Norfolk and Waveney
Integrated Care Board

NHS NORFOLK & WAVENEY INTEGRATED CARE BOARD

GOVERNANCE HANDBOOK

Version 2

Revision History

Document Control Sheet

Revision Date	Summary of changes	Author(s)	Version Number
December 2022 to March 2023	Amendments made to committee terms of reference: Integrated Care Partnership, Performance Committee, Audit and Risk Committee, Quality and Safety Committee, Remuneration, People and Culture Committee, Finance Committee, Conflicts of Interest Committee – additional attendees included. Finance Committee, clarification of Part 1 attendees roles. Updates to Conflicts of Interest Policy, Standards of Business Conduct Policy.	Corporate Affairs	1.2
February 2023	Amendments made to PCCC Terms of Reference and ICB SoRD to reflect delegation of POD which were approved at February 2023 Board		1.3
March 2023	Included v10 of People Approach		1.4

Approvals

This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number
1 July 2022	NHS England	Corporate Affairs	1
28 March 2023	ICB Board	Corporate Affairs	2

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	ICB Board
Effective date	1 July 2022
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.

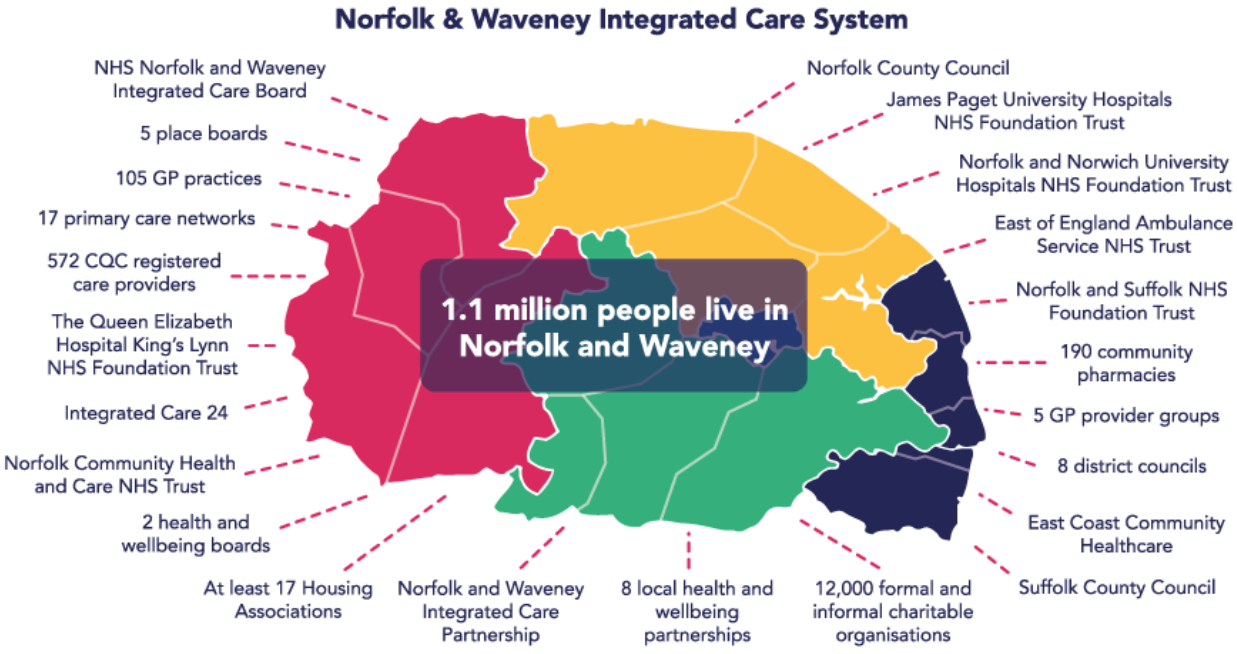
The Governance Handbook includes:

- 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:

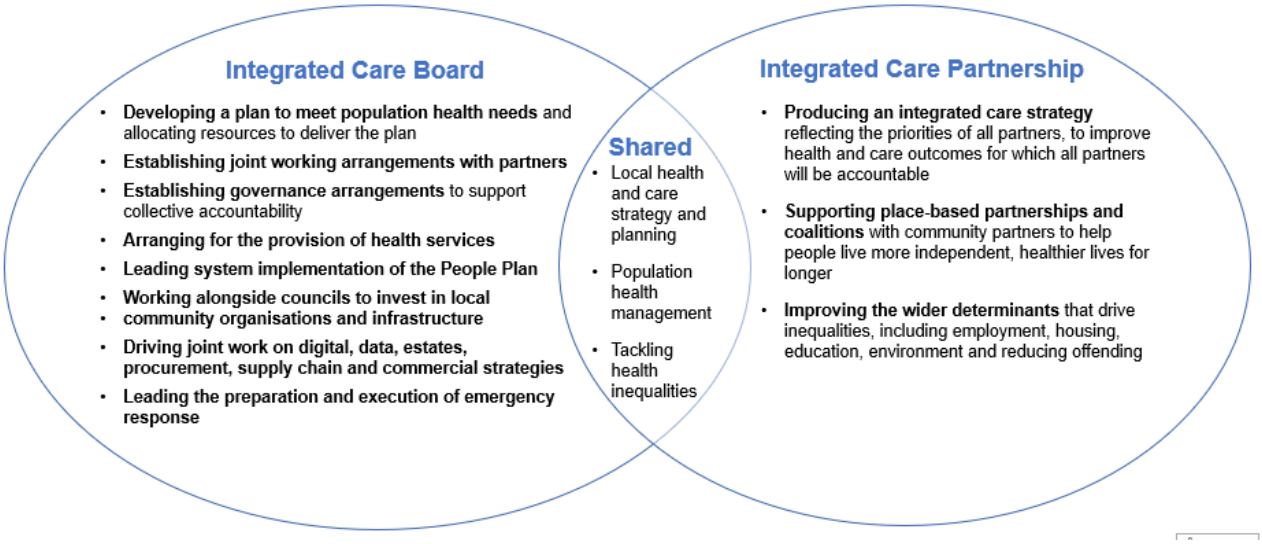
1. Improve outcomes in population health and healthcare
2. Tackle inequalities in outcomes, experience and access
3. Enhance productivity and value for money
4. Help the NHS support broader social and economic development

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:

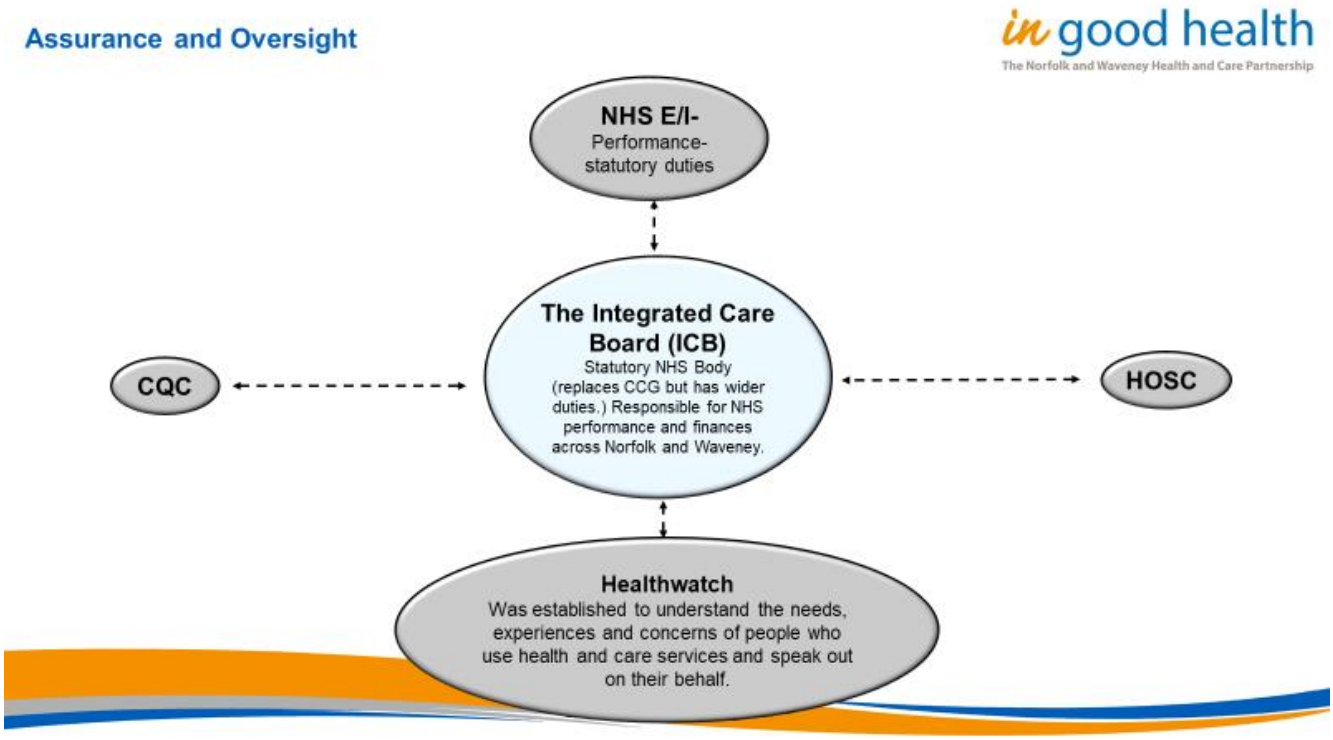
Name of Committee	Remit	Chair
Audit and Risk Committee	The Audit and Risk Committee contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.	Non-Executive Member 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.

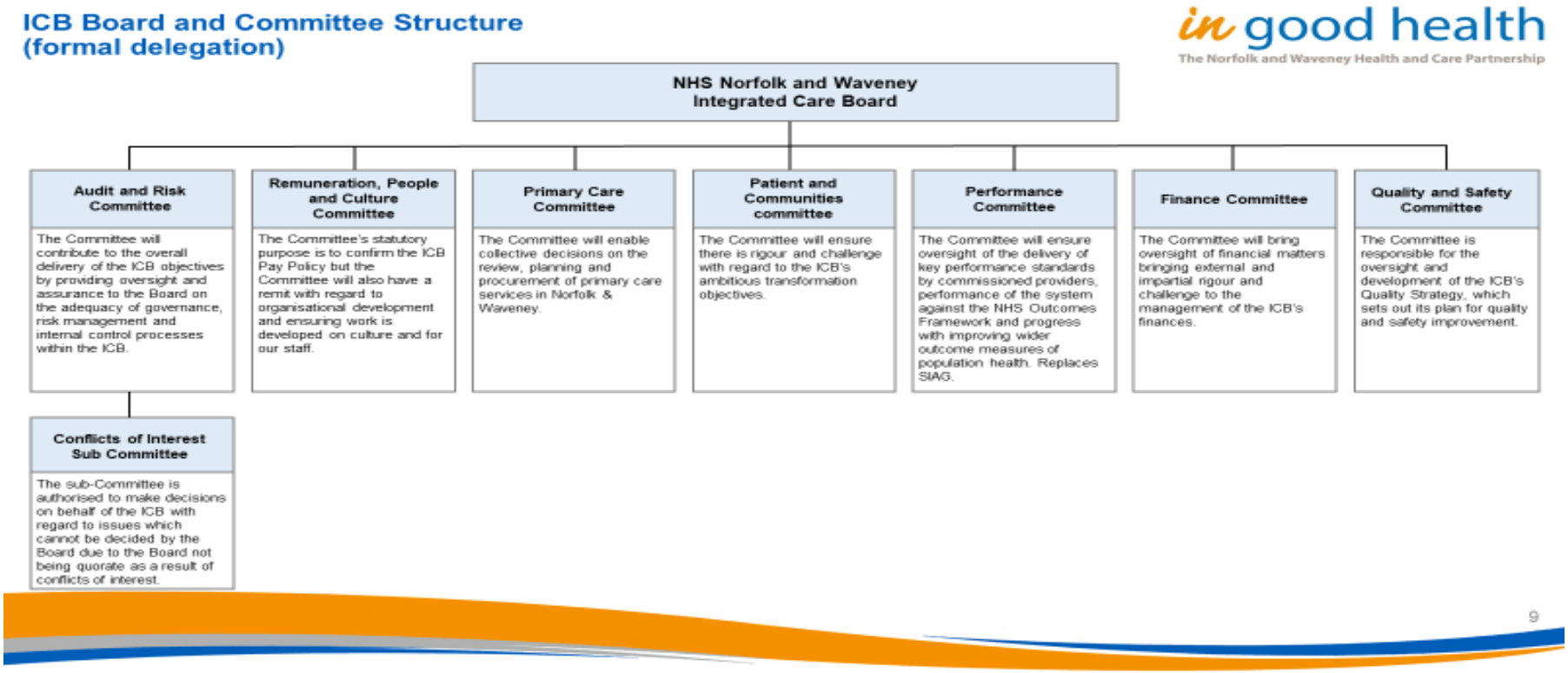
Our Functions and Decisions Map is based on a framework made up of tiered model which allows delegation to different levels. The tiered delegated model can be seen below.

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

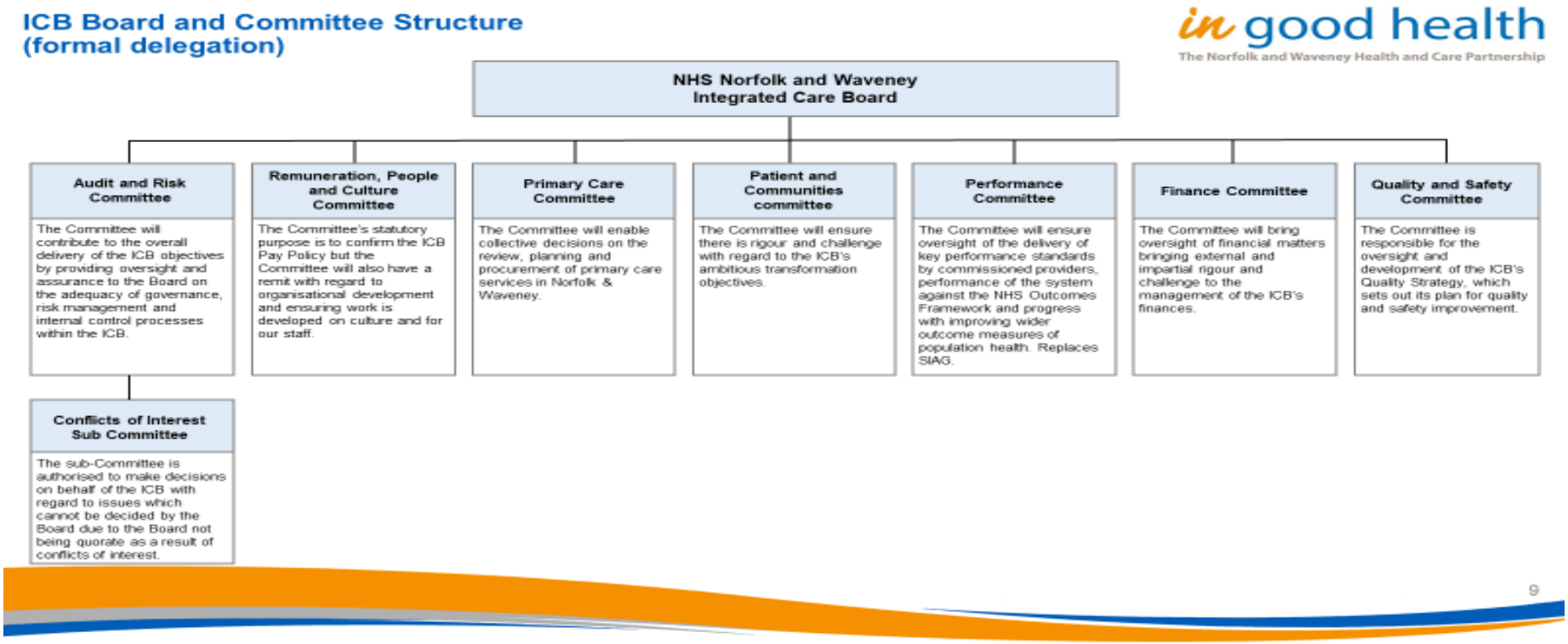
Scheme of Reservation and Delegation (SoRD)

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	NHS England has delegated to the ICB authority to exercise the primary care commissioning and dental functions in accordance with section 13Z of the NHS Act and as set out in Schedule 2 of the Delegation Agreement as follows: **Schedule 2A: Primary medical services** • decisions in relation to the commissioning and management of Primary Medical Services; • planning Primary Medical Services in the Area, including carrying out needs assessments; • undertaking reviews of Primary Medical Services in respect of the Area; • management of the Delegated Funds in the Area; • co-ordinating a common approach to the commissioning and delivery of Primary Medical Services with other health and social care bodies in respect of the Area where appropriate; and • such other ancillary activities that are necessary in order to exercise the Delegated Functions. **Schedule 2B: Primary dental services and prescribed dental services** • decisions in relation to the commissioning and management of Primary Dental, Services; for clarity this includes primary care, community care/special care dental services and secondary care dental services; • planning Primary Dental Services in the Area, including carrying out needs assessments; • undertaking reviews of Primary Dental Services in the Area; • management of the Delegated Funds in the Area;	Terms of Reference

	• co-ordinating a common approach to the commissioning and delivery of Primary Dental Services with other health and social care bodies in respect of the Area where appropriate; and • such other ancillary activities that are necessary in order to exercise the Delegated Functions. **Schedule 2C: Primary ophthalmic services** Ophthalmic services are hosted by Hertfordshire and West Essex Integrated Care Board (H&WE ICB) on behalf of the ICB. In accordance with the Memorandum of Understanding with HWE ICB and other ICBs in the East of England region H&WE ICB will report general optometry services matters to the Committee including information to support decision making as and when matters arise. The ICB remains responsible and accountable for the provision of this service. • decisions in relation to the management of Primary Ophthalmic Services; • undertaking reviews of Primary Ophthalmic Services in the Area; • management of the Delegated Funds in the Area; • co-ordinating a common approach to the commissioning of Primary Ophthalmic Services with other commissioners in the Area where appropriate; and • such other ancillary activities that are necessary in order to exercise the Delegated Functions.	

	Schedule 2D: Pharmaceutical services and local pharmaceutical services Pharmaceutical services are hosted by HWE ICB on behalf of the ICB. NHS England has established mandated local committees to be known as Pharmaceutical Services Regulations Committees (PSRC). The PSRC is an ICB committee with representatives from all East of England ICBs attending. NHS England has delegated decision making to each PSRC in relation to matters under the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 as amended. H&WE ICB will coordinate and host the PSRC to agreed Terms of Reference as set out in the NHS England Pharmacy Manual (https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-manual/). In accordance with the Memorandum of Understanding with HWE ICB and other ICBs in the East of England region H&WE ICB will provide quarterly reports to the Committee on decisions made at the PSRC. Applications and Notifications will be made by H&WE ICB on behalf of the ICB to the PSRC for determination. The ICB remains responsible and accountable for the provision of this service. To support the delivery of these functions the PCCC has established a Primary Medical Services Delivery Group and a Dental Services Delivery Group. The Primary Care	

	Commissioning Committee Scheme of Delegation (attached at Section 4a) sets out where decisions are made.	
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;	**6.1.6 of the Constitution**

	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.	

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 Services, Primary Dental Services and Prescribed Dental Services, Primary Ophthalmic Services, Pharmaceutical Services and Local Pharmaceutical Services	Delegation Agreement

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	1

Approvals

This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number
1 July 2022	ICB Board		1

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 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

Improving lives **together**
Norfolk and Waveney Integrated Care System

Our Approach to Working with People and Communities in Norfolk & Waveney

Working DRAFT v10 January 2023

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 new map & changes to names and structures for inclusion in the governance handbook
V10	23 January 2023	Rebecca Champion	Working Draft	Updated to reflect feedback from public engagement & system developments. Submitted to Patients & Communities Committee

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 was shared with NHS England as a working draft on 27 May 2022 as part of the strategic assurance around working with people and communities.

It received **very positive feedback** as well as some suggestions for improvement that have been reflected in version 10.

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

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.

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, so that we can achieve the ambition laid out in the guidance that partners in an integrated care system (ICS) should work together 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.

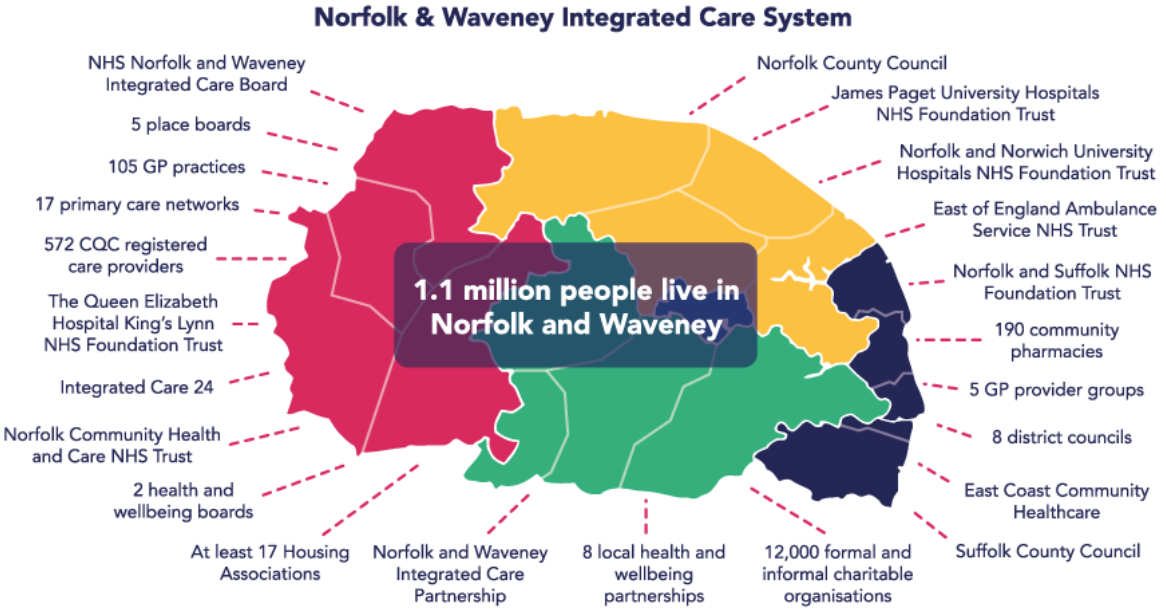
Building on learning during the COVID-19 pandemic, our vision is to improve our collective ability to listen to what people are saying across Norfolk and Waveney about what matters to them. We can do this by going out to the communities we serve, and by building on existing community engagement assets 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.

It will take time to fully achieve our 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.

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 meets every other month and includes two lived experience members. Named representatives from the ICB communications & engagement team are aligned to each of the Place Boards
   - **We will** continue work to align communications & engagement resources at place level with local system partners 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 have a 'You Said, We Did' section on our people and communities hub
   - **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
   - **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 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 at how the voices of people in/leaving prison can be embedded across the ICS
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, and with VCSE partners in the Norfolk & Waveney Community Voices Project
   - **We will** continue to invest in 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 have** developed a website for the ICS which includes accessible information available in a range of formats. It also hosts the people and communities' engagement hub and contains information about the ICS plans and visions using a range of innovative and accessible formats.
   - We will continue to work with our partners to use every available network to reach people who do not or cannot access information online. Much of this will build on partnership work during the COVID-19 pandemic, such as the Great Yarmouth Community Champions 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
- **We will** build on the relationships 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
   - **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
   - **We will** use this approach to tackle other system priorities including urgent and emergency care, and quality improvement
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.
Alignment of named communications and engagement representatives to Place Boards from the ICB team to support Place Boards and health and wellbeing partnerships in developing locally specific comms and engagement activity and 'teams' using existing resources from system 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. Hundreds of interactions have been recorded and work is underway to turn large amounts of qualitative data into useful insight, alongside the development of an online platform. The ultimate vision is 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, and to support the work of the Health and Wellbeing Partnerships. 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 at place level to ensure the right people and communities are working in partnership to improve local health and wellbeing.

Protect NoW - The Protect NoW 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 offers 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. Patient engagement and experience leads are working with healthcare provider representatives from the prisons in Norfolk and Waveney to improve communications channels between local health services and the prison population.

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 has been developed and this will be kept well designed, easy to navigate and a trusted source for information or links to information. This website now hosts the people and communities hub for Norfolk and Waveney, which aims to develop and maintain a shared vision in listening to and working with local people across the ICS. The ICB communications & engagement team includes a post 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 has been developed which makes 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 has been 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 as 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 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.

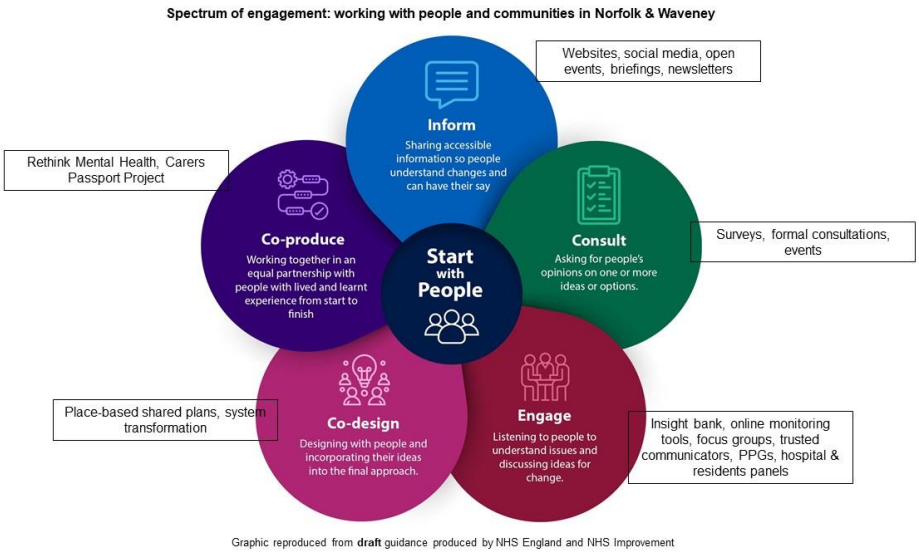
How this ICS approach to working with people and communities will support the NHS ICB legal duties on public involvement

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.



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.

Co-production

Co-production refers to a process of shared power to effect change. The term co-production is generally used to mean an end-to-end process where people with lived experience work with those who design services and projects in an equal partnership, sharing power and often involving a significant commitment and where involvement fees or other forms of reciprocity are offered alongside expenses. Think Personal Act Local (TLAP) is held as an exemplar in promoting co-production and they include a comparison of the various definitions on their website.

Examples of co-production do exist in Norfolk and Waveney and work is underway within the system to align existing work and develop a shared approach:

- Development of a co-production hub as part of our people and communities hub to share examples from the system, to promote co-production principles and to signpost to support materials
- The ICB is now represented, alongside Norfolk County Council, on the Norfolk Making It Real (MiR) steering group which promotes co-production particularly for people with lived experience of physical and learning disabilities
- Named Communications and Engagement representatives are working with system partners at Place and Partnership level to promote and support co-production
- Supporting various NHS England funded initiatives in Norfolk and Waveney such as the co-production projects around Quality Improvement as described below.
- Co-production as an integral part of designing research projects
- Exploring ideas around the development of some system-wide shared principles around co-production for Norfolk and Waveney

Thriving Patient Engagement Around Primary Care

General Practice - 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 strategic support to local PPGs and practices so that the voice of people and communities can be reflected more locally. The ICB commissioned Healthwatch Norfolk to engage with local practices and PPGs to find out what support would be most useful.

The ICB is now working to deliver the key recommendations from the report. A webpage is now in place which features case studies including examples that promote different models of patient engagement. There is also other information and links to resources including a toolkit produced by Healthwatch Norfolk following the period of engagement which aims to give practices and PPGs a step by step guide.

A systemwide annual conference, and smaller more local learn and share events are also planned. The ICB communications and engagement team also offer talks to PPGs about working with people and communities and the development of the ICS.

Care Quality Commission (CQC) – CQC is the independent regulator of health and adult social care in England. They make sure health and social care services provide people with safe, effective, compassionate, high-quality care and they encourage care services to improve, including General Practice. The ICB talked to CQC about practices being able to try new approaches to involving patients as well as the traditional PPG model so they updated their mythbuster to encourage and reassure practices.

Other primary care providers – ICBs are set to take on more responsibility around other primary care services from April 2023 onwards. Other providers include pharmacies, dentists and opticians. This can provide an opportunity to explore supporting other primary care providers to work with people & communities in a similar way to that already well developed within general practice.

Patient Participation Groups (PPGs)

There are 105 GP practices across Norfolk and Waveney. Most of them have patient groups, often referred to as Patient Participation Groups (PPGs).

PPGs work in partnership with their GP practice and are vital in ensuring that the patient voice is heard. We are keen to hear about different models for hearing the patient voice in primary care and will be developing this alongside our current patient groups.

PPGs work in different ways, some meet in person, others communicate with their practice online – all are keen to welcome and involve new members.

PPGs provide an opportunity for local people to get involved with their practice and influence the provision of local health services. Members contribute their views, make suggestions and provide feedback on services they may have used. Groups can also get involved with supporting local health initiatives and can engage with a wide range of health and care professionals.

Norfolk and Waveney ICB is working to develop a programme of support to local PPGs and practices.

We have worked with Healthwatch Norfolk to conduct an evaluation of Patient Participation Groups across Norfolk and Waveney and gather feedback to develop an understanding of what additional support the ICB can provide to help PPGs and practices be the most successful and develop further.

This has led to the development of a new PPG Toolkit that aims to help groups establish and run a successful PPG. You can read the report and download the toolkit below.

Resources

- PPG Toolkit
- Norfolk and Waveney PPG Evaluation report

New resources will be added soon.

Social Media Managed Service

The ICB Digital team has commissioned a paid for social media service managed by Redmoor Health, initially for one year, to help interested practices develop active and positive social media channels. This includes establishing channels where needed and posting positive health improvement messages on behalf of the practices involved. There are currently over forty practices signed up in Norfolk and Waveney.

Having an active account also encourages communications with the practices around a wide variety of topics including promoting their PPGs and hearing feedback on services. The ICB Communications and Engagement team are supporting this initiative by working together with Digital to provide additional social media content over and above the commissioned service. The team are supporting the promotion of this service as a recognition of the future benefits to practices of using social media to work in partnership with their populations.

You can find out more about different PPG activities and projects below.

If you are interested in finding out more about your own PPG, talk to your practice reception team or contact us at nwicb.haveyoursay@nhs.net

PPG Case Studies

Patient Voice in Aldborough

Aldborough Surgery is situated in a large rural area 7 miles from the coast of North Norfolk. It serves a population of approximately 3,700 spread out across numerous parishes between Cromer to Aylsham and Edgefield to North Walsham. Aldbor...

Learn more

Sheringham PPG

Sheringham Patient Participation Group (PPG) was formed in 2008 with membership consisting of patients and some practice staff. The group met monthly in the GP surgery and over the years managed to raise funds for the practice and waiting room equip...

Learn more

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

Norfolk & Waveney ICS is adopting a system wide Quality Management Approach (QMA). 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.

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.

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 has been awarded funding by NHS England to promote co-production in quality improvement. Projects that aim to improve care pathways have been identified by local NHS provider trusts to involve patients in partnership with staff. Learning from these projects during 2023 will inform a toolkit to help staff across the system use co-production principles when making changes to pathways in future.

Norfolk and Waveney Patient Experience and Engagement Leads meetings –have been taking place weekly for several 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 ICB 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.

Most of the governance structures within the ICB and ICS are now in place, and the need to monitor and evaluate the impact of the people and communities work is acknowledged.

The Patients and Communities Committee is now in place as of January 2023. It provides NHS Norfolk and Waveney with assurance that it is delivering its functions in a way that meets the needs of our patients and communities across Norfolk and Waveney. That is based on engagement and feedback from local people and groups.

The Committee also specifically focusses on how NHS Norfolk and Waveney and the wider Integrated Care System is actively addressing and reducing health inequalities experienced by individuals and communities. Key to the Patients and Communities Committee will be two Committee members with lived experience, providing vital input, feedback and challenge to support our work as an organisation and the wider ICS. Recruitment for these members is taking place January – April 2023.

The Committee will also receive insight, make sure it is gathered appropriately, and monitor progress to ensure that change is happening. It will also constantly refer back to the 'so what' question – what this means for our people and communities.

The People and Communities Engagement Hub described above also gives a measurable focal point to engagement activity undertaken by the ICB as part of its legal duties. Specific projects and opportunities for working with people and communities are being advertised, and **'You said, We did/We can't'** reports detailing the results of the feedback and any improvements that resulted are being uploaded.

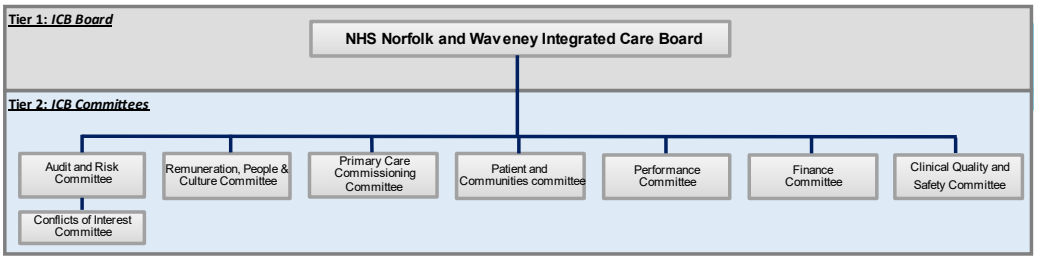
All ICB people and communities activity is being included in a regular systemwide quarterly briefing that is widely shared within the ICB and across the ICS. All system partners are also being encouraged to input into the briefing so that it can become a Norfolk and Waveney resource for the promotion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

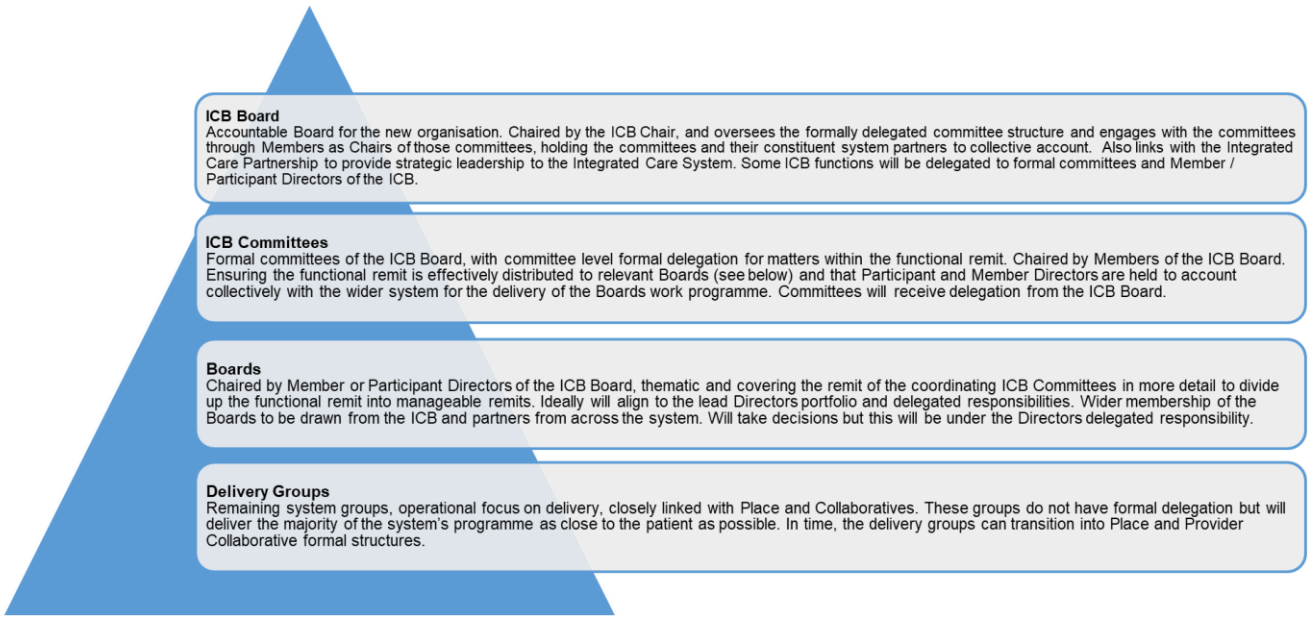
NHS Norfolk and Waveney ICB is committed to embedding the voice of people and communities so that the ICB can listen to and act on the concerns and aspirations of residents. The Patients and Communities Committee will act as a focal point for overseeing how this will happen, led by our Director of Patients and Communities. The committee is chaired by the chief officer of a local VCSE organisation. Meeting papers are made available a week in advance and meetings are held in public.

The ICB Board also includes a programme of learning from our staff, people and communities at all meetings in public to underline that people are at the centre of strategic decision-making. The programme of stories is being developed as much as possible 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.



The ICB Board receives its assurance via the Committees and Executive Management Team (EMT). Scope of assurance for each Committee is set out in the ICB Governance Handbook

As described above, discussions are currently underway around Place Boards and Health and Wellbeing Partnerships, to include 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.



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. They are members of the Patients and Communities Committee.

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.

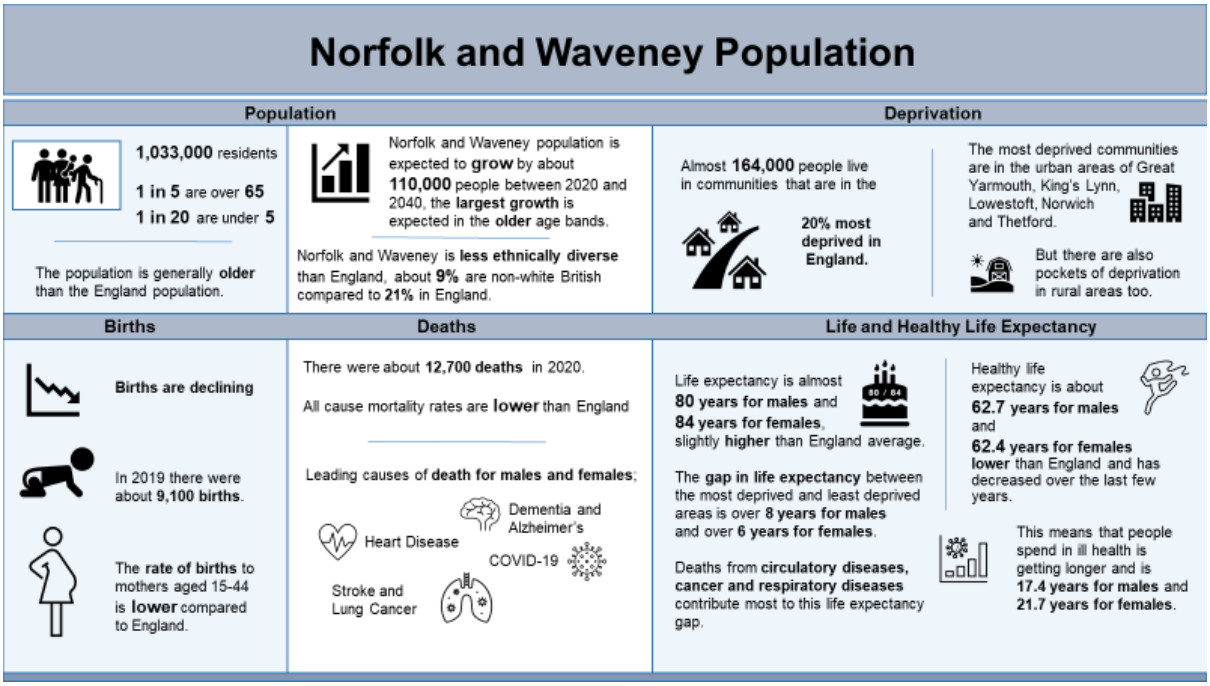
Our collective focus will be to always ensure that the voice, views and feedback of people and communities across Norfolk and Waveney is heard at every opportunity.

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

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 3

Norfolk and Waveney ICS – People and Communities
Easy Read version can be found on our website:

https://improvinglivesnw.org.uk/~documents/documents/edi-resource-hub/easy-read/norfolk-and-waveney-ics-people-and-communities-easy-read-summary-060622

SECTION 8
Conflicts of Interest Policy

Revision History

Document Control Sheet

Revision Date	Summary of changes	Author(s)	Version Number

Approvals

Approval Date	Approval Body	Author(s)	Version Number
28 March 2023	ICB Board	Corporate Affairs	2

Document Control Sheet

Name of document	Conflicts of Interest Policy
Version	1
Date of this version	25 January 2023
Produced by	Corporate Affairs Manager
What is it for?	To ensure the ICB complies with its statutory duty to effectively manage conflicts of interest
Evidence base	NHS England guidance
Who is it aimed at and which settings?	Integrated care board, System partners, the public and patients
Consultation	Non undertaken
Impact Assessment:	Completed and attached to policy
Other relevant approved documents	• Standards of business conduct policy • Secondary employment policy • Disciplinary policy • Recruitment and selection policy • Counter fraud bribery and corruption policy

References:	N/A
Monitoring and Evaluation	This policy will be monitored and reviewed for effectiveness by the Corporate Affairs team on a regular basis
Training and competences	N/A
Reviewed by:	Conflicts of Interest Committee
Approved by:	ICB Board
Date approved:	
Signed:	
Dissemination:	
Date disseminated:	
Review Date:	
Contact for Review:	

Version Control

Revision History	Summary of changes	Author(s)	Version Number

1. Introduction

This policy describes the arrangements that NHS Norfolk and Waveney Integrated Care Board (ICB) has in place to manage conflicts of interest. This policy reflects and supports the ICB's constitution and the Statutory Guidance on Managing Conflicts of Interest in the NHS which was issued by NHS England in February 2017 as well as the interim guidance on the functions and governance of the Integrated Care Board issued by NHS England in March 2022.

The ICB can be described both as a statutory body, as established in legislation to replace Clinical Commissioning Groups from 1 July 2022, and separately as a unitary board.

ICBs manage conflicts of interest as part of their day-to-day activities. Effective handling of conflicts of interest is crucial to give confidence to patients, taxpayers, stakeholders/partners and Parliament that ICB commissioning decisions are robust, fair and transparent and offer value for money. It is essential to manage conflicts of interest to protect and maintain public trust in the NHS. Failure to manage conflicts of interest could lead to legal challenge and even criminal action in the event of fraud, bribery and corruption.

Conflicts of interest are common and sometimes an unavoidable part of the delivery of healthcare and as such it may not be possible or desirable to completely eliminate them; rather, it is how they are managed that matters. Section 14O of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) ("the Act") sets out the minimum requirements of what both NHS England and ICBs must do in terms of managing conflicts of interest.

This policy reflects the legal requirements and the statutory guidance issued by NHS England under sections 14O and 14Z8 of the Act. This policy also describes the systems the ICB has in place to identify and manage conflicts of interest, and to create an environment in which staff, ICB Board and committee members, feel able, encouraged and obliged to be open, honest and upfront about actual or potential conflicts.

The principles of collaboration, transparency and subsidiarity should be at the centre of any decision making. It is expected that all those who serve as members of the ICB Board, its Committees or those who take decisions where they are acting on behalf of the public or spending public money will observe the principles of good governance in the way they do business.

2. Purpose

The aim of this policy is to protect both the organisation and individuals involved, from impropriety or any appearance of impropriety by setting out how the ICB will manage conflicts of interest to ensure there is confidence in the commissioning decisions made and

to ensure the integrity of all members, officers, office holders, staff, stakeholders and suppliers involved with the work of the ICB.

Conflicts of interest may arise where an individual's personal interests, loyalties or those of a connected person (for example a relative or close friend) conflict with those of the ICB or might be perceived to conflict with those of the ICB.

Such conflicts may create problems such as inhibiting free discussion which could result in decisions or actions being made that are not in the interests of the ICB, and risk giving the impression that the ICB has acted improperly.

The ICB's responsibility includes the stewardship of significant public resources and the commissioning of health and social care services to the population of Norfolk and Waveney.

This policy aims to

- Enable the ICB partner organisations, clinicians and others who are involved in the work of the ICB, to demonstrate fairness and transparency, and that actions are in the best interest of patients and the ICB's local population.

- Ensure that the ICB operates within the relevant legal framework and in accordance with good practice, but without being bound by over-prescriptive rules that stifle efficiency or innovation.

- Safeguard clinically led commissioning, whilst ensuring objective investment decisions.

- Provide the public, providers, parliament, and regulators with confidence in the probity, integrity and fairness of our decisions.

- Uphold the confidence and trust between patients, the public and the NHS, in their recognition that parties want to behave ethically but may need support and training to understand when conflicts (actual or potential) may arise and how to manage them if they do.

3. Legal context

Section 14O of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) ("the Act") sets out the minimum requirements of what both NHS England and ICBs must do in terms of managing conflicts of interest

This policy reflects the legal requirements and the statutory guidance issued by NHS England under sections 14O and 14Z8 of the Act.

In addition to complying with the guidance issued by NHS England, ICBs are also required to adhere to relevant guidance issued by professional bodies on conflicts of interest, including the British Medical Association (BMA), the Royal College of General Practitioners, and the General Medical Council (GMC), and to procurement rules including The Public Contract Regulations 2015 and The National Health Service (procurement, patient choice and competition) (no.2) regulations 2013, as well as the Bribery Act 2010

4. Governance Framework – Standing orders, Scheme of Reservation and Delegation and Standard Financial Instructions

All individuals must carry out their duties in accordance with the ICB's Constitution, Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions (SFIs). These set out the statutory governance framework in which the ICB operates and there is considerable overlap between the contents of this policy and provision made within these. Individuals must always refer to, and act in accordance with them at all times to ensure processes are followed.

In the event of doubt, individuals should seek advice from their line manager or Corporate Affairs. Should a conflict arise between the details of this policy and the Constitution, Standing Orders, Scheme of Reservation and Delegation and SFIs then the provision of the Constitution, Standing Orders, Scheme of Reservation and Delegation and SFIs shall prevail

5. What are Conflicts of Interest

For the purposes of this policy a conflict of interest is defined as:

'A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold'

With this in mind, and in accordance with the national guidance, a conflict of interest may be either:

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

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.

A conflict of interest can fall into the following categories:

Financial Interests	Indirect Interests
Individual may get direct financial benefits from the consequences of a commissioning decision	Individual has a close association with an individual who has any type of interest in a commissioning decision

Examples include: • Directorship or employment in a private or public company or other organisation which is doing, or may do, business with health or social care organisations • A shareholder (more than 5% of the issued shares), partner or owner of a private or not for profit company, business or consultancy which is doing, or may do, business with health or social care organisations • A management consultant for a provider • Secondary employment • Receipt of secondary income from a provider • Receipt of a grant from a provider • Receipt of any payments (e.g. honoraria, one off payments, day allowances, travel or subsistence) from a provider • Receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role • Having a pension that is funded by a provider (where the value of this might be affected by their success or failure).	**Examples include:** • Spouse / Partner • Close relative e.g., parent, grandparent, child, grandchild or sibling • Close friend - any confusion relating to the declaration of friendship should be discussed with Corporate Affairs to ensure that all declarations are appropriate (e.g. a friend who works as a checkout operator in a shop that supplies the NHS need not be declared but a contracts manager with an NHS supplier should be • Business partner • Any other relationship which may influence or may be perceived to influence the judgement of the individual (e.g. a reconfiguration of hospital services which might result in the closure of a busy clinic next door to an individual's house) • Where the individual is closely related to, or in a relationship, including friendship, with an individual in the above categories.
Non-financial Professional Interests	**Non-financial Personal Interests**
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	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
Examples include: • An advocate for a particular group of patients • A GP with special interest e.g. in dermatology, acupuncture etc. • A member of a particular specialist professional body (routine GP membership of the RCGP, BMA or a medical defence organisation would not usually in itself amount to an interest which needs to be declared) • An advisor to for the CQC or NICE • A medical researcher	**Examples include:** • A voluntary sector champion for a provider • A volunteer for a provider • A member of a voluntary sector board or any position of authority in or connection with a voluntary organisation • Suffering from a particular condition requiring individually funded treatment • A member of a lobby or pressure groups with an interest in health • A financial advisor.
General Interest This could be any position held in another public body organisation, NHS, Local Authority or a community group which may have potential to give rise to influence decisions made by the ICB. Similarly, if you have made a declaration that you are a member of the ICB or attend any of its committees/working groups to another organisation, this information MUST be reciprocated back to the ICB to ensure consistency across organisations and vice versa	

Whether an interest held by another person gives rise to a conflict of interest will depend upon the nature of the relationship between that person and the individual, and the role of the individual within the ICB. It should be noted that:

- The above categories and examples are not exhaustive and the ICB will exercise discretion on a case-by-case basis.
- The possibility of the perception of wrongdoing, impaired judgement or undue influence shall also be considered a conflict of interest for the purposes of this Policy and should be declared and managed accordingly; and
- Where there is doubt as to whether a conflict of interest exists, it should be assumed that there is a conflict of interest and declared and managed accordingly.

Where an individual has any queries with respect to conflicts of interest they should seek advice from the ICB Corporate Affairs team.

6. Roles and responsibilities

The following roles and responsibilities apply in the context of this policy:

ICB Board and Committees
The ICB Board and its committees are responsible for upholding the principles of good governance and ensuring that ICB is always acting in the best interests the NHS and its communities. In particular, the chairs of these are responsible for ensuring that any declared interests in relation to agenda items at meetings are managed in accordance with this policy.

Audit and Risk Committee
The Audit and Risk Committee is responsible for reviewing the establishment and maintenance of an effective system of integrated governance and internal control. In particular, the Committee is responsible for monitoring compliance with this policy and the organisation's established probity arrangements

Chief Executive
The Chief Executive has overall accountability for the ICB's management of conflicts of interest, which includes the requirements for the management of gifts, hospitality and sponsorship.

Director of Finance
The Director of Finance is responsible for ensuring the adequacy of the ICB's counter fraud arrangements.

Governance Lead
The ICB Governance Lead is responsible for:

- The day-to-day management of matters and queries relating to the application of this policy.
- Maintaining the ICB's Register of Declared Interests
- Providing advice, support, and guidance on how conflicts of interest should be managed
- Ensuring that appropriate administrative processes are put in place;
- Supporting the Conflicts of Interest Guardian and Freedom to Speak Up Guardian in carrying out their roles effectively.

Conflicts of Interest Guardian
The Conflicts of Interest Guardian is in place to further strengthen the scrutiny and transparency of the ICB's decision-making processes. This role will also:

- Act as a conduit for anyone with concerns relating to conflicts of interest.
- Be a safe point of contact for employees or workers of the ICB to raise concerns in relation to conflicts of interest.
- Support the rigorous application of the principles and policies for managing conflicts of interest.
- Provide independent advice and judgment where there is any doubt about how to apply conflicts of interest policies and principles in individual situations.
- Provide advice on minimising the risks of conflicts of interest.

Freedom to Speak up Guardian
The Freedom to Speak Up Guardian is in place to provide an independent and impartial source of advice to staff at any stage of raising a concern.

Executive Management Team
Members of the Executive Management Team and Senior Leadership Team have an ongoing responsibility for ensuring the application of this policy.

All individuals
All individuals are responsible for complying with this policy and for seeking advice if unsure how it applies to them.

7. Decision making staff

Some staff are more likely than others to have a decision-making role or influence on the use of public money. This is because of the requirements of their role. This policy refers to these people as decision making colleagues.

Decision making colleagues in the ICB are:

- executive, non-executive and partner members of the board
- members of ICB committees, and delivery groups which contribute to decision making on the commissioning or provision of services
- those at Agenda for Change band 8d and above, or operating at that level on an interim basis

- administrative and clinical colleagues who:
    - have the power to enter into contracts on behalf of the ICB
    - are involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment and formulary decisions

8. Declaring Interests

It is a statutory requirement that individuals must declare any interest that they have (see Appendix A) in relation to ICB business or a decision to be made, in writing, to be reviewed by their line manager and sent on to the ICB's Corporate Affairs team as soon as they are aware of it and in any event no later than 28 days after becoming aware.

Where an individual is unable to provide a declaration in writing, for example, if a conflict becomes apparent during a meeting, they will make an oral declaration before witnesses

which will be formally written in the meeting record. A written declaration will need to be submitted following the meeting to ensure inclusion on the register.

Individuals contracted to work on behalf of the group, or otherwise providing services or facilities to the group, will be made aware of their obligations under this policy to declare conflicts or potential conflicts of interests. This requirement will be written into their contracts for services

The ICB will ensure as a matter of course that declarations of interest are made and regularly confirmed or updated. This includes the following circumstances:

- **On appointment** – all appointments will be asked to make a formal declaration of interest and in the case of Board members, prior to appointment. The ICB will need to assess the materiality of the interest, in particular whether the individual (or family member/business partner) could benefit from any decision the Board might make). If the interest is significant to the extent that the individual would be unable to make a full and proper contribution to the Board because they are required to exclude themselves from decision-making on so regular a basis, then that individual should not become a member of the Board.

- **Annually -** to ensure the register of interest is accurate and up to date. If there are no interests or changes to declare a 'nil return' should be submitted.

- **At meetings –** a standing agenda item will be on the ICB Board, sub-committee and any working group agendas. Even if an interest has been recorded in the register of interests, it should still be declared in meetings before matters relating to that interest are discussed and any declarations will be recorded in the minutes of the meeting.

- **When prompted by the ICB** – because of the ICB's role in spending taxpayers' money, on at least an annual basis the ICB will ensure that individuals are prompted to update their declarations of interest or make a nil return where there are no interests or changes to declare.

- **On changing role or responsibility** – a further declaration should be made to reflect the change in circumstances; this could involve a conflict of interest ceasing to exist or a new one materialising (for example, where an individual takes on a new role outside the ICB, sets up a new business or relationship, starts a new project / piece of work or may be affected by a procurement decision e.g. if their role may transfer to a proposed new provider). A further declaration should be made to reflect the change in circumstances as soon as possible, and in any event within 28 days of the change.

- **During the procurement process** - anyone participating in the procurement, or otherwise engaging with the ICB, in relation to the provision of services or facilities, will be required to make a declaration of interest which will include nil returns. This includes those who will take part in any tender evaluation or decision making with regards to the award of a contract.

Registers of Interest are maintained by the Corporate Affairs team and these registers are available on the ICB website.

All interests declared will be promptly transferred to the relevant registers by Corporate Affairs. Where interests have expired, these will remain on the relevant register for a minimum of 6 months although a private record of the historic interests will be retained by the ICB for a minimum of 6 years after the date on which it expired

9. Registers of Interest

The ICB shall keep and maintain a Register of Interests (Appendix B) of all interests declared. The ICB Corporate Affairs team ensures that the Register includes sufficient information about the nature of the interest and the details of those holding the interest.

The ICB keeps a Register of Interests for the following:

- All ICB employees – including:
    - All full and part time staff
    - Any staff on sessional or short term contracts
    - Any students and trainees (including apprentices)
    - Agency staff
    - Seconded staff

- Members of the ICB Board and its committees – Including (but not limited to)
    - Executive Directors
    - Non-Executive Members
    - Partner Members

- Any third parties contracted to provide services, any person involved in procurement or commissioning decisions and any individual directly involved with business or decision making.

The register(s) will be publicly available and will be refreshed on an annual basis. Individuals should identify changes to their record on their register as soon as they are aware of it and in any event no later than 28 days of the change. The register will be published on the ICB's website.

In exceptional circumstances, where the public disclosure of information could give rise to a real risk of harm or is prohibited by law, an individual's name and/or other information may be redacted from the publicly available register(s). If an individual believes that substantial damage or distress may be caused to themselves or somebody else by the publication of information about them, they are entitled to request that the information is not published. Such requests must be made in writing. Decisions not to publish information must be made by the Conflicts of Interest Guardian for the ICB, who will seek legal advice where required, and the ICB will retain a confidential un-redacted version of the register(s).

The Register of Interest will include:

- Name of the person declaring the interest
- Position within or relationship with the ICB
- Type of interest, including for indirect interest details of the relationship with the person who has an interest
- The dates from which the interest relates
- The actions taken to mitigate the risk – these should be agreed with the individual's line manager or a senior manager within the ICB.

10. Management of interests in general

In a situation where a person declares an interest but there is no risk of a conflict arising, it required no action. However, should they declare a material interest the following general management action(s) which could be applied by the ICB include:

- restricting the person's involvement in associated discussions and excluding them from decision making
- removing the person from the whole decision-making process
- removing persons' responsibility for an entire area of work
- removing the person from their role altogether if they are unable to operate effectively in it because the conflict is so significant

Each case will be different and context specific. The ICB will always clarify the circumstances and issues with the individuals involved. Colleagues should maintain a written audit trail of information considered and actions taken.

Colleagues who declare material interests should tell their manager or the people they are working about those interests.

The Corporate Affairs team can advise on appropriate management action if this cannot be agreed locally.

11. Management in common situations

This section sets out the principles and rules to be adopted by staff in common situations, and what information should be declared. A condensed 'at a glance' version is available at Appendix C.

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

Any personal gift of cash or cash equivalents (for example: vouchers, tokens, offers of remuneration to attend meetings whilst in a capacity working for or representing the ICB) must always be declared, whatever their value and whatever their source, and the offer which has been declined must be declared to the Corporate Affairs team who has designated responsibility for maintaining the register of gifts and hospitality (Appendix D).

All staff need to consider the risks associated with accepting offers of gifts, hospitality and entertainment when undertaking activities for or on behalf of the ICB or their GP practice.

This is especially important during procurement exercises, as the acceptance of gifts could give rise to real or perceived conflicts of interests, or accusations of unfair influence, collusion, or canvassing.
The information captured below provides a description of what the issues, principles and rules are in respect of the main themes listed above.

<u>Gifts</u>

What are the issues?	Staff in the NHS offer support during significant events in people's lives. For this work they may sometimes receive gifts as a legitimate expression of gratitude. We should be proud that our services are so valued. But situations where the acceptance of gifts could give rise to conflicts of interest should be avoided. Staff and organisations should be mindful

	that even gifts of a small value may give rise to perceptions of impropriety and might influence behaviours 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
Principles and rules	Overarching principle applying in all circumstances: • Staff should not accept gifts that may affect, or be seen to affect, their professional judgement. Gifts from suppliers or contractors: • Gifts from suppliers or contractors doing business (or likely to do business) with an organisation should be declined, whatever their value. • Subject to this, low cost branded promotional aids may be accepted where they are under the value of a common industry standard of £6* in total and need not be declared. *the £6 value has been selected with reference to existing industry guidance issues by the ABPI. Gifts from other sources (e.g., patients, families, service users): • Gifts of cash and vouchers to individuals should always be declined. • Staff should not ask for any gifts. • Gifts valued at over £50 should be treated with caution and only be accepted on behalf of an organisation (i.e., to an organisation's charitable funds), not in a personal capacity. These should be declared by staff. • Modest gifts 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 ICB Board • A description of the nature and value of the gift, including its source. • Date of receipt. • Any other relevant information (for example, circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

Hospitality

What are the issues?	Delivery of services across the NHS relies on working with a wide range of partners (including industry and academia) in different places and, sometimes, outside of "traditional" working hours. As a result, staff will sometimes appropriately receive hospitality. Staff receiving hospitality should always be prepared to justify why it has been accepted and be mindful

	that even hospitality of a small value may give rise to perceptions of impropriety and might influence behaviours. Hospitality means offers of meals, refreshments, travel, accommodation, and other expenses in relation to attendance at meetings, conferences, education and training events, etc.
Principles and rules	Overarching principles applying in all circumstances: • Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement. • Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event. • Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors, these can be accepted if modest and reasonable, but individuals should always obtain senior approval and declare these. **Meals and Refreshments** • Under a value of £25 may be accepted and need not be declared. • Of a value between £25 and £75* may be accepted and must be declared. • Over a value of £75* should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on an organisation's register(s) of interest as to why it was permissible to accept. • A common-sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or an estimate that a reasonable person would make as to its value). **Travel and accommodation** • Modest offers to pay some or all of the travel and accommodation costs related to attendance 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 senior staff (e.g. the ICB governance lead or equivalent), should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on an organisation's register(s) of interest as to why it was permissible to accept travel and accommodation of this type. • A non-exhaustive list of examples includes: - Offers of business class or first-class travel and accommodation - (including domestic travel); and - Offers of foreign travel and accommodation.

What should be declared	• Staff name and their role with the ICB Board • A description of the nature and value of the gift, including its source. • Date of receipt. • Any other relevant information (for example, circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

Sponsored Events

What are the issues	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.
Principles and rules	• Sponsorship of 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. • ICBs 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 the organisation. • All declarations made under this section must be made promptly - A declaration form is at Appendix E.
What should be declared	Organisations should maintain records regarding sponsored events in line with the above principles and rules.

Other forms of sponsorship

What are the issues?	Research is vital in helping the NHS to transform services and improve outcomes. Without sponsorship of research some beneficial projects might not happen. More broadly, partnerships between the NHS and external bodies on research are important for driving innovation and sharing best practice. However, there is potential for conflicts of interest to occur, particularly when research funding by external bodies does or could lead to a real or perceived commercial advantage. There needs to be transparency and any conflicts of interest should be well managed.
Principles and rules	• 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 their organisation. • The organisation will retain written records of sponsorship of research, in line with the above principles and rules.
What should be declared	Staff should declare: • Their name and their role with the ICB Board. • A description of the nature of the nature of their involvement in the sponsored research. • Relevant dates. • Any 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).

Sponsored Posts

What are the issues	Sponsored posts are positions with an organisation that are funded, in whole or in part, by organisations external to the NHS. Sponsored posts can offer benefits to the delivery of care, providing expertise, extra capacity and capability that might not otherwise exist if funding was required to be used from the NHS budget. However, safeguards are required to ensure that the deployment of sponsored posts does not cause a conflict of interest between the aims of the sponsor and the aims of the organisation, particularly in relation to procurement and competition.

Principles and rules	• Staff who are establishing the external sponsorship of a post should seek formal prior approval from their organisation. • Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and confirm the appropriateness of arrangements continuing. • Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. For the duration of the sponsorship, auditing arrangements should be established to ensure this is the case. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise. • Sponsored post holders must not promote or favour the sponsor's specific products, and information about alternative products and suppliers should be provided. • Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.
What should be declared	• The organisation will retain written records of sponsorship of posts, in line with the above principles and rules. • Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content in the rest of this policy.

Shareholdings and other Ownership Issues

What are the issues	Holding shares or other ownership interests can be a common way for staff to invest their personal time money to seek a return on investment. However, conflicts of interest can arise when staff personally benefit from this investment because of their role within an organisation. For instance, if they are involved in their organisation's procurement of products or services which are offered by a company they have shares in then this could give risk to a conflict of interest. In these cases, the existence of such interest should be well known so that they can be effectively managed.
Principles and rules	• Staff should declare, as a minimum, any shareholdings and other ownership interests in a 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. • There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts. • Where shareholdings or other ownership interests are declared and give rise to the risk of conflicts 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 within the ICB Board. • Nature of the shareholdings/other ownership interest. • Relevant dates. • Other relevant information (e.g. action taken to mitigate against a conflict, detail of any approvals given to depart from the terms of this policy).

Patents

What are the issues?	The development and holding of patents and other intellectual property rights allows staff to protect something that they create, preventing unauthorised use of products or the copying of protected ideas. Staff are encouraged to be innovative in their practice and therefore this activity is welcomed. However, conflicts of interest can arise when staff who hold patents and other intellectual property rights are involved in decision making and procurement. In addition, where produce development involves use of time, equipment or resources from their organisation, then this too could create risks of conflicts of interest, and it is important that the organisation is aware of this and it can be managed appropriately.
Principles and rules	• 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 on-going, which are, or might be reasonably expected to be, related to items to be procured or used by their organisation. • Staff should seek prior permission from their 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 of 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 within the ICB Board. • A description of the patent or other intellectual property right and its ownership. • Relevant dates. • Other relevant information (e.g., action taken to mitigate against a conflict, detail of any approvals given to depart from the terms of this policy).

Loyalty Interests

What are the issues?	As part of their jobs staff members need to build strong relationships with colleagues across the NHS and in other sectors. These relationships can be hard to define as they may often fall in the category of indirect interests. They are unlikely to be directed by a formal process or managed via any contractual means – it can be as simple as having informal access to people in senior positions. However, loyalty interest can influence decision making. Conflicts of interest can arise when decision making is influenced subjectively through association with colleagues or organisations out of loyalty to the relationship, they have rather than through an objective process. The scope of loyalty interests is potentially huge, so judgement is required for making declarations.
Principles and rules	Loyalty interests should be declared by staff involved in decision making where they: • Hold a position of authority in another NHS organisation, or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role. • Sit on advisory groups or other paid or unpaid decision making forums that can influence how their 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 with whom close family members and relatives, close friends and associates, and business partners have decision making responsibilities. Where holding loyalty interest gives 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 within the ICB Board. • Nature of the loyalty interest • Relevant dates. • Other relevant information (e.g., action taken to mitigate against a conflict, detail of any approvals given to depart from the terms of this policy.

Donations

What are the issues?	A donation is a charitable financial payment, which can be in the form of direct cash payment or through the application of a will or similar directive. Charitable giving and other donations are often used to support the provision of health and care services. As a major public sector employer, the NHS holds formal and informal partnerships with national and local charities. A supportive environment across the NHS and charitable sector should be promoted. However. Conflicts of interest can arise.

Principled and rules	• Acceptance of donations made by suppliers or bodies seeking to do business with an organisation should be treated with caution and not routinely accepted. In exceptional circumstances a donation from a supplier 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 an organisation or is being pursued on behalf of that organisation's registered charity (if it has one) or other charitable body and is not for their own personal gain. • Staff must obtain permission from their organisation if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign. • Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued. • Staff wishing to make a donation to a charitable fund in lieu of a professional fee they receive may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.
What should be declared	• Organisations should maintain records in line with their wider obligations under charity law, in line with the above principles and rules.

Secondary employment

What are the issues?	The NHS relies on staff with good skills, broad knowledge and diverse experience. Many staff bring expertise from sectors outside the NHS, such as industry, business, education, government and beyond. The involvement of staff in these outside roles alongside their NHS role can therefore be of benefit, but the existence of these should be well known so that conflicts can be either managed or avoided. Outside employment means employment and other engagements, outside of formal employment arrangements. This can include directorships, non-executive roles, self-employment, consultancy work, charitable trustee roles, political roles and roles within not-for-profit organisations, paid advisory positions and paid honorariums which relate to bodies likely to do business with an organisation.
Principled and rules	• Staff should declare any existing outside employment on appointment, and any new outside employment when it arises to their Line Manager. Please read the Secondary Employment Policy for further detail. • Where a risk of conflict of interest is identified, the general management actions outlined in this policy should be considered and applied to mitigate risks.

	• Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from an organisation to engage in outside employment. • Organisations may also have legitimate reasons within employment law for knowing about outside employment of staff, even if this does not give rise to risk of a conflict. Nothing in this policy prevents such enquiries being made.
What should be declared	• Staff name and their role within the ICB Board. • The nature of the outside employment (e.g., who it is with, a description of duties, time commitment). • Relevant dates. • Other relevant information (e.g., action taken to mitigate against a conflict, details of an approvals given to depart from the terms of this policy).

12. Managing Conflicts of Interest at meetings

To support Chairs in their role, the meeting Secretariat will regularly provide the Chair with access to a copy of the Register of Interests prior to meetings. This should include details of any declarations of conflicts, which have already been made by the members
The Meeting Secretariat should invite members and those in attendance, to declare any interests in relation to agenda items to the Chair in advance of the meeting
Meeting Secretariats are required to use the following templates to administer the meetings. Use of these will help to ensure conflicts of interest are discussed and recorded in line with statutory guidelines.

- Meeting Agenda
- Template for recording minutes

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

- Request that the individual does not receive the papers which are relevant or minutes of the meeting which relate to the matter(s) which give rise to the conflict or receive redacted versions.
- Request that the individual leaves the meeting when the relevant matter(s) are about to be discussed or does not attend the meeting.
- Allow the individual to participate in some or all of the discussion when the relevant matter(s) are being discussed but request them to leave the meeting when any decisions are being taken in relation to those matter(s). This may be appropriate where the conflicted individual has important relevant knowledge and experience of the matter(s) which would benefit other members to hear, but this will depend on the nature and extent of the interest which has been declared.
- Noting the interest and ensuring that all in attendance are aware of the nature and extent of the interest but allowing the individual to remain and participate in both the discussion and in any decisions. This is only likely to be the appropriate course of action where it is

decided that the interest which has been declared is either immaterial or not relevant to the matter(s) under discussion.

In the event that the Chair of a meeting has a conflict of interest, the Deputy Chair is responsible for deciding the appropriate course of action to manage the conflict of interest. If the Deputy Chair is also conflicted or not in attendance, then the remaining non-conflicted voting members of the meeting should agree between themselves how to manage the conflict(s).

As a minimum requirement, the following should be recorded in the minutes of all meetings where a conflict of interest has been declared:

- Individual declaring the interest.
- At what point the interest was declared.
- The nature of the interest.
- The Chair's decision and resulting action taken.
- The point during the meeting at which the individual left and returned to the meeting.

Appendix F can be used by meeting Secretariats to record information in these circumstances. Completed forms should be sent to Corporate Affairs.

In addition, the ICB encourages meeting Secretariats and chairs to use the Conflicts Management Plan (Appendix G) to assist with planning appropriate steps which can be taken in certain situations.

13. Managing Conflicts of Interest during the recruitment process

Everyone in the ICB has responsibility to appropriately manage conflicts of interest during the recruitment process because these roles will be involved (in some form) in the decision making processes of the ICB.

Appointing ICB Board Members, Committee Members, and any member of staff
When advertising for a ICB Board Member, Committee member or a member of staff, a request will be made via the recruitment team by the recruiting manager for a Conflict of Interest form to be completed by the successfully shortlisted candidates, and this will need to be brought with them to their interview.
On appointing to any of these roles the ICB will need to consider whether conflicts of interest should exclude individuals from being appointed to the role. This will need to be considered on a case-by-case basis and in conjunction with the principles within the ICB's Constitution. In such cases the Corporate Affairs team must always be consulted for advice prior to any decision being made.
The materiality of the interest will need to be considered, and in particular, whether the individual (or any person with whom they have a close association as listed in the scope of this policy) could benefit (whether financially or otherwise) from any decision the ICB might make. The ICB will also determine the extent of the interest and the nature of the appointee's proposed role within the ICB. If the interest is related to an area of business significant enough that the individual would be unable to operate effectively and make a full and proper contribution in the proposed role, then that individual should not be appointed to the role.
All recruiting managers will need to ensure that they support obtaining the declaration of interest forms for new staff and make the necessary arrangements to manage any declared conflicts of interest.

ICB Board and Committee members from other Organisations

ICBs have been created to give statutory NHS providers, local authorities and primary medical services (general practice) nominees a role in decision-making. It should not be assumed that the ICB Board will always be conflicted because at least three members of the ICB Board must be jointly nominated (the “partner members”) It is crucial that the ICB ensures that the Boards and Committees are appropriately composed and take into account different perspectives individuals will bring from their respective sectors to help inform decision making.

14. Managing Conflicts of Interest through the Commissioning Cycle

The NHS England guidance for Managing Conflicts of Interest in the NHS (February 2017) is clear that conflicts of interest need to be managed appropriately throughout the whole commissioning cycle including within the ongoing management of existing contracts and ICBs must have in place processes to ensure this happens.

At the outset of a commissioning process, all individuals involved, including those from external bodies, must complete a Conflict of Interest form, even if there is nothing to declare (Appendix A). Completed forms must be held by the lead Procurement Manager and either the forms or a collated register must be available at every meeting.

Where Conflicts of Interest are declared, the chair of the meeting, in conjunction with the Corporate Affairs team, must put in place clear arrangements to robustly manage these. This includes consideration as to which stages of the process a conflicted individual should not participate in, and, in some circumstances, whether that individual should be involved in the process at all. The steps taken must be clearly documented in the minutes.

Where a conflict is identified which may impact on the management of an existing contract, a discussion must take place with the Corporate Affairs team, and if necessary the Conflicts of Interest Guardian, so that steps can be put in place to manage this. Any mitigation must also be recorded in minutes that are taken.

ICBs will also need to identify as soon as possible where staff might transfer to a provider (or their role may materially change) following the award of a contract. This should be treated as a relevant interest which will be managed in line with this policy and following advice from the Corporate Affairs team and if necessary the ICB Conflicts of Interest Guardian.

Designing service requirements

The NHS England guidance upon which this policy is based states that ICBs have legal duties under the Act to properly involve patients and the public in their respective commissioning processes and decisions. Public involvement supports transparent and credible commissioning decisions and should happen at every stage of the commissioning cycle from needs assessment, planning and prioritisation to service design, procurement and monitoring.

Conflicts of Interest can arise from the inclusion of members of the public or particular groups who are involved in the decision-making process of the ICB. As such, any member of the public or representative of a particular group involved in the influencing or decision making of the ICB will be required to complete a Declaration of Interest form regardless of a conflict being identified. This will be held by the Procurement Manager alongside any other conflict of interest forms completed as part of the procurement process.

Provider engagement

It is good practice to engage relevant providers, especially clinicians, in confirming that the design of service specifications will meet patient needs. Such engagement, done transparently and fairly, is entirely legal but it is important not to gear the requirement in favour of any particular provider(s). If appropriate, the advice of an independent clinical adviser on the design of the service should be secured.

Conflicts of interest, as well as challenges to the fairness of the procurement process, can arise if a commissioner engages selectively with only certain providers (existing or potential) in developing a service specification for a contract for which they may later bid. The ICB is particularly mindful of these issues when engaging with existing / potential providers in relation to the development of new care models.

Procuring new care models

Where new care models or other arrangements of a similar scale or scope, are being procured it is imperative that conflicts of interest are managed in line with this policy. Where further advice is needed, please seek advice from the Corporate Affairs team.

Managing conflicts of interest relating to procurement

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.

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

In relation to the provider selection regime, where decisions are being taken as part of a formal competitive procurement of services, any individual who is associated with an organisation that has a vested interest in the procurement should recuse themselves from the process.

The procedure for managing conflicts of interest during procurements is set out in the ICB's Procurement and Contracting policies.

Register of procurement decisions

To promote transparency in decision-making, and in line with the NHS England Managing Conflicts of Interest in the NHS (February 2017), the ICB will maintain a register of procurement decisions taken, either for the procurement of a new service or any extension or material variation of a current contract. This will include:

- The details of the decision;
- Who was involved in making the decision (including the name of the ICB clinical lead, the ICB contract manager, the name of the decision making committee and the name of any other individuals with decision-making responsibility);
- Summary of any conflicts of interest in relation to the decision and how these were managed; and
- The award decision taken.

It is the responsibility of Managers involved in Procurements to ensure that details of any procurement decisions taken, including single tender actions are provided to the Corporate Affairs team so that the register of procurement decisions can be maintained. Upon receipt

of new information, the register of procurement decisions will be updated and published on the ICB website by the Corporate Affairs team.

15. Joint working

Individuals must ensure that joint working arrangements are clear and transparent. Joint working is where, for the benefit of patients, organisations pool skills / resources and experience to enable successful delivery of a project or work area, this may also include joint committees. Appropriate governance arrangements must be put in place that ensure that conflicts of interest are identified and managed appropriately, in accordance with statutory guidance, without compromising the ICB's ability to make robust commissioning decisions. The ICB currently works in collaboration with Local Authorities and other system partners.

16. Raising concerns and breaches

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 individuals or organisations. For the purposes of this policy, these situations are referred to as 'breaches'.

This policy has been prepared to help individuals approach their decision making properly where there is a conflict of interest. Individuals are expected to use this policy to fulfil their duty to act only in the best interests of the ICB and to be able to provide a convincing justification for their decisions in the event of challenge. The ICB takes seriously the failure to disclose such information as required by this policy.

It is the duty of every ICB employee, Board member, committee member and GP practice member to speak up about genuine concerns in relation to the administration of the ICB's policy on conflicts of interest management, and to report these concerns. Individuals should not ignore suspicions or investigate themselves, but rather speak to the designated ICB point of contact for these matters.

Concerns around suspected or known breaches of this policy should be raised in the first instance with either the Corporate Affairs team or Director or Finance (unless implicated). If individuals prefer to speak to someone else in strict confidence, they can also contact the Conflicts of Interest Guardian. All such notifications will be held in the strictest confidence and in accordance with the ICB's other policies (including the Freedom to Speak Up Policy).

The Counter Fraud, Bribery and Corruption Policy may be consulted and an appropriate referral made to the Local Counter Fraud Specialist where applicable. The Fraud and Security Management Service may also be consulted directly. The person notifying the Conflicts of Interest Guardian can expect a full explanation of any decisions taken as a result of any investigation.

Please see Appendix H for the procedure on reporting Conflicts of Interest Breaches.

If conflicts of interest are not effectively managed there is the potential for corporate offences to be applied contrary to the Bribery Act 2010 which could lead to unlimited fines and criminal prosecution against directors. The ICB could further face civil challenges to decisions they make. For instance, if breaches occur during a procurement exercise, the ICB risks a legal challenge from providers that could potentially overturn

the award of a contract, lead to damages claims against the ICB, and necessitate a repeat of the procurement process. Breaches also damage public trust and confidence in the NHS generally.

In extreme cases, staff and other individuals could face personal civil liability, a claim for misfeasance in public office or fitness to practice proceedings by their professional regulator. Failure to manage conflicts of interest could also lead to criminal proceedings including for offences such as fraud, bribery and corruption.

It is an offence under the Fraud Act 2006 for individuals to 1) abuse their position; and/or 2) fail to disclose information to the ICB and/or 3) make a false representation in order to make a gain for themselves or another, or to cause a loss or expose the organisation to a loss. Therefore, if an individual becomes aware that someone has failed to disclose relevant and material information, or made a false representation, they should raise the concern in the first instance with the Local Counter Fraud Service who will then liaise with the Corporate Affairs team, Director of Finance, and the Conflicts of Interest Guardian – all such notifications will be dealt with in the strictest confidence in accordance with the other ICB's policies (including the Freedom to Speak Up Policy).

Individuals who fail to disclose any relevant interests or who otherwise breach the ICB's rules and policies relating to the management of conflicts of interest will be subject to investigation and, where appropriate, to disciplinary action. ICB staff, Board and committee members in particular should be aware that the outcomes of such action may, if appropriate, result in the termination of their employment or position with the ICB.

All breaches will be anonymised, recorded and published on the ICBs website along with any outcomes/actions for the purpose of learning and development once investigations have been completed. NHS England will be notified of any breaches, as appropriate, as soon as possible, including as part of the quarterly returns for the Improvement and Assessment Framework.

Appendix A – Declaration of Interest Template

Template Declaration of Interests for ICB Board Members, employees and any person working for, or on behalf of, 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 guidance produced by NHS England on the management of conflicts of interest, the ICB is required to hold and publish the interests of members and employees to comply with our statutory duties.

As a minimum, ICBs are expected to publish the interests of its members who fall into the following categories:

- Board, committees and management groups of the ICB
- Any person involved in procurement decisions and/or service re-design
- Any person at AfC 8d and above
- Any person with delegated functions or authority (as set out within the ICB Governance Handbook)

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….here]

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 NWICB Committees you belong to or attend:	
☐ ICB Board	☐ Integrated Care Partnership
☐ Conflicts of Interest Committee	☐ Audit and Risk Committee
☐ Patient and Communities Committee	☐ Quality and Safety Committee
☐ Remuneration, People and Culture Committe	☐ Primary Care Commissioning Committe
☐ Finance Committee	☐ Performance Committee
☐ Executive Management Team	☐ Senior Management Team
☐ Place Board	☐ Other (please state)

If you are a member of the Primary Care Committee; or a person responsible for matters (contractual or finance) relating to primary care and are registered with a Norfolk and Waveney GP Practice, please record this below	
GP Practice:	

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**	

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.
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.

Type of Interest	Description
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 – Register of Interests Template

NHS Norfolk and Waveney Integrated Care Board (ICB) Register of Interests Declared Interests of the XXXXXXXXXXXXX										
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 – Gifts and Hospitality Guide

<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 rowspan="2"></td><th>When to be caution</th></tr>
<tr><td>When hospitality if offered by actual or potential suppliers or contractors. If it's 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</td></tr>
</table>

Appendix D – Register of Gifts and Hospitality Template

Recipient Name	Position	Date of Offer	Date of Receipt (if applicable)	Declined or Accepted?	Supplier/Offeror: Name and Nature of Business	Details of Gift/Hospitality	Estimated Value	Details of previous offers or Acceptance by the Offeror/Suppier	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 E – Register of Sponsorship Template

Recipient Name	Position	Date of Offer	Date of Receipt (if applicable)	Details of sponsorship	Estimated value	Supplier name and nature of business	Details of any previous offers	Details of Officer reviewing / approving	Declined / accepted	Reason of declining or accepting	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.

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Signed: Date:

Signed: Position: Date:
(Line Manager or a Senior ICB Manager)

Appendix D – Register of Gifts and Hospitality Template

Recipient Name	Position	Date of Offer	Date of Receipt (if applicable)	Declined or Accepted?	Supplier/Offeror: Name and Nature of Business	Details of Gift/Hospitality	Estimated Value	Details of previous offers or Acceptance by the Offer or/Suppier	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)

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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 F- Template for recording interests at meetings

Report from <insert details of committee/ work group>	
Title of paper	<insert full title of the paper>
Meeting details	<insert date, time and location of the meeting>
Report author and job title	<insert full name and job title/ position of the person who has written this report>
Executive summary	<include summary of discussions held, options developed, commissioning rationale, etc.>
Recommendations	<include details of any recommendations made including full rationale> <include details of finance and resource implications>
Outcome of Impact Assessments completed (e.g. Quality IA or Equality IA)	<Provide details of the QIA/EIA. If this section is not relevant to the paper state 'not applicable'>
Outline engagement – clinical, stakeholder and public/patient:	<Insert details of any patient, public or stakeholder engagement activity. If this section is not relevant to the paper state 'not applicable'>
Management of Conflicts of Interest	<Include details of any conflicts of interest declared> <Where declarations are made, include details of conflicted individual(s) name, position; the conflict(s) details, and how these have been managed in the meeting> <Confirm whether the interest is recorded on the register of interests- if not agreed course of action>
Assurance departments/ organisations who will be affected have been consulted:	<Insert details of the people you have worked with or consulted during the process : Finance (insert job title) Commissioning (insert job title) Contracting (insert job title) Medicines Optimisation (insert job title) Clinical leads (insert job title) Quality (insert job title) Safeguarding (insert job title) Other (insert job title)>
Report previously presented at:	<Insert details (including the date) of any other meeting where this paper has been presented; or state 'not applicable'>
Risk Assessments	<insert details of how this paper mitigates risks- including conflicts of interest>

Appendix G – **COI Management Plan**

Conflicts of Interest – Management Plan
Norfolk and Waveney Integrated Care Board

Definition

A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role, is or could be impaired or otherwise influenced by his or her involvement in another role or relationship. The individual does not need to exploit his or her position or obtain an actual benefit, financial or otherwise, for a conflict of interest to occur e.g.

- **Financial interest** – direct financial benefit e.g. shareholder of organisation in receipt of funding, in receipt of secondary income, sponsored research etc.
- **Non-financial professional interest** – e.g. increasing professional reputation or status or promoting career
- **Non-financial personal interest** – e.g. member of voluntary sector organisation or lobbying/pressure group
- **Indirect interest** – close association with another individual who has an interest e.g. close family, friends

A perception of wrong-doing, impaired judgement or undue influence can be as detrimental as any of them occurring. If in doubt, it is better to assume the existence of a conflict of interest and manage it appropriately rather than ignore it.

Some disclosed conflicts will require a Management Plan to be put in place. This should be developed between the Line Manager and the Discloser. Once it has been agreed, the Conflict Management Plan will need to be passed to the Governance Team.

Background

Use this space to tell us about the circumstances that have given risk to the conflict:

Who is potentially conflicted?

Please provide the details of potentially conflicted parties in this section:

Why?

Please use this space to explain why and how the conflict will, or may, occur:

What further mitigation could be taken?

Use this section to consider possible mitigations of the declared conflict, - remember, transparency of decision making is key. Possible mitigations include:

- add to publicly available Register of Interests
- exclude conflicted parties from a specific decision making situation
- ensure decisions are in line with operational/commissioning strategies
- decisions are based on local health needs
- be proactive – early engagement with patients, public, clinicians and other stakeholders, including local Healthwatch and Health and Wellbeing Boards
- early engagement with both incumbent and potential new providers over potential changes to the services commissioned for a local population
- seek advice e.g. clinical senates, networks, commissioning support
- invite Health and Wellbeing Board or another ICB to review the proposal The general safeguards will vary to some extent depending on at what stage in the commissioning cycle the decisions are being made.

Consider the 'Six Rs':

- **Register** – Where details of the existence of a possible or potential conflict of interest are formally registered.
- **Restrict** – Where restrictions are placed on the public official/Board member's involvement in the matter.
- **Recruit** – Where a disinterested third party is used to oversee part or all of the process that deals with the matter.
- **Remove** – Where a public official/Board member chooses to be removed from the matter.
- **Relinquish** – Where the public official/Board member relinquishes the private interest that is creating the conflict.
- **Resign** – Where the public official/Board member resigns from their position with the organisation.

Steps taken to date:

Risk Score before and after mitigation

Consequence (impact)		Likelihood				
		Rare 1	**Unlikely 2**	**Possible 3**	**Likely 4**	**Almost certain 5**
Negligible 1		1	2	3	4	5
Minor 2		2	4	6	8	10
Moderate 3		3	6	9	12	15
Major 4		4	8	12	16	20
Catastrophic 5		5	10	15	20	25

Further mitigation proposed:

Low risk	Normal risks which can be managed by routine procedures	The ICB accepts low risks that are likely to result in identified impact
Moderate risk	Responsibility for assessment and action planning allocated to a named individual	The ICB is willing to accept moderate risks that may result in identified impact
Significant risk	Urgent senior management attention with action plan	The ICB is willing to accept some significant risks in certain circumstances
High risk	Immediate action required by a Director	The ICB is not willing to accept any high risk under any circumstances

Risk Score

	Likelihood	Consequence	Risk Rating
Risk before mitigation			
Risk after mitigation			

Conflict Management Plan Review date: _____
(*The review should take place no later than 12 months from the date of this plan, and sooner should circumstances change)*

Agreement

	Signed	Date
Discloser		
Reviewer		
Corporate team		

Appropriate Actions

This section provides an indication of the actions that should be taken where a conflict is identified.
However, each situation is different, and where there is any uncertainty, guidance should be sought from the Corporate Affairs team.

	Financial	Non-financial professional	Non-financial personal	Indirect
Needs Assessment	Fully participate	Fully participate	Fully participate	Fully participate
Review health outcomes	Fully participate	Fully participate	Fully participate	Fully participate
Design services	Discuss and vote	Discuss and vote	Discuss and vote	Discuss and vote
Decide priorities	Discuss but cannot vote	Discuss and vote	Discuss and vote	Discuss and vote
Review commissioning proposals	Remain but cannot speak or vote	Remain but cannot speak or vote	Remain but cannot speak or vote	Discuss and vote
Performance management	Remain but cannot speak or vote (unless interest is deemed not prejudicial)	Remain but cannot speak or vote (unless interest is deemed not prejudicial)	Remain but cannot speak or vote (unless interest is deemed not prejudicial)	Discuss and vote
Review prioritised business cases	Leave the room	Remain but cannot speak or vote	Remain but cannot speak or vote (unless interest is deemed not prejudicial)	Discuss and vote
Procurement/contracting	Leave the room	Remain but cannot speak or vote (unless interest is deemed not prejudicial)	Remain but cannot speak or vote (unless interest is deemed not prejudicial)	Discuss and vote

Appendix H – COI Breach Form

PRIVATE AND CONFIDENTIAL

CONFLICTS OF INTEREST BREACH FORM

PART 1

Breach Details		
Description of event *(give a brief description of the breach. Only state facts about the breach).*		
Details of those involved:		
Name	**Title**	**Contact details**

Please give this form to the ICB's Corporate Affairs Manager as soon as you have completed Part 1. The Corporate Affairs Manager / COI Guardian will then complete Part 2.

PART 2 *to be completed by Corporate Affairs / COI Guardian*

Outcome of Incident / Next steps	
Date of discussion:	

Please detail the outcome of the discussion between the COI Guardian / Corporate Affairs including next steps, actions and lessons learnt		
Please circle:		
Confidential spreadsheet updated and unique identifier been provided (if appropriate)	Yes	Yes
Does an appropriate person need to investigate?	Yes	No
Please provide details on reasons why Yes/No		
Does it need to be scored under the SIRI criteria?	Yes (and if so the outcome)	No
Does it link to any Whistleblowing / HR Policies?	Yes	No
Please provide details on reasons why Yes/No		
Date that the breach report will be taken to Audit and Risk Committee		
Do Communications need to be notified?	Yes	No
Comments		
Please provide date that NHS England were / will be notified		
Please provide date the anonymised details have been / will be published on the ICBs website		

Please provide the date the original whistleblower has / will be informed of the outcome	

SECTION 9
Standards of Business Conduct Policy

Revision History

Document Control Sheet

Revision Date	Summary of changes	Author(s)	Version Number
March 2023	Minor changes made to correct name of audit and risk committee and to refer to secondary employment policy in section 24		1.1

Approvals
This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number
1 July 2022	ICB Board		1

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.

[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

10.2 **Members must commit to promoting:**

- 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, Sarah Kabirat on 07500 294136 or via email on sarah.kabirat@uk.gt.com.

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 and Risk 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 and Risk 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), Sarah Kabirat to ensure that they are investigated appropriately and to maximise the chances of financial recovery. The CFS can be contacted on 07500 294136 or via email on sarah.kabirat@uk.gt.com. 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 in line with the Secondary Employment Policy.

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.

24.4 In the event that secondary employment is permitted, this should be declared on the persons declaration of interest.

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
1 July 2022	ICB Board		1

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

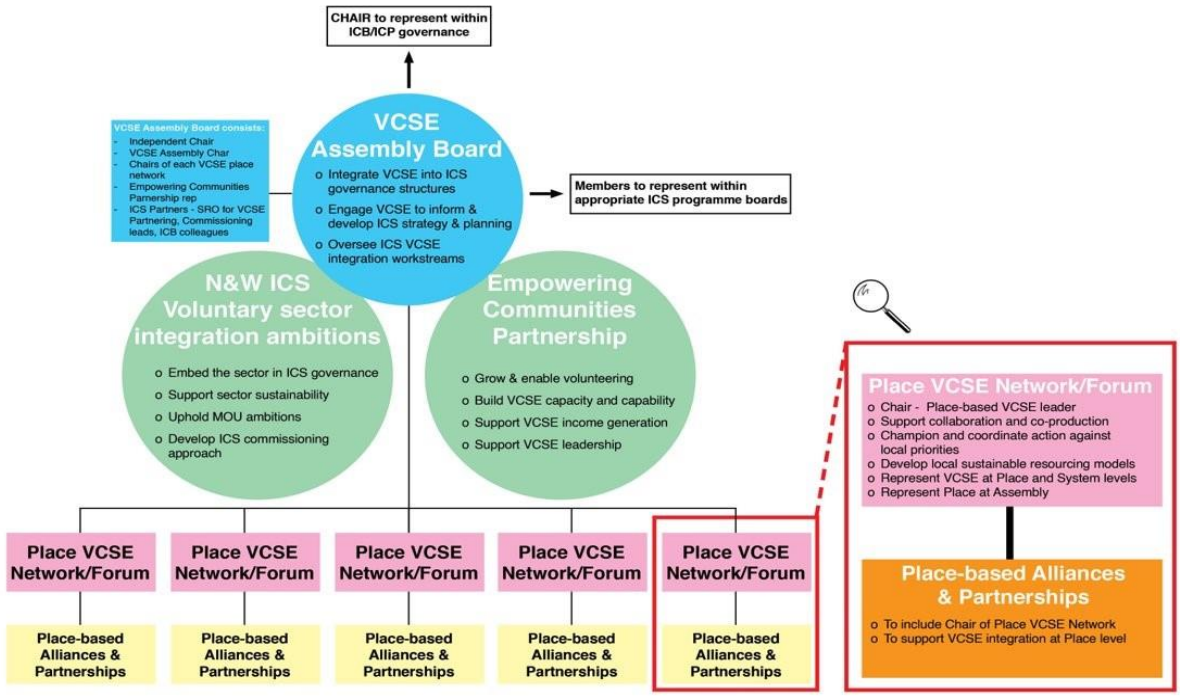
Acle Medical Partnership	Kirkley Mill Surgery
Aldborough Surgery	Lakenham Surgery
Alexandra Road Surgery	Lawson Road Surgery
Andaman Surgery	Litcham Health Centre
Attleborough Surgery	Long Stratton Medical Partnership
Bacon Road Medical Centre	Longshore Surgeries
Beaches Medical Centre	Ludham & Stalham Green
Beccles Medical Centre	Manor Farm Medical Centre
Beechcroft Surgery (inc. Old Palace)	The Market Surgery Aylsham
Birchwood Medical Practice	Mattishall & Lenwade Surgeries – Dr Jones & Partners
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
The Castle Partnership	The Parish Fields Surgery
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 & Aylsham Medical Practice
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 – Dr Castle and Partners – Sole Bay Health Centre
Fleggburgh Surgery	Southgate Medical Centre
Great Massingham Surgery & Docking Surgeries	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 2022, 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 three 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. Place Board Chairs for each Place Board area
29. Primary Care representatives (1)
30. Primary Care representatives (2)

31. Primary Care representatives (3)
32. Primary Care representatives (4)
33. Primary Care representatives (5)
34. Queen Elizabeth Hospital NHS Trust
35. South Norfolk District Council
36. Suffolk County Council, Cabinet Member for Adult Care
37. Suffolk County Council, Executive Director of People Services
38. Voluntary sector representatives (1)
39. 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
16.12.2022	Amended section 4 membership		1.1

Approvals

Approval Date	Approval Body	Author(s)	Version Number
1 July 2022	ICB Board		1
28 March 2023	ICB Board	Corporate Affairs	2

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)
- A minimum of 2 but up to 3 Non-Executive members other than the Chair, 2 of whom must be on the Board of the ICB.

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.

The Medical Director may also be invited to attend one meeting each year prior to year end to give an oversight of risks.

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 Requirements of the Government Functional Standard GovS 013: Counter Fraud – management of counter fraud, bribery and corruption activity, 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 the Counter Fraud Functional Standard Return (CFFSR) Self-Review Assessment, outlining key work undertaken during each financial year to meet the NHS Requirements of the Government Functional Standard GovS 013: Counter Fraud – management of counter fraud, bribery and corruption activity.

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
07.03.2023	Amended section 6 Responsibilities of the Committee	EO	1.1

Approvals
This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number
1 July 2022	ICB Board		1
28 March 2023	ICB Board		2

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 and Risk 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.
- Director of Nursing or nominated deputy

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 priorities only. This section of the meeting will contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the strategic People and culture agenda for the ICB and its partner constituents.

It will do this by scrutinising the delivery of the strategic people priorities in order to provide assurance to the ICB Board that risks to the delivery of the people agenda are being managed appropriately. The committee will receive relevant risks from the Board Assurance Framework (namely those relating to People and Culture agenda) to review assurance on risk mitigation and controls including any gaps in control for the risks allocated to the Committee;

The Committee will also have oversight and provide assurance to the Board that the ICS is delivering against the ten outcomes based functions with their partners in the ICS against an agreed set of Key Performance Indicators; namely:

1. Supporting the health and wellbeing of all staff

2. Growing the workforce for the future and enabling adequate workforce supply:
3. Supporting inclusion and belonging for all, and creating a great experience for staff
4. Valuing and supporting leadership at all levels, and lifelong learning
5. Leading workforce transformation and new ways of working
6. Educating, training, and developing people, and managing talent
7. Driving and supporting broader social and economic development
8. Transforming people services and supporting the people profession
9. Leading coordinated workforce planning using analysis and intelligence
10. Supporting system design and development:

It will also play a key role in ensuring that NHS partner organisations meet expectations in relation to the system people and culture strategic priorities and committee will ensure compliance against any obligations outlined in the NHS People Plan.

The part 1 duties of the Committee will be driven by the system's objectives, performance, 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 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 Speciality 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 Specialitiy 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 July 2022	ICB Board		1

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

Version 2
ICB Board approval 28 March 2023

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
- 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 (a serving Norfolk & Waveney Chief Finance Officer with current experience in an acute NHS provider setting)
- Non-acute Chief Finance Officer (a serving Norfolk & Waveney Chief Finance Officer with current experience in a non-acute NHS provider setting)

- Non-Executive Director (from NHS provider organisation)
- A clinical person with primary care experience.
- A clinical person from a provider, active within the Norfolk & Waveney locality
- 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:	28 March 2023
Next Review:	March 2024

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 a Primary Medical Services Delivery Group and a Dental Services Delivery Group that will undertake specific agreed tasks and decision making as set out in the ICB Governance. The Committee shall appoint the Chair and agree the membership and terms of reference of these groups in accordance with the ICB's constitution, standing orders and SoRD.

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 subject to s.4.10:

- ICB Board Partner Member – Providers of Primary Medical Services
- Local Representative Committee members – Local Medical Committee, Local Dental Committee, Local Pharmacy Committee and Local Optical Committee
- Director of Patients and Communities
- Director of Primary Care
- One practice manager (or other suitably experienced individual) from primary medical services and one from (NHS) primary dental

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 ICB'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 at least 7 calendar 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 will normally meet virtually unless a face to face meeting is deemed necessary.

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

5.5 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.

5.6 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.

5.7 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 5.11 and 5.12 may be followed.

Decision making and voting

5.8 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.

5.9 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.

5.10 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

5.11 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.

5.12 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).

5.13 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 and dental functions in accordance with section 13Z of the NHS Act with specific obligations set out in Schedule 2 of the Delegation Agreement and general obligations set out below:

Schedule 2A: Primary medical services

- decisions in relation to the commissioning and management of Primary Medical Services;
- planning Primary Medical Services in the Area, including carrying out needs assessments;
- undertaking reviews of Primary Medical Services in respect of the Area;
- management of the Delegated Funds in the Area;
- co-ordinating a common approach to the commissioning and delivery of Primary Medical Services with other health and social care bodies in respect of the Area where appropriate; and
- such other ancillary activities that are necessary in order to exercise the Delegated Functions.

Schedule 2B: Primary dental services and prescribed dental services

- decisions in relation to the commissioning and management of Primary Dental, Services; for clarity this includes primary care, community care/special care dental services and secondary care dental services;
- planning Primary Dental Services in the Area, including carrying out needs assessments;
- undertaking reviews of Primary Dental Services in the Area;
- management of the Delegated Funds in the Area;
- co-ordinating a common approach to the commissioning and delivery of Primary Dental Services with other health and social care bodies in respect of the Area where appropriate; and
- such other ancillary activities that are necessary in order to exercise the Delegated Functions.

Schedule 2C: Primary ophthalmic services

Ophthalmic services are hosted by Hertfordshire and West Essex Integrated Care Board (H&WE ICB) on behalf of the ICB. In accordance with the Memorandum of Understanding with HWE ICB and other ICBs in the East of England region H&WE ICB will report general optometry services matters to the Committee including information to support decision making as and when matters arise. The ICB remains responsible and accountable for the provision of this service.

- decisions in relation to the management of Primary Ophthalmic Services;
- undertaking reviews of Primary Ophthalmic Services in the Area;
- management of the Delegated Funds in the Area;
- co-ordinating a common approach to the commissioning of Primary Ophthalmic Services with other commissioners in the Area where appropriate; and
- such other ancillary activities that are necessary in order to exercise the Delegated Functions.

Schedule 2D: Pharmaceutical services and local pharmaceutical services

Pharmaceutical services are hosted by HWE ICB on behalf of the ICB.

NHS England has established mandated local committees to be known as Pharmaceutical Services Regulations Committees (PSRC). The PSRC is an ICB committee with representatives from all East of England ICBs attending. NHS England has delegated decision making to each PSRC in relation to matters under the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 as amended.

H&WE ICB will coordinate and host the PSRC to agreed Terms of Reference as set out in the NHS England Pharmacy Manual (https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-manual/).

In accordance with the Memorandum of Understanding with HWE ICB and other ICBs in the East of England region H&WE ICB will provide quarterly reports to the Committee on decisions made at the PSRC.

Applications and Notifications will be made by H&WE ICB on behalf of the ICB to the PSRC for determination.

The ICB remains responsible and accountable for the provision of this service.

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 care services. 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 services under the NHS Act and detailed in the Delegation Agreement with NHS England.

6.5 In performing its role, and in particular when exercising its commissioning responsibilities, the Committee shall take account of:

a) The recommendations of the executive management team, the relevant Delivery Group 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 all primary care 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 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: 28 February 2023

Version 2

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
21/10/2022	Side by side review against SNEE and C&P terms. Membership queries highlighted.	KW & EK	v0.7 & v0.8
08/11/2022	Review against final version in ICB Governance Handbook. Changes to membership and quoracy. Meeting to confirm changes with Corporate.	EK & AB	v0.9
09/11/2022	Version for Committee review.	EK & AB	v0.10
11/01/2023	Final version for Committee review. Highlighted all amends to the version approved by Board.	EK	v0.11

Approvals
This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number
1 July 2022	ICB Board		1
28 March 2023	ICB Board		2

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 by the National Quality Board '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, of 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.

See the appendix to these terms for an overview of Committee objectives for 2023-2024.

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 and the voice of clinical workforce.

The Chair may ask any or all attendees, 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 Deputy 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):

- 1 Acute Provider Member
- 1 Community Provider Member
- 1 Mental Health Member
- 2 Local Authority Members (Norfolk and Suffolk)
- 1 VCSE Assembly Member
- 1 Independent Provider Partner
- 1 Hospice Provider Partner

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. The ICB Chief Executive Officer is routinely invited to attend.

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 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. 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 using 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, research, 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 and annual plan, including priorities to address variation and 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 Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the DHSC, NHSE 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 and regulation and assure the ICB that these are disseminated and implemented across all ICB 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.

- Ensure that patient outcomes from care are collected and measured, to inform outcomes-based commissioning for quality.

- 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 deaths (including coronial inquests and Reports to Prevent Future Deaths).

- 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 research and evaluation.

- 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 and Infection Prevention and Control).

- Approve ICB arrangements including supporting policies to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality research and patient outcomes.

- Approval of the arrangements for discharging the ICB'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 and Risk 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;

- Member appointments and renewal dates are recorded, 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 complete agenda pack will be circulated at least five calendar days before the date of the meeting. The draft minutes and action log will be shared with all Committee members within five calendar days following the meeting.

- The Chair is supported to prepare and deliver a report of each Committee meeting to the Board;

- 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: Committee Objectives for 2023-2024

- To seek assurance that the Norfolk and Waveney system has a unified approach to quality governance and internal controls that support it to effectively deliver its strategic objectives and provide sustainable, high-quality care and to have oversight of local implementation of the NHS National Patient Safety Strategy.

- To be assured that these structures operate effectively, that timely action is taken to address areas of concern, and to respond to lessons learned from all relevant sources including national standards, regulatory changes, and best practice.

- To oversee and monitor delivery of the ICB key statutory requirements, including scrutiny of the robustness and effectiveness of its arrangements for safeguarding adults and children, infection prevention and control, medicines optimisation and safety, research and evaluation and equality and diversity. To ensure that patient outcomes from care are collected and measured, to inform outcomes-based commissioning for quality.

- To review and monitor those risks on the Board Assurance Framework and Corporate Risk Register which relate to quality, and the delivery of safe, timely, effective and equitable care. To consider the effectiveness of proposed mitigations and to escalate concerns to risk owners and operational leads/forums as agreed by Committee Members.

- To approve ICB arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and secure continuous improvement in quality. To seek assurance that commissioning functions act with a view to supporting quality improvement; developing local services that promote wellbeing and prevent adverse health outcomes, equitably, across all patients and communities in Norfolk and Waveney.

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
6 Sept 2022	Attendee's following EMT discussion	T Litherland	2

Approvals
This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number
1 July 2022	ICB Board		1
28 March 2023	ICB Board		2

1. 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.

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 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.

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 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
- 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 Executive Officer (JPUH) or nominated deputy
- Chief Executive Officer (NNUH) or nominated deputy
- Chief Executive Officer (QEH) or nominated deputy
- Chief Executive Officer (NCHC) or nominated deputy
- Chief Executive Officer (ECCH) or nominated deputy
- Chief Executive Officer (NSFT) or nominated deputy
- 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
- ICB Non Executive Member

5. 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.

6. 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

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:28 March 2023

Version 2

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
27 January 2023	Amendments to references and roles and responsibilities of the Committee	Corporate Affairs	1.1

Approvals
This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number
1 July 2022	ICB Board		1
28 March 2023	ICB Board		2

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.

1.3 The committee contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the Audit and Risk Committee on the adequacy and effectiveness of conflict of interest processes within the ICB.

2 Membership

The Committee members shall be appointed by the board in accordance with the ICB's Constitution. Members of the Sub Committee are:

2.1.1 Non-Executive Member (Chair)

2.1.2 At least one further Non Executive Member from the Board

2.1.3 Executive Director of Finance (Deputy Chair)

2.1.4 Executive 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;

2.5.1 Only members of the Committee have the right to attend meetings. However, meetings of the Committee will also be attended by the following individuals who are not members of the Committee:

- Head of Governance
- Corporate Affairs Manager
- Any individual required to present matters to the Committee for consideration if called upon by the Committee Chair

2.5.2 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.

2.5.3 Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from Health and Wellbeing Board(s), secondary care and community providers.

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. This includes, but is not limited to, receiving reports and making decisions on potential breaches of policy.

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.

7.5 The Sub Committee shall seek assurance on the ICB's delivery of conflicts of interest in accordance with corporate objectives and actions plans. This will involve receiving reports and carrying out tests of the ICB's resilience to effectively manage conflicts of interest management plans.

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 Audit and Risk Committee following each meeting. The Sub Committee shall however act independently of the Audit and Risk Committee.

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.