clarity, any additional Participants and Observers(as detailed within paragraph 5.6. of the Constitution) will not have voting rights.
d) A resolution will be passed if more votes are cast for the resolution than against it.
e) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.
f) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

<u>Disputes</u>

4.9.3. Where necessary or helpful, the board may draw on third party support such as peer review or support from NHS England.

<u>Urgent decisions</u>

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

4.9.5. The powers which are reserved or delegated to the board, may for an urgent decision be exercised by the Chair and Chief Executive (or relevant lead director in the case of committees) subject to every effort having made to consult with as many members as possible in the given circumstances.

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

4.10. Minutes

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

4.10.2. The minutes of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be signed by the person presiding at it.

4.10.3. No discussion shall take place upon the minutes except upon their accuracy or where the person presiding over the meeting considers discussion appropriate.

4.10.4. Where providing a record of a meeting held in public, the minutes shall be made available to the public.

4.11. Admission of public and the press

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

4.11.2. The board may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

4.11.3. The person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the board's business shall be conducted without interruption and disruption.

4.11.4. As permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 as amended from time to time) the public may be excluded from a meeting to suppress or prevent disorderly conduct or behaviour.

4.11.5. Matters to be dealt with by a meeting following the exclusion of representatives of the press, and other members of the public shall be confidential to the members of the board.

5. Suspension of Standing Orders

5.1. In exceptional circumstances, except where it would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or NHS England, any part of these Standing Orders may be suspended by the Chair in discussion with at least two other members,

5.2. A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

5.3. A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Audit Committee for review of the reasonableness of the decision to suspend Standing Orders.

Appendix 3: Lower Super Output Areas covered by Norfolk and Waveney ICB

District of East Suffolk

Lower Super Output Areas covered by Norfolk and Waveney ICB in the District of East Suffolk
East Suffolk (PARTIAL) including LSOAs: E01030240, E01030241, E01030242, E01030259, E01030260, E01030261, E01030262, E01030277, E01030279, E01030281, E01030266, E01030267, E01030271, E01030278, E01030280, E01030246, E01030248, E01030249, E01030250, E01030264, E01030265, E01030255, E01030263, E01030270, E01030289, E01030290, E01030233, E01030235, E01030268, E01030269, E01030288, E01030247, E01030254, E01030256, E01030258, E01030276, E01030257, E01030274, E01030275, E01030287, E01030291, E01030234, E01030236, E01030237, E01030238, E01030223, E01030224, E01030225, E01030227, E01030228, E01030226, E01030286, E01030292, E01030293, E01030294, E01030239, E01030251, E01030252, E01030253, E01030272, E01030273, E01030230, E01030231, E01030232, E01030285, E01030282, E01030283, E01030284, E01030295, E01030229, E01030243, E01030244, E01030245

Norfolk and Waveney
Integrated Care Board

Agenda item: 8

Subject:	**Governance Handbook**
Presented by:	**Karen Barker, Director of Corporate Affairs and ICS Development, NHS Norfolk and Waveney ICB**
Prepared by:	**Amanda Brown, Head of Corporate Governance, NHS Norfolk and Waveney ICB**
Submitted to:	**Board of the Integrated Care Board**
Date:	**1 July 2022**

Purpose of paper:

To present the Governance Handbook for approval by the Board.

Executive Summary:

Introduction
The NHS Norfolk and Waveney Integrated Care Board (ICB) Governance Handbook is attached for Board approval.

The Governance Handbook is designed to support and supplement the ICB Constitution. It sets out a framework which demonstrates the ICB's governance arrangements for exercising its duties and functions. In this respect, whilst it is not a legal requirement to have a Governance Handbook, it supports the ICB to build a consistent corporate approach and form part of the corporate memory.

The Governance Handbook sets out how the general public can inform decision making (see in particular section 7 on People and Communities Approach) and who makes decisions (see the ICB's Functions and Decision Map at section 3.) The general public can always find out what is happening at the ICB via our website at www.improvinglivesnw.org.uk or by attending one of our meetings held in public.

Accordingly, the Governance Handbook will be published on the ICB website for transparency and ease of access and will be updated regularly as a matter of routine.

The document brings together all the ICB's governance documents and contains key governance information as follows:

- Governance Structure
- Functions and Decisions Map
- Delegation Arrangements
- Scheme of Reservation and Delegation
- Standing Financial Instructions
- People and Communities Approach
- Conflicts of Interest Policy
- Standards of Business Conduct Policy
- Petitions Policy

- Eligible nominating PMS (GMS/APMS) Providers
- Working with Voluntary, Community and Social Enterprise sectors

In addition, the Governance Handbook contains the Terms of Reference for all ICB Committees as follows:

- Audit and Risk Committee
- Remuneration, People and Culture Committee
- Patients, and Communities Committee
- Finance Committee
- Primary Care Commissioning Committee
- Quality and Safety Committee
- Performance Committee
- Conflicts of Interest Sub-Committee

The Governance Handbook also contains the Terms of Reference for the Integrated Care Partnership which is a statutory committee of both the ICB and Norfolk County Council and Suffolk County Council

As part of the ICB establishment process the Governance Handbook has been reviewed by NHS England and is required to be published on the ICB website from 1 July 2022.

The arrangements set out in the Governance Handbook will be reviewed internally during the first six months of the Integrated Care Board in order to see how effectively they are working.

Recommendation to Board:

The Board is asked to approve the ICB Governance Handbook.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	Ensuring that the ICB has appropriate governance processes in place is a key part of maintaining the CCG's reputation.
Legal:	Ensuring that the ICB is compliant with statutory requirements.
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Governing Body Assurance Framework	N/A

GOVERNANCE

Process/Committee approval with date(s) *(as appropriate)*	Board of the Integrated Care Board 1 July 2022- For approval.

Norfolk and Waveney
Integrated Care Board

NHS NORFOLK & WAVENEY INTEGRATED CARE BOARD

GOVERNANCE HANDBOOK

Version 1.1

Revision History

Document Control Sheet

Revision Date	Summary of changes	Author(s)	Version Number

Approvals

This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number

Document Control Sheet

Policy title	Governance Handbook
Policy area	This Policy has been prepared and reviewed by the Corporate Affairs team.
Who is it aimed at and which settings?	All staff whether temporary, fixed term, or under consultancy, contract for services or agency arrangements, Governing Body and Committee members, ICB clinical advisors and anyone else undertaking work for the ICB.
Approved by	
Effective date	
Review date	Annually

Contents

SECTION 1
Introduction

Introduction to the Governance Handbook
The purpose of this document is to bring together a range of corporate statutory documents into one place and is described as the NHS Norfolk and Waveney Integrated Care Board Governance Handbook (the "Governance Handbook").

The Governance Handbook is designed to support and supplement the ICB's Constitution. It sets out a framework which demonstrates the ICB's governance arrangements for exercising its duties and functions. In this respect, whilst it is not a legal requirement to have a Governance Handbook, it supports the ICB to build a consistent corporate approach and form part of the corporate memory.

The Governance Handbook sets out how the general public can inform decision making (see in particular section 7 on people and communities approach) and who makes decisions (see the ICB's functions and decision map at section 3.) The general public can always find out what is happening at the ICB via our website at www.improvinglivesnw.org.uk or by attending one of our meetings held in public.

Accordingly, the Governance Handbook will be published on the ICB website for transparency and ease of access and will be updated regularly as a matter of routine.

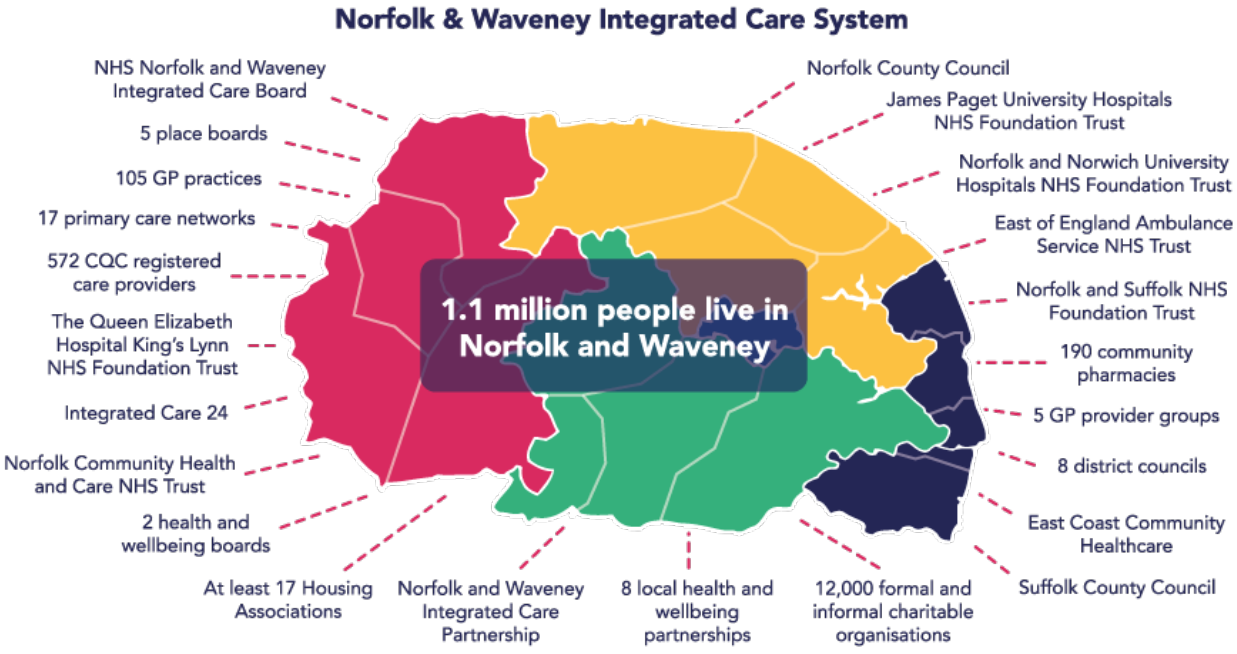
The Governance Handbook includes:

- Introduction
- Governance Structure
- Functions and Decisions Map
- Scheme of Reservation and Delegation (including delegation arrangements)
- Standing Financial Instructions
- People and Communities Approach
- Conflicts of Interest Policy
- Standards of Business Conduct Policy
- Petitions Policy
- Eligible nominating PMS (GMS/APMS) Providers
- Working with Voluntary, Community and Social Enterprise

The Terms of Reference for the ICB's Committees and also the statutory committee of the Integrated Care Partnership are contained in the appendices

SECTION 2
Governance Structure

Integrated Care Systems (ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. This diagram shows the wide range of organisations that form the Norfolk and Waveney Integrated Care System:



The mission of our ICS is: To help the people of Norfolk and Waveney to live longer, healthier and happier lives.

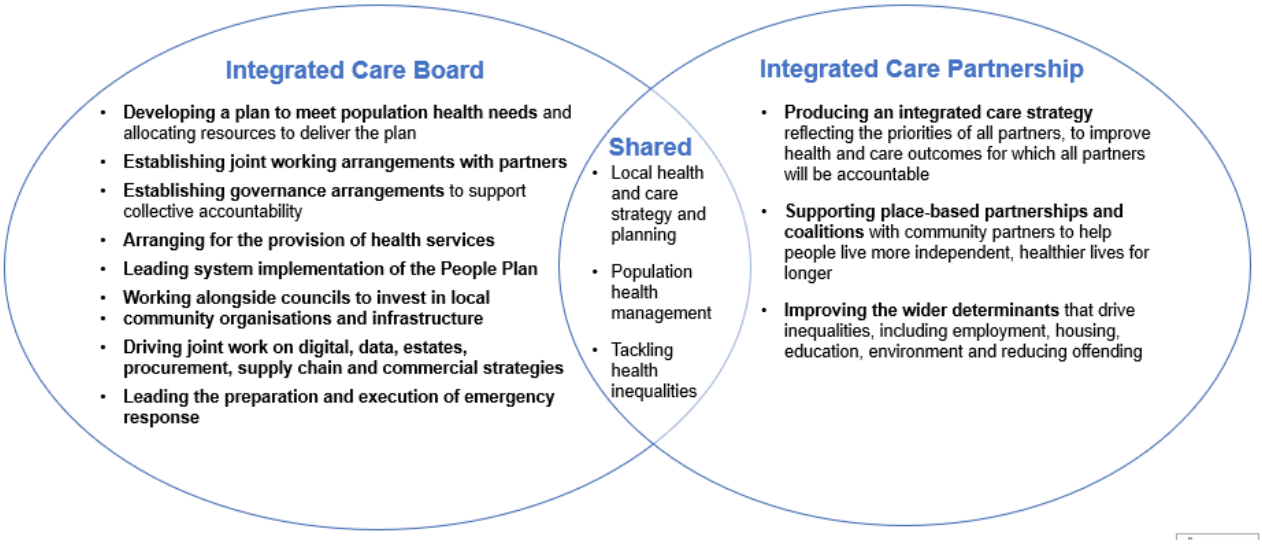
Like all Integrated Care Systems in England, we will work to:

Each ICS must include an Integrated Care Board and an Integrated Care Partnership:

- **NHS Norfolk and Waveney Integrated Care Board (ICB)** is accountable for the overall performance and finances of the NHS in Norfolk and Waveney. The ICB was established on 1 July 2022, following the dissolution of NHS Norfolk and Waveney Clinical Commissioning Group on 30 June 2022. However the ICB has a very different role to the CCG – helping to bring organisations together, working collaboratively, removing traditional barriers and more.

- **Norfolk and Waveney Integrated Care Partnership (ICP)** is responsible for agreeing an integrated care strategy for improving the health care, social care and public health across the whole population. It works to address the wider determinants of health, such as employment and housing. The partnership is established locally and jointly by the Suffolk and Norfolk county councils and the ICB.

The ICP and ICB are of equal importance. Unlike the ICB, the ICP is a statutory committee of the ICS, not a statutory body, and as such its members can come together to take decisions on an integrated care strategy, but it does not take on functions from other parts of the system. The diagram below shows the different roles of the ICB and the ICP:



ICB Constitution

The ICB Constitution is based on the model constitution produced by NHS England (NHSEI). The ICB model constitution is based on the Health and Care Act and NHSE policy as well as legal requirements that must be included in the Constitution. The ICB Constitution has been approved by NHSE and by the ICB Board. Applications for changes to the Constitution are made to NHSE following approval by the Board. The ICB Constitution is published on the ICB website www.improvinglivesnw.org.uk .

The Board of the ICB

The Board of the ICB is a unitary Board that meets in public every other month. Details of meeting dates and times as well as papers can be found on the ICB website. The purpose of the Board is to govern effectively and in doing so, build patient, public and stakeholder confidence that their healthcare is in safe hands. The Board is responsible for:

- Formulating strategy for the organisation (taking into account the ICP's Integrated Care Strategy)
- Holding the organisation to account for delivery of the strategy

- Being accountable for ensuring the organisation operates effectively and with openness, transparency and candour and by seeking assurance that systems of control are robust and reliable
- Shaping a healthy culture for the organisation and the wider ICS partnership.

The Board remains accountable for all the ICB's functions, including those that it has delegated and therefore, appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation.

The members of the Board of the ICB Board can be viewed on the website www.improvinglivesnw.org.uk.

ICB Committees

The following committees support the work of the Board:

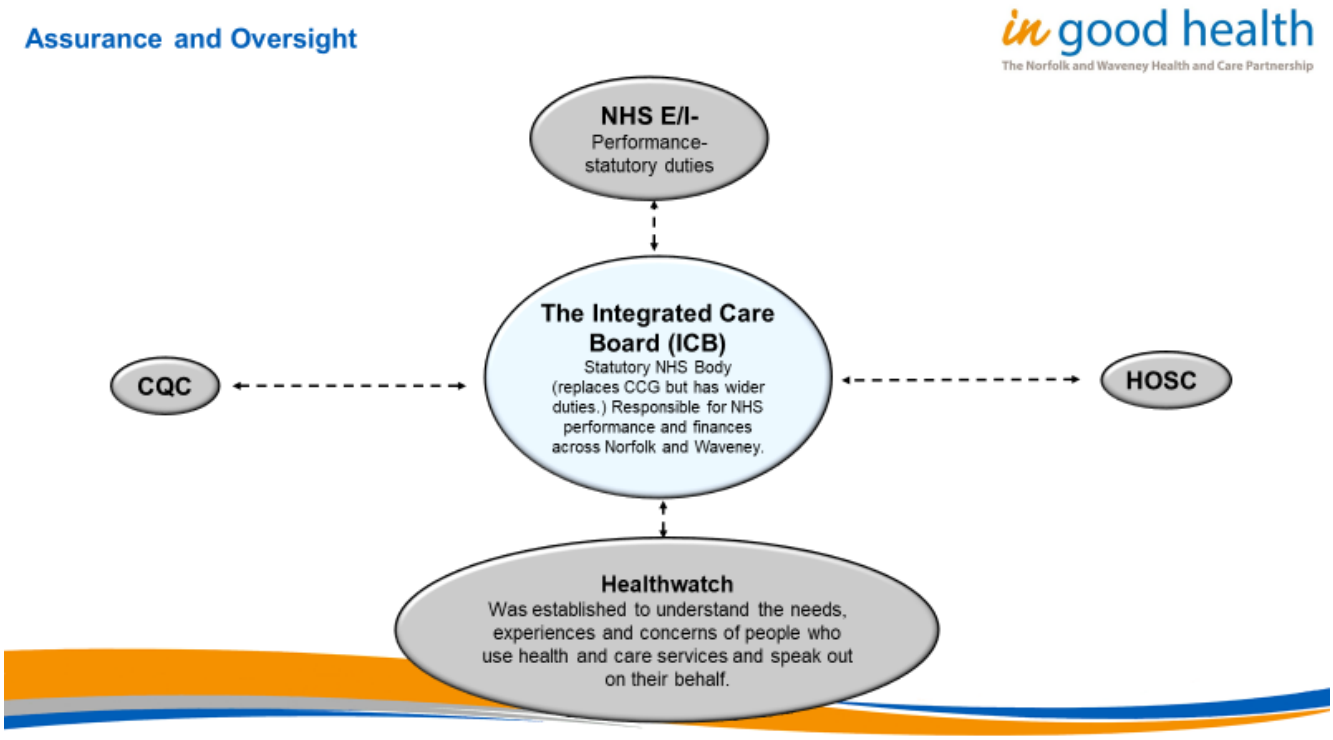
Name of Committee	Remit	Chair
Audit and Risk Committee	The Audit and Risk Committee contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.	Non-Executive Member for Audit and Risk
Remuneration, People and Culture Committee	This Committee's statutory purpose is to confirm the ICB Pay Policy, but the committee will also have a remit with regard to organisational development and ensuring work is developed on culture and for our staff.	Non-Executive Member for Remuneration, People and Culture
Patients, and Communities Committee	The purpose of this committee is to ensure that there is rigour and challenge with regard to the ICB's ambitious transformation objectives.	Non-Executive Member
Finance Committee	This Committee provides oversight of financial matters bringing external and impartial rigour and challenge to the management of the ICB's finances.	Non-Executive Member for Finance
Primary Care Commissioning Committee	The Committee enables collective decisions on the review, planning and procurement of primary care services in Norfolk & Waveney.	Local Authority Partner Member from ICB Board
Quality and Safety Committee	The Committee is responsible for the oversight and development of the ICB's Quality Strategy, which sets out its plan for quality and safety improvement.	Non-Executive Member
Performance Committee	The committee will ensure oversight of the delivery of key performance standards by commissioned providers, performance of the system against the NHS Outcomes Framework and progress with improving wider outcome measures of population health.	ICB Board Partner Member, Primary Medical Services
Conflicts of Interest Committee (sub committee)	The sub-Committee is authorised to make decisions on behalf of the ICB with regard to issues which cannot be decided by the Board due to the Board not being quorate as a result of conflicts of interest.	Non-Executive Member for Audit and Risk

In addition, the Norfolk and Waveney Integrated Care Partnership, as a statutory committee jointly formed between the Norfolk and Waveney Integrated Care Board and Norfolk County Council and Suffolk County Council.

Name of Statutory Committee	Remit	Chair
Integrated Care Partnership	The Integrated Care Partnership will bring together a broad alliance of partners concerned with improving the care, health and wellbeing of the population, with membership determined locally. The ICP is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area.	Cabinet member for Adult Social Care, Public Health and Prevention, Norfolk County Council

Assurance and Oversight

The diagram below sets out the system for assurance and oversight of the ICB.



SECTION 3
Functions and Decision Map

As prescribed by the ICB's Constitution and legislative requirements, the ICB must publish within its Governance Handbook a Functions and Decision Map.

The purpose of a Functions and Decision Map is to provide a high-level structural chart that sets out which decisions are delegated and taken by which parts of the system.

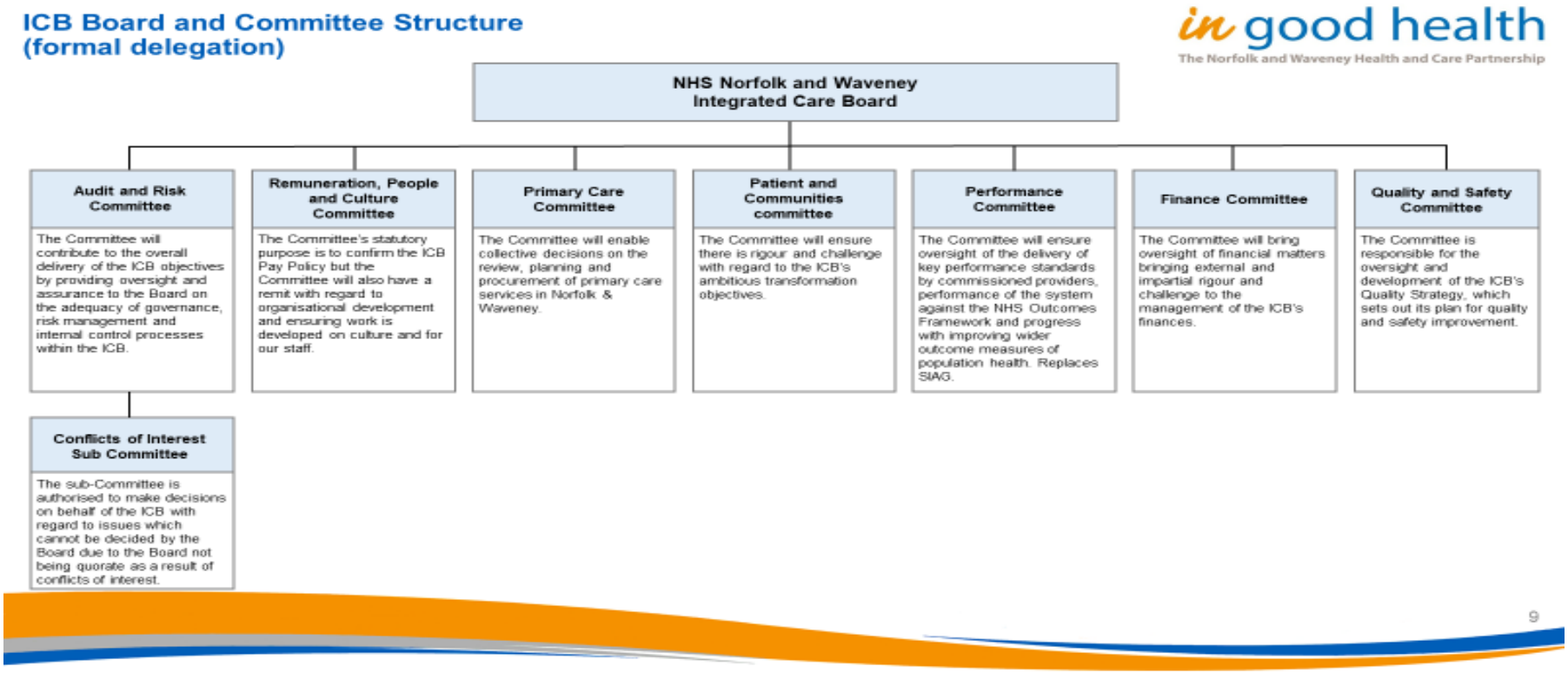
Our Functions and Decisions Map is based on a framework made up of tiered model which allows delegation to different levels. The tiered delegated model can be seen below.

A tiered delegated model

in good health
The Norfolk and Waveney Health and Care Partnership

A tiered delegation model is proposed, that will receive c200 functions from the CCG but will preserve the partnership approach to delivery and improvement and form the basis of a model that can more easily evolve as Place and Provider Collaborative arrangements develop.

Committee structure



SECTION 4
Delegation Agreements

This section sets out the 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.

Delegations under this section are set out in the ICB's Scheme of Reservation and Delegation that can be found in section 5 of this document.

Norfolk and Waveney
Integrated Care Board

SECTION 5

NHS Norfolk and Waveney Integrated Care Board

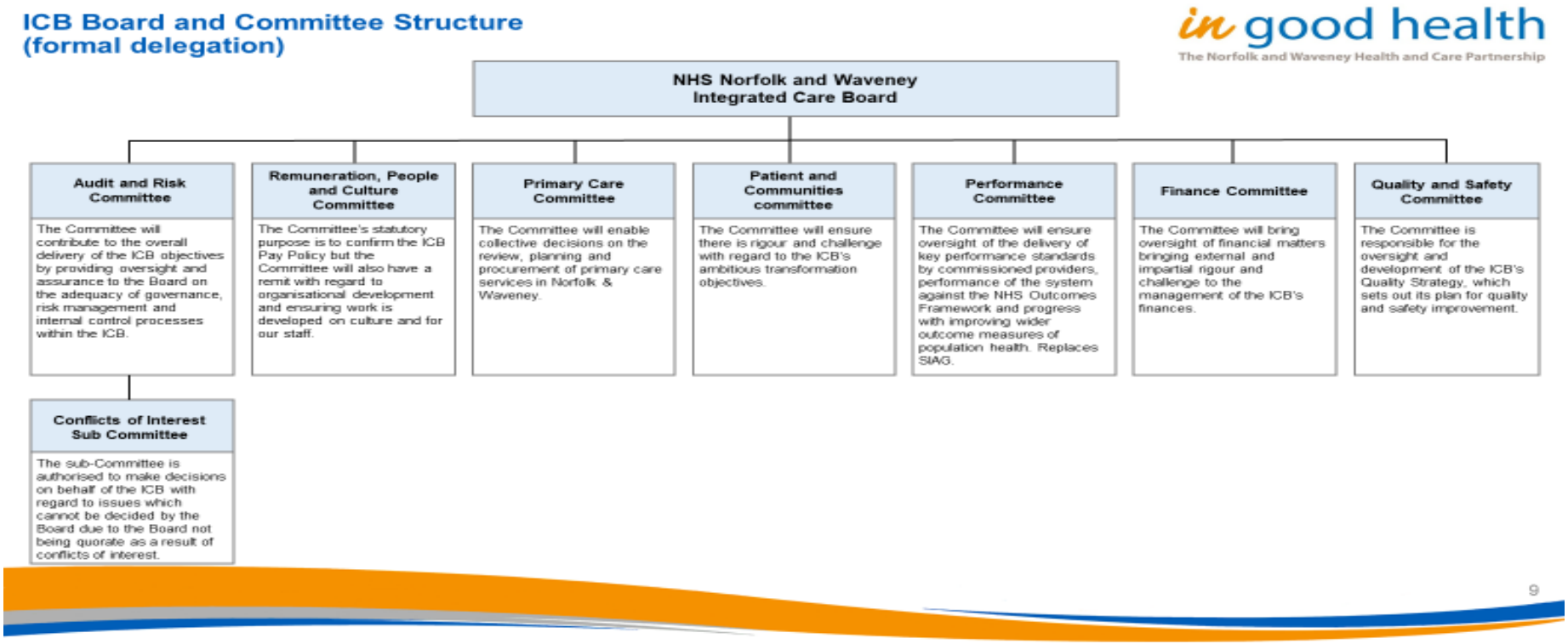
Scheme of Reservation and Delegation (SoRD)

The Scheme of Reservation and Delegation (SoRD) sets out:

- Those functions that are reserved to the Board
- Those functions that have been delegated to an individual or to Committees and Sub-Committees
- Those functions delegated to another body or to be exercised jointly with another body, under section 65Z5 and 65Z6 of the 2006 Act

In line with Section 4.4 of the ICB Constitution, the ICB Board remains accountable for all of its functions, including those that it has delegated. All those with delegated authority are accountable to the Board for the exercise of their delegated functions

This SoRD will be published in full on our website www.improvinglivesnw.org.uk



Decisions and functions reserved to the board

	Decisions and functions reserved to the board	Reference
Annual Report	Approval of the ICB's Annual Report and Accounts	Section 7.4 of the Constitution
Finance	Approval of arrangements for discharging the ICB's statutory financial duties.	
Finance	Approval of variations to the approved budget where variation would have a significant impact on the overall approved levels of income	

	and expenditure of the ICB's ability to achieve its agreed strategic aims.	
Finance	Approval for arrangements for risk sharing and or risk pooling with other organisations (for e.g. pooled funds with other ICBs or pooled budget arrangements under section 75 of the NHS act 2006)	
Remuneration	Remuneration for non-executive members. Any discussions about remuneration for the non-executive members will be held without the non-executive members present	S 3.14 of the Constitution
Scheme of Reservation and Delegation	Approval of the Scheme of Reservation and Delegation including: Decisions that individual employees of the ICB participating in joint arrangements on behalf of the ICB can make. Such delegated decisions must be disclosed in this scheme of reservation and delegation. Approve decisions delegated to joint committee established under section 75 of the 2006 Act.	Section 4.4.2 of the Constitution
IFR	Approval of arrangements for managing exceptional funding requests.	
Corporate	Review of the ICB's governance arrangements to ensure that the ICB continues to reflect the principles of good governance.	
Corporate	Approval on changes to the Constitution (subject to subsequent NHS England approval.)	Section 1.6 of the Constitution
Corporate	Approval of amendments to the Terms of Reference of the Committees of the Board of the Integrated Care Board	Section 4.6.3 of the Constitution
Corporate	Approval of the ICB's Governance Handbook	
Corporate	Approval of the ICB's risk management arrangements	
Corporate	Approving arrangements for handling Freedom of Information requests	s. 1.4.5.f of the Constitution
Audit	Providing assurance of strategic risk	
Audit	Appointment external auditor firm	
Audit	Appointment of internal auditor firm	
Planning	Approval of the Vision and objectives of the ICB	
Planning	Approve consultation arrangements for the ICB's plan	s9 of the Constitution

Planning	Review and approval of the ICB's annual ICB plan	
EPRR	Approve the ICB's arrangements for business continuity and emergency planning.	s1.4.5g of the Constitution
Conflicts of Interest	Ensure that the Register of Interests are reviewed regularly and updated as necessary.	
Duties	Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to promote a comprehensive health service.	
Duties	Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to meet the public sector equality duty.	
Duties	Monitoring of progress of delivery of public sector equality duty.	
Duties	Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to secure public involvement	
Duties	Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to promote awareness of and have regard of the NHS Constitution.	
Duties	Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to act effectively, efficiently, and economically.	
Duties	Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to obtain appropriate advice.	
Duties	Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to promote innovation	
Duties	Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to promote research and the use of research.	
Duties	Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to promote integration.	

Duties	Approve arrangements for co-ordinating the commissioning of services with other ICBs and or with the local authority, where appropriate	

Decisions and functions delegated by the board to ICB committees

Committee	Decisions and functions delegated to the committee	Reference
Audit and Risk Committee	**Standing Orders:** Reporting of non-compliance with the standing Orders of the ICB	Section 3.6 Standing Orders, Constitution
Audit and Risk Committee	**Standing Orders:** Reporting of urgent decisions taken by the Board for review	Section 4.9.6 of the Standing orders, Constitution
Audit and Risk Committee	**Annual report and Accounts:** To ensure that financial systems and governance are established which facilitate compliance with DHSC's Group Accounting Manual.	ToR
Audit and Risk Committee	**Annual report and Accounts:** To review the annual report and financial statements (including accounting policies) before submission to the Board	ToR
Audit and Risk Committee	**Risk and Internal Control:** 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.	ToR
Audit and Risk Committee	**Risk and Internal Control:** To have oversight of system risks where they relate to the achievement of the ICB's objectives.	ToR
Audit and Risk Committee	**Risk and Internal Control:** 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.	ToR

Audit and Risk Committee	**Risk and Internal Control:** To identify opportunities to improve governance, risk management and internal control processes across the ICB.	ToR
Audit and Risk Committee	**Internal Audit:** 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. Recommend appointment of internal auditors.	ToR
Audit and Risk Committee	**External Audit**: 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. The Audit panel will be formed to recommend the appointment of External Auditors.	ToR
Audit and Risk Committee	**Counter Fraud:** Approve the ICB's Counter Fraud and security management arrangements.	ToR
Audit and Risk Committee	**Counter Fraud:** To ensure that the counter fraud service provides appropriate progress reports and that these are scrutinised and challenged where appropriate.	ToR

Audit and Risk Committee	**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.	ToR
Audit and Risk Committee	**Conflicts of Interest**: 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.	ToR
Audit and Risk Committee	**Finance:** To monitor the integrity of the financial statements of the ICB and any formal announcements relating to its financial performance.	ToR
Audit and Risk Committee	**Finance:** To ensure consistency that the ICB acts consistently with the principles and guidance established in HMT's Managing Public Money.	ToR
Audit and Risk Committee	**Finance:** Review of ICB risk sharing or risk pooling arrangements	ToR
Audit and Risk Committee	**Finance:** Approval the ICB's banking arrangements	ToR
Audit and Risk Committee	**IG:** To provide assurance to the Board that there is an effective framework in place for the management of risks associated with information governance.	ToR

Audit and Risk Committee	**IG:** Approval of the arrangements for ensuring the appropriate safekeeping and confidentiality of records and for the storage management and transfer of information and data	ToR
Remuneration, people and culture committee	For the Chief Executive, Members of the Board 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.	s. 8.1.6 of the Constitution
Remuneration, people and culture committee	For the Chief Executive, Members of the Board and other Very Senior Managers -Determine arrangements for termination of employment and other contractual terms and non-contractual terms.	s. 8.1.6 of the Constitution
Remuneration, people and culture committee	Approval of the nominations and appointments process for Board members.	ToR
Remuneration, people and culture committee	Oversight of executive board member performance	ToR
Remuneration, people and culture committee	For all ICB staff -Determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change) including staff on very senior managers grade, including all board members, excluding the Chair and Non-Executive Members.	s. 8.1.6 of the Constitution ToR
Remuneration, people and culture committee	For all ICB Staff- Oversee contractual arrangements.	s. 8.1.6 of the Constitution
Remuneration, people and culture committee	For all ICB Staff -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.	s. 8.1.6 of the Constitution

Remuneration, people and culture committee	For Clinical Advisors- Determine ICB pay policy and oversee contractual arrangements.	s. 8.1.6 of the Constitution
Remuneration, people and culture committee	Oversee the development of an ICB culture and Organisational Development plan, taking into account national People and OD frameworks, and recognising the changing needs of our people to ensure the ICB is best place to work	ToR
Remuneration, people and culture committee	Assurance as to succession planning for the Board.	ToR
Remuneration, people and culture committee	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).	ToR
Remuneration, people and culture committee	Approve human resources policies for employees and for other persons working on behalf of the ICB.	ToR
Remuneration, people and culture committee	Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to promote education and training for persons who are employed or are considering becoming employed in an activity which is connected with the health service.	ToR
Finance committee	To set the strategic financial framework of the ICB and ICS and monitor performance against it.	Terms of Reference
Finance committee	To develop the system financial information systems and processes to be used to make recommendations to the Board on financial planning in line with the strategy and national guidance	Terms of Reference
Finance committee	To work with ICS partners to identify and allocate resources where appropriate to address financial performance, quality and safety	Terms of Reference

	related issues that may arise and to ensure Value for Money in that resource allocation	
Finance committee	To work with ICS partners to consider major investment/disinvestment business cases for material (smaller of 3% of organisational annual expenditure and £5m with a de-minimus level of £1m) service change or efficiency schemes and to agree a process for sign off	Terms of Reference
Finance committee	To articulate the financial position and financial impacts (both short and long-term) to support decision-making	Terms of Reference
Finance committee	To develop a medium- and long-term financial plan, consistent with strategic and operational plans	Terms of Reference
Finance committee	To oversee the management of the system financial target and the ICB's own financial targets	Terms of Reference
Finance committee	To monitor and report to the board overall financial performance against national and local metrics, highlighting areas of concern	Terms of Reference
Finance committee	To monitor and report to the board key service performance which should be taken into account in assessing the financial position	Terms of Reference
Finance committee	To develop the system estates strategy and plan to ensure it properly balances clinical, strategic and affordability drivers (if not covered by separate strategic estates forum)	Terms of Reference
Finance committee	To monitor the system capital programme against the capital envelope and take action to ensure that it is appropriately and completely used	Terms of Reference
Finance committee	To gain assurance that the estates, digital and clinical strategic plans are built into system financial plans and strategy to ensure effective oversight of future prioritisation and capital funding bids	Terms of Reference

Conflicts of Interest Committee	Where decisions are required to be made on behalf of the ICB but cannot due be decided by the Board dues to the Board not being quorate as a result of conflicts of interest decisions are to be taken by the conflicts of interest committee. The committee has authority to act in accordance with this SoRD and its terms of reference.	Terms of Reference
Conflicts of Interest Committee	Responsibility for overseeing the ICB's policies and procedures with regard to conflicts of interest	Terms of Reference
Patients and Communities Committee	Approve the ICB's arrangements for handling complaints.	Terms of Reference
Patients and Communities Committee	Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to have regard to the need to reduce inequalities	Terms of Reference
Patients and Communities Committee	Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to promote the involvement of patients, their carers and representatives in decisions about their healthcare.	Terms of Reference
Patients and Communities Committee	Review and approve arrangements as to the delegations to place boards or place Directors.	Terms of Reference
Quality and Safety Committee	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 put forward the key quality priorities that are included within the ICB strategy/ annual plan, including priorities to address variation/ inequalities in care	Terms of Reference

	• Oversee and monitor delivery of the ICB key statutory requirements	
	• Ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner	Terms of Reference
	• Approve arrangements including supporting policies to minimise clinical risk maximise patient safety and to secure continuous improvement in quality and patient outcomes	Terms of Reference
	• Approval of the arrangements for discharging the CCG's statutory duty associated with its commissioning functions to act with a view to securing continuous improvements to the quality of services.	Terms of Reference
	• 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 DHSC, NHSEI and other regulatory bodies / external agencies (e.g. CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained • Maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation and assure the ICB that these are disseminated and implemented across all sites • 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,	Terms of Reference

	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 PFD report) • To be assured that people drawing on services 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 • Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for equality and diversity as it applies to people drawing on services • Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety. • Receive assurance that the ICB has effective and transparent mechanisms in place to monitor the quality of Children, Maternity and Neonatal care. • Have oversight of and approve the Terms of Reference and work programmes for the groups reporting into the Quality and Safety Committee (e.g., System Quality Group, Infection Prevention and Control, Safeguarding Boards / Hubs etc.).	

Performance Committee	The Committee will ensure oversight of the delivery of key performance standards by commissioned providers, performance of the system against the NHS Outcomes Framework and progress with improving wider outcome measures of population health. The responsibilities and decision making remit will include but not be limited to: a) Evaluation of health services b) Provider resilience and failure c) Performance review and management d) Conduct and lead oversight of both system and commissioned provider performance. e) Hold the system's Groups, Place(s) and Providers to account and provide challenge to the system where this is required to address opportunities to improve performance and outcomes. f) Determine where a Peer Review approach is required to support improvement in the system; overseeing the subsequent review and ensuring the learning is implemented. g) Determine where a 'deep dive' is required on a particular measure and relevant to one or more providers. h) Facilitate targeted national support through the System Improvement Director (SID). i) In line with the SOF and the system's associated SOF segmentation, where relevant, agree with the SID a Service Improvement Plan (SIP). j) Direct improvement resources when required in the system, including defining the parameters of any new improvement plans, peer review of existing plans where expected outcomes are not delivered and coordinating with regulators where formal improvement or intervention support is required.	

	k) Approve the KPIs and outcome metrics for use across the system. l) Agree the scope and approve the development plan for the system's Integrated Performance Report (IPR) for use at System, Place and Provider level. m) Negotiate any metrics or improvement trajectories with NHSE/I, relevant to SOF segmentation as may be required from time to time. n) Support innovation and best practice to be consistently adopted across the system. **o)** Ensure the system is optimally using benchmarking data for performance improvement. p) Work jointly with NHSE/I to lead the oversight of place-based arrangements and individual organisations in line with SOF principles. q) Agree and coordinate any support and intervention carried out by NHSE/I, other than in exceptional circumstances. r) Participate in any place-based system, functional or organisational support and intervention carried out by NHSE/I. s) Create robust cross-organisational arrangements to tackle the systemic challenges that the health and care system is facing. t) Act as a leadership cohort, demonstrating what can be achieved with strong local leadership, operating with increased freedoms and flexibilities	
Primary Care Commissioning Committee	Decisions in relation to the commissioning, procurement and management of Primary Medical Services Contracts and other	Terms of Reference

	primary medical care services under other appropriate contracting arrangements, including but not limited to the following activities: a. decisions in relation to the commissioning, procurement and management of Primary Medical Services Contracts and other primary medical care services under other appropriate contracting arrangements, including but not limited to the following activities: I. decisions in relation to Enhanced Services, including in relation to the PCN Network DES; II. decisions in relation to Local Incentive Schemes (including the design of such schemes); III. decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices; b. decisions about 'discretionary' payments; c. decisions about commissioning urgent care (including home visits as required) for out of area registered patients; d. the approval of practice mergers; e. planning primary medical care services in the Area, including carrying out needs assessments; f. review reports of primary medical care services in the Area; g. decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list); h. management of the Delegated Funds in the Area;	

	i. Premises Costs Directions functions; j. co-ordinating a common approach to the commissioning of primary care services with other commissioners in the Area where appropriate; k. such other ancillary activities as are necessary in order to exercise the Delegated Functions; l. approval of the investment of PMS Monies. m. review, redesign and decommissioning of existing Local Enhanced Services; n. review and design of primary care dashboard; and o. review and monitoring of the primary care risk register; p. Approve arrangements for shared care commissioning	
Integrated Partnership Committee (ICP) statutory joint committee of ICB and Norfolk and Suffolk County Councils	Production and approval of an integrated care strategy for Norfolk and Waveney	Statutory

Decisions and functions delegated to be exercised jointly

Committee/entity that will exercise the function/decision	Decisions and functions delegated to the committee	Legal power	Governing arrangements

Norfolk County Council	Children, Adolescent Mental health Services- specifically commissioning for the integrated delivery of Tier 3 plus integrated education and healthcare solution for children aged 5-14 who have severe and challenging behaviour problems. Pooled fund.	Section 75	Section 75 Agreement dated 1 April 2016 made between NCC (1) and the CCGs of Norfolk and Waveney (2)
Norfolk County Council	Commissioning of a provider for mediation and dispute resolution services as required by Sections 52-57 of the Children and Families Act 2014	Section 75	Section 75 Agreement dated 8 June 2021

Decisions and functions delegated by the board to other statutory bodies

Body		Legal power	Governing arrangements
Norfolk County Council	Integrated Speech and Language Service for Children and Young People aged 0-19 Years	Section 75	Section 75 dated 3 March 2021

Decisions and functions delegated by the board to individual board members and employees

Individual board member or employee	Decisions and functions delegated to the individual	Reference
Chief executive	**General:** Exercise or delegation of those functions of the clinical commissioning group	

	which have not been retained as reserved by the group, delegated to the Governing Body or other committee or sub-committee or a specified member or employee	
	HR: Approval of the arrangements of for discharging the ICBs statutory duties as an employer.	
	Finance: Approval of a comprehensive system of internal control, including budgetary control that underpins effective, efficient, and economic operation of the ICB via delegated limits set out in the financial limits.	
	Finance: Approval of the ICB's corporate budgets that meet the financial duties	
	Finance: Lead responsibility for discharge of the ICB's statutory duty associated with its commissioning functions to act effectively, efficiently, and economically.	
	Finance: Approve the ICB's Financial Limits	
	Corporate: Approve proposals for action on litigation against or on behalf of the ICB.	
	Corporate: Prepare and recommend a scheme of reservation and delegation that sets out who has responsibility for operational decisions within the ICB.	
	Corporate: Prepare the ICB's Governance Handbook	
	Corporate: Exercise the powers that the Board has reserved to itself in an emergency or for an urgent decision along with the Chair.	
	Corporate: Determining arrangements for handling Freedom of Information requests	

	Strategic: Leading of the vision and objectives of the ICB	
	CSU: Approval of any contracts for commissioning or decommissioning commissioning or corporate support services to the ICB.	
Director of People	Responsibility to oversee the discharge of public sector equality duty	
Director of Finance	Prepare the ICB's Financial Limits	
	Oversee and Manage each contract on behalf of the ICB.	
	Approval of all budget movement actions between service areas subsequent to formal approval of the financial plan as delegated from the Board (with reporting to the Finance Committee as necessary.)	
Director of Nursing	ICB Executive Lead for Safeguarding for Adults and Children	
	ICB Executive Lead for Children and Young People (including Looked After Children)	
	ICB Executive Lead for Special Educational Needs and Disability ("SEND")	
	ICB Executive Lead for Infection, Prevention and Control (IPC)	
Director of Performance Transformation and Strategy	Production of the ICB's Plan.	
Chair	Exercise the powers that the Board has reserved to itself in an emergency or for an	

	urgent decision along with the Chief Executive.	
Conflict of Interest Guardian	a) Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest; b) Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest; c) Support the rigorous application of conflict of interest principles and policies; d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation; e) Provide advice on minimising the risks of conflicts of interest.	**6.1.6 of the Constitution**

Decisions and functions delegated to the board by other organisations

Body making the delegation	Decisions and functions delegated to the individual	Reference
NHS England	**Primary medical care commissioning**	

SECTION 6
Model Standing Financial Instructions v1.2

Revision History

Document Control Sheet

Revision Date	Summary of changes	Author(s)	Version Number
14/06/2022	Inserted Model Standing SFIs Template v1.2	AB	

Approvals
This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number

Document Control Sheet

Policy title	Standing Financial Instructions
Policy area	This Policy has been prepared and reviewed by the Corporate Affairs team.
Who is it aimed at and which settings?	
Approved by	
Effective date	
Review date	Annually

Integrated Care Board Model Standing Financial Instructions Template V1.2

Version 1.3, 30 May 2022

NHS England may update or supplement this document. Elements of this guidance are subject to change We also welcome feedback from system and stakeholders to help us continually improve our guidance and learn from implementation. The latest versions of all NHS England guidance relating to the development of ICSs can be found at ICS Guidance.

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, the government has set out plans to put ICSs on a statutory footing.

To support this transition, NHS England is 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

Purpose and statutory framework

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.

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.

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.

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.

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

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

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.

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.

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.

Scope

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.

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.

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

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.

Roles and Responsibilities

Staff

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

Accountable Officer

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.

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

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)
- meeting the financial targets set by NHS England;

- use of incidental powers such as management of ICB assets, entering commercial agreements;
- ensuring the Governance statement and annual accounts & reports are signed;
- ensuring 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.

Audit and risk assurance committee

The board and accountable officer should be supported by an audit and risk assurance 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.

Management accounting and business management

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

The chief financial officer will delegate the budgetary control responsibilities to budget holders through a formal documented process.

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.

In addition, the chief financial officer should have financial leadership responsibility for the following statutory duties:

- the duty of the ICB to perform its functions as to ensure that its expenditure does not exceed the aggregate of its allotment from NHS England and its other income; and
- the duty of the ICB, in conjunction with its partner trusts, to seek to achieve any joint financial objectives set by NHS England for the ICB and its partner trusts.

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.

Income, banking arrangements and debt recovery

Income

An ICB has power to do anything specified in section 7(2) of the Health and Medicines Act 1988 for the purpose of making additional income available for improving the health service.

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 existing Shared Services provider; and

- ensuring the debt management strategy reflects the debt management objectives of the ICB and the prevailing risks;

Banking

The CFO is responsible for ensuring the ICB complies with any directions issued by the Secretary of State with regards to the use of specified banking facilities for any specified purposes.

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.

Debt management

The chief financial officer is responsible for the ICB debt management strategy.

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.

Financial systems and processes

Provision of finance systems

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.

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.

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.

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 finance officer shall periodically seek assurances that adequate controls are in operation.

Procurement and purchasing

Principles

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.

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.

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

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

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.

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.

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.

Undertake any contract variations or extensions in accordance with PCR 2015 and the ICB procurement policy.

Retrospective expenditure approval should not be encouraged. 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.

Staff costs and staff related non pay expenditure

Chief People Officer

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.

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.

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

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

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

Annual reporting and Accounts

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;

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.

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

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.

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.

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.

Losses and special payments

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.

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.

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.

ICBs will work with NHS England teams to ensure there is assurance over all exit packages which may include special severance payments. ICBs have no delegated authority for special severance payments and will refer to the guidance on that to obtain the approval of such payments

All losses and special payments (including special severance payments) must be reported to the ICB Audit and Risk Assurance Committee.

For detailed operational guidance on losses and special payments, please refer to the ICB losses and special payment guide which includes delegated limits.

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 and Risk Assurance 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 .

Capital Investments & security of assets and Grants

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.

Capital commitments typically cover land, buildings, equipment, capital grants to third parties and IT, including:

- authority to spend capital or make a capital grant; and
- authority to enter into leasing arrangements.

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.

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

ICBs shall have a defined and established property governance and management framework, which should:

- ensure the ICB asset portfolio supports its business objectives; and
- complies with NHS England policies and directives and with this guidance

Disposals of surplus assets should be made in accordance with published guidance and should be supported by a business case which should contain an appraisal of the options and benefits of the disposal in the context of the wider public sector and to secure value for money.

Grants

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.

All revenue grant applications should be regarded as competed as a default position, unless, there are justifiable reasons why the classification should be amended to non-competed.

Legal and insurance

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 ICB revenue resources in relation to settling legal matters.

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.

SECTION 7

Our approach to working with people and communities in Norfolk & Waveney

V9 July 2022

Version control	Date	Author	Status	Comments
V1	March 2022	Rebecca Champion	Draft	Initial draft shared with evidence pack to NHSEI
V5	April 2022	Rebecca Champion	Draft	Draft shared with system partners for comment
V7	19 May 2022	Rebecca Champion	Draft	Submitted to system oversight group for comment
V8	27 May	Rebecca Champion	Working Draft	Submitted to NHSEI
V8	8 June – 18 July 2022	Rebecca Champion	Working Draft	Draft shared with public and stakeholders for comment including easy read summary version
V9	23 June 2022	Rebecca Champion	Working Draft	Draft updated to reflect changes to names and structures for inclusion in the governance handbook

This is a working draft which describes an approach to working with people and communities in Norfolk and Waveney. This document and the design of the approach are still under development as local discussions continue, as it is recognised that this approach will take time to fully develop and embed. A version of this document is being shared with NHS England as a working draft on 27 May 2022 as part of the strategic assurance around working with people and communities.

Key Definitions:

Integrated Care System (ICS) - new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.

Integrated Care Board (ICB) - an organisation with responsibility for NHS functions and budgets. Membership of the board includes 'partner' members drawn from local authorities, NHS trusts/foundation trusts and primary care

Clinical Commissioning Group (CCG) – NHS bodies that will be replaced by ICBs on 1st July 2022.

Integrated Care Partnership (ICP) - a statutory committee bringing together all system partners to produce a health and care strategy. Representatives include voluntary, community and social enterprise (VCSE) organisations and health and care organisations, and representatives from the ICB board.

Health and Wellbeing Partnerships (HWP) - are local place-based partnerships work on addressing the wider determinants of health, reducing health inequalities and aligning NHS and local government services and commissioning.

Lived experience - knowledge gained by people as they live their lives, through direct involvement with everyday events. It is also the impact that social issues can have on people, such as experiences of being ill, accessing care, living with debt etc.

More definitions are included in the glossary.

Norfolk and Waveney Integrated Care System

What is integrated care?

NHS + + =

Integrated care involves partnerships between the NHS, local authority, and VCSE sector as they come together to plan and deliver joined up health and care services to improve the lives of people in their area.

Our mission

To help the people of Norfolk and Waveney live longer, healthier, and happier lives.

Our goals

1. To make sure that people can live as healthy a life as possible.
2. To make sure that you only have to tell your story once.
3. To make Norfolk and Waveney the best place to work in health and care.

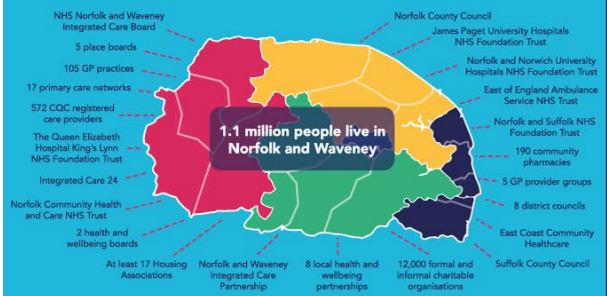
Our ICS includes:

- 17 Primary Care Networks
- NHS Provider Collaboratives
- Place-based partnerships
- Integrated Care Board
- Integrated Care Partnership
- Local health and wellbeing partnerships

We will work to:

- Improve outcomes in population health and healthcare.
- Tackle inequalities in outcomes, experience and access.
- Enhance productivity and value for money
- Support broader social and economic development.

Our geographical area:



Summary – What is this document saying?

People with lived experience tell their story once and it is heard across the ICS

New partnerships are being created to help everyone involved in supporting health and care work together better. Listening to the lived experience of the people and communities in Norfolk and Waveney is vital in helping people live longer, healthier and happier lives. It also helps us make sure that the care and support offered in Norfolk and Waveney is designed around our population.

All the partners in our ICS are talking and listening to people & communities every day. Our vision is that people would tell their story of lived experience once and it's heard by everyone in the ICS. We want to develop on-going relationships with communities to learn what matters to them, and work together to address waiting times, improve access to services and support people to live the healthiest life possible.

We want to build on the existing engagement and insight that happens across all our system partners and find ways of working together to share and learn from this insight. Working together will also mean we can pool our resources and work more efficiently across the ICS.

We learnt during the COVID-19 pandemic that we need to get better at listening to what really matters to our people and communities, especially if we are going to address health inequalities. A really effective way to do that is to use trusted communicators, people who are part of the local community – 'people like me'. A good way to do that is by working with Voluntary, Community & Social Enterprise (VCSE) organisations who already have long standing relationships and networks throughout Norfolk and Waveney.

We recognise that to do all this we will need to use good quality, innovative communications, that are accessible for everyone and available in a range of formats. Whilst we see the value of offering lots of digital opportunities in a large rural area like Norfolk and Waveney, we are also aware that not everyone has a good mobile signal or access to broadband connections and that some people just are not able to access information online. We will all use a range of methods of going out to our people and communities so we can move forward as an ICS together. See Appendix 2.

As of 1 July 2022, NHS Norfolk & Waveney ICB will oversee and work with ICS partners to make sure that we constantly listen to and engage with people and communities – as one whole system. That is why this document sometimes refers to structures and processes in the ICB. Our glossary at the end of this document is designed to help with the new terms and language used.

We hope you enjoy reading about our approach to working with people and communities in Norfolk and Waveney!

Introduction

Integrated Care Systems (ICSs) are new partnerships between the organisations that meet health and care needs across an area. These partnerships will help to coordinate services and to plan in a way that improves the health of people and communities and reduces inequalities between different groups.

The purpose of this document is to outline the strategic approach being undertaken in Norfolk and Waveney ICS to working with people and communities, to enable us to achieve the ambition laid out in the guidance that:

"an integrated care system (ICS) should agree how to listen consistently to, and collectively act on, the experience and aspirations of local people and communities. This includes supporting people to sustain and improve their health and wellbeing, as well as involving people and communities in developing plans and priorities, and continually improving services."

This strategic approach will follow the recommendations of the NHS Confederation in 'Building Common Purpose'. It will give us a way of working with all our partners to ensure that how we work with people and communities, how we respond to their views and experiences, and how we identify and share the impact of what we learn, are aligned.

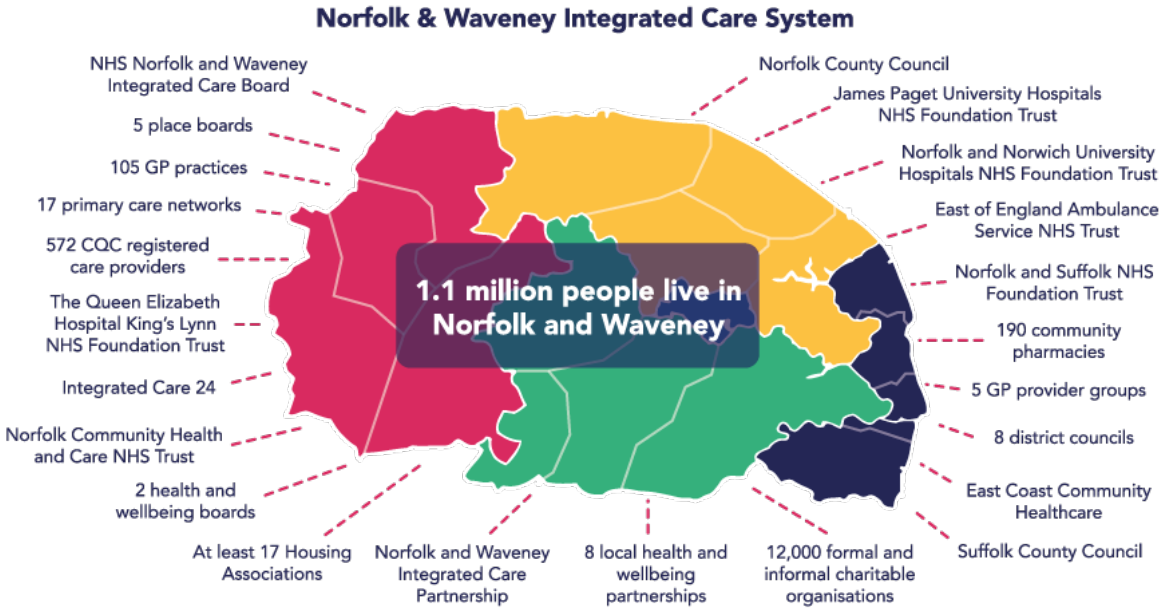
Building on learning during the COVID-19 pandemic, our vision is to improve our collective ability to listen to what people are saying across Norfolk and Waveney about what matters to them. We can do this by going out to the communities we serve, and by building on existing community engagement assets among our ICS partners including the VCSE sector. Feedback and insight can be joined up across ICS partners and channelled into decision making structures, so that insight shared in one part of the ICS is gathered and heard by other partners across the system.

Some aspects of the approach described in this document already exist, some are under development and others are still at an early, visionary stage. It will be made clear how far each area is developed. We are taking an evolving approach which is being designed together, with ICS partners and with the people and communities we serve.

A mapping exercise has begun to understand how our partners hear the voice of the populations they serve, and to look for opportunities to develop this into a systemwide approach. It will take time to fully achieve the vision - it's a huge task –but we are starting from a good place as there's lots of good work and enthusiasm in Norfolk and Waveney already. The COVID-19 pandemic has strengthened existing relationships and helped us forge new ones, so we work together to consistently give our people and communities a voice across the ICS.

Our ICS

The Norfolk and Waveney Integrated Care System is made-up of a wide range of partner organisations, working together to help people lead longer, healthier and happier lives. From 1 July 2022, our Integrated Care System will include the following organisations:



Appendix 1 has a more detailed overview of our population.

Over and above everything else we want to achieve; we've set ourselves three goals:

1. To make sure that people can live as healthy a life as possible.
This means preventing avoidable illness and tackling the root causes of poor health. We know the health and wellbeing of people living in some parts of Norfolk and Waveney is significantly poorer – how healthy you are should not depend on where you live. This is something we must change.

2. To make sure that you only have to tell your story once.
Too often people have to explain to different health and care professionals what has happened in their lives, why they need help, the health conditions they have and which medication they are on. Services have to work better together.

3. To make Norfolk & Waveney the best place to work in health & care.
Having the best staff, and supporting them to work well together, will improve the working lives of our staff, and mean people get high quality, personalised and compassionate care.

Like all Integrated Care Systems in England, we will work to:

- 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.

Aims and principles

The overarching vision for working with people and communities in Norfolk and Waveney is that all ICS partners will consistently collaborate to share insight and learning. This will maximise resources and ensure that the voice of local people, especially from inclusion groups, is shared as widely as possible.

We will work towards the following 10 principles from national ICS guidance when working with people and communities at neighbourhood, place and system level. These will be tested with local people as this approach develops and adapted to reflect local aspirations as needed. They will also reflect the 'I' statements 'Living the life I want' adopted by Norfolk County Council, with the support of all District and Borough Council's, system partners and Suffolk County Council:

1. **Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.**
    - **We have** appointed a Director of Patients and Communities to oversee the all the work with our people and communities. A Patient and Communities Committee is included in the ICB structure (see page 24)
    - **We will** work to align communications & engagement resources at place level to co-produce shared plans, and continue to develop the ICB structures to ensure voice of people and communities reflected at all tiers
2. **Start engagement early when developing plans and feed back to people and communities how their engagement has influenced activities and decisions.**
    - **We have** created a systemwide communications & engagement group to work together as a system wherever possible in planning and feeding back
    - **We will** co-produce a joint set of principles for use by all partners across the ICS to underline the importance of working with people and communities as early as possible in developing plans and feeding back the difference this has made.
3. **Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.**
    - **We have** developed population health management and data review processes in partnership across the system for example Protect NoW (see page 13)
    - **We will** develop the insight bank to systematically record qualitative data collected by system partners to build a 3-dimensional picture of lived experience and improve our ability to listen to informal feedback for example by using social media monitoring tools.
4. **Build relationships with excluded groups, especially those affected by inequalities.**
    - **We have** made strong links with the Health Inclusion Group (see page 13) about how they can support this approach to working with people and communities
    - **We will** look for specific opportunities to develop better relationships with specific communities with quieter voices, for example working with a prison healthcare provider to look ay how the voices of people in/leaving prison can be embedded across the ICS (see page 13)
5. **Work with Healthwatch and the voluntary, community and social enterprise (VCSE) sector as key partners.**
    - **We have** already developed good working relationships with Healthwatch Norfolk and Healthwatch Suffolk (see page 25), and with VCSE partners in the Norfolk & Waveney Community Voices Project (see page 12)

- **We will** continue to build relationships with the VCSE Assembly and with VCSE partners at Place Board in working with people and communities

6. **Provide clear and accessible public information about vision, plans and progress, to build understanding and trust.**
   - **We are** working on a new website for the ICS which will go live on July 1st 2022, and will include accessible information available in a range of formats. It will also host the people and communities engagement hub (see page 20) and will contain information about the ICS plans and visions using a range of innovative and accessible formats. We are also aware that many people do not access information online and we will work with our partners to use every available network to reach our population. Much of this will build on partnership work during the COVID-19 pandemic, such as the Great Yarmouth Community Champions (see page 14) and working with our local library service.
7. **Use community development approaches that empower people and communities, making connections to social action.**
   - **We have** learnt a great deal from the COVID-19 pandemic which has led to the Norfolk & Waveney Community Voices Project (see page 12)
   - **We will** build on the relationships work with our district councils and system partners to empower our people and communities using community development approaches
8. **Use co-production, insight, and engagement to achieve accountable health and care services.**
   - **We have** many examples of good practice in working with experts by experience within Norfolk wand Waveney (see page 13)
   - **We will** work towards an ICS model of co-production using a set of co-produced principles and standards, building on & learning from examples of best practice currently operating within the system
9. **Co-produce and redesign services and tackle system priorities in partnership with people and communities.**
   - **We have** worked with system partners on a carers co-production project to tackle issues for informal unpaid carers around discharge from hospital settings and to promote personalisation and carer awareness training (see page 9)
   - **We will** use this approach to tackle other system priorities including urgent and emergency care
10. **Learn from what works and build on the assets of all ICS partners – networks, relationships, activity in local places.**
    - **We have** based our entire approach to working with people and communities on this principle as we are aware that all our system partners listen to and gather insight from the people they support everyday
    - **We will** continue to look for different digital and non-digital ways to develop this idea

Progress and challenges to date working with people and communities

The Norfolk and Waveney system has made considerable **progress** to date in working with people and communities:

Establishment of a Norfolk and Waveney ICS Communications and Engagement (ICS C&E) group in September 2021, made up of representatives from Norfolk and Suffolk - 8 NHS provider trusts, 2 county councils, 2 Healthwatch's, 8 district councils, Norfolk Police, 2 Chambers of Commerce, Out of Hours/111 provider, Active Norfolk, Norfolk Older People's Strategic Partnership, 4 VCSE organisations, representatives from housing associations.
Establishment of a People & Communities Task & Finish Group made up with representatives from the wider ICS C&E group to oversee the design of this shared approach
Begun a systemwide mapping exercise to understand how insight and feedback is gathered, stored and acted on among all ICS partners
Starting the development of an 'Insight Bank' through the Norfolk and Waveney Community Voices Project pilot which includes recording qualitative feedback gathered by community connectors. The aim to offer the 'bank' as a system wide resource
Joint projects underway with NHS trusts designed to improve working with people and communities in health services e.g. carers co-production project to promote personalisation, and to embed carers awareness training and a carers passport for use initially in hospital settings. This partnership of NHS patient experience and engagement leads are also planning a programme of training and support to promote Patient Leadership
Collaborative working with the children and young people's system - Children and Young People Strategic Alliance (CYPSA). CYPSA are working together to deliver the shared ambition that 'Norfolk is a county where all children and young people can Flourish', and the associated Flourish outcomes framework, which places emphasis on health and wellbeing and the voice of children, young people and their families. This is particularly being progressed through the Stakeholder Engagement & Insight CYPSA subgroup, which seeks to improve quality and collaboration around engagement and insight activity across the children and young people system. Similar opportunities are being investigated for the Waveney area of Suffolk
Embedding Equality Impact Assessments (EIAs) within the work of the CCG to ensure a range of protected characteristics are given due consideration in service transformation across the ICS and to underpin working with people and communities
Aligning people and communities work with Norfolk and Suffolk County Councils. Progress has already been made e.g. aligning similar work in Norfolk Children's Services, building on excellent working relationships with Public Health Norfolk and Norfolk and Waveney Health Overview and Scrutiny Committee (HOSC). Also developing links with the Norfolk and Waveney Integrated Care Partnership (ICP) and planning joint work on shared principles for working with people & communities
Improving joint working with District Councils and Housing Associations to make systemwide links with community and tenant engagement

Ensuring that people and communities work is represented on Norfolk and Waveney Health Inclusion Working Groups
Supporting the Local Maternity and Neonatal System (LMNS) to work in a joined up way with the **Maternity Voices Partnerships (MVPs)** to hear insight from pregnant people and young families in Norfolk and Waveney.

Despite all the progress made so far **challenges** do still exist in the system for working with people and communities:

The size and complexity of the system offers many opportunities to hear the voice of people and communities but is also a huge challenge to map and understand effectively
Implementing new ways of working during times of great pressure on the system means staff are struggling to cope with existing demand as well as develop new partnerships
Demand is driving change so fast making it much harder to work with people and communities effectively
Making the necessary connections with all the different ICS partners particularly finding members of staff with an insight role
Lack of skills and contacts in working effectively and consistently with specific communities of interest despite progress during the COVID-19 pandemic e.g. very vulnerable groups, areas of deprivation, young people
Having all the right skills and resources to effectively join up all the insight from people and communities
Developing the people and communities approach during a time of **diminishing volunteers**

Despite these challenges, the ICS will continue to work together in a coordinated way to identify options and solutions to constantly improve our work with people and communities across Norfolk and Waveney to help people live longer, healthier and happier lives.

Case Study – how working as a system helped Norfolk & Waveney roll-out a nationally recognised COVID-19 vaccination programme

Norfolk and Waveney has received regional and national recognition for its performance during the COVID-19 vaccination programme roll out, and regularly featured in the top five performing health and care systems in England. Despite the challenges of rurality, an older population age profile (often less able to travel) and the constraints of transporting the vaccine safely between widespread sites, Norfolk and Waveney has some of the highest vaccine uptake figures in the country.

The success of the ongoing vaccination programme is underpinned by continued support from colleagues across the system - in general practice, district and borough council neighbourhood teams, Norfolk Constabulary (site security) and Norfolk County Council (Public Health, social care, commissioner of care providers and highway authority) and our NHS provider partners, as well as crucial support from the VCSE sector and a staggering number of volunteers from communities across Norfolk and Waveney.

Partnership working gave everyone involved clear oversight of the latest Public Health uptake data related to age, ethnicity and geographical location, which gave crucial insight for planning of site locations, pop up clinics and roving models.

Identifying gaps in provision early meant we could adapt and tailor our delivery model and hesitancy campaigns to address demand, improve access and address inequality. We have also partnered with community and voluntary sector organisations on a range of inclusion initiatives including the provision of respite care and transport to enable carers to access a vaccine, and proactive in-reach into specific communities most adversely impacted by health inequality or least likely to access services.

Work is now underway to apply this flexible model of working in partnership beyond covid vaccinations to include screening, health services and targeted public health initiatives as key enablers to reducing health inequalities.

Listening to ‘Quieter Voices’ in Norfolk & Waveney - How we think working with people and communities can tackle health inequalities

Norfolk and Waveney ICS is working to draw together the various sources of data available within the system. This will drive much of the ICS activity and will go a long way towards identifying need. Through working with people and communities we want to use the people’s voice to test and assure the data is reflecting what matters to local people. This will enable us to move beyond information about ‘treatment’ & ‘services’ to hear people’s whole lived experience. The following are examples of how the ICS has already developed new ways of addressing health inequalities that are built around insight from local people:

Norfolk and Waveney Community Voices (NWCV) Project – Norfolk and Waveney has many different communities of interest often living alongside and merging with each other. This can make talking and listening to the different people very challenging. We are aware that although they still provide useful insight, the more traditional methods of engaging tend to have a 'response bias' where it is more likely you will hear from people if they are better educated, older, wealthier and white British.

During the COVID-19 pandemic we learnt that to reach people who are less likely to engage with us we had to use trusted communicators at very local levels, often street by street or village by village. We learnt we have to focus on the hardest to hear, underserved and more vulnerable groups and actively go to them to find out what their priorities are.

Building on the success of the Great Yarmouth Community Champions, Norfolk and Waveney is developing the Community Voices Project to work at district council level, using data and local insight to target conversations with local people. A network of community champions and connectors will take conversations out into the community to promote health messages and learn about what matters to people in relation to their wellbeing. We expect to hear about the challenges faced by local people in accessing services, and about the issues that prevent wellbeing across a range of factors, including those outside the direct health sphere such as housing, employment and finances.

Norfolk and Waveney Insight Bank – We are carrying out a trial of an 'insight bank' where all the qualitative data we collect as part of the NWCV project can be stored. It will provide anonymised information useful for all ICS partners giving insight on a street, neighbourhood, place and system level which will be useful for health and care planning and other services too.

An early version has been developed and community champions will be trained to use it. We are also going to source more robust and sustainable software to develop it further and make it a hub for many local resources.

Working with people and communities at 'place'- level - how all the different voices of our people & communities can be part of local decision-making - The vision is to create a thriving environment for conversations with our people & communities using a spectrum of opportunities. Conversations about 'the place where I live' are often much richer.

By joining up and sharing insight gathered across the system we can hear the voice of people from all over the ICS alongside data on Place Boards. We have the opportunity to use new sources of insight from different ICS partners, with the ambition to develop a platform(s) to enable the insight to be searchable by themes, postcode etc.

The pandemic helped all partners across Norfolk and Waveney better reach out to and hear from our more vulnerable, marginalized, underserved communities, who are better reached at place and neighbourhood level. This is especially the case if the conversations are facilitated by trusted intermediaries as referenced in the NWCV project above.

Communications and engagement resources from across the ICS could be brought together to ensure the right people and communities are working in partnership on the 'place shared plan' for improving local health and wellbeing.

Protect NoW - The ProtectNoW programme of work uses data-led, population health management approaches and comprises a growing number of distinct projects, each focused on a common cause of mental and/or physical ill health. It uses behavioural and Public Health insight to establish specific population needs and develop effective interventions through co-production with clinicians, system partners, wider stakeholders, patients and service-users.

Norfolk and Waveney Health Inclusion Group – is a multi-agency group that builds on partnership working during the COVID-19 pandemic and includes many ICS partners outside the NHS. Professionals from statutory and VCSE organisations come together to hear the voice of and understand the needs of vulnerable and health inclusion groups, and align services accordingly. This group would offer grassroots support to work with health inclusion groups to understand what matters to them as part of the people and communities work in Norfolk and Waveney.

Equality Impact Assessments (EIAs) – we will continue to support the production of EIAs for projects and transformation within the engagement function of NHS Norfolk & Waveney Integrated Care Board (ICB). These have been recognised as key to reference that due thought has been given to protected characteristics and communities of interest, and also to highlight areas where the voice of people and communities is missing.

Listening to the voice of people in or leaving prison - it's important that we recognise that the population of Norfolk and Waveney includes a significant number of prisoners. These are vulnerable people who have very little control over how their health appointments are managed outside of the prison. They experience inequality related to prison transfers which can disrupt planned care, they cannot control when or where their appointments take place, their appointment always depends on the prison being able to provide escort staff and so are regularly cancelled causing delays, and appointments are often not confidential due to escort staff having to be present. Accessing care and support outside the prison is a really different and difficult experience for them, so it is important that we find a way for their voice to be heard in a meaningful way.

Experts by experience - Norfolk and Waveney already has a wealth of good practice to build on in working with our communities of interest and people with quieter voices. The Norfolk Strategic Housing Partnership has a co-production alliance which works with people with lived experience of homelessness to influence change. The Domestic Abuse Partnership Board are working on a co-production 'framework' for the commissioning of domestic abuse services to encourage nurturing conversations, without expectation or judgement, and as a tool to empower those using it. Listening to the voice of lived experience is key to delivering the Support in Safe Accommodation strategy. Norfolk and Suffolk NHS Foundation Trust has an embedded approach to participation making sure everyone can have a say in how their care is delivered and how that could be improved.

Rethink Mental Illness – Norfolk and Waveney has a substantial and unique approach to ensuring that mental health transformation is informed as a system by lived experience. Rethink Mental Illness is the charity for people severely affected by mental illness.

The Norfolk and Waveney Health and Care Partnership commissioned Rethink's co-production team to bring the views, skills and experience of people living with mental health needs and carers together with those of people whose jobs are to plan and deliver services - so they can work together. Experts by experience have been recruited to various steering and reference groups to work alongside the programme. Paid Experts by Experience are now also sitting on the Norfolk and Waveney Mental Health Partnership Board, working closely with the Mental Health Trust CEO and the Executive Director of Adult Social Services in the delivery of the programme.

Learning from the COVID-19 pandemic - The recent COVID-19 pandemic drove the need for the system to work together in unprecedented ways, and we have gained a lot of very useful insight which we can build on for working with people and communities going forward.

We found our assumptions about people's views are not always correct, and we need to test our ideas and the language we use. For example, we gathered insight around vaccine hesitancy from the following groups to help inform our messaging and campaigns:

- under-18s
- adults under 30
- migrant workers
- adults with autism/LD and their carers
- pregnant people

We also learned a lot about how messages and information travels around different communities, and how important it is that people can identify and trust the person who delivers those messages. We worked more closely with our system partners who work at grassroots level, such as Healthwatch and our VCSE colleagues to establish new ways of listening to the people and communities they work with through trusted communicators.

Working with the Great Yarmouth Community Champions really helped us understand the needs of underserved communities and those who traditionally have not come forward to share their thoughts and experiences about accessing services. We also learnt that we needed to go to them rather than asking them to come to us. Our very successful roving health model for delivering vaccines also gave us the opportunity to hear from different communities and gave us a blueprint for continuing to deliver services and messages in this way in the future.

Case Studies - Making A Difference - Great Yarmouth Community Champions

Great Yarmouth Community Champion **Ana** shared her 'I've Had Mine' poster in Portuguese in an online Portuguese community chat site. Local residents from that community fed back that they had decided to take up the vaccination offer after seeing her advocating for it.

Brigitta, a Lithuanian Community Champion reached out to local Ukrainian residents to help any refugees or guests link to local services and feel at ease in the community. Following a post on Facebook four local Ukrainian families came forward to offer help and support to refugees accessing local shops and churches and helping families with forming new friendships.

Learning through doing – Another opportunity to learn about working with vulnerable and underserved people and communities came in early 2021 when NHS Charities Together (NHSCT) made funding available to the Norfolk and Waveney system to create mutually beneficial partnerships between the NHS and the VCSE sector, to support those communities most impacted by COVID-19. This provided a unique opportunity to develop new ways of working between health and social care and the voluntary sector, and ultimately to move away from the transactional relationships between 'commissioner and provider' to a much more collaborative and integrated approach.

The programme has provided an opportunity to test new approaches to the way we deliver health and care, and to embed the prevention agenda into the heart of the system. There was significant emphasis on new and enhanced partnerships between NHS and the VCSE to reach vulnerable communities, and priority was given to projects that support those people most adversely affected by the pandemic.

Our successful submission for funding was co-developed and included a portfolio of projects. VCSE organisations were supported to develop their proposals by statutory partners, identifying opportunities to align resources, integrate and further collaborate to bolster and strengthen the development of project ideas. Furthermore, a peer review approach was established to ensure a direct link to system priorities and future advocates within the system that can support successful implementation.

Over the next two years, the ICS will support the implementation and evaluation of the ten projects taken forward as part of Norfolk and Waveney's NHSCT programme, with the learning captured and utilised to further develop our strategic response to VCSE integration.

By systematically aligning insight and learning gathered from all this work across the system we will be able to build a picture of on-going dialogue with local people and communities.

The importance of more local conversations should not be forgotten, and 'Place-based' priorities will be co-designed with local people and communities through development of shared plans. This work will be led by the Place Boards and reviewed annually and gives the ICS an opportunity to work with people and communities in a more locally focused way, using a spectrum of opportunities as laid out on page 19.

The importance of accessible and good quality communications

The local health system recognises that good communications is at the heart of everything we do. It helps build confidence with local services and care professionals. It is essential for effective partnership working and will help build trust. It provides patients with the information that they need to be empowered and so make positive choices and take control of their health.

Good communications involves:

- fostering a culture of good two-way communication, engagement and involvement;
- informing and empowering key stakeholders;
- being honest and realistic;
- recognising and meeting the different information needs of groups and individuals;
- working with other agencies to co-ordinate communication.

We live our lives and communicate online as well as through more traditional media. In Norfolk and Waveney, it is recognised that not everyone is able to, or wishes to, use digital platforms and we will continue to use traditional routes of communication such as newsletters, partner newsletters, leaflets and posters.

However, the digital space offers enormous reach and value for money. The ICS will therefore champion digital platforms to help patients interact with services or obtain the information they require. A new ICS website is being developed and this will be kept well designed, easy to navigate and a trusted source for information or links to information. This website will host the people and communities hub for Norfolk and Waveney, which will be vital in developing and maintaining a shared vision in listening to and working with local people across the ICS. A new post has recently joined the ICB communications & engagement team focusing on digital transformation which will help staff, people and communities understand how advancements in digital technology can help improve health and care experiences.

NHS Norfolk and Waveney ICB, as well as the wider ICS, will use social media such as Twitter, Facebook and other online platforms, to help communicate with local people, and where appropriate, as an engagement tool to stimulate discussion and feedback. A social media policy will be developed which will make clear how social media can be used effectively to contribute to the work of the local health system and to help staff participate online in a respectful, professional and meaningful way that protects the image and reputation of the health system when they are using social media on a personal basis. This will be done in line with similar policies for ICS partner organisations.

Good external communications will be vital in informing and empowering people about Norfolk and Waveney ICS, how public money is spent and how we are working with people and communities in the development of local healthcare services.

It is essential in an ever-changing NHS that patients and the public are able to navigate their way through the services available to them. The ICB will be the custodian of the NHS brand locally, and our communications will support this.
When producing any material for publication, the ICB will take account of the NHS Branding and Accessibility Guidelines to make sure that all our information is accessible to a wide variety of audiences. This includes use of our websites and any social media we may develop, and the need to produce our literature in a range of formats if required.

NHS Norfolk and Waveney ICB is striving to meet the Accessible Information Standard in all its communications and engagement. We are working with Healthwatch Norfolk and Healthwatch Suffolk to support the national accessible information campaign. Norfolk and Waveney ICS has recently appointed a Head of Systems Workforce Equality, Diversity and Inclusion. The aim of this role is to embed the necessary values and behaviours to develop a holistic approach to equality, diversity and inclusion, that puts people and culture at the heart of the ICS.
As a health and care system, it is also important to develop a local brand for the NHS in Norfolk and Waveney. This will help local people understand the role of the ICS and our work with our partners. It is important that the health and care system creates and maintains a reputation for delivering high-quality, safe and responsive care and support to our people and communities. This will be built by the experiences of its stakeholders through direct and indirect contact with the ICS, and how we are portrayed in the media.

A good reputation can be earned by having a clear, locally agreed vision and set of values that is communicated in a clear and positive way. How an organisation behaves also contributes to this and clear communications can help explain why decisions are made. Having a good reputation can help staff morale, and generate local support for change, especially over difficult and contentious issues. It is also an important metric for how NHS bodies and healthcare staff are measured in terms of performance.

The media can influence people's opinions of public services. Many are seen as independent and credible and are influencers nationally and locally. For this reason, good strong relationships with, in particular, the local and regional media, are important. Our local media can be helpful in promoting the work of the ICS and the transformational service changes and improved health and wellbeing outcomes we are

seeking to deliver for local people. And helps hold us to account to our local people and communities, increasing our openness and transparency.

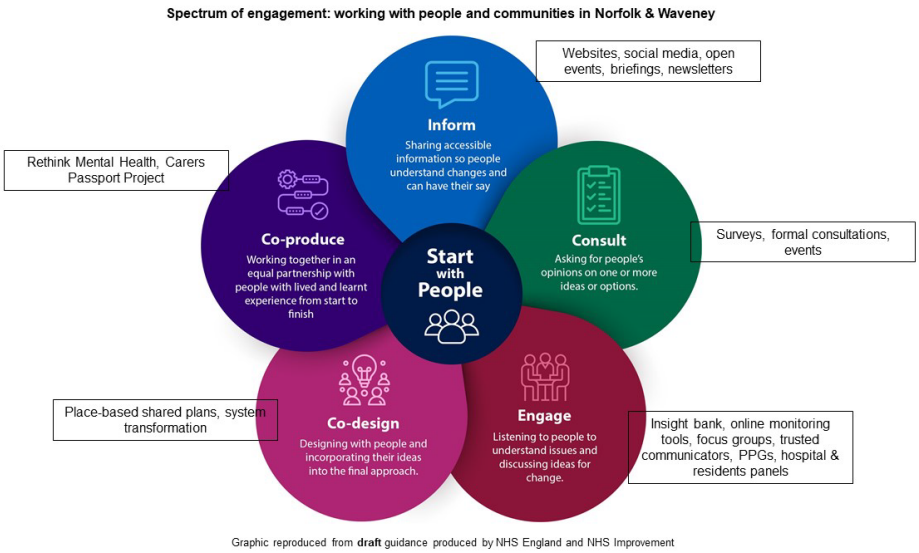
How this ICS approach to working with people and communities will support the NHS ICB legal duties on public involvement

The existing guidance around the NHS legal duties to consult and involve were produced in 2008 and 2017. The new Health and Care Bill will come into effect on 1st July 2022 and will create a very different health and care landscape with a particular emphasis on integration and collaboration. It will continue the legal duties on public involvement, and new statutory guidance is expected to provide the detail of how NHS organisations should work effectively with people and how ICBs will be assessed on this.

The new guidance will change ambitions for how systems work with people – at system, place and neighbourhood levels. The approach being developed in Norfolk and Waveney will:

- ✓ Maximise existing conversations taking place every day with people across the system, starting with the current mapping exercise
- ✓ Involve groups and people we have not been good at listening to before
- ✓ Ensure this information is fed into decision-making structures as they develop
- ✓ Promote the ICB Communications and engagement team as system leaders encouraging trust with ICS partners and local people through the People and Communities Engagement Hub
- ✓ Develop the wider 'system team' of staff in public sector and VCSE organisations who are already working with people and communities and gathering insight
- ✓ Promote methodologies such as Making Every Contact Count (MECC), What Matters to You and Always Events
- ✓ Promote Co-production & Co-design models as part of a wider spectrum of engagement
- ✓ Promote a support programme to encourage thriving patient engagement around primary care

A spectrum of opportunities will be recognised and encouraged by the ICB when working with people and communities within the ICS. All feedback has value and adds to our understanding of the people and communities in Norfolk and Waveney.

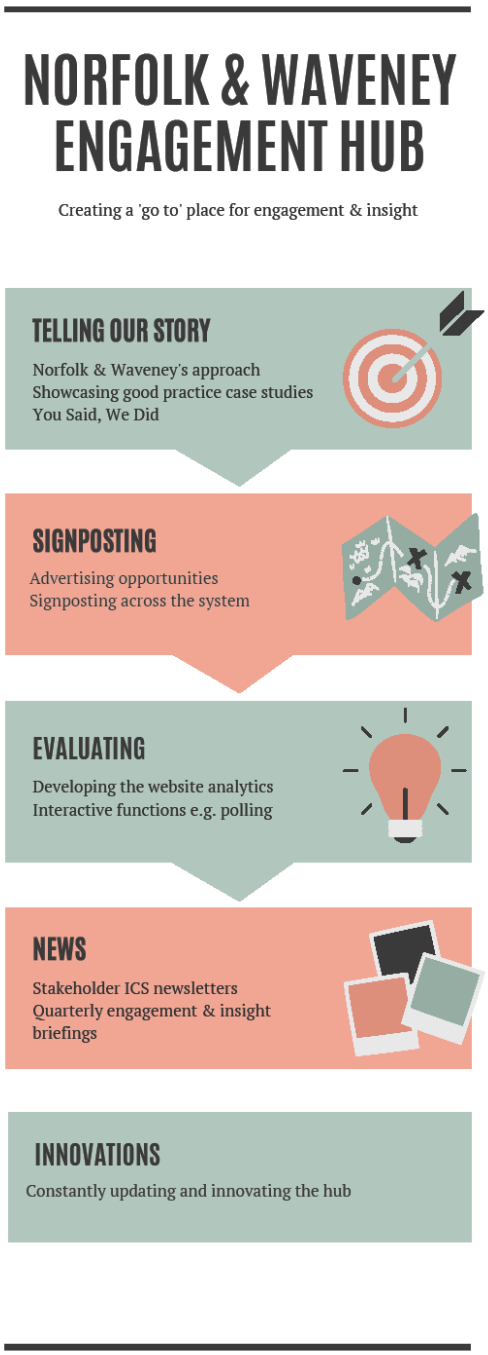


Thriving Patient Engagement Around Primary Care

There are 105 GP practices in Norfolk and Waveney. Most of them have patient groups, often referred to as Patient Participation Groups (PPGs). They offer members of the public the opportunity to become more involved in how the practice runs. This could be about the physical building, waiting times, services offered or wider healthcare issues.

We have 17 primary care networks (PCNs) – this is where GP practices work together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices known as PCNs.

We are working with patient representatives, practices and our local Healthwatch's to develop a programme of support to local PPGs and practices so that the voice of people and communities can be reflected more locally.



Developing a people & communities engagement hub for Norfolk and Waveney:

The CCG Communications and Engagement Team are developing a People & Communities Engagement Hub ready for launch on 1st July to offer a focus for the systemwide vision for working with people and communities.

It will offer the opportunity for the system to work together to create a 'go to' place for engagement and insight. This will include the opportunity for local people to sign up to regular briefings and newsletters that will promote a wide range of opportunities from ICS partners to get involved in shaping services.

We also want to develop a panel of experts by lived experience to help us develop the best and most accessible communications possible.

This will link in with and support existing structured participation opportunities including hospital patient panels, NHS Trust membership schemes, resident's panels in housing associations & County Council neighbourhood panels.

The CCG Communications and Engagement Team has worked with its Project Management Office (PMO) to develop a communications and engagement template. This is one of a suite of documents that will need completing for all the project and transformational work undertaken by the ICB going forward. The template ensures that due consideration is given to working with people and communities at the earliest possible stages of planning to feeding back at the end. A toolkit has been developed to help CCG staff with planning communications and engagement activity in line with our people and communities approach.

Norfolk and Waveney's Quality Management Approach (QMA) – how working with people and communities will impact quality, safety and patient experience

Norfolk & Waveney ICS believes in the importance of working with people and communities to implement systems that help support people to live a longer, healthier and happier life. The overall is ambition to improve our local population services, health outcomes, and patient and staff experience; as well as providing safe, effective, accessible, sustainable and responsive care. To do this Norfolk and Waveney is adopting a system wide Quality Management Approach (QMA).

Norfolk and Waveney ICS has chosen to place quality at the heart of how it plans, transforms, sustains and supports transformation of services.

Our core partners have collaboratively explored how quality can be woven into all that we do. The aspiration is that the ICS will be 'quality led' and that a day-to-day culture of quality improvement will be embedded across all local health and care.

A cornerstone of QMA is patient experience - bringing patient voices into systemwide quality improvement, and in designing of services. Co-design and co-production foster the processes and culture that support our staff, individuals, people and communities to become equal partners in all aspects of quality planning, improvement and control.

Our progress has been carefully co-designed with our partners in NHS England (NHSE), to ensure we benefit from the very latest learning, future proofing our planning, and aiding the further development of national improvement programmes.

Our partners in NHSEI, in conjunction with the Local Government Associations, are helping our Boards to understand the breadth of the Quality agenda, as well as the importance of growing a Quality Culture and Quality Improvement capability.

Our endeavours to position Quality at the heart of what we do, is being independently evaluated by partners in the Department of Health and Social Care, in conjunction with University of Oxford.

The Quality Management Approach within the Norfolk and Waveney ICS incorporates Quality planning, control and improvement, ensuring alignment with Quality Assurance. In blending these different approaches together into a single Quality System for Norfolk and Waveney, we aim to meet our goals and improve care for our service users.

Quality planning (QP)-quality by design.

- Understanding the needs of the citizens a service is serving.
- Making sure we understand the best evidence and the best possible service models.
- Making sure we have clear priorities at every level that are aligned.
- Having clear and simple governance arrangements.
- Ensuring we have resources to deliver changes that focus on a few things that matter most

Quality Control (QC)-Process control

- A set of measures to monitor service quality and performance, chosen by the team and tracked transparently in real time. Measures should be visible to all in the work setting through visible displays, encouraging dialogue with staff and service users.
- Teams should meet regularly to discuss their data, responding to changes appropriately, with clear escalation.

Quality Improvement (QI)

- A systematic approach, using data, to improving the quality and performance of a service that deeply involves those closest to the issue.
- It requires a Project Team with diverse membership to collect data, develop change ideas and test their effectiveness.

Quality Assurance (QA)-Assurance/regulation

- Occasional checks that we are providing 'good' quality care and meeting minimum standards.
- Gaps can be identified, action plans written, and progress rechecked.

The service user voice has been included in the development of the system with patient leaders joining us as we plan. The aim is to extend this involvement into a full co-production model, fully embedded in the quality system. The aim is to improve outcomes for people with lived experience through quality feedback loops, and by bringing patient reported quality feedback to place boards and into transformation projects.

Norfolk and Waveney Patient Experience and Engagement Leads meetings –have been taking place weekly for a couple of years and give an opportunity for people working in NHS provider trusts to meet and share practice across the system. They have also involved representatives from the CCG and have been a vital opportunity to begin to test and develop the idea of the 'wider team' working with people and communities across the ICS to listen to and involve patient experience feedback in quality and wider commissioning.

How will we know this work is helping people and communities?

If this work is effective, our people, communities and ICS partners will be able to see that:

- People feel listened to, and empowered
- People can see the difference their views and insight have made
- The voices of our people and communities are looked for early when planning services
- People have shared their story and it has made a difference and been listened to be partners all over the ICS.

Many of the governance structures within the ICB and ICS are still being developed, but the need to monitor and evaluate the impact of the people and communities work is acknowledged.

All strategic listening such as information drawn from the insight bank and social media monitoring could be fed by regular reports into the place boards to inform work at a locality level. Reporting could also take place at the ICB Patient and Communities Committee, and/or any boards that report to it with a remit covering people and communities. The detail for this is still being decided.

The use of the People and Communities Engagement Hub described above would also give a focal point to engagement activity undertaken by the ICB as part of its legal duties. Functionality is being built into the website hosting the hub including web analytics to monitor use, and polling options to gather rapid 'snapshot' feedback.

Specific projects and opportunities for working with people and communities would need to include a **'You said, We did/We can't'** report detailing the results of the feedback and any improvements that resulted.

All ICB people and communities activity would be included in a regular systemwide quarterly briefing that would be widely shared within the ICB and across the ICS. All system partners will also be encouraged to input into the briefing so that it can become a Norfolk and Waveney resource for the promotion of work with people and communities.

We will use all the existing networks of people and stakeholders to regularly monitor our success in working with people and communities.

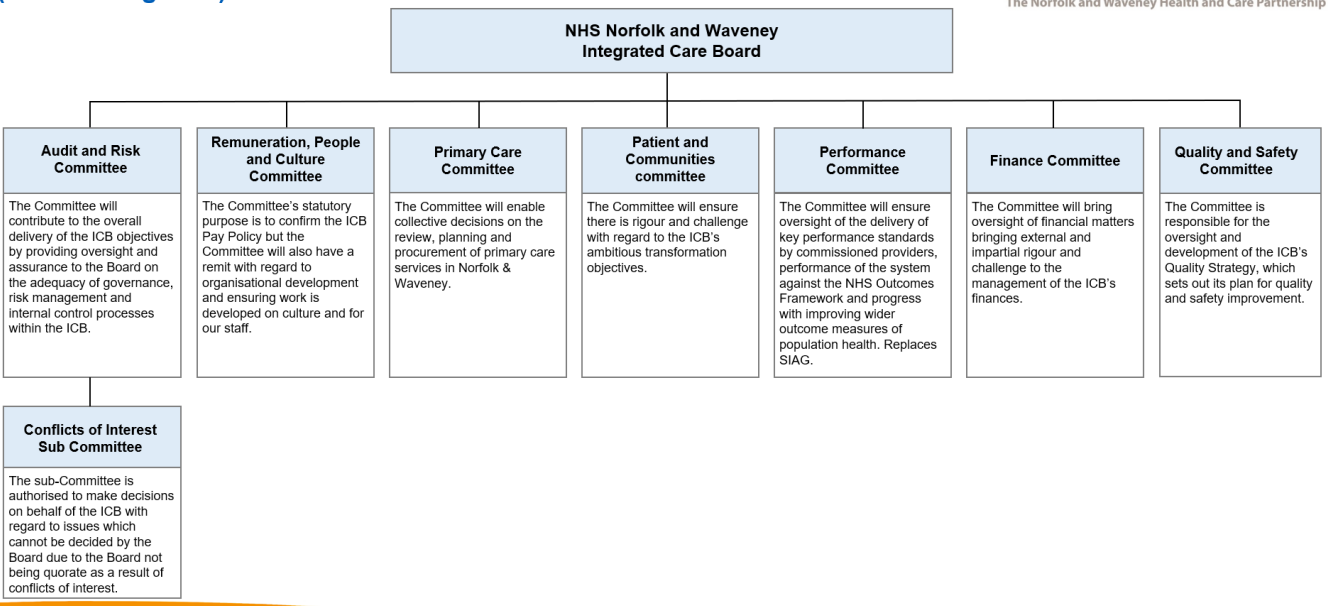
People and communities in ICB Governance and workstreams

NHS Norfolk and Waveney ICB is committed to embedding the voice of people and communities so that the ICB can listen to and act on the concerns and aspirations of residents. Much of the detail around the structures of the ICB are still being decided but it is expected that the Patient and Communities Committee will act as a focal point for overseeing how this will happen. A Director of Patients and Communities has been appointed to oversee the all the work with our people and communities.

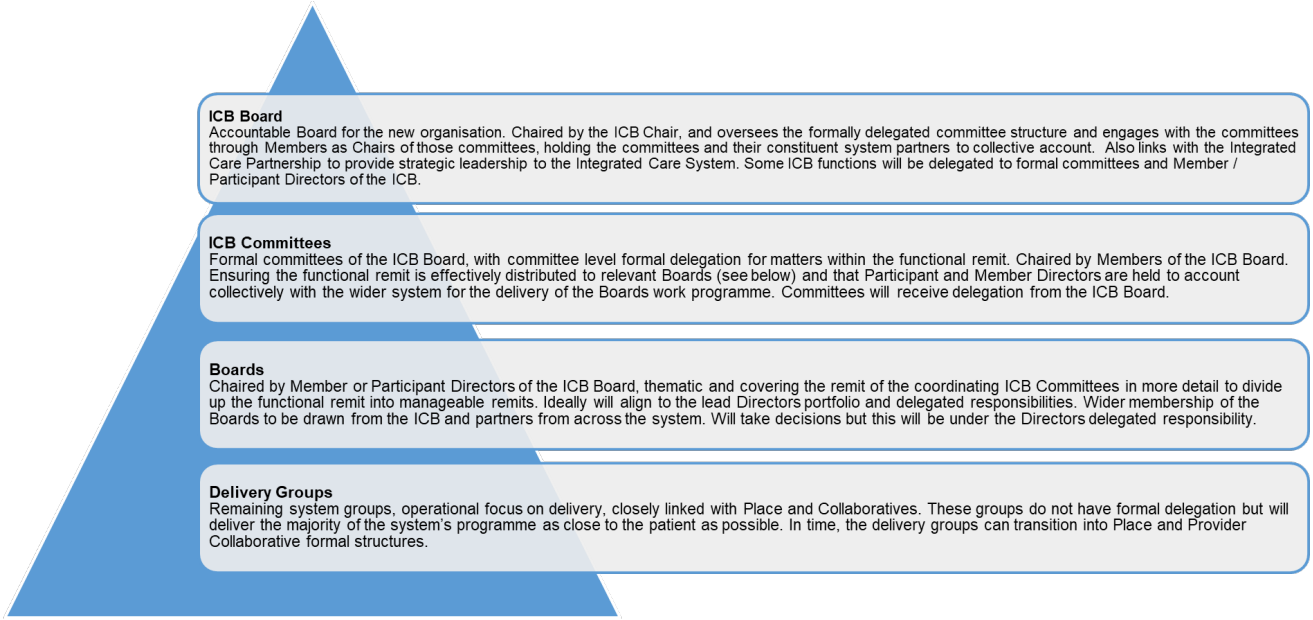
The ICB Board will include a programme of patient stories at all meetings in public to underline that people are at the centre of strategic decision-making. The programme of stories is being developed in partnership with local NHS trusts, local authorities and wider system partners to complement stories they also use at board level and to highlight the stories across the ICS.

ICB Board and Committee Structure (formal delegation)

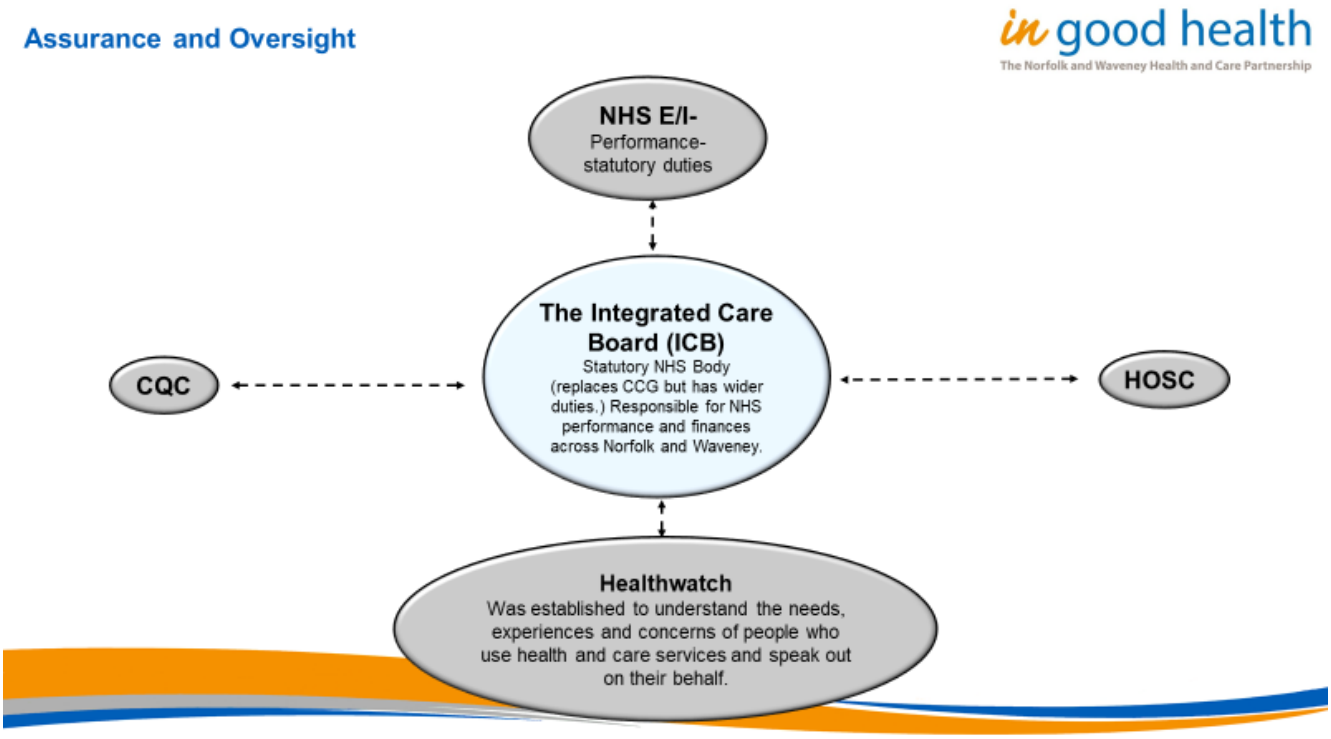
in good health
The Norfolk and Waveney Health and Care Partnership



Discussions are currently underway around Place Boards, including possible communications and engagement structures that would focus on working with people and communities at a much more local level, and drawing on insight from across all ICS partners including trusted communicators in VCSE organisations. The vision is that the place-based networks would have a shared plan co-produced with local people and refreshed each year.



We will continue to build on our good working relationship with Healthwatch Norfolk and Suffolk. The ICB Communications and Engagement Team meets with both Healthwatch organisations every month at operational level, and they are valued members of the Norfolk and Waveney ICS Communications and Engagement Group. Healthwatch also play a key role in the overall assurance and oversight both for the ICB and for the work with people and communities in the wider ICS, as demonstrated in the graphic below.



Norfolk and Waveney ICB will also continue the positive and proactive relationship it enjoys with the Norfolk and Waveney Health Overview and Scrutiny Committee (HOSC), through:

- ✓ regular informal meetings with the Chair and Vice-Chair
- ✓ including proactive information about changes to services and working with people and communities in the members briefings
- ✓ supporting and attending meetings held in public

Equality Impact Assessments (EIAs) have been embedded within the ICB to ensure the voice of underserved communities is given due regard in planning services and in any transformational work. It also highlights areas where more work with particular people and communities would be beneficial to understanding their needs, and links can then made with the communications and engagement team.

The future - The aspirations and ambitions in this document clearly demonstrate a journey to improve communications and engagement with people and communities across Norfolk and Waveney. Whilst a lot of work has taken place over the last 12 months to work together much more closely, it is vital this work continues, at pace, to ensure that all partners across the system work together to share resource, intelligence, insight and feedback.

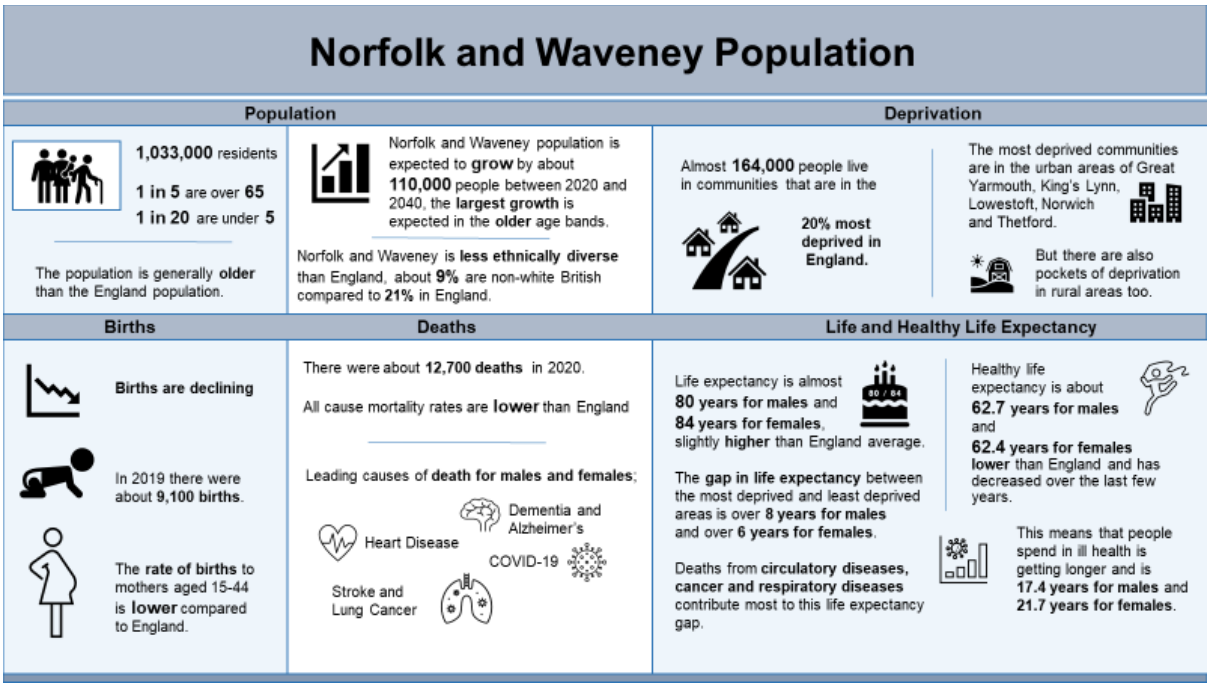
Our collective focus will be to always ensure that the voice, views and feedback of people and communities across Norfolk and Waveney is heard at every opportunity.

The transformation journey ahead will be evaluated at every possible point.

Appendix 1

An overview of the people and communities in Norfolk & Waveney ICS

The Joint Strategic Needs Assessments (JSNAs) available for Norfolk and Waveney have a wealth of information about the local area. Norfolk and Waveney is a large rural area made up of many villages and rural hamlets, market towns and urban areas in Norwich, Kings Lynn, Great Yarmouth, Lowestoft and Thetford. Numerous people move to the area to retire and there are many second and holiday homes. Norfolk and Waveney has many affluent areas that often sit alongside pockets of deprivation, especially in the rural areas.



Age - Norfolk and Waveney has one of the oldest populations in England. About 1 in 4 of the population (25%) is aged 65 and over and about 1 in 30 is aged 85 and over. This makes it the 4th oldest ICS area in the country. The proportion is likely to rise to 28% by 2029. Norwich is the youngest population and North Norfolk the oldest. This has remained the case over the last 10 years.

In 2020 the estimated population was as follows:

- **0–4 years** - 49,700 = **4.8%** of the total population.
- **5-11 years** - 80,200 = **7.8%** of the total population.
- **12-15 years** - 44,300 = **4.3%** of the total population.
- **16-64 years** - 600,600 = **58.2%** of the total population.
- **65+ years** - 257,900 = **25%** of the total population.

More than half of people under 50 live in the areas of Norfolk and Waveney classified as urban city and town, whereas people aged over 50 are more likely to live in more rural areas.

Between 2020 and 2040 there will be a projected increase of almost 110,000 people living in Norfolk and Waveney. The population is projected to increase by approximately 6.7%

between 2019 and 2029, which equates to approximately 68,880 spread over the next ten years. 48,100 of this increase is in the population over 65.

Total live births in Norfolk and Waveney have been just below 70,000 between 2013 and 2019, decreasing from just over 10,000 to just over 9,000 births per year over that period. The most live births have been in Norwich, and the fewest in North Norfolk.

The general fertility rate is the number of live births per 1,000 women aged 15-44 years old. In Norfolk and Waveney this has declined from just over 61 births per 1,000 to just over 54 births per 1,000 from 2013-2019. Rates in Norfolk and Waveney have been lower than the England rates since 2013

Ethnicity - The Norfolk and Waveney population are less ethnically diverse than average in England. Norfolk & Waveney's ethnic make-up was characterised by a predominantly White, 940,607 people (96.7%). The proportion of people with an ethnic group other than White was 3.3%. The most diverse areas across Norfolk and Waveney are Norwich, Great Yarmouth and Breckland. There are around 160 languages spoken in Norfolk & Waveney. English is not the first language of around 12,400 school children in the county.

INTRAN is the non-profit-making partnership that commissions and manages interpreting and translation services on behalf of public-facing organisations throughout the East of England. According to INTRAN the top 10 languages requested are:

- Swahili (Kiswahili)
- Slovakian (Slovensky)
- Romanian (Română)
- Lithuanian (Lietuvis)
- Portuguese (Português)
- Latvian (Latvietis)
- Kurdish Sorani (Kurdî)
- Farsi Persian (فارسی)
- Chinese 普通话 ; 國語
- Russian (русский)

During the COVID-19 pandemic the following languages were also frequently requested:

- Turkish (Türkçe)
- Spanish (Español)
- Polish (Jezyk Polski)
- Arabic (Al Arabiya) العربية
- Bulgarian (български)
- Czech (čeština / český jazyk)

Information in Ukrainian (український) was also included to support those relocated during the conflict between Ukraine and Russia.

Disability - Based on the NHS population and person insight dashboard about 1.2% of the registered population has a disability. This is about 13,200 people and includes people with a physical disability, a learning disability and autism. The information might be an underestimate as it is based mainly on national NHS data returns.

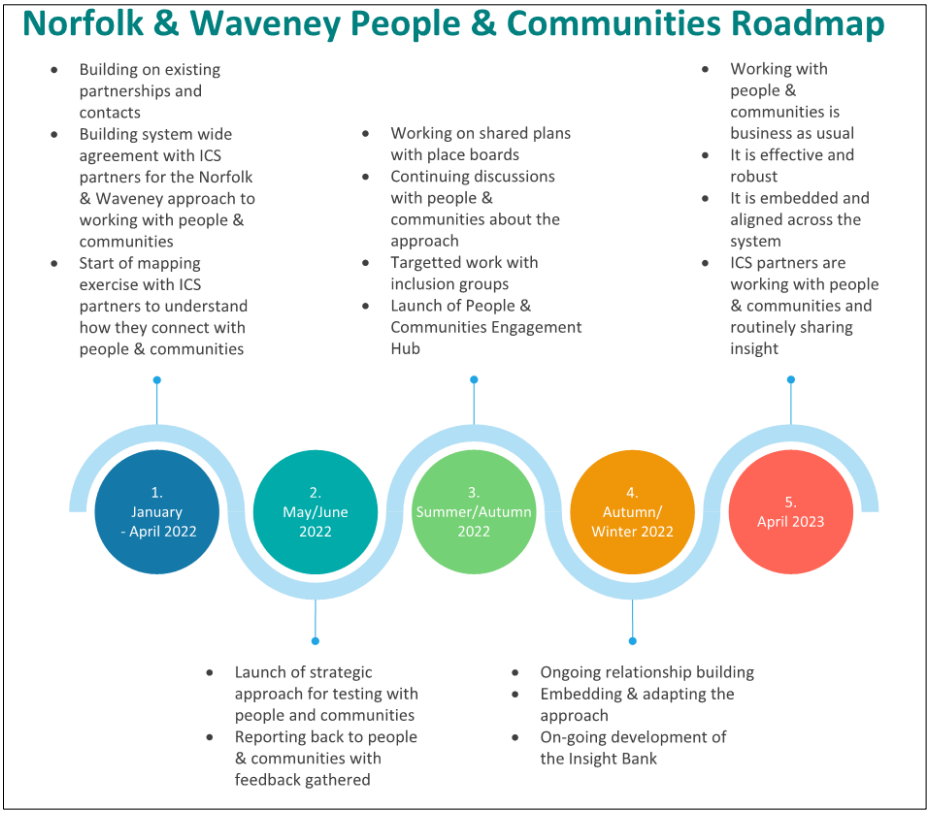
Informal Unpaid Carers – are described by NHS England as ‘anyone, including children and adults who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. The care they give is unpaid.’ They are also known as Family Carers, Companion Carers, Primary Unpaid Carers or Support Companions.

The 2011 UK census reported there are 5712 carers aged between 0 and 24, providing unpaid care in Norfolk. Of these 1,752 were aged 15 or under. The total number of carers reported in Norfolk was over 94,000 and more than 13,000 in Waveney. Both these figures had risen by more than 10% since the 2001 census.

As of February 2022, Carers Matter Norfolk (CMN) have approximately 7,000 adult carers registered with the service, showing there are many unpaid informal carers who do not come forward for help or do not recognise themselves as carers.

Appendix 2

How our approach is being developed in partnership with ICS partners and with our people and communities



Following discussion with Healthwatch Norfolk and Healthwatch Suffolk this approach document will be shared for public comment from **6 June – 18 July 2022**. All attempts have been made to make it as accessible and public-friendly as possible. It will be shared online giving access to accessibility software on the current Norfolk and Waveney Health and Care Partnership website, and the new ICS website when that comes online on 1st July. It will be made available in other formats as needed. A summary document has also been produced in Easy Read (see **Appendix 4**).

The launch of the People and Communities Approach document for Norfolk and Waveney will mark the start of an on-going process of engagement and involvement with local people and communities which will focus on making our insight and participation work across the ICS as effective and meaningful as possible for local people.

This process will be co-produced with system partners involved in the People and Communities Task and Finish group. Progress with this and opportunities to feedback will be widely shared across the system in formats appropriate to the target groups. The People and Communities Engagement Hub hosted on the new ICS website will be the focal point for this work.

Appendix 3

Glossary of acronyms and phrases

Acronym	Full Title	Meaning / Definition
ICS	**Integrated Care Systems**	New partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.
ICB	**Integrated Care Board**	Each Integrated Care System (ICS) will have an Integrated Care Board (ICB), a statutory organisation bringing the NHS together locally to improve population health and establish shared strategic priorities within the NHS.
ICP	**Integrated care partnerships**	(ICPs) are alliances of NHS providers that work together to deliver care by agreeing to collaborate rather than compete. These providers include hospitals, community services, mental health services and GPs.
VCSE	**Voluntary Community and Social Enterprise**	Any organisation working with social purpose that is independent of government and are constitutionally self-governing. They exist for the good of the community, to promote social, economic, environmental or cultural objectives to benefit society as a whole, or particular groups within it. Ranging from small community-based groups/schemes to larger registered Charities.
	Primary care	Primary care is the first point of contact for healthcare for most people. It is mainly provided by GPs (general practitioners), but community pharmacists, opticians, dentists and other community services are also primary healthcare providers.
PCN	**Primary care networks**	GP practices are working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices known as primary care networks (PCNs) to meet the needs of the local populations.
	Population health	The collection of patient data across multiple health information technology systems. This data is then analysed into a single, actionable patient record. Care providers can improve both clinical and financial outcomes using this data.
PHM	**Population Health Management**	Our health and care needs are changing: our lifestyles are increasing our risk of preventable disease and are affecting our wellbeing, we are living longer with more multiple long-term conditions like asthma, diabetes and heart disease – and the health inequality gap is increasing.
CEO	**Chief Executive Officer**	The chief executive officer (CEO) is the highest-ranking person in an organisation.
HWP	**Health & Wellbeing Partnerships**	HWPs are Local health and wellbeing partnerships work on addressing the wider determinants of health, reducing health inequalities and aligning NHS and local government services and commissioning.
LTP	**NHS Long Term Plan**	The NHS LTP was published in 2019 setting out key ambitions for the service over the next 10 years.
	Local Authority	Generally, this is just another word for a local council, but it can refer to any administrative organisation in local government.
LGA	**Local Government Association**	The Local Government Association is the national membership body for local authorities. Its core membership is made up of 339 English councils and the 22 Welsh councils through the Welsh Local Government Association. The LGA is politically-led and cross-party.

	Provider collaboratives	Provider collaboratives bring NHS providers together across one or more ICSs, working with clinical networks, alliances and other partners, to benefit from working at scale.
	Place-based partnerships	Place-based partnerships will bring together the NHS, local councils and voluntary organisations, residents, people who access services, carers and families. These partnerships will lead design and delivery of integrated services in their local area.
	Health and wellbeing partnerships	Health and wellbeing partnerships will bring together colleagues from county and district councils, health services, wider voluntary, community and social enterprise sector organisations and other partners. They will focus on the local population's health and wellbeing by addressing the wider determinants of health to avoid health crises.
DHSC	**Department of Health and Social Care**	Support ministers in leading the nation's health and social care to help people live more independent, healthier lives for longer.
	Acute care	Acute care providers are emergency services and general medical and surgical treatment for acute disorders rather than long-term residential are for chronic illness
	Commissioning	Identifying health needs of local people, planning and purchasing health services which respond to their needs. CCGs are responsible for deciding what services their local residents need from the NHS and buy these services with public money from the most appropriate providers.
	Care Pathway	The care and treatment a patient receives from start to finish for a particular illness or condition. This usually includes several parts of the health service and social care. For example, a care pathway can involve support from a GP, a specialist doctor, home care and a district nurse.
	CQC	Independent regulator of health and social care in England – including hospitals, care homes and other provider organisations.
	FOI	The Freedom of Information Act 2000 provides public access to information held by public authorities.
	Place	The geographical level below an Integrated Care System (ICS) at which most of the work to join up budgets, planning and service delivery for routine health and care services (particularly community-based services) will happen. The Norfolk and Waveney ICS will comprise five places.
	Place-based Working	This is the new way of working set out as part of integrated care systems. It involves bringing together all the health and care organisations that sit within that place area, such as the hospitals, councils, care providers and voluntary groups, to work together as local partners. Their knowledge of the local people's needs means all of these organisations can work together to make sure health and care services meet the needs of the people who live there.
	Neighbourhood	Within each 'place' there are several neighbourhoods, which cover a smaller population size of roughly 30,000 to 50,000 people. They often focus on integrating primary, community and social care through multidisciplinary teams and joint working arrangements. Neighbourhoods are therefore key to the NHS's commitment to deliver more care as close to home as possible.
	System	In relation to integrated care systems (ICS), this refers to the level of the ICS. Key functions at the system level include setting and leading overall strategy, managing collective resources and performance, identifying and sharing best practice to reduce unwarranted variations in care, and leading changes that benefit from working at a larger scale such as digital, estates and workforce transformation.
	Place Boards	A forum that brings together colleagues from health and care to integrate services and focus on effective operational delivery and improving people's care.

Appendix 4

Norfolk and Waveney ICS – People and Communities – Easy Read (embedded below)

Norfolk and
Waveney ICS - People

Improving lives together
Norfolk and Waveney Integrated Care System

Working with people and communities

Norfolk and Waveney Integrated Care System

SECTION 8
Conflicts of Interest Policy

Revision History

Document Control Sheet

Revision Date	Summary of changes	Author(s)	Version Number

Approvals
This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number

Document Control Sheet

Policy title	Conflicts of Interest Policy
Policy area	This Policy has been prepared and reviewed by the Corporate Affairs team.
Who is it aimed at and which settings?	Effective handling of conflicts of interest is crucial for the maintenance of public trust in the health and care system. Importantly, it also serves to give confidence to patients, providers, parliament and taxpayers that the ICB's commissioning decisions are robust, fair, transparent and offer value for money.
Approved by	
Effective date	
Review date	Every two years or sooner if required by changes in legislation or guidance.

1 Policy Summary

Adhering to this policy will help to ensure that we use NHS money wisely, providing best value for taxpayers and accountability to our patients for the decisions we take.

As a member of staff you should…	As an organisation we will…
• Familiarise yourself with this policy and follow it. Refer to the guidancefor the rationale behind this policy https://www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interest-nhs.pdf • Use your common sense and judgement to consider whether the interests you have could affect the way taxpayers' money is spent- you should base this on the perception ofthe average person, not your own perception. • Regularly consider what interests you have and declare these as they arise.If in doubt, declare. • **NOT** misuse your position to further your own interests or those close toyou • **NOT** be influenced, or give the impression that you have been influenced by outside interests • **NOT** allow outside interests you haveto inappropriately affect the decisionsyou make when using taxpayers' money	• Ensure that this policy and supporting processes are clear and help staff understand what they need to do. • Identify a team or individual with responsibility for: ○ Keeping this policy under review to ensure they are in line with the guidance. ○ Providing advice, training, and support for staff on how interests should be managed. ○ Maintaining register(s) of interests. ○ Auditing this policy and its associated processes and procedures at least once every three years. • **NOT** avoid managing conflicts of interest. • **NOT** interpret this policy in a way which stifles collaboration and innovation with our partners

2 Introduction

2.1 NHS Norfolk and Waveney Integrated Care Board ("the ICB) and the people who work with and for us, collaborate closely with other organisations, delivering high quality care for our patients.

2.2 These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely. But there is a risk that conflicts of interest may arise.

2.3 Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly are both key principles in the NHS Constitution. We are committed to maximising our resources for the benefit of the whole community. As an organisation and as individuals, we have a duty to ensure that all our dealings are conducted to the highest standards of integrity and that NHS monies are used wisely so that we are using our finite resources in the best interests of patients and the public.

2.4 Effective handling of conflicts of interest is crucial for the maintenance of public trust in the health and care system. Importantly, it also serves to give confidence to patients, providers, parliament and taxpayers that the ICB's commissioning decisions are robust, fair, transparent and offer value for money. As such, this policy is aligned with the three crucial public service values that underpin the work of the ICB:

Accountability – Everything done by those who work in the NHS must be able to stand the test of parliamentary scrutiny, public judgements on propriety, and professional codes of conduct.

Probity – There should be an absolute standard of honesty in dealing with the assets of the NHS. Integrity should be the hallmark of all personal conduct in the decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of NHS duties.

Openness – There should be sufficient transparency about NHS activities to promote confidence between the NHS organisation and its staff, patients and the public

2.5 Failure to manage conflicts of interest could lead to legal challenge resulting in civil or criminal implications for the ICB and the individual; as well as disciplinary and professional regulatory implications in respect of the individual.

3 Purpose

1) This policy will help our staff manage conflicts of interest risks effectively by:

- Introducing consistent principle and rule
- Providing simple advice about what to do in common situations
- Supporting good judgement about how to approach and manage interests

2) This policy should be considered alongside these other organisational policies:

- The ICB Constitution
- ICB Whistleblowing Policies
- ICB Counter Fraud and Corruption Policies
- ICB Anti-bribery Policies

- ICB Communicating Anti-Fraud Culture Policies
- ICB Sanctions and Redress Policies
- ICB Recruitment Policies
- ICB Disciplinary Policies
- ICB Standing Financial Instructions.

In addition, staff should be aware of statutory guidance issued by NHS England

4 Key terms

1) A conflict of interest is:

"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."

2) A conflict of interest may be:

- 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

4.3 Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

5 Interests

Interests fall into the following categories

Financial interests – Where an individual may get direct financial benefit from the consequences of a decision they are involved in making.

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

Non-financial personal interests – Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because decisions are not linked to their professional career.

Indirect interest – Where an individual has a close association with another individual who has a financial interest, non-financial interest or a non-financial

personal interest and could stand to benefit from a decision they are involved in making.

Please refer to the table attached to Annex A which describes types of conflicts attributable for each of the listed categories above.

6 Guiding principles

6.1 The Nolan Principles set out the ways in which holders of public office should behave in discharging their duties. The seven principles are: Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty and Leadership.

6.2 In addition to the Nolan Principles, the ICB observes the following principles of good governance in the way that it conducts its business. This includes but is not limited to the following:

- The Good Governance Standards of Public Services (2004), Office of Public Management (OPM) and Chartered Institute of Public Finance and Accountancy (CIPFA).
- The seven key principles of the NHS Constitution
- The Equality Act 2010
- Code of Conduct and Code of Accountability in the NHS
- Standards for members of the NHS Boards and ICBs in England.

6.3 Conflicts of interest are inevitable in commissioning, but in most cases, it is possible to handle them with integrity and probity by ensuring they are identified, declared and managed in an open and transparent way. With this in mind, the ICB has adopted the following guiding principles for managing conflicts of interest:

a. Doing business appropriately – ensuring that our needs assessments, consultation mechanisms, commissioning strategies and procurement procedures are right from the outset. Accordingly, this supports the ICB to identify and avoid/manage because the rationale for all decision-making will be clear and transparent and should withstand scrutiny.

b. Being proactive, not reactive – seeking to identify and minimise the risk of conflicts of interest at the earliest possible opportunity, for instance by:

    - Considering potential conflicts of interest when electing or selecting individuals to join the ICB or other decision-making groups;
    - Ensuring individuals receive proper induction and training so that they understand their obligations to declare conflicts of interest

    - Establishing and maintaining the register of interests and agreeing in advance how a range of possible situations and scenarios will be handled, rather than waiting until they arise.

c. **Assuming that individuals will seek to act ethically and professionally** – ensuring there are prompts and checks to identify when conflicts occur, supporting individual to exclude themselves appropriately from decision-making.

d. **Being balanced and proportionate** – identifying and managing conflicts, but not expecting to eliminate them completely.

e. **Openness** – ensuring early engagement with patients, the public, clinicians and other stakeholders in relation to proposed commissioning plans.

f. **Responsiveness and best practice** – ensuring that commissioning intentions are based on local health needs and reflect evidence of best practice – securing 'buy in' from local system partners to the clinical case for change.

g. **Transparency and sound record keeping** – documenting clearly the approach taken at every stage in the commissioning cycle so that a clear audit trail is evident, including an up-to-date register of interests.

h. **Securing expert advice** – ensuring that plans take into account advice from appropriate health and social care professionals (e.g. through clinical networks) and draw on commissioning support for instance around formal consultations and for procurement processes.

i. **Engaging with providers** – engaging early with both incumbent and potential new providers over potential changes to the services commissioned for the local community.

j. **Creating clear and transparent commissioning specifications** – reflecting the depth of engagement and setting out the basis on which any contract will be awarded.

k. **Following proper procurement processes and legal arrangements** – having an unbiased approach to providers and clear, recognised and easily enacted system for dispute resolution.

l. **Creating an environment and culture** – where individuals feel supported and confident in declaring relevant information and raising concerns.

7 Staff

7.1 NHS England has published a number of frequently asked questions for specific staffgroups and how the guidance applies to them. Staff can access these resources at www.england.nhs.uk/ourwork/coi

7.2 The ICB utilises the skills of many different people, all of whom are vital to our work. This includes all people who work for or on behalf of the ICB and may be on differing employment terms including contractors and workers, and who for the purposes of this policy we refer to as 'staff' and are listed below:

- Office holders including non-executive Members and ICB Board Members
- All salaried employees
- All prospective employees who are part-way through recruitment
- Contractors and sub-contractors
- Agency and bank staff as well as those with worker agreements

8 Decision making staff

8.1 Some staff are more likely than others to have a decision making influence on the use of taxpayers' money, because of the requirements of their role. For the purposes of this policy these people are referred to as 'decision making staff.'

8.2 Decision making staff in the ICB are:

- ICB Board Members
- Lay advisors
- Directors and other executive staff
- Members of advisory groups which contribute to direct or delegated decision making on the commissioning or provision of taxpayer funded services
- Individuals who are members of committees that approve investment or disinvestment decisions
- Those at Agenda for Change band 8d and above
- Administrative and clinical staff who have the power to enter into contracts on behalf of the organisation
- Administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment, and formulary decisions.

9 Identification, declaration and review of interests

9.1 All staff should identify and declare conflicts of interests at the earliest opportunity (and in any event within 28 days). If staff are in any doubt as to whether an interest is material then they should declare it, so that it can be considered. Declarations should be made:

- Upon appointment to the ICB (including temporary roles)
- When staff move to a new role, or their responsibilities change significantly
- At the beginning of a new project/piece of work
- As soon as circumstances change and new interests arise (for instance, in a meeting when interests staff hold are relevant to the matters in discussion)
- When their personal circumstances change resulting in a declaration being required.

9.2 A hard copy form is available at Appendix A or from the Corporate Affairs team.

9.3 After expiry, an interest will remain on register(s) for a minimum of six months and a private record of historic interests will be retained for a minimum of six years.

Any questions or concerns should be addressed to nwicbcorporateaffairs@nhs.net

9.4 The ICB has appointed the Chair of the Audit and Risk Committee as its Conflicts of Interest Guardian. This role has oversight of the management of conflicts of interest in the organisation and acts as a point of independent authority and scrutiny.

Any person can raise a concern about conflicts of interests with the relevant Conflicts of Interests Guardian, and contact will remain confidential unless the individual consents to their details being shared.

9.5 The ICB Corporate Affairs team has responsibility for implementing this guidance including:

- Reviewing current policies and bringing them in line with this guidance
- Providing advice, training, and support for staff on how interests should be managed
- Maintaining register(s) of interests
- Auditing policy, process and procedures relating to this guidance at least every three years.

Specific advice on the materiality of an interest or action that needs to betaken in relation to an interest is available from the Corporate Affairs team

10 Proactive review of interests

10.1 We will prompt decision making staff on a regular basis to review declarations they have made and, as appropriate, update them or make a nil return. However, staff should be aware of the need to update their declarations as required in the interim period, in accordance with this policy

10.2 Staff will receive an email asking them to provide a return. If such return is not provided within one month the matter will be escalated to the individual's line manager. Should the relevant declaration not be received within one further month the matter will be escalated to the relevant Executive Director. For members of the ICB Board, the matter will be escalated to the ICB Chair. A report will be provided to the Audit and Risk Committee showing non-compliance

10.3 Gifts and hospitality should be declared on an ongoing proactive basis in accordance with section thirteen below.

11 Records and publication

11.1 The ICB will maintain the following registers:

- Declarations of interest – Register of Interests
- Gifts and Hospitality
- Procurement

11.2 As a minimum, the ICB will:

- Publish the registers described above
- Publish the interests declared by decision making staff of the ICB, which will be updated on a six monthly basis
- Publish a combined register of gifts and hospitality
- Publish a combined register of procurement decisions
- The registers will be published on the ICB's website

11.3 If decision making staff have substantial grounds for believing that publication of their interests should not take place, then they should contact the Corporate Affairs team to explain why. In exceptional circumstances, for instance where publication of information might put a member of staff at risk of harm, information may be withheld or redacted on public registers. However, this would be the exception and information will not be withheld or redacted merely because of a personal preference.

11.4 The ICB fully supports wider transparency initiatives in healthcare, and encourage staff to engage actively with these.

Such transparency initiatives include disclosures as part of the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative.

However, staff are required to seek written permission from the Director of Finance before accepting payments for any of the following activities:

- Speaking at and chairing meetings
- Training services
- Advisory board meetings
- Fees and expenses paid to healthcare professionals
- Sponsorship of attendance at meetings, which includes registration fees and the costs of accommodation and travel, both inside and outside the UK
- Donations, grants, and benefits in kind provided to healthcare organisations.

12 Management of Interests – general

12.1 If an interest is declared but there is no risk of a conflict arising, then no action is warranted. However, if a material interest is declared a management plan will be made and will identify any actions required to manage the risk. The general management actions that could be applied include:

- restricting staff involvement in associated discussions and excluding them from decision making
- removing staff from the whole decision-making process
- removing staff responsibility for an entire area of work
- removing staff from their role altogether if they are unable to operate

effectively in it because the conflict is so significant

12.2 Each case will be different and context-specific, and the ICB Head of Corporate Governance will, in conjunction with the relevant committee chair or executive lead, clarify the circumstances and issues with the individual(s) involved. Staff should maintain a written audit trail of information considered and actions taken.

12.3 Staff who declare material interests should make their line manager or the person(s) they are working to aware of their existence.

12.4 Any disputes on whether an interest needs to be declared or upon the management of an interest shall be referred to the Corporate Affairs team for consideration. If further resolution is required, the matter will be referred to the ICB Chair for decision.

13 Management of Interests – common situations

This section sets out the principles and rules to be adopted by staff in common situations, and what information should be declared. Additional information is available at Appendix D.

13.1 Gifts

A “gift” is defined as any item of cash or goods, or any service which is provided for personal benefit, free of charge or at less than its commercial value.

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

All individuals must not, either directly or indirectly, accept a gift (including rewards benefits and hospitality) from any member of the public or any organisation with whom they are brought into contact by reason of their duties other than:

Gifts from suppliers or contractors:

- Gifts from suppliers or contractors doing business (or likely to do business) with the organisation should be declined, whatever their value.
- Low cost branded promotional aids such as pens or keyrings may be accepted where they are under the value of £6 in total and need not be declared.

Gifts from other sources (patient, families, services users ect)

- Gifts of cash and vouchers to individuals should always be declined
- Staff should not ask for any gifts
- Gifts valued at over £50 should not be accepted. These should be declared by staff
- Modest gifts accepted 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

What should be declared?

- Staff name and their role with the organisation
- A description of the nature and value of the gift, including its source
- Date of receipt
- Any other relevant information (e.g., circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy), Senior approval must be obtained.
- You need to make your declaration at the earliest opportunity and within 28-days of receiving the offer of the gift.

13.2 Hospitality

Guiding principles of hospitality are:

- 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
- Caution should always be exercised when hospitality is offered by actual or potential suppliers or contractors. This can be accepted, and must be declared, if modest and reasonable. Senior approval must be obtained.
- You need to make your declaration at the earliest opportunity and within 28-days of receiving the offer of the hospitality.

Meals and refreshments:

- Under a value of £25 - may be accepted and need not be declared
- Of a value between £25 and £75 - may be accepted and must be declared
- Over a value of £75 - should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on the organisation's register(s) of interest as to why it was permissible to accept
- A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or a reasonable estimate).

Travel and accommodation:

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

- offers of foreign travel and accommodation.

What should be declared?

- Staff name and their role with the organisation
- The nature and value of the hospitality including the circumstances
- Date of receipt
- Any other relevant information (e.g., action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy)

13.3 Outside employment (including directorships and officer appointments)

- Staff should declare any existing outside employment on appointment
- Staff should seek written permission from a director for any new employment (outside of the ICB) and declare it
- Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks

The organisation may also have legitimate reasons within employment law for knowing about outside employment of staff, even when this does not give rise to risk of a conflict. Staff should refer to the ICB policies on recruitment and their individual staff contract. If in doubt staff should discuss the matter with their line manager and/or ICB Corporate Affairs team.

The ICB has determined that individuals may not hold dual employment where they may be asked to undertake tasks which would assist the provider to meet the requirements of their contract with the ICB.

The ICB has further determined that individuals cannot hold a position of 'significant influence' in a provider organisation. 'Significant influence' is defined as Board level (or equivalent) position in any provider organisation. Specifically, a Board level role can only be held in either the ICB or a provider organisation.

The above paragraphs on secondary employment do not apply to ICB Board Partner Members and the VCSE Member who may be employed by a provider organisation.

What should be declared?

- Staff name and their role with the organisation
- The nature of the outside employment (e.g., who it is with, a description ofduties, time commitment)
- Relevant dates
- Other relevant information (e.g., action taken to mitigate against a conflict,details of any approvals given to depart from the terms of this policy)

13.4 Shareholdings and other ownership matters

- 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 organisation
- Where shareholdings or other ownership interests are declared and give

rise to, or risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks

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

What should be declared?

- Staff name and their role with the organisation
- Nature of the shareholdings/other ownership interest, including the percentageshareholding
- Relevant dates
- Other relevant information (e.g., action taken to mitigate against a conflict,details of any approvals given to depart from the terms of this policy)

13.5 Patents

- Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by the organisation
- Staff should seek prior permission from the organisation before entering into any agreement with bodies regarding product development, research, work on pathways etc, where this impacts on the organisation's own time, or uses its equipment, resources, or intellectual property
- Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

What should be declared?

- Staff name and their role with the organisation
- A description of the patent
- Relevant dates
- Other relevant information (e.g., action taken to mitigate against a conflict,details of any approvals given to depart from the terms of this policy)

13.6 Loyalty interests

Loyalty interests should be declared by staff involved in decision making where they:

- Hold positions of authority in another NHS Organisation or commercial, charity, voluntary, professional, statutory, or other body which could be seen to influence decisions they take in their NHS role.
- Sit on advisory groups or other paid or unpaid decision making forums that can influence how an organisation spends taxpayers' money
- Are, or could be, involved in the recruitment or management of close

family members and relatives, close friends and associates, and business partners

- Are aware that their organisation does business with an organisation in which close family members and relatives, close friends and associates, and businesspartners have decision making responsibilities.

What should be declared?

- Staff name and their role with the organisation
- A description of the patent
- Relevant dates
- Other relevant information (e.g., action taken to mitigate against a conflict,details of any approvals given to depart from the terms of this policy)

13.7 Donations

- Donations made by suppliers or bodies seeking to do business with the organisation should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value
- Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the organisation, or is being pursued on behalf of the organisation's own registered charity or other charitable body and is not for their own personal gain
- Staff must obtain permission from the organisation if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the organisation's own
- Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued
- Staff wishing to donate to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

What should be declared?

- The organisation will maintain records in line with the above principles andrules and relevant obligations under charity law.

13.8 Sponsored events

- Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit for the organisation and the NHS
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation
- No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied

- At the organisation'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
- Staff within the organisation involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event
- Staff arranging sponsored events must declare this to the organisation prior to the event
- Any sponsorship should be approved in advance by the ICB Corporate Affairs team. Disputes regarding whether sponsorship should be accepted will be referred to the ICB Chair or Conflicts of Interest Guardian for resolution.

What should be declared?

- The organisation will maintain records regarding sponsored events in line with the above principles and rules

13.9 Sponsored research

- Funding sources for research purposes 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 organisation, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services
- 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 organisation.

What should be declared?

- The organisation will retain written records of sponsorship of research, in linewith the above principles and rules
- Staff should declare:
    - Their name and their role with the organisation
    - Nature of their involvement in the sponsored research
    - Relevant dates
    - Other relevant information (e.g., what, if any, benefit the sponsor derives from the sponsorship, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy)
    - The declaration should be made using the ICB template available on the intranet or at Appendix C

13.10 Clinical private practice

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

- Where they practice (name of private facility)
- What they practice (specialty, major procedures)
- When they practice (identified sessions/time commitment).

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

Medical staff 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

What should be declared?

- Staff name and their role with the organisation
- A description of the nature of the private practice (e.g., what, where and when staff practice, sessional activity, etc)

For a visual guide of the above categories please see Appendix D

14 Strategic decision-making groups

14.1 In common with other NHS bodies the ICB uses a variety of different groups to make key strategic decisions about things such as:

- Entering into (or renewing) large scale contracts
- Awarding grants
- Making procurement decisions.
- Selection of medicines, equipment, and devices.

14.2 The interests of those who are involved in these groups should be well known so that they can be managed effectively. For this organisation these groups are:

- The Board of the ICB
- Integrated Care Partnership
- Finance Committee
- Primary Care Commissioning Committee
- Remuneration, People and Culture Committee
- Audit & Risk Committee
- Conflicts of Interest Committee
- Performance Committee

- Quality and Safety Committee

14.3 These groups should adopt the following principles:

- Chairs should consider any known interests of members in advance, and begin meetings by asking for declarations of relevant material interests
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise
- Any new interests identified should be added to the organisation's register(s)
- The vice chair (or other non-conflicted member) should chair all or part of the meeting if the chair has an interest that may prejudice their judgement.

14.4 If a member has an actual or potential interest the Chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

- Requiring the member to not attend the meeting
- Excluding the member from receiving meeting papers relating to their interest
- Excluding the member from all or part of the relevant discussion and decision
- Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate
- Removing the member from the group or process all together

14.5 The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. Good judgement is required to ensure proportionate management of risk

15 Procurement

15.1 Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour, which is against the interest of patients and the public.

15.2 Those involved in procurement exercises for and on behalf of the organisation should keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage of procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process.

15.3 The ICB will publish registers of procurement decisions, which will include any actions that have been taken to manage conflicts of interests.

15.4 Advice on managing conflicts of interests in relation to procurement decisions can be obtained from the procurement team.

16 Breaches

16.1 There will be situations when interests will not be identified, declared, or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as 'breaches'.

16.2 Staff who are aware of actual breaches of this policy, or who are concerned that there has been, or may be, a breach, should report these concerns to one or all of the following:

- The ICB's Conflicts of Interest Guardian
- Director of Corporate Affairs and ICS Development
- Anti-Crime Specialist

16.3 To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Every individual has a responsibility to do this.For further information about how concerns should be raised please refer to the Freedom to Speak Up (Whistleblowing) Policy available on the ICB intranet

16.4 The organisation will investigate each reported breach according to its own specific facts and merits and give relevant parties the opportunity to explain and clarify any relevant circumstances. Following the investigation, the ICB will:

- Decide if there has been or is potential for a breach and if so what the severity of the breach is
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum
- Consider who else inside and outside the organisation should be made aware
- Take appropriate action as set out in the next section.

16.5 Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of the organisation and could involve organisational leads for staff support (e.g., Human Resources), fraud (e.gAnti-Crime Specialists), members of the management or executive teams and organisational auditors.

Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process, and procedures
- Consideration as to whether HR/employment law/contractual action should betaken against staff or others
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS Protect, the Police, statutory healthbodies (such as NHS England, NHS Improvement or the CQC), and/or health professional regulatory bodies.

16.6 Inappropriate or ineffective management of interests can have serious implications for the organisation and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

16.7 A report on any breaches, the impact of these, and action taken will be considered by the Audit & Risk Committee at the meeting following identification of the breach.

To ensure that lessons are learnt, and management of interests can continually improve, anonymised information on breaches, the impact of these, and action taken will be prepared and published on the ICB website as appropriate or made available for inspection by the public upon request.

Appendix A

Template Declaration of interests for ICB Board Members, employees and those working for the ICB.

Name:	
Position within, or relationship with, NHS Norfolk and Waveney ICB	

Detail of interests held (complete all that are applicable):

Type of Interest* *See reverse of form for details	**Description of Interest (including for indirect Interests, details of the relationship with the person who has the interest)**	**Date interest relates From & To**		**Actions to be taken to mitigate risk (to be agreed with line manager or a senior ICB manager)**

***If you have more interests to list please insert extra lines**

If you have no interests to declare and wish to submit a nil return, please tick this box ☐

Data Protection and Freedom of Information
In accordance with the Data Protection Act 2018 the information provided in completing this form will be held by the ICB in both paper and electronic forms. For further details on how the ICB processes personal information please see our Fair Processing Notice. It should also be noted that information provided to the ICB may be subject to release under the Freedom of Information Act 2000.

Statutory duties and publication
Consistent with Section 140 of the NHS Act 2006 and NHS England's guidance to ICBs on the management of conflicts of interest we are required to hold and publish the interests of members and employees to comply with our statutory duties.

As a minimum, and as described within the guidance, ICBs are expected to publish the interests of its members (i.e. board and committees), those involved in procurement decisions, any persons involved in developing new care models, those at AfC 8d and above, management with authority to enter into contracts and management whom have the authority to make or influence commissioning decisions on behalf of the ICB.

Staff who fall into the above categories should expect their interests to be published online unless in exceptional circumstances where the public disclosure of information could lead to a real risk of harm or is prohibited by law. Similarly, if a person believes that substantial damage or distress may be caused to them or somebody else by the public disclosure of information, they are entitled to request that the information is not published. Requests should be set out in the free text box below.

Reasons for non-disclosure of information….

In this case, if the request to withhold the information is approved, the person's name will be removed from the record and the interest will be published anonymously.

**please see page 2 and 3 for more information

Please confirm below which Norfolk & Waveney ICB Committees you belong to or attend:	
☐ ICB Board	☐ Integrated Care Partnership
☐ Conflicts of Interest Committee	☐ Audit and Risk Committee
☐ Performance Committee	☐ Quality and Safety Committee
☐ Remuneration, People and Culture Committee	☐ Primary Care Commissioning Committee
☐ Finance Committee	☐ Other

I am registered with a surgery which is a member of Norfolk and Waveney ICB	
If yes, the surgery I am registered with is:	

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to the ICB as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, or internal disciplinary action may result.

Signed				**Date**	
Signed		**Position**		**Date**	

(Line Manager or Senior ICB Manager)

Please return completed forms to: nwicbcorporateaffairs@nhs.net

Type of Interest	Description
Financial Interests	This is where an individual may get direct financial benefits from the consequences of a commissioning decision. This could, for example, include being: • A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations; • A shareholder (or similar owner interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations. • A management consultant for a provider; • In secondary employment (see paragraph 56 to 57); • In receipt of secondary income from a provider; • In receipt of a grant from a provider; • In receipt of any payments (for example honoraria, one off payments, day allowances or travel or subsistence) from a provider • In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and • Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).
Non-Financial Professional Interests	This is where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career. This may, for example, include situations where the individual is: • An advocate for a particular group of patients; • A GP with special interests e.g., in dermatology, acupuncture etc. • A member of a particular specialist professional body (although routine GP membership of the RCGP, BMA or a medical defence organisation would not usually by itself amount to an interest which needed to be declared); • An advisor for Care Quality Commission (CQC) or National Institute for Health and Care Excellence (NICE); • A medical researcher.

Type of Interest	Description
Non-Financial Personal Interests	This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is: • A voluntary sector champion for a provider; • A volunteer for a provider; • A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation; • Suffering from a particular condition requiring individually funded treatment; • A member of a lobby or pressure groups with an interest in health.
Indirect Interests	This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision (as those categories are described above). For example, this should include: • Spouse / partner; • Close relative e.g., parent, grandparent, child, grandchild or sibling; • Close friend; • Business partner.

Appendix B

NHS Norfolk and Waveney Integrated Care Board (ICB) Register of Interests Declared Interests of the XXXXXXXXXXXX										
Name	Current position	Declared Interest- (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional	Non-Financial Personal Interests			From	To	

Appendix C

Recipient Name	Position	Date of Offer	Date of Receipt (if applicable)	Declined or Accepted?	Supplier/Offer or: Name and Nature of Business	Details of Gift/Hospitality	Estimated Value	Details of previous offers or Acceptance by the Offer or/Supplier	Reason for Accepting or Declining	Details of the officer reviewing and approving the declaration made and date	Other Comments

The information submitted will be held by the ICB for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 2018. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and in the case of 'decision making staff' (as defined in the statutory guidance on managing conflicts of interest for ICBs), may be published in registers that the ICB holds.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to the ICB as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, professional regulatory or internal disciplinary action may result.
Decision making staff should be aware that the information provided in this form will be added to the ICB's registers which are held in hardcopy for inspection by the public and published on the ICB's website.

Decision making staff must make any third party whose personal data they are providing in this form aware that the personal data will held in hardcopy for inspection by the public and published on the ICB's website and must inform the third party that the ICB's privacy policy is available on the ICB's website. If you are not sure whether you are a 'decision making' member of staff, please speak to your line manager before completing this form.

Signed: Date:

Signed: Position: Date:
(Line Manager or a Senior ICB Manager)

Appendix D

<table>
<tr><th>What is a gift of hospitality?</th><th>What can't I accept?</th></tr>
<tr><td>Gift:
Any item of cash or goods, or any service which is provided for personal benefit, free of charge or at less than its commercial value.

Hospitality:
Meals/drinks/visits/entertainment/lecture courses organised by potential suppliers. It must only be accepted when there is legitimate reason, must be proportionate to the nature and purpose of the event and must be recorded.</td><td rowspan="4">• Gifts from suppliers or contractors doing business with the ICB (or likely to) whatever the value
• Cash and vouchers

Meals and refreshments:
• Over £75 must be refused (unless exceptional and senior approval is given – reason for approval must be recorded on the register)

Travel and accommodation:
• If its beyond modest and not normal for the ICB, it should only be accepted in exceptional circumstances and must be declared with a clear reason recorded on the register – for example business or first-class travel, foreign travel and accommodation</td></tr>
<tr><th>What can I accept?</th></tr>
<tr><td>Meals and refreshments:
• Under £25 may be accepted and need not be declared.
• £25 - £75 may be accepted, but must be declared.

Travel and accommodation:
• Modest offers to pay for some travel and accommodation costs related to attendance may be accepted and must be declared.</td></tr>
<tr><td>Low cost branded promotional aids e.g. pens and keyrings under £6</td></tr>
<tr><td>Modest gifts under £25 from non-suppliers, and non-contractors</td></tr>
<tr><th>What to do if I accept a gift or hospitality</th><th>How do I refuse a gift?</th></tr>
<tr><td>Within no later than 14 days you must complete the form (at appendix C) and return it to the Corporate Affairs team for inclusion on the register.</td><td>Politely refuse, explaining the policy and advise the donor that, if they wish, they are welcome to make a contribution to a charitable cause instead</td></tr>
<tr><th>What happens to my form and the register?</th><th>What must you not do</th></tr>
<tr><td>• The information from your form is included in the master register
• The master register has to be published on the ICB's website and in the Annual Report and Accounts
• You can ask that your information is not published.
• The ICB has to report quarterly on its management of interests, gifts and hospitality and this information will be shared with regulators as part of this process.</td><td>You must not ask for any gifts or hospitality

You should not accept gifts that may affect or be seen to affect your professional judgement.</td></tr>
<tr><td></td><th>When to be caution</th></tr>
<tr><td></td><td>When hospitality if offered by actual or potential suppliers or contractors. If it's</td></tr>
</table>

	modest and reasonable it can be accepted (subject to senior approval) Gifts over £25 can only be accepted on behalf of the ICB (i.e. to a charitable fund) bit not in a personal capacity. **They must be declared** Multiple gifts from the same source, over a 12 month period, must be treated the same as single gifts over £25 where the cumulative value exceeds £75

SECTION 9
Standards of Business Conduct Policy

Revision History

Document Control Sheet

Revision Date	Summary of changes	Author(s)	Version Number

Approvals
This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number

Document Control Sheet

Policy title	Standards of Business Conduct Policy
Policy area	This Policy has been prepared and reviewed by the Corporate Affairs team.
Who is it aimed at and which settings?	.
Approved by	
Effective date	
Review date	Every two years or sooner if required by changes in legislation or guidance.

1. Statement of Intent

1.1. Compliance with the national Code of Conduct and Code of Accountability in the NHS (revised 2004) and other codes as set out at section 1.3 below is integral to the work of NHS Norfolk and Waveney Integrated Care Board (the "ICB"). These Codes form the core framework for the conduct of business in our organisation and apply to members of the Board, its committees, employees of the ICB.

1.2. In response to audit recommendations, the adoption of these Codes by Practice by the members of the Board, its committees and employees will be affirmed formally on an annual basis on behalf of the ICB by the Board.

1.3 That there are 4 main codes of conduct and good governance that apply to NHS organisations. These documents are:

- Code of conduct and accountability (revised 2004)
- Standards for members of NHS boards and CCG Governing Bodies in England (2013)
- Code of conduct for NHS managers (2002)
- Standards of business conduct for NHS staff (1993) (Amended, in part, by the Bribery Act 2010)

And any future iterations of the above codes.

2. Code of *Conduct*

2.1. **Public service values must be at the heart of the National Health Service** and high standards of corporate and personal conduct, based upon the recognition that patients come first, have been a requirement throughout the NHS since its inception.

2.2. There are three crucial public service values that underpin the work of the health service:

2.2.1. **Accountability** – everything done by those who work in the NHS must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct;

2.2.2. **Probity** – there should be an absolute standard of honesty in dealing with the assets of the NHS: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff, and suppliers, and in the use of information acquired in the course of NHS duties**;**

2.2.3. **Openness** – there should be sufficient openness about NHS activities to promote confidence between the ICB Board, Members of the ICB, its staff, and patients and the public.

2.3. General Principles

2.3.1. **Public service values matter** in the NHS and those who work in it have a duty to conduct NHS business with probity. They have a responsibility to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct.

2.3.2. The success of the Code depends on vigorous and visible examples from Members of the Board of the ICB, and the consequent influence on the

behaviour of all those who work within the organisation. Members of the board of the ICB, have a clear responsibility for corporate standards of conduct, and acceptance of the Code informs and governs decisions and conduct.

2.4 Openness and Public Responsibilities

2.4.1 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.

2.4.2 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.

2.4.3 The confidentiality of personal and individual patient information must be respected at all times.

3. Accountability- Code of *Accountability*

3.1. This code of practice is the basis upon which NHS organisations seek to fulfil the duties and responsibilities conferred upon them by the Secretary of State for Health.

3.2. The ICB will co-operate fully with the Department of Health, the National Audit Office and the Care Quality Commission when required to account for the use it has made of public funds, the delivery of patient care and compliance with the statutes, directions, guidance and policies of the Secretary of State. The Public Accounts and Public Administration Select Committees scrutinise the work of the health service.

3.3. In addition, the ICB will be accountable to NHS England for how we fulfil our statutory duties. The ICB will also account to our local community for how we commission high quality health care, the Norfolk health and well-being board and the Suffolk health and well-being Board for how we deliver the joint health and well-being strategy and Norfolk County Council and Suffolk County Council in their overview and scrutiny role for the services we are commissioning.

3.4 Reporting and Controls

3.4.1 The Code requires that a balanced and readily understood assessment of the ICB's performance be presented to NHS England, the National Audit Office and the local community by means of timely publication of the Annual Report and Annual Accounts. The detailed financial guidance issued by the NHS England in this regard, including the role of internal and external auditors, must be scrupulously observed.

4. The Board

4.1 The Board of the ICB comprises:
- 4.1.1 Independent Chair;
- 4.1.2 Chief Executive;
- 4.1.3 Non-Executive Members;
- 4.1.4 Director of Nursing, Director of Finance and a Medical Director;
- 4.1.5 Partner Members; and
- 4.1.6 Other members including VCSE Board Member and an ICP Member

4.2 Members of the Board share corporate responsibility for all decisions made, with a clear division of responsibility between the Chair and the Chief Executive.

4.3 The Chief Executive is directly accountable to the Board for meeting the ICB's objectives and to the Chief Executive of NHS England for the performance of the organisation. The Chair and non-executive members are responsible for monitoring the executive management of the organisation and are responsible to NHS England for the discharge of these responsibilities.

5 Probity

5.1 The ICB considers integrity and honesty as key public service values. These are central to the operations of the ICB and those that work within it. It is recognised that the ICB should not only act with probity in all its processes but also be perceived to have acted in this way. Accordingly, the ICB has adopted a stringent conflict of interest policy as set out in its Conflict of Interest Policy and in the ICB's Constitution at section 6.

5.2 Adherence to Conflicts of Interest requirements is mandatory and any breaches will be reported and published on the ICB's website; disciplinary action may also be taken.

6 Openness

6.1 The ICB will promote transparency at all times by:

6.1.1 Ensuring early engagement on proposed commissioning plans with patients and the public, Norfolk Health and Well-being Board, Suffolk Health and Well-being Board, current and potential providers and clinical networks;

6.1.2 Setting out clearly in the Constitution the way in which decisions will be made;

6.1.3 Holding Board meetings in public (except where this would not be in the public interest) and also holding a public meeting to present the Annual Report and considering whether they wish to hold any other meetings in public;

6.1.4 Publishing details of expenditure over £25,000;

6.1.5 Publishing information about remuneration for senior staff;

6.1.6 Have a Register of Interests for:

- Board members;
- Employees
- Committee members; and
- Any individual directly involved with the business or decision making of the ICB;

6.1.7 Having systems to declare interests.

6.2 This will enable patients to see what services are being commissioned and how the quality of these services is being constantly improved as well as how public money is being spent. The ICB also has a communications and engagement strategy which further sets out how it will communicate with Members of the ICB, providers, and patients, the public and other stakeholders.

6.3 In addition, 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.

6.4 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.

7 Code of Conduct for NHS Managers

7.1 This Code, in addition to those already described, forms a key part of the contract held by Very Senior Managers – those executive members of the Board. Very Senior Managers undertake to:

7.1.1 *'make the care and safety of patients my first concern and act to protect them from risk;*

7.1.2 *respect the public, patients, relatives, carers, NHS staff, and partners in other agencies;*

7.1.3 *be honest and act with integrity;*

7.1.4 *accept responsibility for my own work and the proper performance of the people I manage;*

7.1.5 *show my commitment to working as a team member by working with all my colleagues in the NHS and the wider community; and*

7.1.6 *take responsibility for my own learning and development'.*

8 Standards of Business Conduct for NHS Staff, HSG (93) 5- Amended, in part, by the Bribery Act 2010.

8.1 All NHS Staff are expected to:

8.1.1 ensure that the interests of patients remain paramount at all times;

8.1.2 be impartial and honest in the conduct of their official business;

8.1.3 use the public funds entrusted to them to the best advantage of the service, always ensuring value for money.

8.2 It is the responsibility of staff to ensure that they do not:

8.2.1 abuse their official position for personal gain or to benefit their family or friends (including but not limited recruitment of family or friends);

8.2.2 seek advantage or further private business or other interests, in the course of their official duties.

8.3 Registration of Interests

8.3.1 It is the responsibility of all staff to ensure that they register their interests and declare all real or perceived conflicts of interests as a matter of course and on an ongoing basis. Staff should ensure that the register of interests is updated as soon as an interest or conflict is known.

8.3.2 That they do not seek advantage of a non-pecuniary personal benefit where an individual may enjoy a qualitative benefit from the consequence of a commissioning decision which cannot be given a monetary value (e.g. a

reconfiguration of hospital services which might result in the closure of a busy clinic next to an individual's house).

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

9 The Nolan Principles[1]

9.1 The Code of Conduct and Code of Accountability in the NHS reflect the Committee for Standards in Public Life's Seven Principles of Public Life – also known as the Nolan Principles (set out below). The Nolan Principles of business conduct have been adopted by the ICB and apply to all staff employed by the ICB.

- **Selflessness**
  Holders of public office should act solely in terms of the public interest.

- **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.

- **Objectivity**
  Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

- **Accountability**
  Holders of public office are accountable to the public for their decisions and actions and must admit themselves to the scrutiny necessary to ensure this.

- **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.

- **Honesty**
  Holders of public office should be truthful.

- **Leadership**
  Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

10 Standards for NHS Boards and ICB Board Members

10.1 All members of NHS boards and ICB Boards must understand and be committed to the practice of good governance and to the legal and regulatory frameworks in which they operate. As individuals they must understand both the extent and limitations of their personal responsibilities.

10.2 **Members must commit to promoting:**

[1] Source: Standards Matter. A review of good practice in promoting good behaviour in public life, January 2013. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228884/8519.pdf

- the values of the NHS Constitution;
- equality; and
- human rights

in the treatment of patients and service users, their families and carers, the community, colleagues and staff, and in the design and delivery of services for which they are responsible.

10.3 **They must seek:**

- excellence in clinical care, performance, patient experience, and the accessibility of services;
- to make sound decisions individually and collectively;
- long-term financial stability and the best value for the benefit of patients, service users and the community;
- to ensure their organisation is fit to serve its patients and service users, and the community;
- to be fair, transparent, measured, and thorough in decision-making and in the management of public money; and
- to be ready to be held publicly to account for their organisation's decisions and for its use of public money.

11 Managing Conflicts of Interest: General

11.1 To ensure the integrity and probity of decision-making the ICB is required to make arrangements to manage conflicts of interest and potential conflicts of interest so that decision making is taken and seen to be taken without possibility of the influence of external or private interest[2]. Individuals must declare any interest they have in writing to the Board as soon as practicable after the person becomes aware of it and in any event no later than 28 days of becoming aware. The Board will instruct the Director of Corporate Affairs and ICS Development to update the Registers of Interests accordingly. Members of the Board of the ICB, its committees and staff will act impartially and will not be influenced by social or business relationships; no-one will use their public position to further their private interests. Where there is potential for private interests to be material and relevant to NHS business, these will be declared, recorded in the relevant minutes, and entered into the Register of Interests, which is available for public inspection on our website at www.improvinglivesnw.org.uk and available on request from our headquarters.

11.2 Members of the Board of the ICB, its committees and staff will declare, and keep up to date, details of any personal or business interests, which may influence, or may be *perceived* to influence, their judgement. As a minimum the Register of Interests will be reviewed on an annual basis.

11.3 **Interests can be captured in four different categories**:

11.3.1 Financial interests: This is where an individual may get direct financial benefits from the consequences of a commissioning decision. This could, for example, include being:

- A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations. This includes involvement with a potential provider of a new care model;
- A shareholder (or similar ownership interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations;
- A management consultant for a provider; or
- A provider of clinical private practice.

This could also include an individual being:

- In employment outside of the ICB;
- In receipt of secondary income;
- In receipt of a grant from a provider;
- In receipt of any payments (for example honoraria, one-off payments, day allowances or travel or subsistence) from a provider;
- In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and
- Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).

11.3.2 Non-financial professional interests: This is where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career. This may, for example, include situations where the individual is:

- An advocate for a particular ICB of patients;
- A GP with special interests e.g., in dermatology, acupuncture etc.
- An active member of a particular specialist professional body (although routine GP membership of the Royal College of General Practitioners (RCGP), British Medical Association (BMA), Royal College of Nursing or a medical defence organisation would not usually by itself amount to an interest which needed to be declared);
- An advisor for the Care Quality Commission (CQC) or the National Institute for Health and Care Excellence (NICE);
- Engaged in a research role;
- The development and holding of patents and other intellectual property rights which allow staff to protect something that they create, preventing unauthorised use of products or the copying of protected ideas; or
- GPs, other healthcare professionals and practice managers, who are members of the Board or committees of the ICB, should declare details of their roles and responsibilities held within their GP practices.

11.3.3 Non-financial personal interests: This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is:

- A voluntary sector champion for a provider;
- A volunteer for a provider;
- A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation;
- Suffering from a particular condition requiring individually funded treatment;
- A member of a lobby or pressure group with an interest in health.

11.3.4 Indirect interests: This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision (as those categories are described above) for example, a:

- Spouse / partner
- Close family member or relative e.g., parent, grandparent, child, grandchild or sibling;
- Close friend or associate; or
- Business partner.

A declaration of interest for a "business partner" in a GP partnership should include all relevant collective interests of the partnership, and all interests of their fellow GP partners (which could be done by cross referring to the separate declarations made by those GP partners, rather than by repeating the same information verbatim).

Whether an interest held by another person gives rise to a conflict of interests will depend upon the nature of the relationship between that person and the individual, and the role of the individual within the ICB.

11.4 If in doubt whether a conflict exists, the individual concerned should assume that a potential conflict of interest exists.

12 Arrangements for Managing Conflicts

12.3 The Board will ensure for every interest declared arrangements are in place to manage the conflict. The Board can take advice on this role from the Director of Corporate Affairs and ICS Development. Where a conflict of interest is seen to exist there are a number of ways in which the conflict may be managed depending on the magnitude of its impact. These actions include but are not limited to the Board confirming to the individual in writing:

12.3.2 permission to participate and contribute to a discussion but not allowed to count towards the quorum for any decision or vote;

12.3.3 permission to observe the discussion, but prohibited from participating in the discussion and not allowed to count towards the quorum for any decision or vote;

12.3.4 Permission to receive relevant meeting papers but be excluded from the meeting for the relevant item. The individual(s) may be called back to the meeting following conclusion of all discussion in relation to that item. However, should the same item be raised in later discussions they should be excluded again;

12.3.5 Prohibiting access to papers relating to the relevant item and exclusion from the meeting for the relevant item

12.4 Where no arrangements have been confirmed the Chair of the meeting may require the individual to withdraw from the meeting or part of it, in accordance with section 10.1.3 above. The individual will comply with these arrangements which must be recorded in the minutes of the meeting.

12.5 Managing Meetings

12.5.2 Before attending any meeting, Members of the Board or committee members and staff will consider whether they have a conflict of interest pertaining to the meeting's agenda; they will declare such interests as soon as they are recognised, (preferably in writing) and have an on-going duty to consider whether a conflict of interest exists.

12.5.3 If the conflict has been declared previously and a plan for management has been put in place by the Board in accordance with section 10.1 above, this should be followed. If this is a new conflict of interest, this must be discussed with the Chair of the meeting who will determine if it represents a material conflict.

12.5.4 Where a conflict is of such magnitude or will persist for such a significant period of time that in the view of the Chair in consultation with the Chief Executive that it will materially impact on the ability of the affected member to carry out his duties effectively, then the affected member can be asked to either stand down from the Board or other committee or to make arrangements to end the conflict of interest for example by resigning from another post.

13 Failure to comply with Conflicts of Interest requirements

13.1 If an individual fails to comply with this policy and as set out in section 6 of the ICB Constitution, the individual will be subject to the ICB Disciplinary Policy. The matter, if considered appropriate, may also be referred to the Anti- Crime Specialist, for investigation, and may lead to criminal proceedings being commenced.

14 Failure to Disclose / Declare

14.1 The ICB is committed to the national Code of Conduct and Code of Accountability in the NHS (revised 2004) and as such takes the failure to disclose such information as required by this policy seriously. It is an offence under the Fraud Act 2006, for personnel to fail to disclose information to the ICB in order to make a gain for themselves or another or to cause a loss or expose the organisation to a loss. Therefore, where personnel have failed to disclose relevant and material information, the policy on Counter Fraud, Bribery and Corruption should be consulted and an appropriate referral made to the ICB's Anti-Crime Specialist, Lisa George on 07825 827024 or via email on lisa.george@tiaa.co.uk or lisa.george4@nhs.uk.

15 Procurement

Providing Assurance: Transparent Commissioning

15.1 The template attached at Appendix 1 sets out the factors that will provide assurance to the Board and the Audit Committee – and other interested parties including local communities, the Health and Wellbeing Board and auditors – that services have been commissioned in a consistent and transparent way; that they meet local needs and priorities; and that a robust process has been followed.

15.2 The details of all contracts awarded following procurement will be published on appropriate websites (for example Contracts Finder, OJEU).

Managing Conflicts of Interest: Commissioning Services from GP Practices

15.3 It is an essential feature of reforms that ICBs should be able to commission a range of community-based services, including primary care services, to improve quality and outcomes for patients. Where the provider for these services might be a GP practice, the ICB will demonstrate that those services:

15.3.1 clearly meet local health needs and have been planned appropriately;

15.3.2 go beyond the scope of the GP contract; and that

15.3.3 the appropriate procurement approach is used.

Procurement and Register of procurement decisions

15.4 Any ICB staff or Board members involved in procurement, their family, or if there is someone known to them that stands to benefit personally from awarding the contract, they should declare this immediately. They must declare and record on the Register of Staff Interests any monetary interest (or other relevant personal or professional material benefit) which may influence, (or may be construed by others to influence) their impartiality in the procurement decision making process. Relevant and material interests are defined by the Policy as:

15.4.1 Directorships, including non-executive directorships held in private companies or PLC's (with the exception of those of dormant companies);

15.4.2 Ownership, part-ownership or directorship of private companies, businesses or consultancies likely or possible seeking to do business with the NHS;

15.4.3 Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS;

15.4.4 A position of authority in a charity or voluntary organisation in the field of health and social care;

15.4.5 Any connection with a voluntary or other organisation for NHS services or commissioning NHS services;

15.4.6 To the extent not covered above, any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the ICB, including but not limited to lenders or banks.

15.5 If staff have any doubt about the relevance or materiality of an interest, this should be discussed with the Director of Corporate Affairs and ICS Development. In any instance where staff wilfully choose not to inform the Director of Corporate Affairs and ICS Development and is later found to have benefitted personally from the award of a

contract the Director of Corporate Affairs and ICS Development will seek to follow the ICB disciplinary procedure and the matter may also be referred to the Anti-Crime Specialist for investigation.

15.6 The ICB will maintain a register of procurement decisions taken, including the details of the decision; who was involved in making the decision (e.g. Board or committee members and others with decision-making responsibility); and a summary of any conflicts of interest in relation to the decision and how this was managed by the ICB. The register will form part of the ICB's annual accounts and will be signed off by external auditors.

15.7 The ICB recognises the importance of managing any conflicts or potential conflicts of interest that may arise in relation to procurement. The Procurement, Patient Choice and Competition Regulations 2013 place requirements on commissioners to ensure that they adhere to good practice in relation to procurement, do not engage in anti-competitive behaviour that is against the interest of patients, and protect the right of patients to make choices about their healthcare. The regulations set out that commissioners' must manage conflicts and potential conflicts of interests when awarding a contract by prohibiting the award of a contract where the integrity of the award has been, or appears to have been, affected by a conflict; and keep appropriate records of how they have managed any conflicts in individual cases.

16 Bribery Act 2010

16.1 The ICB has a responsibility to ensure that all its employees including Members of the ICB, Board and any committee members are made aware of their duties and responsibilities under the Bribery Act 2010. Under this act there are four offences:

16.1.1 Bribing or offering to bribe another person (section1)

16.1.2 Requesting, agreeing to receive, or accepting a bribe (section 2)

16.1.3 Bribing, or offering to bribe a foreign public official (section 6)

16.1.4 Failing to prevent bribery (section 7)

16.2 All the ICB's employees, including Members of the board of the ICB, and any committee members should be aware of the Bribery Act 2010 and should refer to the sections below on acceptance of gifts and hospitatlity for further guidance.

17 Acceptance of Gifts

17.1 Under the Bribery Act 2010, it is an offence for personnel corruptly to accept any gifts or consideration as an inducement or reward for:

17.1.1 doing, or refraining from doing, anything in their official capacity; or

17.1.2 showing favour or disfavour to any person in their official capacity.

17.2 Under the Bribery Act 2010, any money, gift, or consideration received by a person engaged in public service from a person or organisation holding or seeking to obtain a contract will be deemed by the courts to have been received corruptly unless the employee proves the contrary.

In cases of doubt personnel should decline the gift or hospitality or consult with the Director of Corporate Affairs and ICS Development prior to accepting.

Staff and organisations should be mindful that even gifts of a small value may give rise to perceptions of impropriety and might influence behaviour if not handled in an appropriate way.

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.

17.3 **Overarching principles**

- Gifts should not be accepted that may affect, or be seen to affect, their professional judgement. This overarching principle should apply in all circumstances;

- 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 to the Director of Corporate Affairs and ICS Development and recorded on the register.

18 Gifts from suppliers or contractors

18.1 Gifts from suppliers or contractors doing business (or likely to do business) with the ICB should be declined, whatever their value (subject to this, low cost branded promotional aids may be accepted and not declared where they are under the value of a common industry standard of £6[3]). The person to whom the gifts were offered should also declare the offer to the Director of Corporate Affairs and ICS Development so the offer which has been declined can be recorded on the register.

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

18.2 ICB staff, Board and committee members and individuals within GP member practices should not ask for any gifts.

18.3 Modest gifts under a value of £50 may be accepted and do not need to be declared.

18.4 Gifts valued at over £50 should be treated with caution and only be accepted by the Chief Finance Officer on behalf of the ICB and not in any personal capacity. These should be declared.

18.5 A common sense approach should be applied to valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).

[3] The ABPI Code of Practice for the Pharmaceutical Industry. http://www.pmcpa.org.uk/thecode/Pages/default.aspx.

18.6 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.

19 Acceptance of Hospitality

19.1 Delivery of services across the NHS relies on working with a wide range of partners (including industry and academia) in different places and, sometimes, outside of 'traditional' working hours. As a result, ICB 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.

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

19.3 Overarching principles

- ICB staff, Board or committee members, 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.

19.4 Meals and Refreshments

- Under a value of £25 may be accepted and need not be declared.
- Of a value between £25 and £75[4] may be accepted and must be declared.
- Over a value of £75 should be refused unless (in exceptional circumstances) senior approval is given in writing by the Chief Finance Officer. 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).

19.5 Travel and Accommodation

[4] The ABPI Code of Practice for the Pharmaceutical Industry: http://www.pmcpa.org.uk/thecode/Pages/default.aspx

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

19.6 Failure to disclose gifts or hospitability in line with the procedures set out above could lead to criminal, civil or disciplinary sanctions being applied as described in paragraph

20 Commercial Sponsorship

21.1. Sponsorship of NHS events by external parties is valued. Offers to meet some or part of the costs of running an event secures their ability to take place benefiting NHS staff and patients. Without this funding there may be fewer opportunities for learning, development and partnership working. However, there is potential for conflicts of interest between the organiser and the sponsor, particularly regarding the ability to market commercial products or services. As a result, there should be proper safeguards in place to prevent conflicts occurring.

21.2 When sponsorships are offered, the following principles must be adhered to:

- 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.
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.
- No information should be supplied to the sponsor from which they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.
- 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.
- The ICB should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.
- Staff should declare involvement with arranging sponsored events to their ICB.

21.3 Offers of sponsorship may be accepted only if:

21.3.1 they are reasonably justifiable and in accordance with the principles set out in this policy.

21.3.2 Permission must be obtained from the Chief Finance Officer in writing, in advance using the form attached at Appendix 2 and will be recorded in the Gifts & Hospitality Register. The Chief Finance Officer should obtain permission from the Chief Officer.

21.4 Acceptance of corporate sponsorship should not in any way compromise commissioning or procurement decisions of the ICB or be dependent upon the purchase or supply of goods or services.

21.5 All offers of commercial sponsorship whether accepted or declined must be declared and included in the ICB's Register of Interests.

21.6 For the avoidance of doubt the ICB will adhere to the principles set out in the Managing Public Money document issued by HM Treasury dated July 2013 or any future iterations of the document.

21.7 **Other forms of sponsorship**

Organisations external to the ICB or NHS may also sponsor posts or research. However, there is potential for conflicts of interest to occur, particularly when research funding by external bodies does or could lead to a real or perceived commercial advantage, or if sponsored posts cause a conflict of interest between the aims of the sponsor and the aims of the organisation, particularly in relation to procurement and competition. There needs to be transparency and any conflicts of interest should be well managed. For further information see Managing Conflicts of Interest in the NHS: Guidance for staff and organisations.

22. Suppliers and Contractors

22.1 All ICB staff who are in contact with suppliers and contractors (including external consultants), and in particular those who are authorised to sign purchase orders or enter into contracts for goods and services are expected to adhere to professional standards in line with those set out in the Code of Ethics of the Chartered Institute of Purchasing and Supply[5].

22.2 All ICB staff must treat prospective contractors or suppliers of services to the ICB equally and in a non-discriminatory way and act in a transparent manner.

22.3 The ICB staff involved in the awarding of contracts and tender processes must take no part in the selection process if a personal interest or conflict of interest is known. Should such an interest become apparent, it must be declared using the ICB's Declaration of Interest Form as soon as possible. ICB staff should not at any time give undue advantage to any private businesses or other interests in the course of their duties.

22.4 The ICB has legal duties under the both European and UK procurement law and ICB staff must comply with the ICB's Procurement Strategy, Prime Financial Policies, and any relevant detailed financial policy in all contract opportunities.

[5] Code of Ethics of the Chartered Institute of Purchase and Supply available at https://www.cips.org/CIPS-for-Business/supply-assurance/Corporate-Ethical-Procurement-and-Supply/Corporate-Code-of-Ethics/

22.5 ICB staff must not seek, or accept, preferential rates or benefits in kind for private transactions carried out with companies they have official dealings with on behalf of the ICB. This does not apply to member benefit scheme schemes offered by the NHS or Trade Unions.

22.6 Every invitation to tender to a prospective bidder for ICB business must require each bidder to give a written undertaking, not to engage in collusive tendering or other restrictive practice and not to engage in canvassing the ICB, its employees or officers concerning the contract opportunity tendered.

23 Reporting/Raising Concerns and Breaches

23.1 There may be occasions when interests have not been identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of deliberate actions. All ICB management, staff and members should speak up about any genuine concerns in relation to compliance this policy. Officers can raise these concerns directly with their own line manager or alternatively with the Head of Corporate Governance.

23.2 All reported concerns will be treated with the appropriate confidentiality and investigated in line with the relevant ICB policies and procedures.

23.3 The Head of Corporate Governance will take a report on breaches and responses to the Audit Committee and the Board on an annual basis.

23.4 All staff must report any suspicions of fraud, bribery and corruption as soon as they become aware of them to the ICB's Counter Fraud Specialist (CFS), Lisa George to ensure that they are investigated appropriately and to maximise the chances of financial recovery. The CFS can be contacted on 07825 827024 or via email on lisa.george@tiaa.co.uk or lisa.george4@nhs.uk. Alternatively staff can contact the NHS Fraud and Corruption Reporting Line on 0800 028 40 60 or report the fraud online at https://cfa.nhs.uk/reportfraud

23.5 Officers may wish to report concerns using the internal Freedom to Speak Up: Raising Concerns Policy.

24. Secondary Employment

24.1 Employees, committee members, contractors and others engaged under contract with the ICB are required to obtain prior permission from their department Director to engage in any employment or consultancy work in addition to their work with the ICB.

24.2 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; and
- Self-employment, including private practice, 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.

24.3 The ICB reserves the right to refuse permission where it believes a conflict will arise and cannot be effectively managed.

25 Personal Conduct

a. Lending or borrowing

i. The lending or borrowing of money between staff should be avoided, whether informally or as a business, particularly where the amounts are significant.

ii. It is a particularly serious breach of discipline for any member of staff to use their position to place pressure on someone in a lower pay band, a business contact, or a member of the public to loan them money.

b. Gambling

No member of staff may bet or gamble when on duty or on ICB premises, with the exception of small lottery syndicates or sweepstakes related to national events such as the World Cup or Grand National among immediate colleagues.

c. Trading on official premises

Trading on official premises is prohibited, whether for personal gain or on behalf of others. Canvassing within the office by, or on behalf of, outside bodies or firms (including non-ICB interests of staff or their relatives) is also prohibited. Trading does not include small tea or refreshment arrangements solely for staff.

d. Collection of money

Charitable collections must be authorised by Corporate Services. Other flag day appeals are not permitted, and collection tins or boxes must not be placed in offices. With line management agreement, collections may be made among immediate colleagues and friends to support small fundraising initiatives, such as raffle tickets and sponsored events. Permission is not required for informal collections amongst immediate colleagues on an occasion like retirement, marriage or a new job.

e. Bankrupt or insolvent staff

Any member of staff who becomes bankrupt or insolvent must inform their line management and Human Resources as soon as possible. Staff who are bankrupt or insolvent cannot be employed in posts that involve duties which might permit the misappropriation of public funds or involve the handling of money.

f. Arrest or conviction

A member of staff who is arrested and refused bail or convicted of any criminal offence must inform their line management and Human Resources as the earliest opportunity.

26 References

a. Relevant polices and reference material that should be read in conjunction with this policy include:

- The ICB's Constitution;

- Managing Conflicts of Interest: Revised Statutory Guidance for CCGs, first published March 2013, updated June 2017;
- Conflicts of Interest in Primary Care: CAT A and B;
- NHS England, *Code of Conduct: Managing Conflicts of Interest where GP practices are potential providers of ICB-commissioned services,* first published June 2012;
- Policy on Fraud, Financial Irregularities and Corruption;
- Code of Conduct and Code of Accountability in the NHS (2004);
- Code of Conduct for NHS Managers 2002;
- Standards of Business Conduct for NHS Staff – HSG (93) 5 - Amended, in part, by the Bribery Act 2010;
- Code of Ethics of the Chartered Institute of Purchase and Supply;
- Standards for members of NHS boards and CCG Governing Bodies in England (2012)

Managing Public Money issued by HM Treasury dated July 2013.

Appendix 1

Annex G: 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?[i]	
11. What additional external involvement will there be in scrutinising the proposed decisions?	

SECTION 10
Petitions Policy

Revision History

Document Control Sheet

Revision Date	Summary of changes	Author(s)	Version Number

Approvals
This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number

Document Control Sheet

Policy title	Petitions Policy
Policy area	This Policy has been prepared and reviewed by the Corporate Affairs team.
Who is it aimed at and which settings?	.
Approved by	
Effective date	
Review date	Every two years or sooner if required by changes in legislation or guidance.

1. Introduction

A petition represents the expression of the views of the people who sign it. For the NHS Norfolk and Waveney Integrated Care Board ("the ICB"), petitions are an important mechanism for local people to have a voice on local health matters.

To ensure that voices are heard appropriately and in order to avoid the danger of listening only to active lobby groups, petitions will not be viewed in isolation but as one piece of evidence and information which contributes to an overall picture of public opinion. Petitions can be raised as a discrete statement by the signatories or as a response to a public consultation or proposal being made by the ICB.

This policy outlines how the ICB will handle any petitions received from the local community.

2. Scope

This policy relates to the receipt and management of either hard copy or e- petitions.

Petitions may be pro-active e.g. unsolicited; where there is public opinion that a new service may be required to fill a perceived gap in service provision or re-active i.e. in response to an ICB initiated proposal to change an existing service.

The policy sets out how petitions will be received whether outside a formal consultation period or during a formal consultation period.

For the purpose of this policy a petition is considered to be a written document signed by a number of people demanding some form of action from the ICB.

3. There is currently no clear, legally binding guidance to the NHS on handline petitions.

When considering the receipt and management of e-petitions, the ICB wishes to ensure that it follows best practice and has drawn on published terms and conditions for submitting e-petitions utilised by HM Government.

4. Criteria for the consideration of petitions

In order to be received for consideration, petitions should meet the criteria outlined below:

- A petition amounting to any number of signatures will be considered by the ICB in their commissioning decisions. The sentiment indicated in the petition will be forwarded to the most appropriate internal commissioning process. This will be determined by the subject of the petition e.g. the petition may be passed to the relevant commissioning manager to incorporate into a service specification and/or relevant subgroup or committee for consideration.

- Where a petition, with significant support (with a minimum of 1000 signatures) has been received by the ICB, the Chief Executive Officer shall consult with the Chair of the Board as to whether the petition should be included as a specific item for the agenda and consideration of the next meeting of the Board to agree any appropriate actions.

- Petitions may be received in paper or electronic (e.g. email, web based or social media) format.

- Petitions should be addressed to NHS Norfolk and Waveney ICB and include a statement of petition which should include:

  - the proposition which is being promoted by the petition
  - the timeframe over which the petition has been collected

- The following information about each petitioner should be included:

  - Name
  - Postcode
  - Signature (in the case of a written petition)
  - Email address (in the case of an electronic petition). If this data is not collected due to the data controller not sharing the data eg a social media (eg Facebook), the petition will only be acknowledged as an indicator of public sentiment.

- The name and address of the petition organiser, who must be resident within the Norfolk and Waveney area, should be provided on the first page of the petition.

5. Acceptance of Petitions

An acknowledgement of receipt of the petition will be provided to the lead petitioner within 5 clear working days of receipt with a clear explanation about what will happen next.

Petitions will not be considered if they are repeated, vexatious or if they concern issues which are outside the ICB's remit. Petitions will also not be considered if the information contained is confidential, libellous, false, defamatory or offensive.

A petition will be considered as a repeat petition if:

a) it covers the same or substantially similar subject matter to another petition received within the previous six months;
b) it is presented by the same or similar individuals or groups as another petition received within the previous six months.

A petition will be considered as a vexatious petition if:

c) it focuses on an individual grievances
d) it focuses on the actions or decisions of an individual and not the organisation

A petition will be considered as outside the CCGs' remit if:

e) it focuses on a matter relevant to another organisation
f) it requests information available via Freedom of Information legislation
g) its aim is to correspond on personal issue(s) with an individual(s)
h) signatories are not based in the UK

A petition will be considered as confidential, libellous, false or defamatory if:

i) it contains information which may be protected by an injunction or court order
j) j) it contains material which is potentially confidential, commercially sensitive, or which may cause personal distress or loss

A petition will be considered as offensive if:

k) it contains language that may cause offence, is provocative or extreme in its views

Where a petition does not meet the requirement set out in the criteria above then the ICB will respond in writing within **ten working days** to confirm that the petition has been received and that, as the petition does not meet the criteria. The reason for rejection will be given clearly and explicitly.

5.1 Petitions received outside formal consultation period

For petitions received outside a formal consultation period, the Chief Executive Officer may delegate responsibility for receiving a petition to a nominated representative. The Chief Executive Officer or nominated representative may arrange for a short private meeting with the petition organiser to formally receive the petition. All photographic opportunities may be politely declined by the ICB during this meeting.

Once received, the Chief Executive Officer or nominated representative will ensure that the petition receives appropriate and proportionate consideration and that a response is made in writing.

5.2 Petitions received during a formal consultation period

If a petition relates to a subject, proposal or matter about which the ICB is actively seeking public opinion, and if the petition is submitted before the publicised close date of the engagement or consultation process, the petition will be considered as an item of correspondence, in the same way that any other response would be considered. Petitions will be considered as valid for consideration as part of the consultation if they meet the requirements set out in the criteria outlined in this policy.

6. Management of Petitions

When a report on the outcome of consultation is prepared, the following issues will be taken into account when considering a petition:

- If a petition is raised about a perceived lack of or missing service, consultation is not a public referendum or public vote. Influence will be afforded to the most cogent ideas and arguments, based upon clinical effectiveness, quality, patient safety, clinical and cost effectiveness and not necessarily to the views of the most numerous stakeholders.

- The petition should be relevant to the subject of the consultation. It may not necessarily use the same words, but it should have a bearing on the proposal(s) that the ICB has put forward.

- The petition should reflect the latest proposals and policy statements being made by the ICB and not relate to issues that are no longer under consideration. This is particularly relevant when considering the timescale during which signatures have been collected.

- The petition should provide an accurate reflection of the proposals in the consultation, rather than including misleading information or statements.

- The petition should relate to the consultation and to the proposed action of the ICB (and/or its stakeholders), rather than to broader policy agenda beyond the scope of the consultation.

- The petition's concerns will be assessed in relation to the aims being put forward in the consultation, and the rationale and constraints behind it. For example, a petition that proposes a realistic alternative option will normally be given greater weight than a petition that simply opposes an option that has been put forward for valid reasons.

- The petition's concerns will also be assessed in relation to the impact on other populations if these demands were accepted. This assessment could take into account views expressed in other petitions (which may conflict) or in more direct responses to the consultation.

The organiser of the petition will receive correspondence from the ICB as the body that has initiated the consultation, in the same manner as other respondents (e.g. acknowledgement, an outcome letter describing how the issues raised during consultation have or will influence the decisions made following consultation) within 28 days of receipt of the petition.

Petitions will be formally acknowledged in the analysis of consultation responses, along with all the other responses. If what Petitioners call for is accepted or rejected, the reasons for this should be given.

Hard copy and electronic petitions will be stored in a secure place within the ICB for 3 years and will then be destroyed as Confidential Waste (in the case of hard copies) or deleted (e-petitions.).

7. Return of petitions

Hard copy petitions should be addressed to:

The Chief Executive Officer
C/o Associate Director for Communication & Engagement
NHS Norfolk and Waveney Integrated Care Board
Norfolk County Council
County Hall
Norwich

Electronic petitions should be addressed to:
nwicb.contactus@nhs.net

8. Duties and responsibilities

Board	The Board has responsibility for establishing a scheme of governance for the formal review and approval of such documents.

Chief Executive Officer	The Chief Executive Officer has overall responsibility for the operational management, including ensuring that ICB process documents comply with all legal, statutory and good practice guidance requirements.
All Staff	All staff, including temporary and agency staff, are responsible for: • Compliance with relevant process documents. Failure to comply may result in disciplinary action being taken. • Co-operating with the development and implementation of policies and procedures and as part of their normal duties and responsibilities. • Identifying the need for a change in policy or procedure as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and advising their line manager accordingly. • Identifying training needs in respect of policies and procedures and bringing them to the attention of their line manager. • Attending training / awareness sessions when provided

9. Implementation

This policy will be available to all staff for use and be aware of.
All directors and managers are responsible for ensuring that relevant staff within their own directorates and departments have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

10. Training Implications

It has been determined that there are no specific training requirements associated with this policy/procedure.

11. Related Documents

Other related policy documents

ICB People and Communities Approach.

Legislation and statutory requirements

There is currently no clear, legally binding guidance to the NHS on handling petitions. The CCG has drawn upon published terms and conditions for submitting e-petitions, utilised by HM Government.

12. Monitoring, review and archiving

Monitoring

The Executive Committee will agree a method for monitoring the dissemination and implementation of this policy. Monitoring information will be recorded in the policy database.

Review

The Director of Corporate Affairs and ICS Development will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval. No policy or procedure will remain operational for a period exceeding three years without a review taking place.

Staff who become aware of any change which may affect a policy should advise their line manager as soon as possible. The Director of Corporate Affairs and ICS Development will consider the need to review the policy or procedure outside of the agreed timescale for revision.

Archiving

The Director of Corporate Affairs and ICS Development will ensure that archived copies of superseded policy documents are retained in accordance with Records Management: Code of Practice for Health and Social Care 2016.

SECTION 11

Eligible nominating PMS (GMS/APMS) Providers

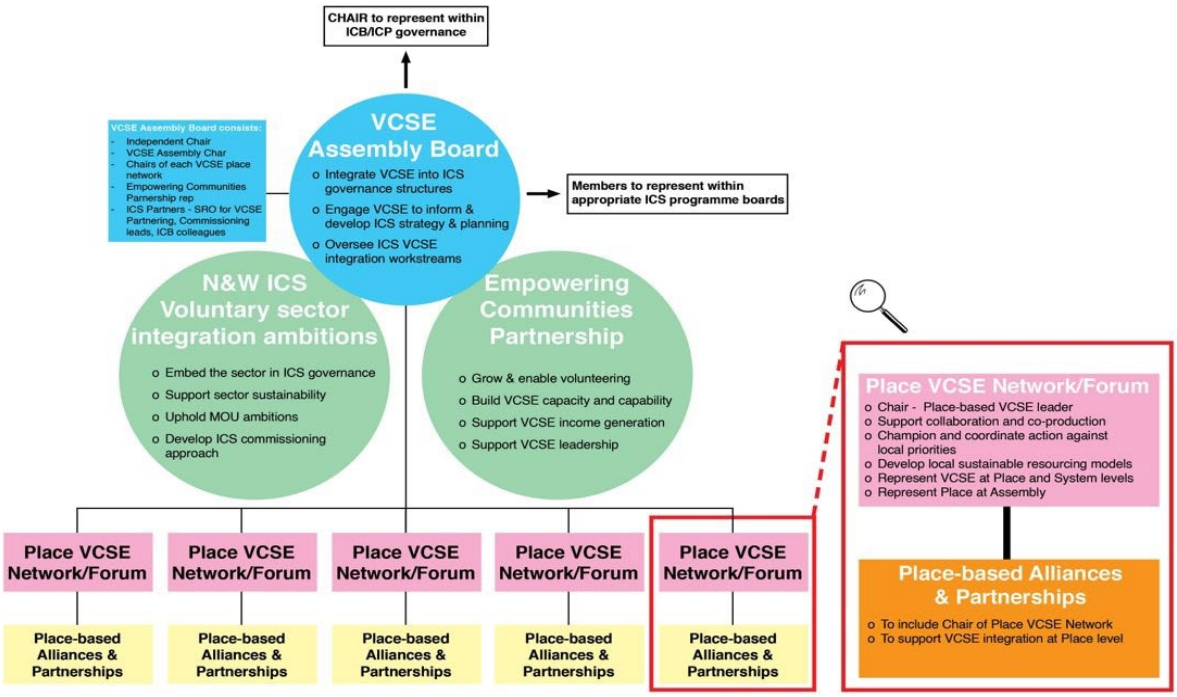
Acle Medical Partnership	Kirkley Mill Surgery
Aldborough Surgery	Lakenham Surgery
Alexandra Road Surgery	Lawson Road Surgery
Andaman Surgery	Litcham Health Centre
Attleborough Surgery	Long Stratton Medical Partnership
Bacon Road Medical Centre	Longshore Surgeries
Beaches Medical Centre	Ludham & Stalham Green
Beccles Medical Centre	Manor Farm Medical Centre
Beechcroft Surgery (inc. Old Palace)	Market Surgery Aylsham
Birchwood Medical Practice	Mattishall & Lenwade
Blofield Surgery	Millwood Surgery
Boughton Surgery	Mundesley Medical Centre
Bridge Road Surgery	Nelson Medical Centre
Bridge Street Surgery	Norwich Practices Ltd
Brundall Medical Partnership	Oak Street Medical Practice
Bungay Medical Practice	Old Catton Medical Practice
Burnham Market Surgery	Old Mill & Millgates Medical Practice
Campingland Surgery	Orchard Surgery
Castle Partnership	Parish Fields
Chet Valley Medical Practice	Park Surgery
Church Hill Surgery	Paston Surgery
Coltishall Medical Practice	Plowright Medical Centre
Cromer Group Practice	Prospect Medical Centre
Cutlers Hill Surgery	Reepham \ Hungate Street Surgery
Drayton, St Faiths & Horsford	Rosedale Surgery
East Harlings & Kenninghall	Roundwell Medical Centre
East Norfolk Medical Practice	School Lane Practice
East Norwich Medical Partnership	School Lane Surgery, Thetford
Elmham Surgery	Sheringham Medical Practice
Fakenham Medical Practice	Shipdham Surgery
Feltwell Surgery	Sole Bay Health Centre
Fleggburgh Surgery	Southgate Medical Centre
Great Massingham Surgery	St James Medical Practice
Grimston Medical Centre	St Stephens Gate Medical Practice
Grove Surgery	Terrington St Johns Surgery
Harleston Medical Practice	The Coastal Villages Practice
Heacham Group Practice	The Hollies Surgery
Heathgate Medical Practice	The Humbleyard Practice
Hellesden Medical Practice	The Lawns Medical Practice
High Street Surgery	The Magdalen Medical Practice
Hingham Surgery	The Staithe Surgery

Holt Medical Practice	The Taverham Partnership
Hoveton & Wroxham	The Woottons Surgery
Howdale Surgery	Theatre Royal Surgery
Theatre Royal Surgery	Watlington Medical Centre
Thorpewood Surgery	Watton Medical Practice
Toftwood Surgery	Wells Health Centre
Trinity & Bowthorpe	Wensum Valley Medical Practice
UEA Medical Centre	West Pottergate
Upwell Health Centre	Windmill Surgery
Victoria Road Surgery	Woodcock Road Surgery
Vida Healthcare	Wymondham Medical Practice
Village Heath - St Clements Surgery	Yare Valley Medical Practice (Lionwood)

SECTION 12

Working with Voluntary, Community and Social Enterprise organisations

The diagram below sets out how the VCSE sector is embedded and works to inform the Integrated Care Board's planning and decision making.



APPENDIX A

Norfolk and Waveney Integrated Care Partnership (ICP)

Terms of Reference and Procedure Rules

1. Context and Role of the Integrated Care Partnership

The role of the Integrated Care Partnership (ICP) in Norfolk and Waveney is to promote the close collaboration of the health and care system, building on the existing Norfolk Health and Wellbeing Board and other partnerships with the expanded geography that includes Waveney, to ensure better health and care outcomes for all our residents.

It provides a forum for stakeholders to come together as equal partners to discuss and resolve crosscutting issues. The ICP is a statutory committee of both the Integrated Care Board and Norfolk and Suffolk County Council's under the Health and Care Act 2021, it plays a central role in the planning and improvement of health and care in Norfolk and Waveney and will support place-based partnerships**.**

It drives and enhances integrated approaches and collaborative behaviours at every level and promotes an ethos of working in partnership with people and communities, and between organisations to address challenges that the health and care system cannot address alone.

Together, the ICP will generate an Integrated Care Strategy to improve health and care outcomes and experiences for our residents, for which all partners will be accountable.

2. Principles

The Norfolk and Waveney ICP will operate under these guiding principles:

1. Partnership of equals – to find consensus and make decisions including working though difficult issues, where appropriate.
2. Collective model of accountability – partners hold each other mutually accountable for shared and individual organisational contributions to objectives.
3. Improving outcomes for communities – including improving health and wellbeing, supporting people to live more independent lives, reducing health inequalities, and tackling the underlying social determinants.
4. Collaboration and integration – a culture of broad collaborations and integration at every level of the system to improve outcomes and reduce duplication and inefficiency.
5. Co-production and inclusivity – create a learning system which makes decisions based on evidence and insight.

3. Membership

The Membership of the ICP mirrors the existing Norfolk Health and Wellbeing Board, with additional membership to consider Waveney and place partnerships. Whilst it is important for the ICP to engage with a wide range of stakeholders and understand

the differing viewpoints across the system and communities, membership will be kept to a productive level.

The membership for the Norfolk and Waveney ICP is attached at appendix A.

4. Appointment of Chair

The Chair of the ICP will be selected from among the members of the ICP and agreed jointly by the ICB, Norfolk and Suffolk Local Authorities.

This appointment process will take place at the start of the meeting with an officer informing members of the need to elect a chair. Nominations will then be called and then seconded. If more than one nomination is received this will be dealt with by way of a majority vote of those present. If only one nomination is forth coming the officer will then ask for any objections, if objections are received a vote will take place which will be carried by a majority vote by those present. Once this process takes place and the nomination is passed, then the Chair commences the meeting. If the nomination is rejected the whole process will commence again until agreement by majority of those present is reached.

The Chair will be appointed at the first meeting of the ICP and annually at a meeting of the ICP thereafter.

The Chair will be expected to:-

- be able to build and foster strong relationships in the system
- have a collaborative leadership style be committed to innovation and transformation
- have expertise in delivery of health and care outcomes
- be able to influence and drive delivery and change

The ICP will appoint three Vice Chairs drawn from its membership. These will also be appointed at the first meeting of the ICP and annually thereafter.

5. Duties and Responsibilities

The ICP is a core part of the Norfolk and Waveney Integrated Care System, driving their direction and priorities.

The ICP will be rooted in the needs of people, communities, and places.

The ICP will help to develop and oversee population health strategies to improve health outcomes and experiences.

The ICP will support integrated approaches and subsidiarity.

The ICP will take an open and inclusive approach to strategy development and leadership, involving communities and partners to utilise local data and insights.

The ICP will work to embed safeguarding as everyday business across the Norfolk and Waveney Integrated Care System

The ICP will develop an Integrated Care Strategy which the ICB, Norfolk and Suffolk County Council's will be required by law to have regard to when making decisions, commissioning, and delivering services.

The ICP is expected to highlight where coordination is needed on health and care issues and challenge partners to deliver the action required. These include, but are not limited to, helping people live more independent, healthier lives and safer lives for longer, free from abuse and harm, taking a holistic view of people's interactions with services across the system and the different pathways within it, addressing inequalities in health and wellbeing outcomes; experiences and access to health services; improving the wider social determinants that drive these inequalities, including employment, housing, education environment, safeguarding, and reducing offending; improving the life chances and health outcomes of babies, children and young people, and improving people's overall wellbeing and preventing ill-health.

The ICP will provide a forum for agreeing collective objectives, enable place-based partnerships and delivery to thrive alongside opportunities for connected scaled activity to address population health challenges.

The ICP will set the strategic directions and workplans for organisational, financial, clinical, and informational integration, as well as other types.

6. Authority, Accountability, Reporting and Voting Arrangements

The ICP is tasked with developing a strategy to address the Health, Social Care and Public Health needs of their system, and of being a forum to support partnership working. The ICB and Local Authorities will have regard to ICP Strategies when making decisions. The ICP has no executive powers, other than those specifically delegated in these terms of reference. Individual members will be able to act with the level of authority and the powers granted to them by way of their constituent bodies' policies and make decisions on that basis. The ICP is able to discuss and agree recommendations for approval by the constituent members' statutory bodies. Its role is primarily one of oversight and collective co-ordination.

The aim will be for decisions of the ICP to be achieved by consensus decision making. Voting will not be used, except as a tool to measure support, or otherwise, for a proposal. In such a case, a vote in favour would be non-binding. The Chair will work to establish unanimity as the basis for all decisions.

Meetings of the ICP will be open to the public unless the matter falls within one of the categories of information, outline in Appendix B. In this instance the ICP may determine public participation will be withdrawn for that item.

Meetings will be live streamed and recorded, to be made available to the public afterwards.

Minutes of the meeting will be taken and approved at the next meeting of the ICP.

Final minutes will be made available on the websites of the ICB, Norfolk and Suffolk County Councils.

7. Attendance

Members are expected to attend 75% of meetings held each year. It is expected that members will prioritise these meetings.

Where it is not possible for a member to attend, they may nominate a named deputy to attend meetings in their absence and must notify the Secretariat, at hwbchairman@norfolk.gov.uk, who that person will be.

Members and those presenting must attend meetings in person.

The quorum, as described at section 8, must be adhered to for all meetings including urgent meetings.

Attendance will be recorded within the minutes of each meeting and monitored annually.

8. Quorum

A quorum will be reached when at least the Chair and four members from different partnership organisations are present.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no recommendations for decision by the constituent member bodies may be taken.

In the unlikely event that a member has been disqualified from participating in the discussion of an item on the agenda, for example by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

Nominated deputies attending a meeting on behalf of a member may count towards the quorum.

9. Notice and Frequency of Meeting

Generally, meetings will be held four times a year but more frequently if required for specific matters.

As a matter of routine, an annual schedule of meetings will be prepared and distributed to all members. In other specific instances, or in cases where the date or time of a meeting needs to be changed, notice shall be sent electronically to members at least five working days before the meeting. Exceptions to this would be in the case of emergencies or the need to conduct urgent business.

An agenda and any supporting papers specifying the business proposed to be transacted shall be delivered to each member and made available to the public five working days before the meeting, potential exception being in the case of emergencies or the need to conduct urgent business. Supporting papers, shall accompany the agenda.

Secretariat support to the ICP will be provided by Norfolk County Council.

10. Public Questions

The public are entitled to ask questions at meetings of the ICP and questions should be put in writing and sent by email at least two working days before the meeting. If the question relates to urgent matters, and it has the consent of the Chair to whom the question is to be put, this should be sent by 4pm on the day before the meeting.

Questions should be sent to the Chair, at hwbchairman@norfolk.gov.uk, and will be answered as appropriate, either at the meeting or in writing.

The Chair on behalf of the ICP may reject a question if it:

a) is not about a matter for which the ICP has collective responsibility or particularly affects the ICP; or

b) is defamatory, frivolous, or offensive or has been the subject of a similar question in the last six months or the same as one already submitted under this provision.

Who may ask a question and about what

A person resident in Norfolk and Waveney, or who is a non-domestic ratepayer in Norfolk and Waveney, or who pays Council Tax in Norfolk and Waveney, may ask at a public meeting of the ICP through the Chair any question within the terms of reference of the ICP about a matter for which the ICP has collective responsibility or particularly affects the ICP. This does not include questions for individual ICP members where responsibility for the matter sits with the individual organisation.

Rules about questions:

Number of questions – At any public ICP meeting, the number of questions which can be asked will be limited to one question per person plus a supplementary. No more than one question plus a supplementary may be asked on behalf of any one organisation. No person shall be entitled to ask in total under this provision more than one question, and a supplementary, to the ICP in any six-month period.

Other restrictions – Questions are subject to a maximum word limit of 110 words. Questions that are in excess of 110 words will be disqualified. The total time for public questions will be limited to 15 minutes. Questions will be put in the order in which they are received.

Supplementary questions – One supplementary question may be asked without notice and should be brief (fewer than 75 words and take less than 20 seconds to put). It should relate directly to the original question or the reply. The Chair may reject any supplementary question s/he does not consider compliant with this requirement.

Rules about Responses:

The Chair shall exercise his/her discretion as to the response given to the question and any supplementary.

Not attending – If the person asking the question indicates they will not be attending the ICP meeting, a written response will be sent to the questioner.

Attending – If the person asking the question has indicated they will attend, response to the questions will be made available at the start of the meeting and copies of the questions and answers will be available to all in attendance. The responses to questions will not be read out at the meeting.

Supplementary questions – The Chair may give an oral response to a supplementary question or may require another Member of the ICP or Officer in attendance to answer it. If an oral answer cannot be conveniently given, a written response will be sent to the questioner within seven working days of the meeting.

Written response – If the person who has given notice of the question is not present at the meeting, or if any questions remain unanswered within the 15 minutes allowed for questions, a written response will be sent within seven working days of the meeting.

Rejection of a question

A question may be rejected if it:

a) is not about a matter for which the ICP has collective responsibility or particularly affects the ICP; or

b) is defamatory, frivolous, or offensive or has been the subject of a similar question in the last six months or the same as one already submitted under this provision; or

c) requires the disclosure of confidential or exempt information, as defined in the Access to Information Procedure Rules.

11. Managing Conflicts of Interest

A conflict of interest may be defined as “a set of circumstances by which a reasonable person would consider that an individual’s ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold”.

The ICP specifically recognises and acknowledges that its members have legal responsibilities to the organisations which they represent and that this may give rise to conflicts of interest being present. However, discussions at the meetings are to be focussed on the needs of the Norfolk and Waveney population and health and care. Therefore, members will not be excluded from engaging in discussions that will benefit the system as a whole.

Members of the ICP shall adopt the following approach for managing any actual or potential material conflicts of interest:

- To operate in line with their organisational governance framework for managing conflicts of interest/probity and decision making.
- For the Chair to take overall responsibility for managing conflicts of interest within meetings as they arise.
- To work in line with the ICS system objectives, principles, and behaviours.
- Members are to ensure they advise of instances where the register of members interest for the Norfolk and Waveney system requires updating in relation to any interests that they have.

In advance of every ICP meeting consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This action will be led by the Chair with support from their governance advisor.

At the beginning of each meeting of the ICP, members and attendees will be required to declare any interests that relate specifically to a particular item under consideration. If the existence of an interest becomes apparent during a meeting, this must be declared at the point at which it arises. Any such declaration will be formally recorded in the minutes for the meeting.

Elected members will be bound by their own codes of conduct and provisions for declaration of interests.

12. Working groups

To assist with performing its role and responsibilities, the ICP is authorised to establish working groups and to determine the membership, role, and remit for each working group. Any working group established by the ICP will report directly to it.

13. Other Boards

As a key part of the health and care system the ICP will seek active engagement and collaboration with the Norfolk and Waveney ICB, Norfolk and Suffolk HWBs, Place Boards, Health and Wellbeing Partnerships, Safeguarding Adults Boards, Safeguarding Childrens Partnerships, County Community Safety Partnerships, Autism Partnership Boards, and the Learning Disabilities Partnership Boards.

14. Review

The ICP will review these terms of reference at least annually or more regularly if needed, considering policy changes in respect of the Integrated Care System.

Appendix A

Membership of the Integrated Care Partnership

1. Borough Council of King's Lynn & West Norfolk
2. Breckland District Council
3. Broadland District Council
4. Cambridgeshire Community Services NHS Trust
5. Chair of the Voluntary Sector Assembly
6. East Coast Community Healthcare CIC
7. East of England Ambulance Trust
8. East Suffolk Council
9. Great Yarmouth Borough Council
10. Healthwatch
11. James Paget University Hospital NHS Trust
12. Norfolk Care Association
13. Norfolk Community Health & Care NHS Trust
14. Norfolk Constabulary
15. Norfolk County Council, Cabinet member for Adult Social Care, Public Health and Prevention
16. Norfolk County Council, Cabinet member for Childrens Services and Education
17. Norfolk County Council, Director of Public Health
18. Norfolk County Council, Executive Director Adult Social Services
19. Norfolk County Council, Executive Director Children’s Services
20. Norfolk County Council, Leader (nominee)
21. Norfolk & Norwich University Hospital NHS Trust
22. Norfolk & Suffolk NHS Foundation Trust
23. Norfolk & Waveney ICB, Chair
24. Norfolk & Waveney ICB, Chief Executive Officer
25. North Norfolk District Council
26. Norwich City Council
27. Police and Crime Commissioner
28. Primary Care representatives (1)
29. Primary Care representatives (2)
30. Primary Care representatives (3)
31. Primary Care representatives (4)

32. Primary Care representatives (5)
33. Queen Elizabeth Hospital NHS Trust
34. South Norfolk District Council
35. Suffolk County Council, Cabinet Member for Adult Care
36. Suffolk County Council, Executive Director of People Services
37. Voluntary sector representatives (1)
38. Voluntary sector representatives (2)

Appendix B

Categories of Information

Information relating to any individual.

Information which is likely to reveal the identity of an individual.

Information relating to financial or business affairs of any particular person (including the authority holding that information).

Information relating to any consultations or negotiations, or contemplated consultations or negotiations, in connection with any labour relations matter arising.

Information relating to any action taken or to be taken in connection with the prevention, investigation, or prosecution of crime.

APPENDIX B

NHS Norfolk and Waveney Integrated Care Board

Audit and Risk Committee

Terms of Reference

Revision History

Revision Date	Summary of changes	Author(s)	Version Number

Approvals

Approval Date	Approval Body	Author(s)	Version Number

1. Constitution

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.

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

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

2. Authority

The Audit 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.

For the avoidance of doubt, the Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD:

3. Purpose

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

The duties of the Committee will be driven by the 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.

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

4. Membership and attendance

Membership

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

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

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

Members will possess between them knowledge, skills and experience in: accounting, risk management, internal, 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.

Members of the Committee will be:

- Non-Executive member with a lead for Audit and Risk (Chair)
- 2 Non-Executive members from the Board of the ICB
- One other member either from the Board or wider system partners.

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.

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

Attendees

Only members of the Committee have the right to attend Committee meetings, however 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;
- Representatives of both internal and external audit;
- Individuals who lead on risk management and counter fraud matters;
- Director of Corporate Affairs and ICS Development
- Head of Corporate Governance
- Director of Commissioning Finance
- Associate Director of Financial Management

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.

Attendance

Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

Access

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

5. Meetings Quoracy and Decisions

The Audit and Risk 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 and Risk Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

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

Quorum

For a meeting to be quorate a minimum of 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 accordance 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. The decision will be reported at the next meeting of the Committee.

6. Responsibilities of the Committee

The Committee's duties can be categorised as follows.

Integrated governance, risk management and internal control

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

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

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.

Internal audit

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

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

- Monitoring the effectiveness of internal audit and carrying out an annual review.

External audit

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

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit;

- 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.

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 and Risk 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).

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.

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.

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.

To approve the arrangements for ensuring the appropriate safekeeping and confidentiality of records and for the storage management and transfer of information and data.

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.

Approval of the ICB's banking arrangements

Review of ICB risk sharing or risk pooling arrangements

Conflicts of Interest

The Chair of the Audit and Risk 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.

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.

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.

7. Behaviours and Conduct

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, Scheme of Reservation and Delegation, Conflicts of Interest Policy and Standards of Business Conduct Policy.

Equality and diversity

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

8. 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

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

The Audit and Risk 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.

9. Secretariat and Administration

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

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

10. Review

The Committee will review its effectiveness at least annually.

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

Date of approval:

Date of review:

APPENDIX C

NHS Norfolk and Waveney Integrated Care Board

Remuneration, People and Culture Committee

Terms of Reference

Revision History

Revision Date	Summary of changes	Author(s)	Version Number

Approvals
This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number

1. Constitution

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

These terms of reference, which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.
The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. Authority

The Remuneration, People and Culture 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 SoRD but may /not delegate any decisions to such groups.

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

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 staff on very senior managers grade, including all board members, excluding the Chair and Non-Executive Members.

The Board has also delegated the following functions to the Committee, please see section 6 below.

4. Membership and attendance

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

The Board will appoint no fewer than three members of the Committee including two independent members of the Board.

The Chair of the Audit Committee may not be a member of the Remuneration, People and Culture Committee.

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

No employee may be a member of the Committee

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

The members of the Committee are:

- Three non-executive members of the ICB who are not the Chair of the Audit and Risk Committee.

The following attend the Committee for Part 1 only.

- One other member appointed from the wider Norfolk and Waveney system with the relevant experience as to people and culture.

Chair and Vice Chair

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

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
- The ICB's People Director or their nominated deputy
- Director of Finance or their nominated deputy
- Chief Executive or their nominated deputy
- Director of Corporate Affairs and ICS Development or nominated deputy

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.

5. Meetings Quoracy and Decisions

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, People and Culture Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.
In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.
Quorum
For a meeting to be quorate a minimum of two of the non-executive members is required, including the Chair or Vice Chair.
If any member of the Committee has been disqualified from participating on an 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. Responsibilities of the Committee

The Committee will hold a part 1 meeting to cover issues as to system people and culture only. The Committee will also hold a part 2 meeting to consider matters as set out below which include remuneration, terms and conditions for the ICB, its employees, members of the Board and Clinical Advisors.

The Committee's duties are as follows:

For the Chief Executive, Members of the Board 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;
- Oversee the development of:
  ..1. an ICB culture and Organisational Development plan, taking into account national People and OD frameworks, and recognising the changing needs of our people to ensure the ICB is the best place to work
  ..2. The ICB EDI workplan
  ..3. The ICB staff engagement action plans (based on the staff survey)
  ..4. the CQC well led agenda
  ..5. the ICB H&W action plans
  ..6. the ICB people dashboard
-

For Clinical Advisors:

- Determine ICB pay policy
- Oversee contractual arrangements

For the avoidance of doubt, remuneration for the ICB Chair and Non-Executives will not be considered by the Remuneration, People and Culture Committee.

The Committee will also be responsible for:

- Approval of the nominations and appointments process for Board members;
- Oversight of executive board member performance.
- Assurance as to 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).
- Approve human resources policies for employees and for other persons working on behalf of the ICB.
- Approval of the arrangements for discharging the CCG's statutory duty associated with its commissioning functions to promote education and training for persons who are employed or are considering becoming employed in an activity which is connected with the health service.

7. Behaviours and Conduct

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

8. 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.
The Remuneration, People and Culture Committee will submit a report to the Board following each of its meetings. Where reports identify individuals, they will not be made public and will be presented at part 2 of the Board. Public reports will be made as appropriate to satisfy any requirements in relation to disclosure of public sector executive pay.

9. Secretariat and Administration

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

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;

- Records of members' appointments and renewal dates 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; and

- Action points are taken forward between meetings.

10. Review

The Committee will review its effectiveness at least annually.
These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Date of approval:

Date of review:

APPENDIX D

Norfolk and Waveney Integrated Care Board
Patients and Communities Committee
Terms of Reference

Revision History

Revision Date	Summary of changes	Author(s)	Version Number

Approvals
This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number

1. CONSTITUTION

The Patients and Communities Committee ("the Committee") is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

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

The Committee is a committee of the Board and its members are bound by the Standing Orders and other policies of the ICB.

2. PURPOSE OF THE COMMITTEE

The Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that meets the needs of patients and communities, that is based on engagement and feedback from local people and groups, and that takes account of and reduces the health inequalities experienced by individuals and communities.

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

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

3. DELEGATED AUTHORITY

The 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 and may be amended from time to time.

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

4. MEMBERSHIP AND ATTENDANCE

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 one who is a Non-Executive Member of the Board (from the ICB). 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.

Conflicts of Interest
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.

Chair and Deputy chair

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.

Members

The Members of the Committee are as follows

- Non-Executive Member of the ICB Board (Chair)
- Non- Executive Member of the ICB Board
- VCSE Board Member on the ICB Board
- Patients and Communities Director, NHS Norfolk and Waveney ICB
- Medical Director Norfolk and Waveney ICB or the Director of Nursing
- A person with primary care experience
- Senior Public Health Officer Norfolk County Council
- A representative from the Place Boards
- A representative from the Health and Wellbeing Partnerships
- A representative from Healthwatch
- Two experts by experience from local communities

5. MEETING QUORACY AND DECISIONS

The Committee shall meet at least bi-monthly basis. Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

Quoracy

The quorum for the meeting will be 3 Members including at least on Chair or Deputy Chair and one ICB executive

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. For the avoidance of doubt the deputy will be counted as part of the quorum.

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. If an urgent decision is required, the process set out below may be followed.

Decision making and voting

Decisions will be taken in accordance 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 or their nominated deputy 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.

Urgent decisions

In the event that an urgent decision is required, if it is not possible for the Committee to meet virtually an urgent decision may be exercised by the Committee Chair and relevant lead director subject to every effort having been made to consult with as many members as possible in the given circumstances (minimum one other member).

The exercise of such powers shall be reported to the next formal meeting of the Committee for formal ratification and noted in the minutes.

6. RESPONSIBILITIES OF THE COMMITTEE

The responsibilities of the Committee will be authorised by the ICB Board. It is expected that the Committee will:

Complaints

- Approve the ICB's arrangements for handling complaints
- Receive regular reports about complaints received by the ICB and performance against the organisation's Complaints Policy.
- Oversee the sharing of lessons learnt from complaints received by the ICB across the organisation and the Integrated Care System.

- Provide assurance to the ICB Board regarding the organisation's performance against its Complaints Policy and processes.

Listening to, engaging and working with people and communities

- Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to promote the involvement of patients, their carers and representatives in decisions about their healthcare.

- Approve an annual communications and engagement plan for the ICB that sets out how the organisation will help to deliver Integrated Care System's approach to working with people and communities in Norfolk and Waveney.

- Receive regular reports setting-out the ICB's implementation of its annual communications and engagement plan and the organisation's contribution to delivering the Integrated Care System's approach to working with people and communities in Norfolk and Waveney.

- Consider how the ICB and the Integrated Care System could improve how we listen to, engage and work with people and communities.

- Oversee the sharing of insight gained from engagement with people and communities across the ICB and the Integrated Care System.

- Provide assurance to the ICB Board regarding the effectiveness of the organisation's approach to listening to, engaging and working with people and communities.

Addressing health inequalities

- Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to have regard to the need to reduce inequalities

- Receive regular reports from the Norfolk and Waveney Health Inequalities Oversight Group about the Integrated Care System's work to reduce health inequalities.

- Consider how the ICB and the Integrated Care System could improve its work to address health inequalities.

- Provide assurance to the ICB Board regarding the effectiveness of the organisation's work to address health inequalities.

Integration with the voluntary, community and social enterprise sector

- Receive regular reports about the work of the ICB and the Integrated Care System to improve integration between the statutory and voluntary, community and social enterprise sectors.

- Consider how the ICB and the Integrated Care System could improve integration between the statutory and voluntary, community and social enterprise sectors.

Development funding

- Agree how the ICB should use development funding received from NHS England.

- Agree how the ICB should use any funding received by the ICB as a result of bids to external bodies with regard to health inequalities or patient engagement.

Place

- Review and approve arrangements as to the delegations to place boards or place Directors.

7. ACCOUNTABILITY and REPORTING ARRANGEMENTS

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 written report on assurances received, escalating any concerns where necessary.

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

8. BEHAVIOURS AND CONDUCT

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.

Equality and diversity

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

9. 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.

10. SECRETARIAT AND ADMINISTRATION

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

- The agenda and papers are prepared and distributed in 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 highlighting to the Chair those that do not meet the minimum requirements;
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
- Good quality minutes are taken in accordance with the Standing Orders and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept;
- The Chair is supported to prepare and deliver reports to the Board;
- The Committee is updated on pertinent issues/ areas of interest/ policy developments;
- Action points are taken forward between meetings and progress against those actions is monitored.

11. REVIEW

The Committee will review its effectiveness at least annually and complete an annual report submitted to the Board.
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.
The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Date of approval:

Date of review:

APPENDIX E

Finance Committee
Terms of Reference

NHS Norfolk and Waveney Integrated Care Board

1. Contents

2. Purpose

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

Its main purpose is to contribute to the overall delivery of the ICS objectives by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial plan and strategy, consistent with the ICS Strategic Plan and its operational deliverables.

The Finance Committee will be run in two separate parts (with differing core membership for each element), this includes:

- Financial performance of NHS organisations within the formal ICS footprint - system control total (Part 1)
- Financial performance of the ICB (Part 2)

3. Authority

The Finance Committee is authorised by the Board to:

3.1 investigate any activity within its terms of reference

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

3.3 commission any reports it deems necessary to help fulfil its obligations

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

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

3.6 Advise the Board and / or any of its committees of findings and insights it considers are relevant for noting or discussion

4 Remit and Responsibilities

The Committee will hold a part 1 meeting to cover system wide issues and a part 2 meeting to consider issues internal to the ICB.

The Committee's duties are as follows:

System financial management framework

4.1 to set the strategic financial framework of the ICB and ICS and monitor performance against it

4.2 to develop the system financial information systems and processes to be used to make recommendations to the Board on financial planning in line with the strategy and national guidance

4.3 to ensure health and social inequalities implications are taken into account in financial decision-making

Resource allocation (revenue)

4.4 to develop an approach to distribute the resource allocation through commissioning and direct allocation to drive agreed change based on the ICS strategy

4.5 to advise on the process regarding the deployment of system wide transformation funding and monitor the financial impact of transformation initiatives

4.6 to work with ICS partners to identify and allocate resources where appropriate to address financial performance, quality and safety related issues that may arise and to ensure Value for Money in that resource allocation

4.7 to work with ICS partners to consider major investment/disinvestment business cases for material service change or efficiency schemes (smaller of 3% of organisational annual expenditure and £5m with a de-minimus level of £1m) and to agree a process for sign off where system funding is required

National framework

4.8 to advise the ICS member organisations on any changes to NHS and non-NHS funding regimes and consider how the funding available to the ICS can be best used within the system to achieve the best outcomes for the local population

4.9 to oversee national ICB and ICS level financial submissions

4.10 to ensure the required preparatory work is scheduled to meet national planning timelines

Financial monitoring information

4.11 to develop a reporting framework for the ICB (using the chart of accounts devised by NHS England and the integrated single financial environment (ISFE)) and the ICS as a system of bodies

4.12 to articulate the financial position and financial impacts (both short and long-term) to support decision-making

4.13 to work with ICS partners to agree common approaches across the system such as financial reporting, estimates and judgements

4.14 to work with ICS partners to seek assurance over the financial reports from system bodies and providing feedback to them

4.15 to oversee the development of financial and activity modelling to support the ICB and ICS priority areas

4.16 to develop a medium- and long-term financial plan, consistent with strategic and operational plans

4.17 to develop an understanding of expenditure run rates across a system, system cost drivers and the impacts of service change on costs

4.18 to ensure appropriate information is available to challenge and manage financial issues, risks and opportunities across the ICS

4.19 to manage financial and associated risks by developing and monitoring a finance risk register

4.20 to leverage the use of non-financial data to triangulate against financial insights, and vice versa

Financial Performance

4.21 to oversee the management of the system financial target and the ICB's own financial targets

4.22 to agree key outcomes to assess delivery of the ICS financial plan and strategy

4.23 to monitor and report to the board overall financial performance against national and local metrics, highlighting areas of concern

4.24 to monitor and report to the board key service performance which should be taken into account in assessing the financial position

System efficiencies

4.25 to ensure system efficiencies are identified and monitored across the ICS, in particular opportunities at system level where the scale of the ICS partners together and the ability to work across organisations can be leveraged

4.26 to ensure financial resources are used in an efficient way to deliver the objectives of the ICS and to monitor and support resource utilisation that is consistent with long term financial sustainability

4.27 to review exception reports on any material breaches of the delivery of agreed efficiency improvement plan including the adequacy of proposed remedial action plans

Communication

4.28 to co-ordinate and manage communications on financial governance with stakeholders internally and externally

4.29 to develop an approach with partners, including the ICS health and care partnership, to ensure the relationship between cost, performance, quality and environment sustainability are understood

People

4.30 to develop a system finance staff development strategy to ensure excellence by attracting and retaining the best finance talent

4.31 to ensure that suitable policies and procedures are in place to comply with relevant regulatory, legal and code of conduct requirements

Capital

4.32 to develop the system estates strategy and plan to ensure it properly balances clinical, strategic and affordability drivers (if not covered by separate strategic estates forum)

4.33 to monitor the system capital programme against the capital envelope and take action to ensure that it is appropriately and completely used

4.34 to gain assurance that the estates, digital and clinical strategic plans are built into system financial plans and strategy to ensure effective oversight of future prioritisation and capital funding bids

Committee Development

4.35 to provide a programme of development to ensure Committee members are able to fulfil their committee duties, through a combination of training, education and information sharing sessions

5 Accountability and Reporting

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

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

5.3 The Committee will provide an annual report to the Board to describe how it has fulfilled its terms of reference and give details on progress and a summary of key achievements in the delivery of its responsibilities

6 Membership

6.1 The Finance Committee members shall be appointed by the Board in accordance with the ICB Constitution

6.2 When determining the membership of the Finance Committee active consideration will be made to diversity and equality. Members of the committee may be co-opted to ensure diversity of thinking in decision making

6.3 The board will appoint no fewer than four members of the Committee including one who is an Non-Executive Member of the Board. Other members of the committee need not be members of the board but may be

6.4 Members should possess between them knowledge, skills and experience in accounting, risk management and technical or specialist issues pertinent to the ICB's business.

6.5 The members of the Committee are as follows:

- Non-Executive member with the lead for Finance (Chair)
- Non-Executive
- ICB Executive Board Member (Either the Chief Executive Officer, Director of Nursing or Medical Director)
- Director of Finance
- Director of Performance, Transformation and Strategy

The following members attend the Committee for Part 1 only and bring their own delegation (where applicable from their own organisations.)

Acute Chief Finance Officer (representative for all acutes)
Non-acute Chief Finance Officer (representative for all non-acute NHS organisations)
Non-Executive Director (from NHS provider organisation)

A person with primary care experience.
A finance lead from Local Authority
A person with financial expertise from the VCSE or wider community.

6.6 There will be a standing invitation to a finance representative from the NHS England regional team. They will not have voting rights at the meeting

6.7 Where a conflict of interest is deemed to exist, the Chair (or vice-Chair) can ask the member not to attend the meeting (or part thereof) or allow the member to attend but not vote

6.8 Meetings will take place on a minimum of 10 occasions throughout any given financial year

6.9 Members should make reasonable endeavours to attend meetings and are expected to attend at least 90% of meetings held each year to ensure consistency, unless agreed with the chair in extenuating circumstances.

6.10 Where a member is unable to attend, efforts should be made to ensure a suitable representative attends, as nominated by the member and agreed with the Chair

Chair and Vice Chair

6.11 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

6.12 The Chair of the Committee shall be independent

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

6.14 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference

Attendees

6.15 Only members of the Finance Committee have the right to attend meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the committee. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with discussions on any particular matter

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

6.17 The Chair of the ICB may also be invited to attend one meeting a year in order to gain an understanding of the committee's operations

7 Secretary and Administration

7.1 The Finance Committee shall be supported with a secretariat function, led by the ICB Director of Commissioning Finance, which will ensure that:

The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead

Records of members' appointments and renewal dates and the Committee 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 Finance Committee is updated on pertinent issues/ areas of interest/ policy developments

Action points are taken forward between meetings and progress against those is monitored

Attendance of those invited to each meeting is monitored and the Chair is made aware as soon as possible of those meetings that do not meet the minimum quoracy requirements

8 Meeting Quoracy and Decision

8.1 For a meeting to be quorate a minimum of 50% voting members are required, including the Chair or Vice Chair

8.2 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

8.3 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

8.4 Decisions will be taken in according with the Standing Orders. The Finance Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote

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

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

8.7 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. Where such action has been taken between meetings, then these will be reported to the next meeting

9 Conduct of the Finance Committee

Benchmarking and Guidance

9.1 The Finance 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

Conflict of Interest

9.2 In discharging duties transparently, conflicts of interest must be considered, recorded and managed. Members should have regard to the NHS guidance on managing conflicts of interest

9.3 All 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 a conflict of interest arises, the Chair may require the affected member to withdraw at the relevant point

ICB Values

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

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

Equality, Diversity and Inclusion

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

10 Review

10.1 The Finance Committee will review on an annual basis its own performance and effectiveness including membership and terms of reference. The ICB Board will approve any resulting changes to the terms of reference or membership

Date Approved:	
Next Review:	

APPENDIX F

Norfolk and Waveney Integrated Care Board
Primary Care Commissioning Committee
Terms of Reference

1 Constitution

1.1 The Primary Care Commissioning Committee (the Committee) is established by the Norfolk and Waveney 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 Committee is authorised by the Board to:

- Investigate any activity within its terms of reference.
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference.
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation (SoRD) but may not delegate any decisions to such groups.

2.2 For the avoidance of doubt, the Committee will comply with the ICB Standing Orders, Standing Financial Instructions and the SoRD.

3 Purpose

3.1 To contribute to the overall delivery of the ICB's objectives to create opportunities for the benefit of local residents, to support Health and Wellbeing, to bring care closer to home and to improve and transform services by providing oversight and assurance to the ICB Board on the exercise of the ICB's delegated primary care commissioning functions and any resources received for investment in primary care.

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

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

4 Membership and attendance

Membership

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

4.2 The Board will appoint no fewer than 4 members of the Committee based on their specific knowledge, skills and experience.

4.3 The members of the Committee who will attend Part 1 and Part 2 meetings are:

- A Local Authority Partner Member from the ICB Board (Chair)
- Non-Executive Director (Deputy Chair)
- Director of Nursing or their nominated deputy
- Director of Finance or their nominated deputy

4.4 Where a member of the Committee is unable to attend a meeting, a suitable deputy may be agreed with the Committee Chair. The nominated deputy will count in the quorum for the meeting and be able to cast a vote if required.

Chair and Vice Chair

4.5 The Chair of the ICB will appoint a Chair of the Committee who has the specific knowledge, skills and experience making them suitable to chair the Committee.

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

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

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

Attendees

4.9 Only members of the Committee have the right to attend Committee meetings. The following individuals, who are attendees and not members of the Committee, will be invited to attend Part 1 and Part 2 meetings:

- NHS England
- ICB Board Partner Member – Providers of Primary Medical Services
- Local Medical Committee Representative
- Director of Patients and Communities
- Associate Director of Primary Care
- Two Practice Managers drawn from general practice

The following attendees will be invited to attend Part 1 meetings only:

- Healthwatch Norfolk
- Healthwatch Suffolk
- Health and Wellbeing Board representative - Norfolk
- Health and Wellbeing Board representative – Suffolk

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

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

Attendance

4.12 Where an attendee of the Committee who is not a member of the Committee is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

5 Meetings Quoracy and Decisions

5.1 The Committee will meet at least 4 times a year in public subject to the application of 5.4 below. The Committee will operate in accordance with the CCG's Standing Orders. The Secretary to the Committee will be responsible (or delegate where appropriate) for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each voting member and non-voting attendee no later than 5 days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he/they shall specify. Additional meetings may take place as required in public or private as appropriate for the nature of the business to be transacted.

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

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

5.4 The Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

Quorum

5.4 For a meeting to be quorate a minimum of 3 Members of the Committee are required, including the Chair or Vice Chair of the Committee.

5.5 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.6 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. If an urgent decision is required, the process set out at 5.10 and 5.11 may be followed.

Decision making and voting

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

5.8 Only members of the Committee or nominated deputy may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

5.9 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote or in their absence the Vice Chair.

Urgent Decisions

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

5.11 In the event that an urgent decision is required, if it is not possible for the Committee to meet virtually an urgent decision may be exercised by the Committee Chair and relevant lead director subject to every effort having been made to consult with as many members as possible in the given circumstances (minimum of one other member).

5.12 The exercise of such powers shall be reported to the next formal meeting of the Committee for formal ratification and noted in the minutes.

6 Responsibilities of the Committee

6.1 NHS England has delegated to the ICB authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act.

6.2 Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the ICB acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

- Management of conflicts of interest (section 14O);
- Duty to promote the NHS Constitution (section 14P);
- Duty to exercise its functions effectively, efficiently and economically (section 14Q);
- Duty as to improvement in quality of services (section 14R);
- Duty in relation to quality of primary medical services (section 14S). The Committee has the remit for reviewing primary care quality. Due to the interface with other services, however, the Quality and Safety Committee will maintain oversight of issues which may require more system wide assurance and support.;

- Duties as to reducing inequalities (section 14T);
- Duty to promote the involvement of each patient (section 14U);
- Duty as to patient choice (section 14V);
- Duty as to promoting integration (section 14Z1);
- Public involvement and consultation (section 14Z2).

6.3 The functions of the Committee are undertaken in the context of a desire to promote increased quality, efficiency, productivity and value for money and to remove administrative barriers.

6.4 The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.

6.5 This includes the following:

b. decisions in relation to the commissioning, procurement and management of Primary Medical Services Contracts and other primary medical care services under other appropriate contracting arrangements, including but not limited to the following activities:

IV. decisions in relation to Enhanced Services, including in relation to the PCN Network DES;

V. decisions in relation to Local Incentive Schemes (including the design of such schemes);

VI. decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices;

b. decisions about 'discretionary' payments;

c. decisions about commissioning urgent care (including home visits as required) for out of area registered patients;

d. the approval of practice mergers;

e. planning primary medical care services in the Area, including carrying out needs assessments;

f. review reports of primary medical care services in the Area;

g. decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list);

h. management of the Delegated Funds in the Area;

i. Premises Costs Directions functions;

j. co-ordinating a common approach to the commissioning of primary care services with other commissioners in the Area where appropriate;

k. such other ancillary activities as are necessary in order to exercise the Delegated Functions;

l. approval of the investment of PMS Monies.

m. review, redesign and decommissioning of existing Local Enhanced Services;

n. review and design of primary care dashboard; and

o. review and monitoring of the primary care risk register;

p. Approve arrangements for shared care commissioning

6.6 In performing its role, and in particular when exercising its commissioning responsibilities, the committee shall take account of:

a) The recommendations of the clinical executive, the executive management team and other Board committees;

b) The needs assessment and plan for primary medical care services in the areas covered by the ICB including the resilience of general practice providers;

c) The co-ordination of a common strategic and operational approach to the commissioning of primary care services generally including supporting developments in respect of integration with providers and local authority services including co-location of services;

d) The management of the budget for commissioning of primary medical care services in the area covered by the ICB;

e) In accordance with its duties to reduce inequalities,14T, in the exercise of its functions, the Committee will have regard to the need to:

- Reduce inequalities between patients with respect to their ability to access health services, and
- reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services

7 Behaviours and Conduct

ICB values

7.1 Members will be expected to conduct business in line with the ICB values, objectives and follow the seven principles of public life (the Nolan Principles), comply with the standards set out in the Professional Standards Authority guidance.

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

Equality and diversity

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

Conflicts of Interest

7.4 Members and those attending a meeting of the Committee will be required to declare any relevant interests to the ICB in accordance with the ICB's Conflicts of Interest

Policy.

7.5 A register of Committee members' interests and those of staff and representatives from other organisations who regularly attend Committee meetings will be produced for each meeting. Committee members will be required to declare interests relevant to agenda items as soon as they are aware of an actual or potential conflict so that the Committee Chair can decide on the necessary action to manage the interest in accordance with the Conflicts of Interest Policy.

Confidentiality

7.6 Issues discussed at Committee meetings held in private, including any papers, should be treated as confidential and may not be shared outside of the meeting unless advised otherwise by the Chair.

8 Accountability and reporting

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

8.2 The Chair of the Committee, if not a member of the ICB Board, may be invited to attend Board meetings at the request of the Chair of the ICB.

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

8.4 The minutes of the meetings, including any virtual meetings, shall be formally recorded by the secretary. A report of the Committee's work will be submitted to the Board following each meeting.

8.5 The Committee Chair shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

9 Secretariat and Administration

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

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Committee Chair with the support of the relevant executive lead.
- Attendance of those invited to each meeting is monitored, highlighting to the Chair those that do not meet the minimum requirements.
- Good quality minutes are taken in accordance with the Standing Orders and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept.
- The Chair is supported to prepare and deliver reports to the Board.
- The Committee is updated on pertinent issues/ areas of interest/ policy developments.
- Action points are taken forward between meetings and progress against those

actions is monitored.

10 Review

10.1 The Committee will review its effectiveness annually.

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

Date of approval:

Date of review:

APPENDIX G

Norfolk and Waveney Integrated Care Board
Quality and Safety Committee
Terms of Reference DRAFT v0.4

Revision History

Revision Date	Summary of changes	Author(s)	Version Number
13/05/2022	Initial draft based on national template.	Karen Barker & Nikki Bartrum	DRAFT 0.1
20/05/2022	Review and clarifications, addition of appendix with draft reporting structure charts.	Karen Watts, Evelyn Kelly & Frances Bolger	DRAFT 0.2
25/05/2022	Review of FB comments and questions, inclusion of scheme of delegation items and inclusion of Committee Part 1 and Part 2 definitions and membership.	Karen Barker	DRAFT 0.3
01/06/2022	Rename to 'Quality and Safety Committee' Review of KB answers and resolution of questions. Inclusion of Maternity under responsibilities. Removal of appendix with draft reporting structure charts.	Karen Watts, Evelyn Kelly & Nikki Bartrum	DRAFT 0.4
01/06/2022	Removed 'Approval of the arrangements for discharging the CCG's statutory duty associated with its commissioning functions to assist and support the NHS England in relation to its duty to improve the quality of primary medical services.' following review by MB and SP; this function is covered by PCCC.	Evelyn Kelly	DRAFT 0.5

Approvals
This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number

CONSTITUTION

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

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

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

PURPOSE OF THE COMMITTEE

The Quality and Safety Committee has been established to provide the ICB with assurance that is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Act 2022. This includes reducing inequalities in the quality of care.

The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high quality care. The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

DELEGATED AUTHORITY

The Quality and Safety 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 and may be amended from time to time. The Quality and Safety Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

MEMBERSHIP AND ATTENDANCE

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 (from the ICB). 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.

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.

Members

The Members attending Part 1 and Part 2 meetings of the Committee are as follows (please see Section 6 below with regard to Part 1 and Part 2 meetings):

- Non-Executive Director (Chair)
- Non-Executive Director (Deputy Chair)
- ICB Director of Nursing
- ICB Medical Director
- ICB Primary Medical Services Partner Member
- ICB Local Authority Partner Member

The following Members attend the Committee for Part 1 only and bring their own delegation (where applicable from their own organisations):

- Acute Provider Representation
- 1 Mental Health Lead
- 1 Community Lead

Additional attendees will be called upon by the Chair as required and will include representation from the Urgent & Emergency Care system as well as the voluntary sector and other providers and provider collaboratives.

MEETING QUORACY AND DECISIONS

The Quality and Safety Committee shall meet on a monthly basis. Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

Quoracy

There will be a minimum of one Non-Executive Member, plus at least the Director of Nursing or Medical Director. 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.

RESPONSIBILITIES OF THE COMMITTEE

The Committee will hold a Part 1 meeting to cover system wide issues and a Part 2 meeting to consider issues internal to the ICB.

The responsibilities of the Quality and Safety Committee are authorised by the ICB. It is expected that the Quality and Safety Committee will:

- 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 put forward the key quality priorities that are included within the ICB strategy / annual plan, including priorities to address variation / inequalities in care.

- Oversee and monitor delivery of the ICB key statutory requirements.

- Review and monitor those risks on the Board Assurance Framework 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 DHSC, NHSEI and other regulatory bodies and external agencies (e.g., CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained.

- Maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation and assure the ICB that these are disseminated and implemented across all 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 PFD report).

- Receive assurance that the ICB has effective and transparent mechanisms in place to monitor the quality of Children, Maternity and Neonatal care.

- To be assured that people drawing on services 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.

- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for equality and diversity as it applies to people drawing on services.

- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety.

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

- Approve arrangements including supporting policies to minimise clinical risk maximise patient safety and to secure continuous improvement in quality and patient outcomes.

- Approval of the arrangements for discharging the CCG's statutory duty associated with its commissioning functions to act with a view to securing continuous improvements to the quality of services.

ACCOUNTABILITY and REPORTING ARRANGEMENTS

The Quality and Safety 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.

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

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

BEHAVIOURS AND CONDUCT

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.

Equality and Diversity

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

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.

SECRETARIAT AND ADMINISTRATION

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

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
- Attendance of those invited to each meeting is monitored and that those that do not meet the minimum requirements are highlighted to the Chair;
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
- 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 maintained;
- The Chair is supported to prepare and deliver reports to the ICB;
- The Committee is updated on pertinent issues, areas of interest and 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 and complete an annual report submitted to the Board.

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.

The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Date of approval: **Date of review:**

APPENDIX H

Norfolk and Waveney Integrated Care Board

Performance Committee

Terms of Reference

Revision History

Revision Date	Summary of changes	Author(s)	Version Number
26 May 2022	Originate document	A Palmer	1

Approvals
This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number

CONSTITUTION

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

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

The Committee is a committee of the Board and its members are bound by the Standing Orders and other policies of the ICB.

PURPOSE OF THE COMMITTEE

The Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that ensures a high performing system.

The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB regarding the delivery of key performance standards by commissioned providers, performance of the system against the NHS Outcomes Framework and progress with improving wider population health outcome measures.

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

DELEGATED AUTHORITY

The 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 and may be amended from time to time.

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

MEMBERSHIP AND ATTENDANCE

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 at least two who are Members or Participants of the ICB Board. Other attendees of the Committee need not be Members or Participants 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.

Conflicts of Interest

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.

Chair and Deputy chair

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.

Members

- ICB Board Partner Member, Primary Medical Services (Chair)
- Director of Performance, Transformation and Strategy (Deputy Chair)
- Non- Executive Member
- Medical Director or nominated deputy
- Nursing Director or nominated deputy
- Patient and Communities Director or nominated deputy
- NHSEI Director or nominated deputy (to discharge NHSEI's statutory responsibilities in relation to provider undertakings or other SOF requirements, from time to time the NHSEI Director may need to chair an extraordinary part 2 of the committee)

Other attendees will vary from time to time and may include:

- Director of Population Health Management (ICB)
- Head of System Transformation (ICB)
- Chief Operating Officer or nominated deputy representing the Norfolk Acute Hospitals Group CinC (may be rotated)
- Chief Operating Officer or nominated deputy of each remaining NHS commissioned provider (NCHC, NSFT and ECCH)
- Public Health representative or nominated deputy
- Primary Care representative (PCN CD) or nominated deputy
- County Council representative(s)
- Representative of the ICB performance team
- Representative of the ICB business intelligence team

12. MEETING QUORACY AND DECISIONS

The Committee shall meet at least six times a year (to be determined by the ICB). Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

Quoracy

The quorum for the meeting will be three members, one of which must be the Chair or Deputy Chair.

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. For the avoidance of doubt the deputy will be counted as part of the quorum.
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. If an urgent decision is required, the process set out at 5.10 and 5.11 may be followed.

Decision making and voting

Decisions will be taken in accordance 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 or their nominated deputy 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.

Urgent decisions

In the event that an urgent decision is required, if it is not possible for the Committee to meet virtually an urgent decision may be exercised by the Committee Chair and relevant lead director subject to every effort having been made to consult with as many members as possible in the given circumstances (minimum one other member).

The exercise of such powers shall be reported to the next formal meeting of the Committee for formal ratification and noted in the minutes.

13. RESPONSIBILITIES OF THE COMMITTEE

The responsibilities of the Committee will be authorised by the ICB Board. It is expected that the Committee will:

a) Conduct and lead oversight of both system and commissioned provider performance, including evaluation of health services, provider resilience and failure and performance review and management.

b) Hold the system's Groups, Place(s) and Providers to account and provide challenge to the system where this is required to address opportunities to improve performance and outcomes.

c) Determine where a Peer Review approach is required to support improvement in the system; overseeing the subsequent review and ensuring the learning is implemented.

d) Determine where a 'deep dive' is required on a particular measure and relevant to one or more providers.

e) Facilitate targeted national support through the System Improvement Director (SID).

f) In line with the System Oversight Framework (SOF) and the system's associated SOF segmentation, where relevant, agree with the SID a Service Improvement Plan (SIP).

g) Direct improvement resources when required in the system, including defining the parameters of any new improvement plans, peer review of existing plans where expected outcomes are not delivered and coordinating with regulators where formal improvement or intervention support is required.

h) Approve the KPIs and outcome metrics for use across the system.

i) Agree the scope and approve the development plan for the system's Integrated Performance Report (IPR) for use at System, Place and Provider level.

j) Negotiate any metrics or improvement trajectories with NHSE/I, relevant to SOF segmentation as may be required from time to time.

k) Support innovation and best practice to be consistently adopted across the system.

l) Ensure the system is optimally using benchmarking data for performance improvement.

m) Work jointly with NHSE/I to lead the oversight of place-based arrangements and individual organisations in line with SOF principles.

n) Agree and coordinate any support and intervention carried out by NHSE/I, other than in exceptional circumstances.

o) Participate in any place-based system, functional or organisational support and intervention carried out by NHSE/I.

p) Create robust cross-organisational arrangements to tackle the systemic challenges that the health and care system is facing.

q) Act as a leadership cohort, demonstrating what can be achieved with strong local leadership, operating with increased freedoms and flexibilities

ACCOUNTABILITY and REPORTING ARRANGEMENTS

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 written report on assurances received, escalating any concerns where necessary.

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

BEHAVIOURS AND CONDUCT

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.

Equality and diversity

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

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.

SECRETARIAT AND ADMINISTRATION

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

- The agenda and papers are prepared and distributed in 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 highlighting to the Chair those that do not meet the minimum requirements;

- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
- Good quality minutes are taken in accordance with the Standing Orders and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept;
- The Chair is supported to prepare and deliver reports to the Board;
- The Committee is updated on pertinent issues/ areas of interest/ policy developments;
- Action points are taken forward between meetings and progress against those actions is monitored.

REVIEW

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

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.

The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Date of approval:

Date of review:

APPENDIX I

Norfolk and Waveney Integrated Care Board

Conflict of Interest Sub Committee

Terms of Reference

Revision History

Revision Date	Summary of changes	Author(s)	Version Number

Approvals
This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number

Conflict of Interest Sub Committee - Terms of Reference

Introduction

1.1 The Conflicts of Interest Sub Committee (the 'Sub Committee') is a Sub Committee of the Board of the NHS Norfolk and Waveney Integrated Care Board ("the ICB").

1.2 The Sub Committee is established in accordance with the NHS Norfolk and Waveney ICB Constitution. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Sub Committee.

2 Membership

Members of the Sub Committee are:

2.1.1 Non-Executive Member (Chair)

2.1.2 At least one further Non Executive from the Board

2.1.3 Director of Finance (Deputy Chair)

2.1.4 Medical Director

2.2 The Chair of the Sub Committee shall be the Non-Executive Member who Chairs the Audit and Risk Committee.

2.3 In the absence of the Chair the Director of Finance will preside.

2.4 A Sub Committee member shall cease to hold office if:

2.4.1 He/she ceases to meet the eligibility criteria for their role as set out in the Constitution;

3 Secretary

3.1 The Director of Corporate Affairs and ICS Development shall be secretary to the Sub Committee and will provide administrative support and advice. The duties of the secretary in this regard shall include but are not limited to:

3.1.1 Supporting the Chair in management of the Sub Committee's business;

3.1.2 Agreement of the agenda with the chair of the Sub Committee together with the collation of connected papers;

3.1.3 Taking of the minutes and keeping a record of matters arising and issues to be carried forward;

3.1.4 Advising the Sub Committee as appropriate on best practice, national guidance and other relevant documents.

4 Quorum

4.1 A quorum shall be one Non-Executive Members and one of the Executive Directors (Director of Finance or Medical Director).

5 Decision Making

5.1 Sub Committee members may participate in meetings by the use of telephone, video conferencing facilities and/or webcam where such facilitates are available (subject to the approval of the Chair). Participation via remote technology as described above shall be deemed as presence in person at the meeting.

5.2 Generally it is expected that the Sub Committee's decisions will be reached by consensus. Should this not be possible then a vote of members will be required, the process for which is set out below:

5.2.1 **Eligibility** – Each member as provided in section 2 who is physically present at the meeting or present in accordance with section 5.2 above is entitled to one vote;

5.2.2 **Majority necessary to confirm a decision** – Each question put to the vote at a meeting shall be determined by a majority of votes of those members voting on the question;

5.2.3 **Casting vote** - In the case of an equal vote, the Chair of the meeting shall have an additional and casting vote;

5.2.4 **Dissenting views** – Should a vote be taken, the outcome of the vote, along with any dissenting views, must be recorded in the minutes of the meeting.

6 Frequency and notice of meetings

6.1 Meetings will be held as and when required.

6.2 Items of business to be transacted and all supporting papers for such items for inclusion on the agenda need to be notified to the Chair of the meeting wherever possible at least one week before the meeting takes place.

6.3 The agenda and supporting papers will be circulated wherever possible at least one week before the date the meeting will take place.

6.4 With the agreement of the Chair, items of urgent business may be added to the agenda after circulation of papers to members.

6.5 Members may participate in meetings by the use of telephone, video conferencing facilities and/or webcam where such facilities are available (subject to the approval of the Chair). Participation in a meeting in any of these ways will count towards the quoracy of the meeting subject to the approval of the Chair.

7 Remit and responsibilities of the Sub Committee

7.1 The Sub Committee is authorised to make decisions on behalf of the ICB with regard to issues which cannot be decided by the Board due to the Board not being quorate as a result of conflicts of interest.

7.2 The Committee has the responsibility for overseeing the ICB's policies and procedures with regard to conflicts of interest.

7.3 The Sub Committee has authority to act in accordance with the ICB's Constitution, Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation.

7.4 The Sub Committee is authorised by the Board to commission any reports or surveys it deems necessary to help it fulfil its obligations.

8 Relationship with the Board

8.1 The minutes of Sub Committee meetings shall be formally recorded by the Secretary of the Sub Committee. A report of the Sub Committee's work will be submitted to the Board following each meeting. The Sub Committee shall however act independently of the Board.

8.2 The ICB's annual report shall include a section describing the work of the Sub Committee in discharging its responsibilities.

9 Policy and best practice

The Sub Committee will apply best practice in the decision-making process for example by following Conflicts of Interest guidance published by NHS England and NHS Improvement.

The Sub Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

10 Conduct of the Sub Committee

10.1 The Sub Committee will conduct its business in accordance with national guidance and relevant codes of conduct and good governance practice, including the Nolan Principles.

10.2 Declarations of interest will be a standing item on all meeting agendas.

10.3 Members who have any direct/indirect financial or personal interest in a specific agenda item will declare their interest. The Chair of the meeting will decide the course of action required, which may include exclusion from participation in the discussion and decision making.

10.4 All declarations of interest and actions taken in mitigation will be recorded in the minutes.

10.5 The Sub Committee will assess its performance, membership and terms of reference annually and draw up its own plans for improvement. The Board will approve any subsequent amendment to the terms of reference.

Norfolk and Waveney
Integrated Care Board

Agenda item: 9

Subject:	**ICB Policy Approval and Transfer**
Presented by:	**Karen Barker, Director of Corporate Affairs and ICS Development, NHS Norfolk and Waveney ICB**
Prepared by:	**Heidi Davey, Senior Manager Corporate Governance and ICS Development, NHS Norfolk and Waveney ICB**
Submitted to:	**ICB Board**
Date:	**1 July 2022**

Purpose of paper:

- To approve the transfer of all NHS Norfolk and Waveney CCG policies to the ICB, to be reviewed in accordance with their individual review dates (subject to any earlier review required e.g. by legislation);
- To approve the Complaints Policy and publishing on the website.
- To note the policies that have already been reviewed and included in the Governance Handbook (considered at item 8.)

Executive Summary:

The former NHS Norfolk and Waveney Clinical Commissioning Group (CCG) had in place a full suite of policies that cover all aspects of business and how it discharged its responsibilities to patients, staff, partners and stakeholders whilst meeting its statutory obligations. The recommendation to the Board is that all policies be transferred as a 'full suite' to the ICB.

Report

Each policy, once transferred as above, will then be reviewed in line with its individual review date subject to any earlier review required, for example by legislation. The review will update and capture any changes required as a result of the transfer to the ICB by each team as subject matter experts.

Updated policies will then be taken through their appropriate approval processes.

In preparation of the ICB constitution and accompanying Governance Handbook a number of policies are required to have been reviewed and prepared in readiness for the 1 July 2022. These are listed below and referenced in the ICB Constitution:

- Standards of Business Conduct Policy
- Conflicts of Interest Policy and Procedures
- Policy for Public Involvement and Engagement (Named in the Governance Handbook as "an approach to working with people and communities in Norfolk and Waveney")

- Complaints Policy

These documents have been reviewed and updated and can be found in the ICB Governance Handbook (see Item 8) and will be approved and published via the Governance Handbook. This is with the exception of the Complaints Policy which is attached and if approved will be published on the ICB's website www.improvinglivesnw.org.uk).

Recommendation to the Board:

- To approve the transfer of all NHS Norfolk and Waveney CCG policies to the ICB, to be reviewed in accordance with their individual review dates (subject to any earlier review required e.g. by legislation);
- To approve the Complaints Policy and publishing on the website.
- To note the policies that have already been reviewed and included in the Governance Handbook (considered at item 8.)

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	N/A
Legal:	N/A
Information Governance:	A suite of IG policies is included within this approval request.
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	By having a robust suite of policies in place, it will help the ICB to detail and deliver in a transparent way its responsibilities across all aspects of its business including those referenced in its constitution.
Conflicts of Interest:	An updated policy relating to this area of business is included to ensure the detail of how this obligation will be met.
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	For Board approval 1 July 2022

NHS
Norfolk and Waveney
Integrated Care Board

Norfolk and Waveney ICB

Complaints Handling Policy and Procedure

Document Control Sheet

This document can only be considered valid when viewed via the ICB's intranet. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one online.

Approved documents are valid for use after their approval date and remain in force beyond any expiry of their review date until a new version is available.

Name of document:	**Complaints Handling Policy and Procedure**
Version:	**1**
Date of this version:	**July 2022**
Produced by:	Corporate Affairs
What is it for?	If a person is unhappy about any matter reasonably connected with the exercise of the Integrated Care Board's (ICB's) functions, they are entitled to make a complaint, have it considered, and receive a response. This policy details that process.
Evidence base:	Parliamentary and Health Service Ombudsman – Principles for Remedy
Who is it aimed at and which settings?	The policy is for use by all patients, carers and service users of Norfolk and Waveney.
Impact Assessment:	N/A
Other relevant approved documents	N/A
References:	• The Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009 • Mental Capacity Act 2005 • Human Rights Act 1998 • Data Protection Act 1998 / 2018 • Freedom of Information Act 2000.
Monitoring and Evaluation	This policy will be monitored and reviewed for effectiveness by the Complaints and Enquiries Manager in August 2023.
Training and competences	N/A
Consultation	N/A
Reviewed by:	
Approved by:	
Date approved:	
Signed:	
Dissemination:	
Date disseminated:	
Review Date:	July 2024
Contact for Review:	Corporate Affairs

Contents

1. INTRODUCTION

NHS Norfolk and Waveney Integrated Care Board (hereafter known as 'the ICB') complaints policy and procedure is written in accordance with **The Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009** which came into force on 1st April 2009.

If a person is unhappy about any matter reasonably connected with the exercise of the ICB's functions, they are entitled to make a complaint, have it considered, and receive a response. In particular, these complaints may relate to the commissioning of health care or other services under an NHS contract, or making arrangements for the provision of such care or other services with an independent provider or with an NHS trust,

Matters excluded from consideration under these arrangements are listed in Appendix 4.

The ICB aims to manage complaints by the procedure of local resolution. The primary objective of this process is to provide the opportunity for investigation and resolution of the complaint, as quickly as is sensible in the circumstances and minimising the need for the complainant to escalate concerns to the Parliamentary and Health Service Ombudsman (PHSO). It aims to satisfy the complainant while being fair to staff. Local resolution should be open, honest, fair, flexible and conciliatory.

Complaints are recognised by the ICB as a vital form of feedback to help improve both the service the organisation and providers offer. The ICB aims to ensure all complainants feel listened to, have their complaint investigated thoroughly and that any response is delivered in a personalised way.

2. POLICY STATEMENT

NHS Norfolk and Waveney ICB is committed to providing an accessible, fair and effective means for people (and/or their representatives) to express their views. It is also recognised staff have the right to make a complaint to senior managers on behalf of, or in the interests of, a patient.

The ICB aims to promote a culture in which all forms of feedback are listened to and acted upon. Complaints, compliments, general comments and suggestions are encouraged. It is recognised such information is invaluable as a means of identifying both problems and areas of good practice and as such can be used as a tool for improving services.

Being open: Often, all that is required is a simple apology and/or explanation. This should, wherever possible, be given at the earliest opportunity by all front-line staff. Patients have a right to expect openness in their healthcare.

No discrimination: Patients should always be reassured that making a complaint will not affect their eligibility for, or the nature of, current or future treatment. This is achieved through the complete separation of complaint documentation from the patient's medical records. Complainants and members of staff are asked to inform the ICB's Complaints and Enquiries Manager if they have any concerns about this.

Complaints about care that is felt to discriminate against a person will be reported to the ICB's Patient and Communities Committee.

Dignity and respect: Complaints about care that compromises the dignity of, or respect shown to, a person will be overtly reported to the ICB's Patient and Communities Committee.

Mindful of people's human rights: The ICB respects and observes the Absolute, Limited, and Qualified Rights contained in legislation and applies these rights to all its business undertakings. The Rights are set out at Appendix 1.

Mental Capacity Act 2005, revised 2007: The ICB is also mindful of the statutory principles contained in this legislation, an overview of which is set out at Appendix 2.

Legal Action: Should a complainant explicitly indicate an intention to take any form of legal action the matter will be treated under the appropriate procedure.

The ICB's Complaints and Enquiries Manager may investigate the complaint if it does not compromise or prejudice the concurrent investigation, but this can be discontinued at any time if circumstances change.

3. COMPLAINTS HANDLING POLICY

3.1 Responsibilities

The Chief Executive is accountable for the quality of the care commissioned and will, therefore, have an overview of all recorded dissatisfaction expressed by patients and service users.

Director for Corporate Affairs and ICS Development is the senior person appointed by the Chief Executive to ensure the process for handling and reporting on complaints on behalf of the ICB complies with this policy.

3.2 What is a complaint?

A complaint is a verbal or written expression of concern or dissatisfaction about a matter relative to the ICB's functions or decisions, which requires a response and/or redress.

3.3 Who can complain?

A complaint can be made under this policy by:

- A patient or person affected or likely to be affected by the actions or decisions of the ICB;
- someone acting on behalf of the patient or person concerned, with their consent;
- someone acting on behalf of a person mentioned above, and in any case where that person has died;
- a child, or in the case of a child, someone acting on their behalf, who must be a parent, legal guardian or other adult person who has care of the child. Where the child is in the care of a local authority or a voluntary organisation, the representative must be an authorised person identified by the local authority or voluntary organisation, and must be making the complaint in the best interests of the child;
- someone who is unable by reasons of physical or mental incapacity to make the complaint themselves.

3.4 Local Resolution

The first stage of the NHS complaints procedure is called 'local resolution' and complaints should be made, in the first instance, to the organisation providing the service.

Local resolution aims to resolve complaints quickly and as close to the source of the complaint as possible, using the most appropriate means; for example, the use of conciliation. Local resolution enables concerns to be raised immediately by speaking to a member of staff who may be able to resolve issues without the need to make a formal complaint.

3.5 **Making a Formal Complaint**

If local resolution does not resolve matters and the complainant wishes to continue with their complaint they can do this orally or in writing (including e-mail) to the Complaints and Enquiries Manager for NHS Norfolk and Waveney ICB at the following address:

The Complaints and Enquiries Manager
Lakeside 400
Old Chapel Way
Broadland Business Park
Thorpe St Andrew
Norwich
NR7 0WG

Tel - 01603 595857

Email – nwicb.complaintsservice@nhs.net

The complaint will be recorded as being made on the date on which it was received by the Complaints and Enquiries Manager.

3.6 **Time limit for making a complaint**

A complaint should be made within 12 months of the event(s) concerned, or within 12 months of the date on which the matter came to the notice of the complainant. The Complaints and Enquiries Manager has discretion to waive this time limit if there are good reasons for the complaint not having been made within that time frame.

3.7 **Independent Contractor Complaints**

The ICB does not commission services provided by dentists, pharmacists or opticians. The ICB holds delegated responsibility for commissioning Primary Medical Services (General Practice), however the responsibility for performance management of GPs remains a function of NHS England.

Commented [PJ(NAWC1]: Not sure if this holds true when we become an ICB?

Complaints or concerns relating to these providers should not be raised with the ICB. GP surgeries, dentists, pharmacies and opticians have their own complaints procedures to follow, or alternatively a complaint or concern can be escalated to NHS England, by:

- Telephone: 0300 311 22 33
- Email: england.contactus@nhs.net
- Letter: NHS England, PO Box 16738, Redditch, B97 9PT

Should the ICB receive complaints about GP surgeries that it feels cause to consider, the outcome of any investigation will be shared with the surgery wherever possible, in line with information governance guidance.

3.8 **Duty of Candour**

The ICB welcomes the government's commitment to introducing a duty of candour within the NHS. This recommends that all providers of NHS care should owe a duty of candour to their commissioners under which they provide, amongst others;

- Timely reports, prepared to an agreed protocol, of all complaints made by NHS patients;
- In cases when complaints are upheld, Complaints Action Plans to address the weaknesses that have been identified;

- Progress reports in relation to implementation of complaints action plans

The ICB is committed to improving the quality of care and the services it commissions. The Clinical Quality team will review and monitor the reports received from providers and will report to the Patient and Communities Committee to ensure the quality of services provided is of a high standard and they continually strive for further improvement. This will be addressed with providers through the existing quality monitoring mechanisms.

4. COMPLAINTS HANDLING PROCEDURE

4.1 Acknowledgement and record of complaint

The Complaints and Enquiries Team will send to the complainant a written acknowledgement of the complaint within **three working days** of the date on which the complaint was received. This acknowledgement will include:

- if necessary, a consent form to be signed and returned by the patient if they are not the person who has identified the concerns to be investigated;
- information concerning how to access the local NHS advocacy provider, POHWER (Norfolk) or Voiceability (Suffolk);
- information concerning how to access the Parliamentary and Health Service Ombudsman;

4.2 Complaints in Writing

The ICB's Complaints and Enquiries Team will review the complaint, then identify the appropriate senior manager to investigate the matter.

Where the complaint involves services or care commissioned from or provided by more than one organisation, the ICB's Complaints and Enquiries Manager will liaise with the complaints manager(s) of the other organisation(s) to ensure all aspects of the complaint are appropriately investigated and responded to. This is provided appropriate consent has been provided by the complainant/patient to do so.

4.3 Verbal Complaints

When a verbal complaint is made to the ICB's Complaints and Enquiries Team, the letter of acknowledgement and associated enclosures must be accompanied by a written file note summarising the issues raised, with an invitation to the complainant to sign and return it. This will ensure all aspects of the complaint have been thoroughly understood.

4.4 Investigation

The ICB's Complaints and Enquiries Manager will discuss the investigation of high-risk cases with the ICB's Chief Executive and Director of Nursing. The investigation must be of sufficient rigour and detail to enable the ICB to provide an open, honest and comprehensive response to the complainant. The investigating officer will request the review of patient records and statements from the staff involved as necessary and provide a response to the complaint to the ICB's Complaints and Enquiries Manager.

Investigating managers will share a copy of the written complaint response with any person who was the subject of the complaint.

4.5 Response

The complainant should receive a full written response from the ICB's Chief Executive as soon as reasonably practical following completion of the investigation and within a preferred timescale of 30 working days following receipt of the complaint if possible. It should be noted that in stances where consent is required from a complainant to proceed with the complaint, the 30 working day timescale will start on the date formal consent is received.

If it is not achievable to respond with the target timescale, the ICB's Complaints and Enquiries Team will write to the complainant explaining the reason, and an achievable date will be negotiated. A response must be sent within six months of the date of a complaint being received.

If a complainant is not happy with aspects of the response, they are encouraged to contact the ICB's Complaints Team in the first instance, but they will also have the option of appealing to the PHSO.

5. PHSO AND PRINCIPLES FOR REMEDY

The ICB will follow the principles of good administration outlined by the PHSO and will consider the impact of the organisation's actions on the individual concerned. The key principles are as follows:

i. Getting it right

- Acting in accordance with the law and with due regard for the rights of those concerned
- Acting in accordance with the public body's policy and guidance (published or internal)
- Taking proper account of established good practice
- Providing effective services, using appropriately trained and competent staff
- Taking reasonable decisions, based on all relevant considerations

ii. Being customer focused

- Ensuring people can access services easily
- Informing customers what they can expect and what the public body expects of them
- Keeping to its commitments, including any published service standards
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly including, where appropriate, co-ordinating a response with other providers

iii. Being open and accountable

- Being open and clear about policies, procedures and decisions, and ensuring that information and any advice provided is clear, accurate and complete
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately
- Keeping proper and appropriate records
- Taking responsibility for its actions

iv. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests
- Dealing with people and issues objectively and consistently
- Ensuring that decisions and actions are proportionate, appropriate and fair

v. Putting things right

- Acknowledging mistakes and apologising where appropriate
- Putting mistakes right quickly and effectively
- Providing clear and timely information on how and when to appeal or complain
- Operating an effective complaints procedure, this includes offering a fair and appropriate remedy when a complaint is upheld

vi. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective

- Asking for feedback and using it to improve services and performance
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.

6. ROLE OF THE PHSO

The PHSO is completely independent of the NHS and of government and derives his powers from the Health Service Commissioners Act 1993. The Ombudsman is the final arbiter in the complaints process where it has not been possible to resolve concerns locally. The ICB will co-operate fully with any investigation undertaken by the Ombudsman. Further information on the role and work of the Ombudsman is available at:

Parliamentary and Health Service Ombudsman
Millbank Tower
Millbank
London, SW1P 4QP

Tel: 0345 015 4033
e-mail: phso.enquiries@ombudsman.org.uk
Website: www.ombudsman.org.uk

7. ROLE OF THE COMPLAINTS ADVOCACY SERVICE (POHWER/VOICEABILITY SUFFOLK) AND PATIENT ADVOCATES

POHWER (Norfolk residents) and VoiceAbility (Suffolk residents) have an important role in helping complainants at each stage of the process. Their contact details can be found below:

POHWER
- Telephone: 0300 456 2370
- Email: pohwer@pohwer.net
- Letter: PO Box 14043, Birmingham, B6 9BL

VoiceAbility
- Telephone: 01473 857631(Mon-Fri 9am-5pm)
- Email: tvspartnership@voiceability.org
- Letter: VoiceAbility, Total Voice Suffolk, Ipswich Road, Stowmarket, Suffolk, IP14 1BE.

Under the Mental Capacity Act 2005, the role of advocacy for patients who lack capacity is undertaken by the Independent Mental Capacity Advocate Service (IMCA). All complainants are sent information with POHWER's/VoiceAbility's details to inform them of their role in providing support and information.

8. COMPLAINTS AND DISCIPLINARY PROCEDURES

The complaints procedure is concerned only with resolving complaints and not with investigating disciplinary matters. Whether disciplinary action is warranted is a separate matter for management outside of the Complaints Procedure and there must be a separate process of investigation.

9. MONITORING AND LEARNING FROM COMPLAINTS

- All complaints will be recorded on the ICB's database and complaint files maintained for a period of not less than ten years;
- The Complaints and Enquiries Manager will provide regular reports, every three months, to the Patient and Communities Committee. The report will provide information about the number of complaints; the services involved; the reasons for complaints and any ongoing trends.
- The ICB's Complaints and Enquiries Manager will prepare information regarding complaints handling which will be included in the ICB's Annual Report.

10. STAFF SUPPORT

The ICB acknowledges the importance of supporting those involved in complaints and recognises the need to ensure that all parties are provided with timely and appropriate support.

11. HABITUAL, UNNECESSARILY AGGRESSIVE OR REPETITIVE COMPLAINANTS

Habitual, unnecessarily aggressive or repetitive complainants are an increasing problem for staff, reflecting a pattern experienced throughout the NHS. The difficulty in handling such complainants can place a strain on time and resources and cause undue stress for staff that may need support in difficult situations. Staff are trained to respond in a professional and helpful manner to the needs of all complainants. However, there are times where nothing further can reasonably be done to assist the complainant or to rectify a real or perceived problem. Appendix 3 sets out the procedure for the management of habitual, unnecessarily aggressive or repetitive complainants.

12. REVIEW

The Complaints Policy and Procedure will be reviewed every two years, or sooner, if changes occur in legislation. The effectiveness of the policy will be reviewed in the light of performance against response timeframes; numbers resolved and referred complaints as well as implementation of lessons learned.

The procedure will also be reviewed in the light of any audit recommendations, learning and developments cycles or changes to organisational structure that may impact on how the procedures operate.

APPENDIX 1: ARTICLES OF HUMAN RIGHTS

Articles of Human Rights

The Human Rights Act 1998 gives further effect to the rights and freedoms contained in the European Convention on Human Rights. Article 1 of the European Convention is introductory and is not incorporated into the Human Rights Act.

Article 2: Right to Life
A person has the right to have their life protected by law. There are only certain very limited circumstances where it is acceptable for the state to take away someone's life, e.g. if a police officer acts justifiably in self-defence.

Article 3: Prohibition of Torture
A person has the absolute right not to be tortured or subjected to treatment or punishment which is inhuman or degrading.

Article 4: Prohibition of Slavery and Forced Labour
A person has the absolute right not to be treated as a slave or to be required to perform forced or compulsory labour.

Article 5: Right to Liberty and Security
A person has the right not to be deprived of their liberty except in limited cases and provided there is a proper legal basis in UK law.

Article 6: Right to a Fair Trial
A person has the right to a fair and public hearing within a reasonable period of time.

Article 7: No Punishment without Law
A person normally has the right not to be found guilty of a crime arising out of actions which, at the time they committed them, were not criminal.

Apart from the right to hold particular beliefs, the rights in Articles 8-11 may be limited where that is necessary to achieve an important objective.

Article 8: Right to Respect for Private and Family Life
A person has the right to respect for their private and family life, their home and their correspondence.

Article 9: Freedom of Thought, Conscience and Religion
A person is free to hold a broad range of views, beliefs and thoughts and to follow a religious faith.

Article 10: Freedom of Expression
A person has the right to hold opinions and express their views on their own or in a group. This applies even if those views are unpopular or disturbing.

Article 11: Freedom of Assembly and Association
A person has the right to assemble with other people in a peaceful way. They also have the right to associate with other people, including the right to form a trade union.

Article 12: Right to Marry
Men and women have the right to marry and start a family; however, national law will still govern how and at what age this can take place.
(Article 13 is not included in the Human Rights Act)

Article 14: Prohibition of Discrimination
A person has the right not to be treated differently because of their race, religion, sex, political views or any other personal status unless this can be justified objectively.

APPENDIX 2: MENTAL CAPACITY ACT 2005, REVISED 2007

Introduction

The Mental Capacity Act 2005 (the Act) provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. Everyone working with and/or caring for an adult who may lack capacity to make specific decisions must comply with this Act when making decisions or acting for that person, when the person lacks the capacity to make a particular decision for themselves. The same rules apply whether the decisions are life-changing events or everyday matters.

The Act's starting point is to confirm in legislation that it should be assumed that an adult (aged 16 or over) has full legal capacity to make decisions for themselves (the right to autonomy) unless it can be shown that they lack capacity to make a decision for themselves at the time the decision needs to be made. This is known as the presumption of capacity. The Act also states that people must be given all appropriate help and support to enable them to make their own decisions or to maximise their participation in any decision-making process.

The underlying philosophy of the Act is to ensure that any decision made, or action taken, on behalf of someone who lacks the capacity to make the decision or act for themselves is made in their best interests.

The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. But the Act also aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack capacity to make decisions to protect themselves.

The Act sets out a legal framework of how to act and make decisions on behalf of people who lack capacity to make specific decisions for themselves. It sets out some core principles and methods for making decisions and carrying out actions in relation to personal welfare, healthcare and financial matters affecting people who may lack capacity to make specific decisions about these issues for themselves.

Many of the provisions in the Act are based upon existing common law principles (i.e. principles that have been established through decisions made by courts in individual cases). The Act clarifies and improves upon these principles and builds on current good practice which is based on the principles.

The **five statutory principles**, contained in Section 1 of The Act, are:

- A person must be assumed to have capacity unless it is established that they lack capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- An act done or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

APPENDIX 3: THE MANAGEMENT OF PERSONS WHO ARE IDENTIFIED AS HABITUAL, UNNECESSARILY AGGRESSIVE OR REPETITIVE COMPLAINANTS

1. Introduction

This guidance should only be used as a last resort and after all reasonable measures have been taken to assist the person concerned. All staff are expected to be familiar with the NHS Complaints Procedure.

The decision to categorise a person as a habitual, unnecessarily aggressive or repetitive complainant will follow discussion between the ICB's Chief Executive, Complaints and Enquiries Manager and an appropriate member of the Executive Management Team.

It should be emphasised that the classification of an individual as a 'habitual, unnecessarily aggressive or repetitive' complainant will NOT mean that any new issues, having no connection with original concerns, will not be dealt with through the usual process.

2. Criteria for definition of a habitual, unnecessarily aggressive or repetitive caller or complainant

Complainants may be deemed to be habitual, unnecessarily aggressive or repetitive callers where previous or current contact with them shows that they meet two or more of the following criteria:

- Persist in pursuing a complaint where the NHS Complaints Procedure has been fully and properly implemented and exhausted
- Change the substance of a complaint or continually raise new issues or seek to prolong contact by repeatedly raising further concerns or questions upon receipt of a response whilst the complaint is being addressed. (Care must be taken not to discard new issues that are significantly different from the original complaint. These might have to be addressed separately)
- Do not clearly identify the precise issues they wish to be investigated, despite reasonable efforts by staff and others (e.g. advocacy agencies) to help them specify their concerns
- The complaint or issue is trivial or appears to consume an excessive amount of resources
- Having, in pursuing their concerns, had an excessive number of contacts with the ICB by telephone, letter or fax. Staff should be instructed to keep a clear record of the number of contacts to demonstrate their excessive nature
- Display unreasonable demands or expectations and fail to accept these may be unreasonable, for example insist on immediate responses from senior staff when they are not available and this has been explained
- Have threatened or used actual physical violence. All such cases must be documented on an incident form in accordance with policy, in case of further action
- Have harassed or been personally abusive or verbally aggressive on more than one occasion towards staff dealing with them. All cases must be documented on an incident form in accordance with policy, in case of further action.

The use of actual physical violence, albeit on one occasion only, will result in the application of measures described under (3) to limit the personal contact ordinarily available to complainants.

2. Procedure for staff handling habitual, unnecessarily aggressive or repetitive callers or complainants

- Ensure all relevant procedures and reasonable action has been correctly implemented. If you are at all uncertain, please check with the ICB's Complaints and Enquiries Manager or Director for Corporate Affairs and ICS Development.

- Even the most difficult of callers may have issues that contain genuine substance.

- Remain professional and polite. This does not mean that you have to listen continually to the same story of complaint, nor that you cannot politely, but firmly terminate the call.

- Record the date, time and how long you were on the telephone and inform the ICB's Complaints and Enquiries Manager as soon as possible.

- When a caller has been officially declared a habitual, unnecessarily aggressive or repetitive caller, the ICB's Chief Executive may decide no further telephone communication will be accepted.

- Where there is ongoing correspondence or investigation, the ICB's Complaints and Enquiries Manager will write to the caller setting the parameters for a code of behaviour and the lines of communication. These will be communicated to all appropriate staff to ensure consistency of approach.

Where investigation or correspondence is completed, the ICB's Complaints and Enquiries Manager will, at an appropriate stage, write to the caller informing him/her the ICB has responded fully to the points raised and that there is nothing further that can be added, therefore correspondence is at an end. The ICB may wish to state that further correspondence will be acknowledged, but not answered.

It should be emphasised that the classification of an individual as habitual, unnecessarily aggressive or repetitive will not mean that any new issues having no connection with the original complaint or dispute will not be dealt with in the normal way.

APPENDIX 4: MATTERS EXCLUDED FROM CONSIDERATION UNDER THIS POLICY

The following complaints are excluded from the scope of the arrangements described within this policy:

- A complaint made by an NHS body which relates to the exercise of its functions by another NHS body.
- A complaint made by a primary care provider which relates either to the exercise of its functions by an NHS body or to the contract or arrangements under which it provides primary care services, unless those arrangements fall within the ICB's sphere of responsibility. In such cases, the ICB's Dispute Resolution Procedure should be invoked.
- A complaint made by an employee about any matter relating to his/her contract of employment.
- A complaint made by an independent provider or an NHS trust about any matter relating to arrangements made by the ICB with that independent provider or NHS trust.
- A complaint which is being or has been investigated by the PHSO or Local Government Ombudsman.
- A complaint arising out of the ICB's alleged failure to comply with a data subject request under the Data Protection Act 1998 / 2018 or a request for information under the Freedom of Information Act 2000.
- A complaint about which the complainant has stated in writing that s/he intends to take legal proceedings.

Norfolk and Waveney
Integrated Care Board

Agenda item: 10

Subject:	**Approval of Emergency Preparedness, Resilience and Response (EPRR) Arrangements**
Presented by:	**Rt Hon. Patricia Hewitt, Chair, NHS Norfolk and Waveney ICB**
Prepared by:	**Nikki Bartrum, Corporate Governance Manager, NHS Norfolk and Waveney ICB**
Submitted to:	**ICB Board**
Date:	**1 July 2022**

Purpose of paper:

For approval.

Executive Summary:

The Health and Care Bill, passed by Parliament, includes an amendment to the Civil Contingencies Act (CCA) to designate Integrated Care Boards (ICB) as Category 1 responders from 1 July 2022. Previously, Clinical Commissioning Groups (CCGs) have been category 2 responders, so this change means additional statutory responsibilities and accountabilities for ICBs in comparison to the current duties placed upon CCGs.

Category 1 responders are organisations at the core of emergency response and are subject to the full list of civil protection duties to:

- Assess the risk of emergencies occurring and use this to inform contingency planning
- Put in place emergency plans
- Put in place business continuity management arrangements
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- Share information with other local responders to enhance co-ordination
- Cooperate with other local responders to enhance co-ordination and efficiency

Other Category 1 responders for health are:

- Department of Health on behalf of Secretary of State for Health
- NHS England
- Acute service providers
- Ambulance service providers
- UK Health Security Agency (previously Public health England)
- Local authorities (inc. Directors of Public Health)

The NHS Act 2006 (as amended) places a duty on ICBs to appoint an individual to be responsible for discharging their duties under section 252A. This individual is known as the Accountable Emergency Officer (AEO).

The AEO must be a Board level director who will have executive authority and responsibility for ensuring that the organisation complies with legal and policy requirements. The AEO will be responsible for:

- Ensuring that the ICB, and any sub-contractors, are compliant with the emergency preparedness, resilience and response (EPRR) requirements as set out in the CCA 2004, the NHS Act 2006 (as

amended) and the NHS Standard Contract, including the NHS England Emergency Preparedness, Resilience and Response Framework and the NHS England Core Standards for EPRR.
- Ensuring that the ICB is properly prepared and resourced for dealing with an incident.
- Ensuring that the ICB, any providers they commission and any subcontractors have robust business continuity planning arrangements in place which are aligned to ISO 22301 or subsequent guidance which may supersede this.
- Ensuring that the ICB complies with any requirements of NHS England, or agents of NHS England, in respect of monitoring compliance.
- Providing NHS England with such information as it may require for the purpose of discharging its functions.
- Ensuring that the ICB is appropriately represented by director level engagement with, and effectively contributes to any governance meetings, subgroups or working groups of the LHRP and/or LRF, as appropriate.

It is proposed that the ICB's Medical Director is appointed as the AEO and that this role also co-chairs the Local Health Resilience Partnership. This arrangement will be reviewed by 30.09.22.

The AEO will be supported by the Principal Resilience Officer in ensuring that the ICB discharges its EPRR duties.

This paper seeks approval of the ICB's AEO arrangements.

Recommendation to ICB/Committee:

The Board are asked to note the contents of this paper and:

- Approve the appointment of the Medical Director as the ICB's Accountable Emergency Officer. This arrangement will be reviewed by 30.09.22.
- Agree that the Accountable Emergency Officer co-chairs the Local Health Resilience Partnership.

Key Risks	
Clinical and Quality:	Risk to the safety of patients and public if emergency plans fail. Failure to complete actions could have an impact on the quality of clinical services
Finance and Performance:	Risk of failure to comply with CCG statutory duties, with the Civil Contingencies Act 2004 and with NHS England's EPRR requirements.
Impact Assessment (environmental and equalities):	None
Reputation:	Risk to organisational reputation resulting from failure to respond in an emergency and to recover business as usual functions.
Legal:	As an ICB we must comply with the Civil Contingencies Act 2004 and associated legislation.
Information Governance:	Failure to ensure all actions are taken with regards to IG during an incident could result in legal challenge.
Resource Required:	Accountable Emergency Officer, Principal Resilience Officer, Corporate Affairs
Reference document(s):	As above
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the ICB Assurance Framework	n/a

GOVERNANCE

Process/Committee approval with date(s) *(as appropriate)*	

Norfolk and Waveney
Integrated Care Board

Agenda item: 11

Subject:	**Board Assurance Framework (BAF)**
Presented by:	**Karen Barker, Director Corporate Affairs and ICS Development NHS Norfolk and Waveney ICB**
Prepared by:	**Martyn Fitt, Corporate Affairs Manager NHS Norfolk and Waveney ICB**
Submitted to:	**ICB Board**
Date:	**1 July 2022**

Purpose of paper:

To present the Board with a copy of the ICB's Board Assurance Framework.

Executive Summary:

The Board is presented with a summary table of the current risks for the Integrated Care Board (ICB). Please see below at Appendix one.

Effective risk management is an essential part of the ICB's system of internal control and supports the provision of a fair and well-illustrated Annual Governance Statement

All necessary due diligence was undertaken by NHS Norfolk and Waveney Clinical Commissioning Group as part of the transition to ensure the safe transfer of all open risks to the ICB once formally established. Therefore, the summary table provided at Appendix one sets out the risks that the CCG Governing Body agreed to transfer at their meeting dated 24 May 2022. The table also sets out their current risk score and the Directorate within the ICB who is working on the risk.

Further work will be completed on this in the coming weeks as new Directors are established in posts and further information provided on current actions and mitigations.

Recommendation to Board:

To receive and review the risks presented.

Key Risks	
Clinical and Quality:	None
Finance and Performance:	None
Impact Assessment (environmental and equalities):	None
Reputation:	It is important the Board is apprised of the key risks in the organisation currently.
Legal:	N/A

Information Governance:	N/A
Resource Required:	Corporate Affairs risk management resource
Reference document(s):	None
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	See table.

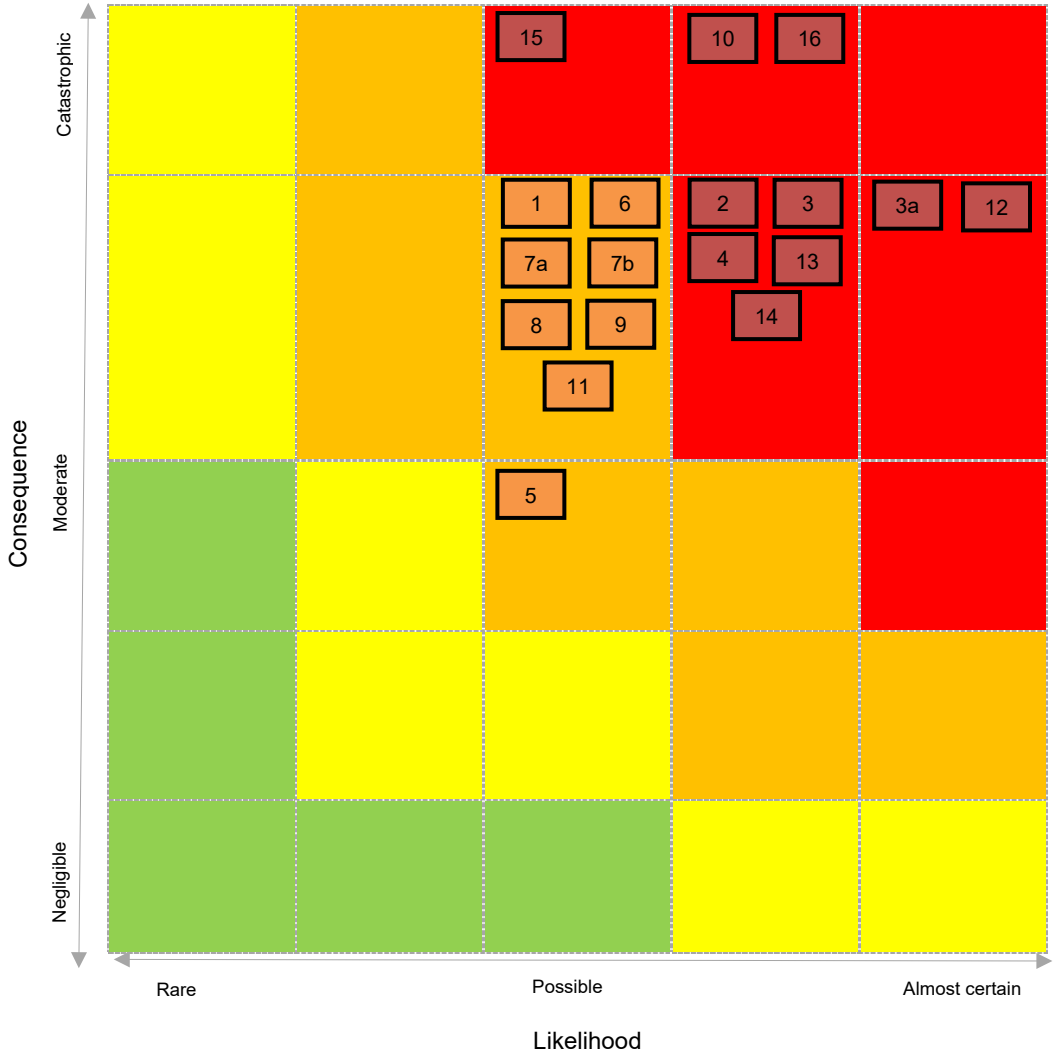
Appendix one - Summary of risks transferred to NWICB

Ref	Risk title	Risk description	Risk scores			Directorate
			Unmitigated	Mitigated	Tolerated	
BAF01	Living with COVID-19	There is continued risk that new variants may contribute to increase in transmission and alter severity of illness. The local healthcare system is currently going through a period of high system pressure set against restoration and recovery, and compliance with robust Infection Prevention and Control Measures.	4x5=20	3x4=12	1x5=5	Director of Nursing
BAF02	System Urgent & Emergency Care (UEC) pressures	There continues to be a risk that the Norfolk and Waveney health and social care system does not have sufficient resilience or capacity to meet the urgent and emergency care needs of the population whenever a need arises. This can result in longer than acceptable response times to receive treatment and as a result potentially poorer outcomes for our patients.	5x4=20	4x4=16	3x4=12	Director of Patients and Communities
BAF03	Financial Plan 2022/23	If the ICB does not deliver the 2022/23 Financial Plan of a deficit of £14.2m, then the ICB may not be able to maintain spending on current levels of service; or continue with plans for further investment. This may lead to a reduction in the levels of services available to patients.	5x4=20	4x4=16	2x4=8	Director of Finance
BAF03a	Underlying deficit position	If the ICB underpins its financial position via non-recurrent funding, this provides a risk to future years' financial sustainability	5x4=20	5x4=20	3x4=12	Director of Finance
BAF04	Providers in CQC 'Inadequate' Special Measures (NSFT)	There is a risk that services provided by Norfolk & Suffolk Foundation Trust (NSFT) do not meet the required standards in a timely and responsive way. If this happens, people who use our services will not receive access to services and care that meets the required quality standard. This may lead to clinical harm, poor patient experience and delays in treatment or services	4x4=16	4x4=16	2x4=8	Director of Nursing
BAF05	Cancer diagnosis and treatment	Due to COVID impact there is a risk that there is a failure to improve early diagnosis and treatment. If this happens there may be poorer health outcomes for cancer patients and a failure to rapidly reduce elective backlogs. This may lead to increased waiting times and potential harm to patients.	4x4=16	3x3=9	2x3=6	Medical Director
BAF06	Primary Care	There is a risk services provided by general practice across Norfolk and Waveney system may be impacted by Covid 19 due to the impact of staff testing positive, staff isolating, increased demand from patients that have put off accessing services during the pandemic, and the delivery of the PCN Covid vaccination campaign. If this happens, significant pressures will be placed on practices and other primary care services, as well as urgent and emergency care and community services.	5x4=20	3x4=12	3x4=12	Director of Patients and Communities

BAF07a	Barriers to full delivery of the Mental health transformation programme - Adults	There is a risk that during a period of unprecedented mental health demand and acuity of need current system capacity and models of care are not sufficient to meet the need If this happens individual need will not be met at the earliest opportunity, by the right service or by the most appropriate person and need will escalate. This may lead to worsening inequality and health outcomes, increased demand on other services and reputational risk	**4x4=16**	**3x4=12**	**2x4=8**	Director of Nursing
BAF07b	Barriers to full delivery of the Mental health transformation programme - CYP		**4x4=16**	**3x4=12**	**2x4=8**	Director of Nursing
BAF08	Health inequalities	There is a risk that the impact of covid coupled with the failure to successfully deliver the system plans will lead to a widening of health inequalities, and significantly poorer outcomes for the most vulnerable groups in our population	**4x4=16**	**3x4=12**	**1x4=4**	Director of Population Health Management
BAF09	#WeCareTogether People Plan	There is a risk that there is failure in the implementation of our *#WeCareTogether* People Plan in respect to improving health and wellbeing, creating new opportunities, maximising skills of our staff and creating a positive and inclusive culture at work. If this happens then we will not achieve our goal to be the 'best place to work'. This may lead to increased sickness and turnover, high vacancies and poor patient care, and our people may experience bullying and discrimination.	**4x4=16**	**3x4=12**	**1x3=3**	Director of People
BAF10	RAAC Planks	There is a risk that current roofing structures at two Norfolk and Waveney Acute Trusts are potentially unsafe due to RAAC Planks. If this happens it would have far reaching consequences across all areas of the ICB and system. This may lead to risking the safety to patients, visitors and staff.	**5x5=25**	**4x5=20**	**3x5=15**	Director of Place and System Support
BAF11	Staff burnout	There is a risk that in the current climate as the pandemic continues, with pressures, workloads and activity increasing across the whole system, our staff are starting to feel tired and exhausted. This could lead to burnout with poor physical and mental wellbeing, low morale and motivation. This could lead to an increase in staff absence rates (short and longer term), retention and most worryingly significant mental and physical issues. If this happens this could have a significant impact on the services that they deliver.	**4x4=16**	**3x4=12**	**1x4=4**	Director of People
BAF12	Elective Recovery	There is a risk that the number of patients waiting for elective treatment in Norfolk and Waveney, which has grown significantly during the pandemic, cannot be reduced quickly enough to a level that meets NHS Constitutional commitments and which protects patients from the risk of clinical harm. If this happens, it will contribute to a poor patient experience, fail to meet Constitutional requirements and may lead to an increased risk of clinical harm resulting from prolonged waits for treatment.	**5x4=20**	**5x4=20**	**3x4=12**	Medical Director

BAF13	NHS Continuing Healthcare	There is a risk that NHS Continuing Healthcare (CHC) funded packages will not be filled by the provider either due to the complexity of the care required and/or their capacity or the proposed cost of care. If this happens significant pressures will be placed on the CHC nurses to source a package of care. Staff vacancies and absences may increase and the infrastructure to support provision of safe and effective care packages will be compromised. This may lead to increased financial cost to secure a care package, could impact on hospital discharges and admissions and poor outcomes for people requiring NHS funded care in the community.	**5x4=20**	**4x4=16**	**3x3=9**	Director of Nursing
BAF14	EEAST Response times and patient harms	There is a significant risk of patient harm if the Ambulance Service is unable to assess, treat and convey patients according to emergency needs. If systemwide pressures continue to result in longer handover time of patients at Emergency Departments and ambulances waiting to clear for redeployment into the system, there is a risk that service delivery will continue to be impacted across the Norfolk & Waveney footprint	**5x5=25**	**4x4=16**	**3x3=9**	Director of Patients and Communities
BAF15	Impact on Business Continuity in the event of a Successful Ransomware Cyber Attack	Current heightened risk of hostile cyber attack affecting the UK may, via a ransomware attack, impact on the ICB's ability to maintain business continuity, if access to data stored within Office 365 on the national NHS tenant, is compromised or prohibited (by data getting onto and corrupting the local network via Ransomware)	**5x4=20**	**3x5=15**	**2x3=6**	Director of Data and Digital
BAF16	Personal data	There is a risk that the ICB's constitution and statutory / delegated functions will not permit it to process personal data without consent, once the protection of the current COPI Notice ceases on 30 June 2022; particularly functions that have been stood up during the pandemic. This also includes the risk to the CEfF (the access to controlled financial data pertaining Patient Identifiable Data). The ICB has not as yet been given legal right to access personal confidential data	**4x5=20**	**4x5=20**	**3x3=9**	Director of Data and Digital

Risk visual



			Month (April 22 to March 23)											
Ref	Risk	RA*	1	2	3	4	5	6	7	8	9	10	11	12
1	Living with COVID-19	5				12								
2	System Urgent & Emergency Care Pressures	12				16								
3	Financial Plan 2022/23	8				16								
3a	Underlying deficit position	12				20								
4	Providers in CQC 'Inadequate' Special Measures (NSFT)	8				16								
5	Cancer diagnosis and treatment	6				9								
6	Primary Care	12				12								
7a	Mental Health Transformation – adults	8				12								
7b	Mental Health Transformation – adults	8				12								
8	Health Inequalities	4				12								
9	#WeCareTogether People Plan	3				12								
10	RAAC Planks	15				20								
11	Staff burnout	4				12								
12	Elective Recovery	12				20								
13	NHS Continuing Healthcare	9				16								
14	EEAST Response Times and Harms	9				16								
15	Cyber security	6				15								
16	Personal data	9				20								

**RA – Risk Appetite

Norfolk and Waveney
Integrated Care Board

Agenda item: 12

Subject:	**ICB Board and Champion Roles**
Presented by:	**Karen Barker, Director of Corporate Affairs and ICS Development, NHS Norfolk and Waveney ICB**
Prepared by:	**Heidi Davey, Senior Manager Corporate Governance and ICS Development, NHS Norfolk and Waveney ICB**
Submitted to:	**ICB Board**
Date:	**1 July 2022**

Purpose of paper:

To consider and approve the alignment of the roles listed below.

Executive Summary:

NHS England issued guidance in December 2021 which sets out a new approach to ensuring board oversight of important issues by discharging the activities and responsibilities previously held by some non-executive director (NED) champion roles, through committee structures.

It also describes which roles should be retained and provides further sources of information on each issue.

Report

There are a range of issues which at various times have required additional board level focus to respond to and learn from high-profile failings in care or leadership. This has resulted in reviews and reports establishing a requirement for boards to designate Non Executive Member ("NEM") champions for specific issues to deliver change. This has led to an increasing number of roles spanning quality, finance and workforce.

The number of NEM champion roles started to make it difficult for organisations to discharge them all effectively, particularly with a limited number of NEMs, many do not have a role description, making it difficult to measure their impact on delivering change.

NHS England have worked with stakeholders to review the issues the roles were originally established to address and to consider the most effective means of making progress now. There are a small number that are statutory requirements and some that still require an individual to drive change or fulfil a functional role. These are set out below.

Board Champions and Leads

The table below captures roles that are mandated or that continue to require/are enhanced by an individual to discharge those responsibilities as a Board Champion. These roles should be retained.

Mandated and Board Champion Roles		
Requirement	**Attached to Role or Suggested Leads**	**Guidance Descriptor of Role**
Information Asset Owner	Chief Executive Officer Tracey Bleakley	Mandated
Caldicott Guardian	Director of Nursing – Patricia Dorsi	Mandated
Senior Information Responsible Officer (SIRO)	Director of Finance Steven Course	Mandated
EPRR Responsible Officer – Emergency Accountable Officer.	Medical Director Frankie Swords (Interim) To be reviewed by 30.09.22.	Mandated (see item 10 of the Board agenda 1.07.22)
Freedom to Speak Up Non Executive Champion	Non-Executive Member of the Board Hein Van Den Wildenberg	Board Champion
Wellbeing Lead	Link with the workforce team in relation to staff and their wellbeing. Non-Executive Member Cathy Armor	Board Champion
Conflicts of Interest Guardian	Audit & Risk Committee Chair David Holt	In guidance Committee Discharge

Recommendation to the Board:

To approve the alignment of the roles identified within the table above.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	N/A
Legal:	N/A
Information Governance:	N/A

Resource Required:	N/A
Reference document(s):	A new approach to non-executive member champion roles – NHSEI December 2021
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	This item has not been discussed at any other Board meeting or committee.

NHS
Norfolk and Waveney
Integrated Care Board

Agenda item: 13

Subject:	**NHS Norfolk and Waveney ICB Board Committee**
Presented by:	**Karen Barker, Director of Corporate Affairs and ICS Development, NHS Norfolk and Waveney ICB**
Prepared by:	**Karen Barker, Director of Corporate Affairs and ICS Development, NHS Norfolk and Waveney ICB**
Submitted to:	**ICB Board**
Date:	**1 July 2022**

Purpose of paper:

To approve the establishment of the Committees of the Board of the ICB.

Executive Summary:

The ICB must ensure that it can effectively discharge its full range of functions. Therefore, to support the Board in this it must establish Committees.

Report

1.1 The Board of the Norfolk and Waveney ICB is asked to approve the following Committees and sub committees

- 1.1.1 Audit and Risk Committee
- 1.1.2 Remuneration, People and Culture Committee
- 1.1.3 Patients, and Communities Committee
- 1.1.4 Finance Committee
- 1.1.5 Primary Care Commissioning Committee
- 1.1.6 Quality and Safety Committee
- 1.1.7 Performance Committee
- 1.1.8 Conflicts of Interest Sub-Committee

1.2 As a minimum all ICBs must establish audit, remuneration and quality committees.

1.3 The Health and Social Care Act 2022 gives significant flexibility on the membership of the ICB committees and sub committees allowing individuals to be appointed who are neither ICB Board members nor employees.

1.4 The Chairs of the Committee to be appointed are as follows:

Committee	Chair
Audit and Risk Committee	David Holt, Non Executive Member

Remuneration, People and Culture Committee	Cathy Armor, Non-Executive Member
Patients, and Communities Committee	To be appointed Non-Executive Member
Finance Committee	Hein Van Den Wildenberg, Non-Executive Member
Primary Care Commissioning Committee	James Bullion, Local Authority Partner Member
Quality and Safety Committee	Cathy Armor, Non-Executive Member (until the appointment of the fourth Non-executive member.)
Performance Committee	To be appointed. ICB Board Partner Member, Primary Medical Services
Conflicts of Interest Sub-Committee	David Holt, Non-Executive Member

2. The Integrated Care Partnership ("ICP")

The Norfolk and Waveney Integrated Care Partnership is a statutory committee jointly formed between the Norfolk and Waveney Integrated Care Board and Norfolk County Council and Suffolk County Council. The Norfolk and Waveney ICP brings together a broad alliance of partners concerned with improving care, health and wellbeing of the population. The membership of the ICP has been determined locally. The ICP is responsible for producing the integrated care strategy on how to meet the health and wellbeing needs of the population in the Norfolk and Waveney ICS area.

The Board of the ICB is required to appoint the ICB founder member of the ICP and to form the ICP from the ICB's perspective. It is proposed that the ICB founder member of the ICP is Rt Hon Patricia Hewitt, Chair of the Norfolk and Waveney ICB.

Recommendation to the Board:

To approve:

1. The establishment of the above committees, set out at section 1.1;
2. The appointment of the Chairs of the Committees, set out at section 1.4.
3. To note that the Board has approved the Terms of Reference for each Committee as set out in the Governance Handbook which includes the membership of each Committee.
4. To agree that the ICB forms the ICP along with Norfolk County Council and Suffolk County Council.
5. To agree Rt Hon Patricia Hewitt, Chair of the Norfolk and Waveney ICB as the ICB founder member of the ICP.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A

Reputation:	N/A
Legal:	The ICB has to have Committees to support the Board in delivering its functions.
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	This item has not been discussed at any other Board meeting or committee of the ICB, as the ICB is being established today.

Norfolk and Waveney
Integrated Care Board

Agenda item: 14

Subject:	**ICB Board meeting dates for 2022/23**
Presented by:	**Karen Barker, Director of Corporate Affairs and ICS Development, NHS Norfolk and Waveney ICB**
Prepared by:	**Chris Williams, Senior Support Manager – Chief Officer, NHS Norfolk and Waveney ICB**
Submitted to:	**ICB Board**
Date:	**1 July 2022**

Purpose of paper:

To approve the ICB Board meeting dates for 2022/23.

Executive Summary:

The ICB Board will meet regularly in public to discuss the work of the organisation and to make decisions about local health and care services. Members of the public will also have the opportunity to ask questions about items being discussed by the Board at their meetings. This paper proposes a set of dates for the Board to meet in public in 2022/23.

Report

The ICB Board will meet regularly in public to aid transparency, scrutiny of and accountability for the decisions the Board makes and how it spends the public money it receives. It is proposed that the ICB Board meets in public on the following dates in 2022/23:

- 27 September
- 22 November 2022
- 24 January 2023
- 28 March 2023

All meetings will be 1.30pm – 3.30pm. Some meetings will be in person and others will be held via MS Teams. A public notice of the time and place of meetings to be held in public and how to access each meeting will be given by posting it at the offices of the ICB body and electronically on the website at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it

is convened. Papers and minutes of all meetings held in public will also be published on the ICB's website.

Due to unforeseen circumstances, or in order to enable the organisation to discharge its functions effectively, it may be necessary to change the proposed dates or to add in an additional meeting at short notice. While every effort will be made to avoid this, a public notice will be made as set-out above for all ICB Board meetings in public.

The full details for holding ICB Board meetings are set-out in the ICB's Constitution.

Recommendation to the Board:

To approve the ICB Board meeting dates for 2022/23 as set-out in the paper.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	N/A
Legal:	N/A
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	By meeting in public, it will help the ICB Board to deliver the seventh principle of the NHS Constitution: The NHS is accountable to the public, communities and patients that it serves
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	This item has not been discussed at any other Board meeting or committee.