Essex ICB

Governance Handbook

April 2026

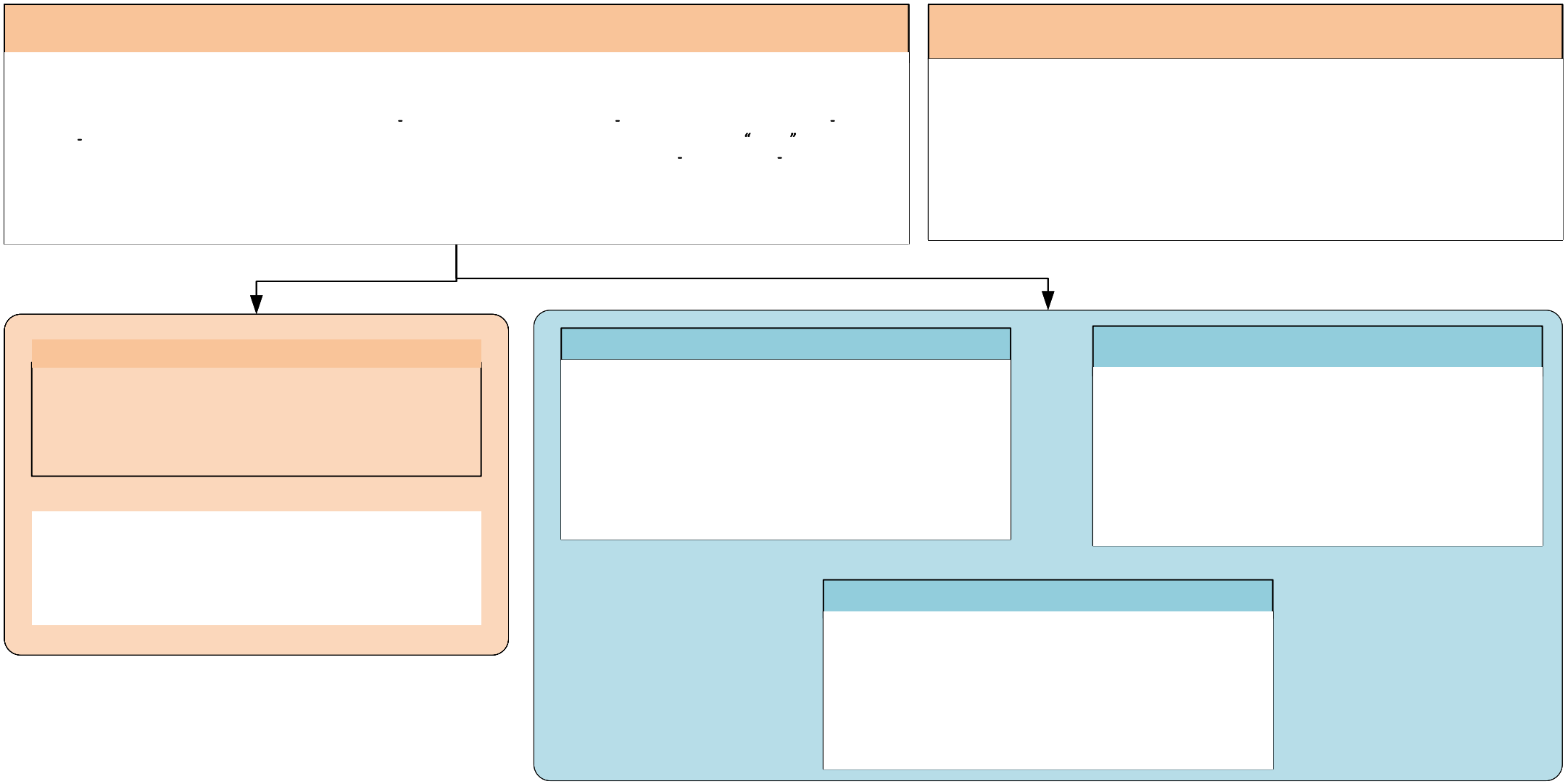
Section:	Detail:
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Two	Terms of reference (TOR) ▪ Schedule of Committee Membership ▪ Audit, Risk and Compliance Committee TOR ▪ Remuneration Committee TOR ▪ Executive Committee TOR ▪ Commissioning, Quality and Resource Committee TOR ▪ Neighbourhood Health Committee TOR Joint Committee terms of reference ▪ Integrated Care Partnership TOR Management of Meetings ▪ Summary of meeting etiquette (Petitions, Questions, Role of Observers and Participants.) ▪ Process for New Governance Groups ▪ Guidance for Meeting Administration
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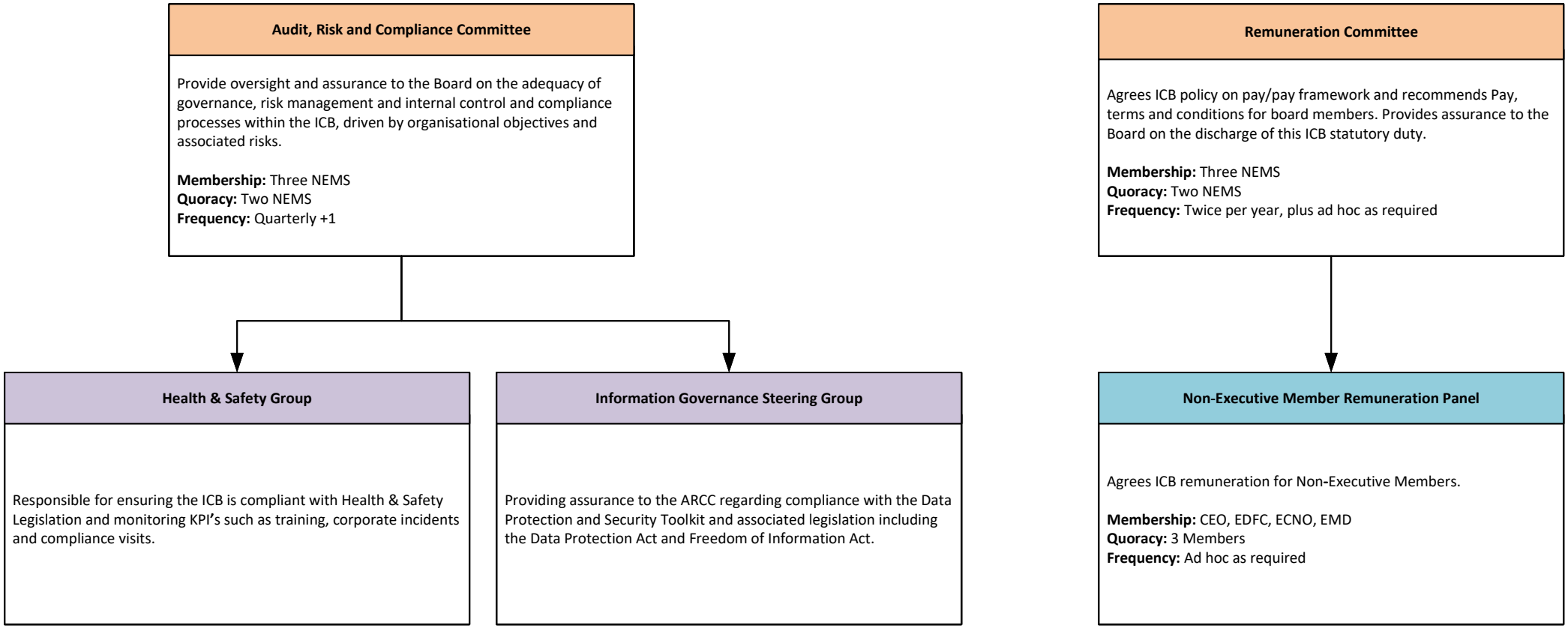
NHS
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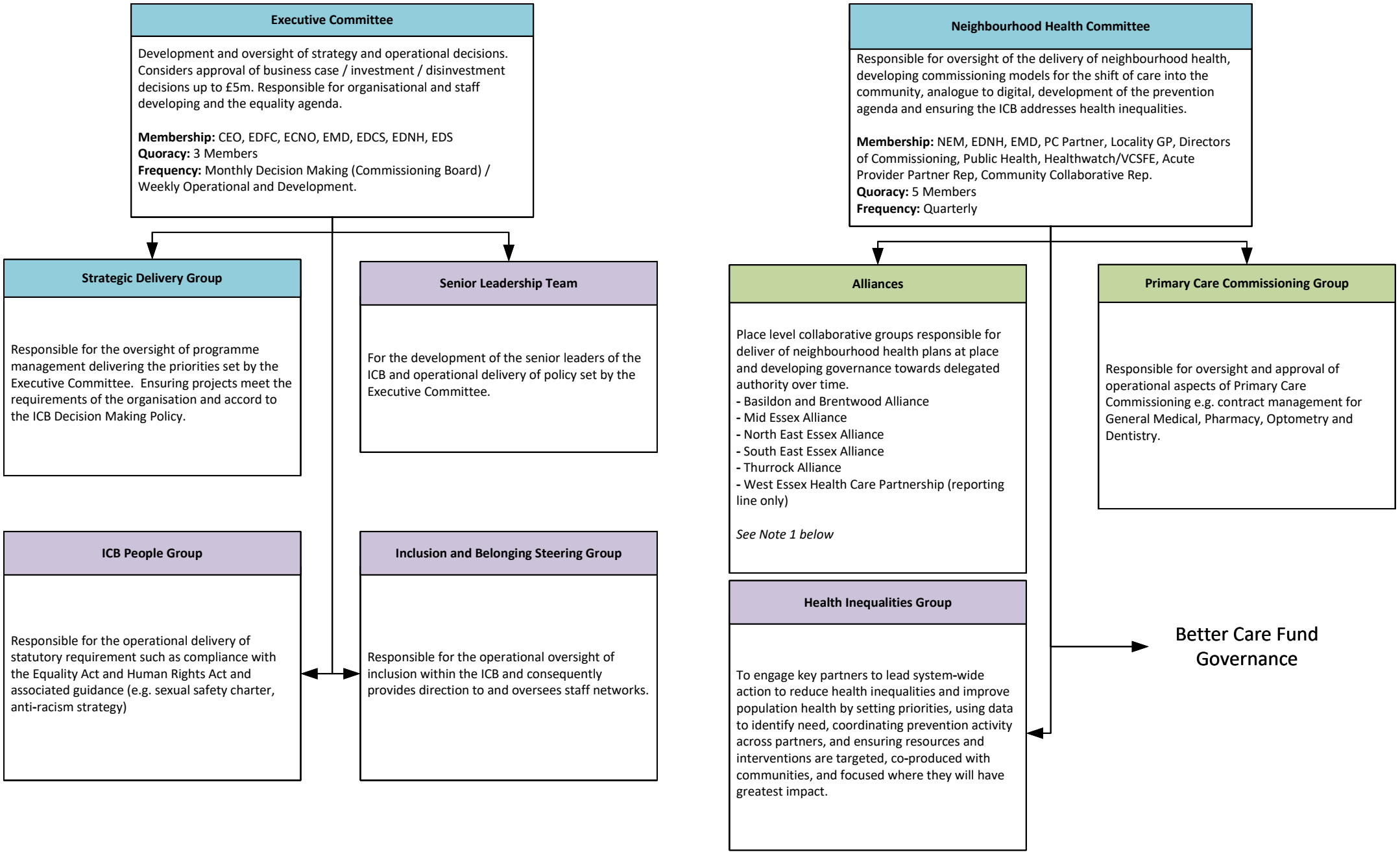
1. Functions, Delegation and Decisions

1.1. ICB Functions Map, including Committee Structure

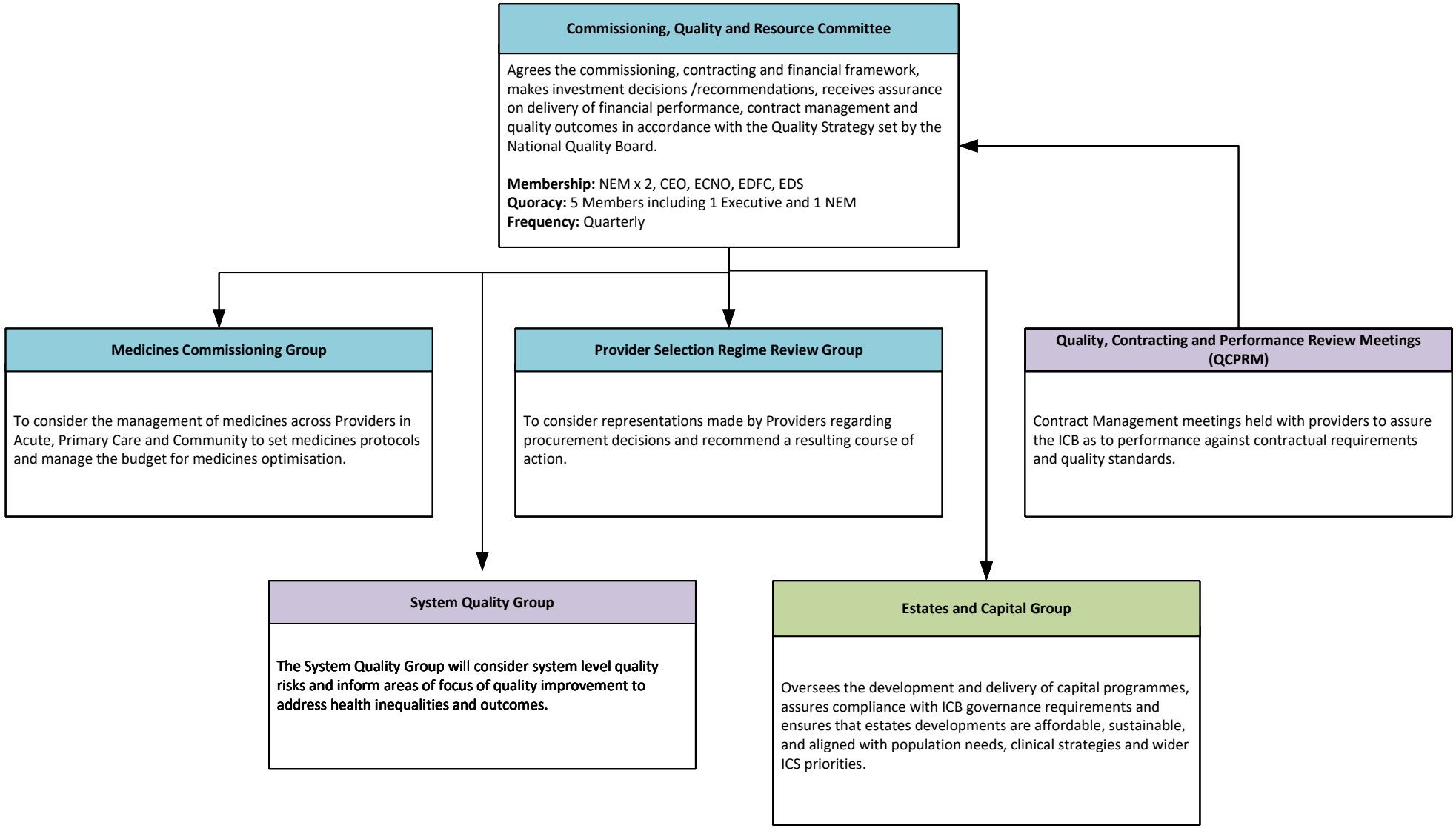
1.2. Scheme of Reservation and Delegation, including Schedule of Detailed Delegated Financial Limits


Key:
Statutory & Assurance
Decision Making
Assurance
Developing Decision Making & Assurance


Audit, Risk and Compliance Committee
Provide oversight and assurance to the Board on the adequacy of governance, risk management and internal control and compliance processes within the ICB, driven by organisational objectives and associated risks.
Membership: Three NEMS
Quoracy: Two NEMS
Frequency: Quarterly +1
Remuneration Committee
Agrees ICB policy on pay/pay framework and recommends Pay, terms and conditions for board members. Provides assurance to the Board on the discharge of this ICB statutory duty.
Membership: Three NEMS
Quoracy: Two NEMS
Frequency: Twice per year, plus ad hoc as required
Health & Safety Group
Responsible for ensuring the ICB is compliant with Health & Safety Legislation and monitoring KPI's such as training, corporate incidents and compliance visits.
Information Governance Steering Group
Providing assurance to the ARCC regarding compliance with the Data Protection and Security Toolkit and associated legislation including the Data Protection Act and Freedom of Information Act.
Non-Executive Member Remuneration Panel
Agrees ICB remuneration for Non-Executive Members.
Membership: CEO, EDFC, ECNO, EMD
Quoracy: 3 Members
Frequency: Ad hoc as required



Note 1: The existing Alliance structures inherited from the former Mid and South Essex, Suffolk and North East Essex, and Hertfordshire and West Essex ICBs will be retained within the Essex ICB for a transition period of up to six months. Maintaining the current arrangements during this period is intentional and ensures that the subsequent restructure is fully informed and appropriately aligned with emerging Neighbourhood Health guidance (pending at the time of publication) and the implications of Local Government Reform. This approach will support a cohesive and well-sequenced transition to the future operating model.


Commissioning, Quality and Resource Committee
Agrees the commissioning, contracting and financial framework, makes investment decisions /recommendations, receives assurance on delivery of financial performance, contract management and quality outcomes in accordance with the Quality Strategy set by the National Quality Board.
Membership: NEM x 2, CEO, ECNO, EDFC, EDS
Quoracy: 5 Members including 1 Executive and 1 NEM
Frequency: Quarterly
Medicines Commissioning Group
To consider the management of medicines across Providers in Acute, Primary Care and Community to set medicines protocols and manage the budget for medicines optimisation.
Provider Selection Regime Review Group
To consider representations made by Providers regarding procurement decisions and recommend a resulting course of action.
Quality, Contracting and Performance Review Meetings (QCPRM)
Contract Management meetings held with providers to assure the ICB as to performance against contractual requirements and quality standards.
System Quality Group
The System Quality Group will consider system level quality risks and inform areas of focus of quality improvement to address health inequalities and outcomes.
Estates and Capital Group
Oversees the development and delivery of capital programmes, assures compliance with ICB governance requirements and ensures that estates developments are affordable, sustainable, and aligned with population needs, clinical strategies and wider ICS priorities.

NHS
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Scheme of Reservation and Delegation

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

- Those functions that are reserved to the Essex Integrated Care Board (ICB) Board
- Those functions delegated by the Board to ICB committees
- Those decisions and functions delegated to be exercised jointly
- Those decisions and functions delegated by the Board to other statutory bodies
- Those decisions and functions delegated by the Board to individual Board Members and employees
- Those decisions and functions delegated to the Board by other statutory bodies
- Those functions, authority and financial levels that have been delegated to an individual or to committees and sub-committees (detailed delegated financial limits)

Essex ICB Board will remain accountable for all of their functions, including those that it has delegated. All those with delegated authority are accountable to the ICB Board.

Decisions and functions reserved to the Board

Functions will be exercised by the Board unless they are delegated. This is the default position for any function that is not expressly delegated. The Board has set out specifically those matters it is choosing to reserve. The Board, regardless of any delegation arrangements it has made, remains legally accountable for the exercise of its functions.

	Decisions and functions reserved to the Board	Reference
The Board	**General Enabling Provision** The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers. The Board will establish the necessary systems and processes to comply with relevant law and regulations, directions issued by the Secretary of State, directions issued by NHS England, statutory guidance and advice issued by NHS England and relevant authorities	Constitution 4.2.2

Scheme of Reservation and Delegation

	Decisions and functions reserved to the Board	Reference
	and respond to reports and recommendations made by Healthwatch organisations in the ICB area.	
The Board	**<u>Regulations and Control</u>** Consider and approve proposed amendments to vary the ICB Constitution by the Chief Executive prior to making an application to vary the constitution to NHSE, in accordance with the associated procedures.	Constitution 1.6.2, Standing Orders 2.1.3, 2.1.4
	Approve Standing Orders (SOs), a schedule of matters reserved to the Board (Scheme of Reservation and Delegation (SoRD)) of powers delegated from the Board to the Executive Team and other Committees, Functions and Decisions Map, Standing Financial Instructions (SFIs) and the Governance Handbook for the regulation of its proceedings and business.	Constitution 1.6.2, 1.7.2, 4.4.2, Standing Orders 2.1.3, 2.1.4
	Approve delegation arrangements to ICB Committees, Joint Committees, to other Statutory Bodies, individual Board Members and employees is reserved to the Board. Including approval of committee terms of reference.	Constitution 4.6.1, 4.6.3, 4.6.6, 4.7.1
	The power to approve arrangements for Pooled Funds is reserved to the Board.	Constitution 4.7.3
	Approve arrangements for the management of conflicts of Interest defined within the Conflicts of Interest Policy, including publication of registers of interest.	Constitution 6.1.1, 6.3.2
	Require and receive the declaration of Board members' (and others as required) interests to discharge its duty to manage conflicts of interest.	Constitution 6.1.3, 6.1.4, 6.1.5, 6.3.1, 6.3.2, 6.3.7
	Approve arrangements for dealing with complaints and ensure a clear complaints process is published.	Constitution 7.2.4

Scheme of Reservation and Delegation

	Decisions and functions reserved to the Board	Reference
	Ensure the ICB Complies with the Freedom of Information Act 2000 and Information Commissioner Office requirements.	Constitution 7.2.5
	Ensure systems and processes exist to comply with the requirements of the NHS Provider Selection Regime.	Constitution 7.3.2, 7.3.3
	Comply with Local Authority Health Overview and Scrutiny Requirements.	Constitution 7.3.4
	Ensure the ICB complies with all relevant procurement regulations (The Procurement Act (2023), Provider Selection Regime and any associated regulations.	Constitution 7.3.5
	Adopt the Executive structure to facilitate the discharge of business by the ICB and to agree modifications thereto except where these functions have been delegated to a Joint Committee.	
	Receive reports from committees including those that the ICB is required by the Secretary of State or other regulation to establish and to action appropriately.	
	Confirm the recommendations of the ICB's committees where the committees do not have executive powers.	
	Approve arrangements relating to the discharge of the ICB's responsibilities as a corporate trustee for funds held on trust, where this might be appropriate.	
	Discipline members of the Board who are in breach of statutory requirements or SOs.	
The Board	**Appointments/Dismissal** Appoint the Ordinary Members of the Board, exercised by the Chair.	Constitution 2.1.5, 2.2.2, 2.2.4

Scheme of Reservation and Delegation

	Decisions and functions reserved to the Board	Reference
	Approve removal of members of the Board (other than the Chief Executive and Executive Members) at the recommendation of the Chair, to be executed by the Chair.	Constitution 3.13
	The Chair of the ICB will be appointed by NHS England as set out within legislation. Appoint and dismiss other committees (and individual members) that are directly accountable to the Board.	Constitution 4.6.1
	Appointment of Internal or External Auditors and the Counter Fraud officer following recommendations from the Audit Committee.	Constitution 4.6.8
The Board	**Strategy, Annual Operational Plan and Budgets** Approve a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years.	Constitution 7.2.8
	Approve and publish an Integrated Care System Plan (Population Health Improvement Plan) and Capital Resource use Plan refreshed annually.	Constitution 7.2.8, 7.4.1
	Define the strategic aims and objectives of the ICB.	
	Oversee and maintain accountability for the management of the ICB Risk Management Framework.	
	Approve plans in respect of the application of available financial resources to support the agreed Annual Operational Plan (Financial Framework and Annual Budgets).	
	Approve annually the [minimum] three-year debt management strategy.	SFI 6.2.6

Scheme of Reservation and Delegation

	Decisions and functions reserved to the Board	Reference
	Approve proposals for ensuring quality and developing clinical governance in services provided by the ICB or its constituent practices (ICB Quality Improvement Strategy), having regard to any guidance issued by the Secretary of State. Approve and publish the ICB Engagement Framework setting out how the ICB complies with and delivers its duties to engage with the public. Approve Outline and Final Business Cases for Commissioning Investment if this represents a variation from the Plan, in line with the ICB SFIs and Schedule of Detailed Delegated Financial Limits.	Constitution 1.4.7 Constitution 9.1.7
The Board	**Policy Determination** Approve ICB Policies, except where delegated to specific committees for approval in accordance with the Committee Terms of Reference.	
The Board	**Audit and Counter Fraud** Receive the annual management letter from the External Auditor and agreement of the Executive Team's proposed action, taking account of the advice, where appropriate, of the Audit Committee. Receive an annual report (and Head of Internal Audit Opinion) from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee. Receive an annual report from the Counter Fraud officer and agree action on recommendations where appropriate of the Audit Committee.	
The Board	**Annual Reports and Accounts** Receive and approve the ICB's Annual Report and Annual Accounts, to be externally audited and published.	Constitution 7.2.3, 7.4.1

Scheme of Reservation and Delegation

	Decisions and functions reserved to the Board	Reference
	Receive and approve the Annual Report and Accounts for funds held on trust, where appropriate.	
The Board	**Monitoring** Receipt of such reports as the Board sees fit from the Executive Team and other committees in respect of its exercise of powers delegated.	

Decisions and functions delegated by the Board to the ICB committees

Committee	Decisions and functions reserved to the Committee	Reference
Audit, Risk and Compliance Committee	The Committee will, in accordance with its terms of reference, as approved by the Board as if written into the Scheme of Reservation and Delegation and ICB Constitution, provide oversight and assurance to the ICB Board on the adequacy of the governance, risk management and internal control processes within the ICB including: - Integrated governance, risk management and internal control - Internal Audit, External Audit, Counter Fraud and other assurance functions - Freedom to Speak Up - Information Governance - Financial Reporting - Statutory Compliance - Conflicts of Interest - Emergency Preparedness, Resilience and Response and Business Continuity - Sustainability - Individual Funding Request process - Management	Constitution 4.6.8 SFIs 6.7 – 6.8, 6.10.2

Scheme of Reservation and Delegation

Committee	Decisions and functions reserved to the Committee	Reference
	The Committee shall have oversight of and responsibility for recommending the governance arrangements to the ICB Board (including the delegation of functions to and from the ICB).	SFI 5.2
	The Committee shall advise the Board on the matters within its remit.	SFI 5.2
	The Committee shall review instances of non-compliance with Standing Orders, Standing Financial Instructions and other key governance documents. This shall include being notified of any retrospective expenditure approval.	Standing Orders 3.1.6 SFI 6.4.10
	The Committee shall be notified of all losses and special payments.	SFI 6.9.5
	The Committee shall approve policies for which it is the sponsoring committee.	
	The Committee shall receive a report of any decisions made using Constitutional provision for 'urgent decisions'.	Standing Orders 4.9.6
Remuneration Committee	The Committee will, in accordance with its terms of reference, as approved by the Board as if written into the Scheme of Reservation and Delegation and ICB Constitution, exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006 and implement NHSE guidance, including: - Determining the remuneration, termination arrangements, recruitment and appraisal process and succession planning of the Chief Executive, Directors and other Very Senior Managers and Board members (other than the Chair and non-executive members). - Agreeing the pay policy and framework, payments outside of Agenda for Change and termination arrangements and special payments (including severance) for all staff groups.	Constitution 3.14.1, 8.1.6

Scheme of Reservation and Delegation

Committee	Decisions and functions reserved to the Committee	Reference
	- Oversee organisational change as it relates to its workforce, including aligning strategy to the 10 Year Workforce Plan and ensuring statutory compliance. - Have oversight of contractual and non-standard arrangements. The Remuneration Committee shall approve policies for which it is the sponsoring committee. The Remuneration Committee shall establish a Non-Executive Remuneration Panel to consider and agree arrangements for remuneration of Non-Executive Members.	Constitution 3.14.1
Non-Executive Remuneration Panel	The Panel will, in accordance with its terms of reference, as approved by the Board as if written into the Scheme of Reservation and Delegation and ICB Constitution exercise the function of setting the remuneration of Non-Executive Members of the Board.	Constitution 3.14.1
Executive Committee	The Committee will, in accordance with its terms of reference, as approved by the Board, as if written into the Scheme of Reservation and Delegation and ICB Constitution provide collective, multi-professional leadership to ensure the effective operation of the ICB and the delivery of its strategic objectives. The Committee acts as the executive decision-making forum of the ICB (within the limits of delegated authority), ensuring that strategic intent is translated into operational delivery, performance improvement, financial sustainability and organisational development. The Committee supports the Board by: - Providing robust executive oversight, scrutiny and stewardship of the ICB's plans, programmes and operational performance; - Driving alignment across the organisation to ensure consistent delivery of strategic priorities, statutory duties and financial responsibilities; - Enabling and empowering the workforce to deliver high-quality, value-driven services and transformation;	

Scheme of Reservation and Delegation

Committee	Decisions and functions reserved to the Committee	Reference
	- Fostering an inclusive, collaborative and high-performing culture across the organisation; and - Ensuring that risks, issues and opportunities are identified, managed and escalated appropriately.	
Commissioning, Quality and Resource Committee	The Committee will, in accordance with its terms of reference, as approved by the Board, as if written into the Scheme of Reservation and Delegation and ICB Constitution, provide oversight and assurance to the Board in relation to the ICBs strategic commissioning, financial stewardship, contracting and quality duties. The Committee will triangulate the ICBs approach to quality, finance and performance, supporting the new role of the ICB as strategic commissioner, providing the Board with clear oversight and assurance that the ICB is meeting its statutory functions by aligning commissioning intent with quality outcomes, financial sustainability and optimal use of resources, and ensuring the delivery of high-quality, value-driven healthcare within the resources available. This includes: - Strategic Commissioning - Quality Governance - Finance and Resources - Capital and Estates - Performance Oversight - Contracting and Market Management - Population Health, Data and Intelligence - Risk Management - Making investment and disinvestment decisions - Investigating any activity within the scope of its terms of reference.	

Scheme of Reservation and Delegation

Committee	Decisions and functions reserved to the Committee	Reference
	The Committee will provide oversight and assurance that the ICB is delivering its functions in a manner that secures continuous improvement in the quality of services, in line with statutory duties (including section 14Z34 of the Health and Care Act 2022) and the nationally-defined dimensions of quality. This includes alignment with the expectations for ICB quality oversight within the Strategic Commissioning Framework, which emphasises monitoring quality outcomes across commissioned services and embedding quality in commissioning, contracting and evaluation processes. This shall be reported within the ICB Annual Report. The committee is responsible for the development, monitoring and implementation of the ICB's Quality Improvement Strategy, which sets out its plan for quality, safety, governance, learning and improvement across all commissioned services. The Committee will assure the Board that quality, safety and performance standards are met and that improvement plans are effective and sustainable. The Committee shall approve policies for which it is the sponsoring committee, including those relating to commissioning, quality governance, contracting, procurement oversight, resource stewardship and associate areas. The Committee has established sub-groups for the oversight of contract management, medicines management, quality improvement, commissioning and estates prioritisation and for processing appeals to procurement decisions made under the Provider Selection Regime. Sub-groups will act within their approved terms of reference and may not take decisions reserved to the Committee or the Board.	Constitution 7.4.1

Scheme of Reservation and Delegation

Committee	Decisions and functions reserved to the Committee	Reference
Neighbourhood Health Committee	The Committee will, in accordance with its terms of reference as approved by the Board, as if written into the Scheme of Reservation and Delegation and ICB Constitution, provide oversight and assurance to the ICB Board on the development, commissioning, delivery and governance of Neighbourhood Health models across Essex. The Committee's responsibilities reflect national policy for neighbourhood health, which requires integrated local delivery models involving NHS, local authorities, social care, public health and community partners to improve access, experience and outcomes. The Committee will: - Oversee the development and implementation of Neighbourhood Health Plans. - Provide oversight of neighbourhood-level service models. - Oversee and receive assurance on the development and functioning of Integrated Neighbourhood Teams (INTs). - Provide oversight of primary care commissioning functions. - Provide oversight of Health Inequalities and Prevention work. - Ensure alignment of Neighbourhood Health development with Section 75 and Better Care Fund governance. - Receive assurance on neighbourhood performance, including outcomes, access, experience, integration metrics and progress against national implementation expectations. - Investigate any activity within the scope of its terms of reference. The Committee has specific delegated responsibility for managing the ICB element of the Better Care Fund (BCF) and associated iBCF investment, in accordance with the schedule of detailed financial delegated limits.	

Scheme of Reservation and Delegation

Committee	Decisions and functions reserved to the Committee	Reference
	The Committee shall approve policies for which it is the sponsoring committee, including those relating to neighbourhood governance, integration, primary care neighbourhood alignment, and prevention and inequalities frameworks. The Committee has established sub-groups for the oversight of primary care commissioning / contract management, health inequalities and prevention and Alliance working. Five Alliances have been established namely Basildon and Brentwood Alliance, Mid Essex Alliance, North East Essex Alliance, South East Essex Alliance, and Thurrock Alliance (the Health and Care Partnership (West Essex Alliance) as a sub-committee of Princess Alexandra Hospital, will report into this committee). The purpose of which is to create opportunities for the benefit of residents of the Alliances in accordance with Alliance Plans, to support health and wellbeing, bring care closer to home and to improve and transform services, undertaking appropriate local engagement and propose, co-ordinate and deliver local elements of the estates strategy. Sub-groups will act within their approved terms of reference and any specific delegation made to them as part of this document, but may not take decisions reserved to the Committee or the Board.	

Scheme of Reservation and Delegation

Decisions and functions delegated to be exercised jointly

Committee/entity that will exercise the function/decision	Decisions and functions delegated by the Board	Legal power	Governing arrangements
ICB/Essex County Council	**Better Care Fund** In accordance with Section 75 of the 2006 Act as amended the ICB and Council have entered into arrangements to established pooled budgets for the purpose of discharging the duties set out within the Act. All governance arrangements are defined within Section 75 Agreements as if written into the SORD.	Section 75, NHS Act 2006	Section 75 Agreement
ICB/Thurrock Council	**Better Care Fund** In accordance with Section 75 of the 2006 Act as amended the ICB and Council have entered into arrangements to established pooled budgets for the purpose of discharging the duties set out within the Act. All governance arrangements are defined within Section 75 Agreements as if written into the SORD.	Section 75, NHS Act 2006	Section 75 Agreement
ICB/Southend Council	**Better Care Fund** In accordance with Section 75 of the 2006 Act as amended the ICB and Council have entered into arrangements to established pooled budgets for the purpose of discharging the duties set out within the Act. All governance arrangements are defined within Section 75 Agreements as if written into the SORD.	Section 75, NHS Act 2006	Section 75 Agreement

Scheme of Reservation and Delegation

Decisions and functions delegated by the Board to other statutory bodies

Body	Decisions and functions delegated by the Board	Legal power	Governing arrangements
Central East Integrated Care Board	For the operational management of the following services as defined within supporting delegation agreements / memorandum of understanding, as approved by the Board as if written into the Scheme of Reservation and Delegation: - Community Pharmacy and Optometry Contract Management - Children and Young People Mental Health Services	S65Z5 of the 2006 Act	Memorandum of Understanding and delegation agreement. Children's Commissioning Collaborative Agreement via the Executive Children's Commissioning Collaborative Forum.
Norfolk and Suffolk Integrated Care Board	For the operational management of the following services as defined within supporting delegation agreements / memorandum of understanding, as approved by the Board as if written into the Scheme of Reservation and Delegation: - Specialised commissioning of services not retained by NHS England. - Contract management of the East of England Ambulance Service NHS Trust	S65Z5 of the 2006 Act	Memorandum of Understanding and delegation agreement. Collaborative working agreement for

Scheme of Reservation and Delegation

Body	Decisions and functions delegated by the Board	Legal power	Governing arrangements
			specialised services.

Decisions and functions delegated by the Board to individual Board Members and employees

Board Member / employee	Decisions and functions delegated by the Board	Reference
Chair	**<u>Regulations and Control</u>**	
	Authenticate use of the seal.	Standing Orders 6.1.3
	Suspend Standing Orders in conjunction with 2 other Board members.	Standing Orders 5.1.1
	In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from the relevant Director, will provide a settled view which shall be final.	Standing Orders 3.1.4
	To call meetings of the Board and preside over Board meetings.	Standing Orders 4.1.2, 4.2.1
	In conjunction with the Chief Executive (or relevant lead Director in the case of committees) and one other member, make an urgent decision on behalf of the Board/Committee.	Standing Order 4.9.5
	Discipline members of the Board (other than Executive Directors) who are in breach of statutory requirements or SOs.	
	<u>Appointments/Dismissal</u>	
	Appoint the Chief Executive of the ICB subject to the approval of NHS England.	Constitution 3.4.1

Scheme of Reservation and Delegation

Board Member / employee	Decisions and functions delegated by the Board	Reference
	Approve the appointments of the Partner Members of the Board.	Constitution 2.2.1, 3.5.4, 3.6.5, 3.7.4
	Approve the appointment of Executive Members of the Board.	Constitution 2.1.5, 2.2.2, 3.8.2, 3.9.3, 3.10.3, 3.12.3
	Approve the appointment or re-appointment of Non-Executive Members of the Board.	Constitution 3.11.2
	Appoint the Vice Chair of the Board and a Senior Non-Executive Member.	Constitution 3.11.8, 3.4
	Approve appointment of members of any committee	Constitution 4.6.6; Standing Orders 4.2.3
	With the exception of the Executive Board Members, suspend or terminate members of the Board, as approved by the Board.	Constitution 3.13.3
Chief Executive Officer (CEO)	**Regulations and Control** Propose amendments to the Constitution to be considered and approved by the ICB prior to making an application to vary the Constitution to NHS England.	Constitution 1.6.2, Standing Orders 2.1.3, 2.1.4
	Establish a procedure for the use of the seal and keep (or nominate a manager to keep) the seal secure.	Standing Orders 6.1.1, 6.1.3
	Propose to the Board the adoption of the Executive structure to facilitate discharge of ICB business.	

Scheme of Reservation and Delegation

Board Member / employee	Decisions and functions delegated by the Board	Reference
	Discipline the Executive Director members of the Board who are in breach of statutory requirements or SOs.	
	Appointments/Dismissal	
	Subject to the approval of the ICB Chair, appoint the Partner Members of the Board.	Constitution 3.5.4, 3.6.5, 3.7.4
	Subject to the approval of the ICB Chair, appoint the Executive Members of the Board.	Constitution 3.8.2, 3.9.3, 3.10.3, 3.12.3
	Subject to the recommendation of the selection panel, approve the appointment of the Non-Executive Members and their re-appointment (within the limit of terms of office)	Constitution 3.11.2, 3.11.7
	Statutory Functions / Duty	
	In accordance with section 252A of the 2006 Act (as amended) act as the Accountable Emergency Officer (AEO) and Gold Commander for responding to Emergency Planning Resilience and Response events and declared incidents. This may as required be delegated to an appropriate Executive Director.	
	Operational Responsibilities	
	To approve and be the signatory of delegation agreements on behalf of the ICB.	
	Ensure there is appropriate Internal Audit provision within the ICB for which the Executive Director of Finance and Commercial will have operational responsibility.	SFI 6.7
	To be the lead Executive Officer for the Executive Committee ensuring appropriate escalations to the ICB Board.	

Scheme of Reservation and Delegation

Board Member / employee	Decisions and functions delegated by the Board	Reference
Executive Director of Finance & Commercial (EDFC)	**Regulations and Control** Authenticate use of the seal.	Standing Orders 6.1.3
	Develop systems and processes to comply with the requirements of the NHS Provider Selection Regime.	Constitution 7.3.2, 7.3.3
	Establish processes to ensure compliance with all relevant the Procurement Act (2023), Provider Selection Regime and any associate regulations.	Constitution 7.3.5
	Annual Reports and Accounts Preparation of the annual accounts and accounting tables within the Annual Report in accordance with relevant guidance and regulations, including those for funds held on trust. Submit an annual assurance statement regarding losses and special payments, ensuring robust reporting to the audit, risk and compliance committee.	Constitution 7.2.3 SFI 6.6, 6.9
	Arrange for annual accounts to be externally audited and published. This includes the appointment of an auditor in accordance with the Audit and Accountability Act 2014.	SFI 6.8
	Statutory Functions / Duty Ensure systems are in place to deliver the financial duties of the ICB (Sections 223GB, 223N, 223H and 223 J). Including establishing the annual budget and budget management processes.	Constitution 1.4.7, 7.2.8
	Develop the Capital Resource Use Plan for approval by the Board and report how the ICB has exercised its functions in accordance with the Plan within the Annual Report.	Constitution 7.4.1 SFI 6.11
	Operational Responsibilities	

Scheme of Reservation and Delegation

Board Member / employee	Decisions and functions delegated by the Board	Reference
	To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation, and best practice: Financial planning and analysis; operational finance (including operation of a finance system and debt management); governing and managing the execution of grants; contracting and procurement as defined under Health Care Services (Provider Selection Regime) Regulations 2023; Purchase of Non-Healthcare as defined under Procurement Act 2023 and transitional arrangements as defined in the Procurement Act (Commencement No. 3 and Transitional and Saving) Regulations 2025, and the Procurement Act 2023 (Commencement No.3 and Transitional and Saving Provisions) (Amendment) Regulations 2024; estates delivery and capability building; financial improvement;.	SFIs 6.1, 6.2, 6.3, 6.7, 6.11
	On behalf of the Chief Executive Officer, ensure that internal audit services are robust, have an internal audit charter, comply with the Public Sector Internal Audit Standards and provide a head of internal audit opinion	SFI 6.7
	To be the joint-lead Executive Officer ensuring appropriate advice and explanations are provided to the Commissioning, Quality and Resource Committee.	
	To be the Senior Information Risk Owner (SIRO) for the ICB.	
	Maintain and refresh (where appropriate and subject to approval of the Board) the Schedule of Detailed Delegated Financial Limits.	
	Establish and maintain the financial framework of the ICB as defined within Standing Financial Instructions as if written into the SoRD.	
	Respond to the annual management letter from External Audit preparing proposed actions for to present to the Board after review by the Audit Committee.	

Scheme of Reservation and Delegation

Board Member / employee	Decisions and functions delegated by the Board	Reference
	Ensure appropriate arrangements are in place for the provision of counter fraud services. The Executive Director of Finance and Commercial may temporarily delegate functions to be undertaken in their absence to an appropriate deputy. To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	SFI 6.10
Executive Medical Director	**Operational Responsibilities** To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice: Clinical leadership, clinical operations, individual funding requests, medicines management, utilisation management, clinical effectiveness, research and development and innovation; Stewardship. To be the lead Executive Officer ensuring appropriate advice and explanations are provided to the Clinical & Professional Congress. To ensure that adequate processes are in place for the management of Specialised Commissioning as delegated by NHS England, providing assurance in that regard to the Board. To oversee, review, advise upon and recommend changes to service restriction policies for approval by the Executive Team or wider committees / Board accordingly. To act as the Freedom to Speak Up Guardian. To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	

Scheme of Reservation and Delegation

Board Member / employee	Decisions and functions delegated by the Board	Reference
Executive Chief Nursing Officer	**Strategy, Annual Operational Plan and Budgets** Develop and propose to the Board the ICB Quality Improvement Strategy. **Statutory Functions / Duty** Ensure systems are in place to deliver improvement in quality of services (Section 14Z34) and report on the discharge of these duties within the Annual Report. Establish and publish clear arrangements for dealing with complaints in accordance with the Complaints Regulations including publishing an annual complaints report. **Operational Responsibilities** To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice: Patient Safety; Complaints; Infection Prevention and Control; Care Education and Treatment Reviews, Special Education Needs and Disabilities; Safeguarding and All Age Continuing Care (including Individual Placements Team); Strategic Commissioning for Children and Young People and Learning Disability and Autism. To act as the Board designated lead (and supported by other Executive Officers) for: - Children and young people (aged 0-25) - Children and young people with special education needs and disabilities (SEND). - Safeguarding (all-age), including looked after children. - Learning disability and autism (all-age). - Down syndrome (all-age). To manage the commissioning Teams responsible for Mental Health and Babies, Children and Young People services focussing on workstreams to oversee contractual performance (alongside the quality Team) and work collaboratively for service transformation.	Constitution 1.4.7, 7.2.8, 7.4.1 Constitution 7.2.4

Scheme of Reservation and Delegation

Board Member / employee	Decisions and functions delegated by the Board	Reference
	To be the joint-lead Executive Officer ensuring appropriate advice and explanations are provided to the Commissioning, Quality and Resource Committee. To act as the Caldicott Guardian and the Designated Safeguarding Lead. To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	
Executive Director of Corporate Services	**Strategy, Annual Operational Plan and Budgets** Develop and present to the Board for approval, proposals for organisational development. Develop and present to the Board for approval, the Equality and Diversity Strategy; having overarching responsibility for the delivery of employer responsibilities for equality, diversity and inclusion (and associated national reporting) as well as the co-ordination of wider equality, diversity and inclusion responsibilities delivered by the Strategy, Quality and Neighbourhood Health Directorates. Lead the development and delivery of a people strategy to deliver the requirements of the 10-year workforce plan (due 2026). Lead on the development and delivery of an Organisational Development strategy/plan to support the achievement of organisational vision, objectives, strategies and plans. **Regulations and Control** Ensure processes are in place to comply with Local Authority Health Overview and Scrutiny Requirements. Report urgent decisions to the Board for ratification.	SFI 6.5 Constitution 7.3.4 Standing Order 4.9.6

Scheme of Reservation and Delegation

Board Member / employee	Decisions and functions delegated by the Board	Reference
	Annual Reports and Accounts Preparation of the Annual Report in accordance with relevant guidance and regulations.	Constitution 7.4.1
	Statutory Functions / Duties In accordance with section 14Z30(2) of the 2006 Act establish systems and processes (defined within the Standards of Business Conduct Policy (including the management of conflicts of interest) to manage conflicts of interest (including gifts and hospitality) and publish the registers of interest on the ICB website.	Constitution 6.1.3, 6.1.4, 6.1.5, 6.3.1, 6.3.2, 6.3.7
	To ensure that key governance documentation (Constitution, Standing Orders, Governance Handbook, Register of Interests and other key documents and policies as appropriate) are considered annually, reviewed and updated as necessary and published on the ICB website.	Constitution 7.2.7, Standing Orders 2.1.2
	Publish agenda's, papers and minutes for meetings held in public, including details about meeting dates, times and venues.	Constitution 7.2.2; Standing Orders 4.1.4, 4.3.3
	Ensure adequate arrangements are in place to govern Board and Committee meetings in accordance with the Constitution, Standing Orders and best practice, including the development of committee terms of reference.	Constitution 4.6.3, 4.6.6; Standing Orders 4.10, 4.11
	In accordance with section 14Z45 of the Act establish processes for public involvement and consultation in relation to commissioning arrangements and report on the discharge of these duties within the Annual Report; ensuring the ICB meets the ten principles set out by NHSE for working with people and communities.	Constitution 1.4.7, 7.2.8, 7.4.1, 9.1.1, 9.1.2, 9.1.3
	In accordance with section 116B(1) of the Local Government and Public Involvement in Health Act 2007 ensure that due regard is given to assessments and strategies.	Constitution 1.4.7

Scheme of Reservation and Delegation

Board Member / employee	Decisions and functions delegated by the Board	Reference
	Ensure systems are in place to reduce inequalities (Section 14Z35) and report on the discharge of these duties within the Annual Report.	Constitution 1.4.7, 7.2.8, 7.4.1
	In accordance with section 14Z38 of the Act establish arrangements for obtaining appropriate advice.	Constitution 1.4.7
	In accordance with section 14Z43 of the Act meet the duty to have regard to wider effect of decisions and report of the discharge of this duty within the Annual Report.	Constitution 1.4.7, 7.2.8, 7.4.1
	In accordance with section 116B(1) of the Local Government and Public Involvement in Health Act 2007 ensure that due regard is given to assessments and strategies.	Constitution 1.4.7
	Operational Responsibilities To be the lead Executive Officer ensuring appropriate advice and explanations are provided to the Audit Committee.	
	To be the lead Executive Officer ensuring appropriate advice and explanations are provided to the Remuneration Committee.	
	To have oversight of and ensure the correct functioning of the ICB and its Committees.	
	Ensure that non-compliance with Standing Orders are reported to the next formal meeting of the Board for action or ratification.	Standing Orders 3.1.6
	Establish a robust system for the management of risk (including defining the strategic aims and objectives; identify, evaluate and report on risks, establishment of a risk management policy).	

Scheme of Reservation and Delegation

Board Member / employee	Decisions and functions delegated by the Board	Reference
	Management the policy framework of the ICB ensuring that policies are reviewed, updated and approved in a cyclical manner.	
	To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice: Human Resources (ICB internal function), including the operation of a payroll system and the governance framework that supports the ICBs employees' life cycle; designed to fulfil the ten designated people functions.	SFI 6.5
	Ensure the ICB discharges its responsibilities to lead the ICS Engagement Framework.	Constitution 9.1.7
	To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	
	To act, on behalf of the Chief Executive, as the Emergency Accountable Officer.	
	To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice: Governance (including Board, Legal, Information Governance, Health & Safety, sustainability); Communications; the Delivery Unit; People Services; Digital, and IT; Emergency Planning Resilience and Response; Business Support; response to the Lampard Inquiry.	
	To ensure that adequate arrangements are in place for the management of claims and legal matters, including ensuring the arrangement of adequate insurance via NHS Resolution (e.g., Public Liability, Clinical Negligence Schemes for Trusts, Liabilities to Third Party Scheme, Property Expenses Scheme).	SFI 6.12
	To undertake the role of Chief Information Officer. To ensure the ICB complies with legislation and guidance related to the protection of data, working alongside the SIRO and Caldicott Guardian.	

Scheme of Reservation and Delegation

Board Member / employee	Decisions and functions delegated by the Board	Reference
	Establish adequate arrangements to discharge ICB duties in relation to the Freedom of Information Act 2000 and Information Commissioner Office requirements. To provide the operational services for Corporate IT and Primary Care Digital Services. To work collaboratively with partners to deliver the digital transformation agenda and national asks. To provide ongoing assurance of cybersecurity, business continuity, privacy, and data protection. To ensure the efficient collection, and the timely and appropriate distribution of information to support operational and strategic decisions.	Constitution 7.2.5
Executive Director of Strategy	**Operational Responsibilities** To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice: ICB Strategy: Community Resilience and Mobilisation; contribute to the development of a successful ICP and Strategic Partnerships. To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice: Business Intelligence and Analytical Unit; Population Health Management; Strategy, Strategic Commissioning for Acute and Mental Health Services. To act, on behalf of the Chief Executive, as the Emergency Accountable Officer. **Strategy, Annual Operational Plan and Budgets** Develop and publish a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years.	Constitution 7.2.8

Scheme of Reservation and Delegation

Board Member / employee	Decisions and functions delegated by the Board	Reference
	Develop the Integrated Care System Plan for approval by the Board reviewing, within the annual report, the extent to which the ICB has exercised its functions.	Constitution 7.2.8
Executive Director of Neighbourhood Health	**Operational Responsibilities** To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice at place: Neighbourhood Health Development; Partnership Working with Local Authority and Voluntary, Charity, Faith and Social Enterprise; health Inequalities; Primary Care Training Hub; Strategic Commissioning (including Primary Care; Pharmacy, Optometry and Dental; Vaccinations and Community Services. Be accountable for delivery of Alliance Plans and the ICB element of the Better Care Fund and the way in which BCF funds are utilised. To be the lead Executive Officer ensuring appropriate advice and explanations are provided to Alliances and the ICB. Being responsible for local partnership working, engagement with communities and the delivery of public health, early intervention models of prevention. To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	
Audit Committee Chair	To act as the Conflicts of Interest Guardian.	Constitution 6.1.6
On Call Director	To fulfil the duties required as set out by the Emergency Planning Team for managing escalations, incidents and out of hours cover as set out within associated ICB Policies.	

Scheme of Reservation and Delegation

Board Member / employee	Decisions and functions delegated by the Board	Reference
Budget Holders	To fulfil budget holder duties as set out within the Standing Financial Instructions and in accordance with the delegated limits set out within. To be accountable for and sign contracts within their budgetary remit (Directors and above), where approval for the contracted service is complete in accordance with this scheme of reservation and delegation e.g. The Director of Primary Care signing primary care contracts.	

Scheme of Reservation and Delegation

Decisions and functions delegated to the Board by other statutory bodies

Body making the delegation	Decisions and functions delegated to the Board	Reference
NHS England	In accordance with its statutory powers under section 65Z5 of the NHS Act, NHS England have delegated the exercise of Delegated Functions (for Primary Medical Services, Pharmacy, Optometry and Dentistry and Specialised Services) to the ICB to commission a range of services for the people of the area as follows: • Decisions in relation to the commissioning, and management of Primary Medical Services, Pharmacy, Optometry and Dentistry. • Planning Primary Medical Services, Pharmacy, Optometry and Dentistry in the Area, including carrying out needs assessment. • Undertaking review of Primary Medical Services, Pharmacy, Optometry and Dentistry in respect of the Area. • Management of Delegated Funds in the Area. • Co-ordinating a common approach to the commissioning and delivery of Primary Medical Services, Pharmacy, Optometry and Dentistry with other health and social care bodies in respect of the Area where appropriate; • For the operational management of those specialised services delegated by NHS England; and • Such other ancillary activities that are necessary in order to exercise the Delegated Functions. Such arrangements have been set out in the 'delegation agreement' and shall prevail as if written into the SORD.	Delegation Agreement (Primary Care). Delegation Agreement for Specialised Services.
Central East Integrated Care Board and Norfolk and Suffolk	Home Oxygen Service – the ICB shall act as lead commissioning on behalf of the East of England ICBs	Memorandum of Understanding

Scheme of Reservation and Delegation

Body making the delegation	Decisions and functions delegated to the Board	Reference
Integrated Care Board		

Scheme of Reservation and Delegation

Schedule of Detailed Delegated Financial Limits

Provision	Who can authorise	Notes
1. Virements		
a. Within cost centre	Budget Holders	Note 1
b. Between cost centre in same directorate	Budget Holders	Note 1
c. Between cost centre in different directorate	Executive Directors	
d. New allocations (specified use)	Executive Directors	Or Senior Finance Manager
e. New allocations (general)	Executive Directors	Or nominated deputy

Scheme of Reservation and Delegation

Provision		Who can authorise	Notes
2. Approval Limits for committing expenditure and service contracts, including variation of contracts, but excluding staff pay costs (see notes 2 & 3)			*Business cases to be presented in accordance with the Decision Making Policy.*
a. Within existing agreed budgets			
i.	< £250,000 (and within budget holder limits)	Budget Holders	Note 1
ii.	< £500,000	Executive Director	
iii.	£500,000 - £15,000,000	Executive Committee	Note 5
iv.	£15,000,000 - £30,000,000	CQR Committee	
v.	> £30,000,000	ICB Board	
b. In-year proposals with no budgetary provision			
i.	< £5,000,000	Executive Committee	
ii.	£5,000,000 - £15,000,000	CQR Committee	
iii.	> £15,000,000	ICB Board	
c. Approval of invoices within approved contract values:			
i.	< £1,000,001	Budget Holders	Note 1
ii.	£1,000,001 - £15,000,000	Executive Director	
iii.	£15,000,000 - £50,000,000	Executive Director of Finance and Commercial	Or Associate Director of Finance
iv.	> £50,000,000 to NHS providers with Essex system	Executive Director of Finance and Commercial	Or Associate Director of Finance
v.	> £50,000,000 with other providers	Executive Director of Finance and Commercial	

Scheme of Reservation and Delegation

Provision	Who can authorise	Notes
d. Approval of expenditure greater than tender price / business case. Subject to remaining within approval and tender limits identified above		
i. < 10% of approved tender	Chief Executive Officer or Executive Director of Finance and Commercial	
ii. > 10% of approved tender or business case would require review of need and affordability in accordance with the business case process identified in 2 (above).	Follow the limits as per business case section 2. Above.	
e. Approval of ICB Capital investment *Where there is a revenue implication of capital investment approval will also need to be via a and b above.*		Capital investment relating to Primary Care to be endorsed by NH Committee prior to seeking approvals as below.
i. < £250,000	Executive Director	Director of Estates
ii. < £500,000	Executive Director of Finance and Commercial	
iii. £500,000 - £2,500,000	Estates and Capital Group	
iv. £2,500,000 - £5,000,000	Executive Committee	
v. £5,000,000 - £10,000,000	CQR Committee	
vi. > £10,000,000	ICB Board	

Scheme of Reservation and Delegation

Provision	Who can authorise	Notes
3. Quotation, tendering and contract procedures for expenditure / income proposals, whether capital or revenue, purchases or disposals of non-clinical services / products procured in accordance with the Procurement Act (2023)	*To clarify, these limits relate to contracts where the ICB is the contracting authority. Where another system partner is the contracting authority, that organisations limits and processes will apply.*	The value of the goods and services should be the total contract value, not the annual value and should be inclusive of fees but exclusive of VAT. Where the number of years is not specified or is open ended from year to year, a 3-year period should be assumed for the purpose of this calculation).
a. £501 - £5,000 (minimum of 2 verbal quotations)	Budget Holders	Note 1
b. £5,001 - £50,000 (minimum 3 written quotations)	Budget Holders	Note 1
c. NON-CLINICAL GOODS / SERVICES (inc VAT)		
i. £50,001 - £207,720	Executive Director	Note 4
ii. > £207,720	Executive Director	Note 6
d. CLINICAL GOODS / SERVICES (inc VAT)		
iii. £50,001 - £663,540	Executive Director	Note 1
iv. < £663,540	Executive Director	
e. Waiving of quotations and tenders subject to SOs and SFIs	Executive Director of Finance and Commercial	All waivers to be reported to Audit Committee.

Scheme of Reservation and Delegation

Provision	Who can authorise	Notes
4. Arrangements for the discharge of responsibilities under the Health Care Services (Provider Selection Regime) Regulations 2023.	*All provisions set out below may be authorised in accordance with the thresholds set out under section 2.*	
a. Complete and approve direct award without competition	Executive Directors	Or Budget Holders or Attain
b. Approval of 'most suitable provider'	Executive Directors	Or Budget Holders or Attain
c. Approval of PSR competitive process	Executive Directors	Or Budget Holders or Attain
d. Review and response to Provider representations	Provider Selection Regime Review Group	
e. Secondary review subsequent ICB response to Provider representations	NHS England Independent Panel	

Scheme of Reservation and Delegation

Provision	Who can authorise	Notes
5. Management of Budgets/Expenditure for Staff Pay, Agency and Consultancy		
a. Engagement of staff not on the Establishment (within available budget and full year cost) – costs per employee:		
i. > £50,001	Executive Director	
ii. £50,001 - £100,000	Chief Executive Officer or Executive Director of Finance and Commercial	Prior approval required from NHSE for contract appointments
iii. £100,001 - £250,000	Chief Executive Officer AND Executive Director of Finance and Commercial	Prior approval required from NHSE
iv. > £250,001	Chief Executive Officer AND Executive Director of Finance and Commercial Reported to Remuneration Committee for information and scrutiny EXCEPT, if the appointment relates to CEO or CFO (in iii or iv above) the process will be reviewed by Remuneration Committee and recommended to the ICB Board for approval.	Prior approval required from NHSE
v. IN ADDITION, for the recruitment agency / contract staff, all contract with either a total value of £50,000 or above, a day rate of £600 or greater and/or contracts that exceed 6 months.	> £600 per day – NHSE Regional Rep > £800 per day – NHSE CFO > £900 per day – NHSE Regional & National	Require NHSE prior approval.

Scheme of Reservation and Delegation

Provision	Who can authorise	Notes
6. Signing of Contracts, Contract Variations and Leases		
a. Signing of contracts (including Grants, MOUs and LOAs) where due process has been followed i.e. procurement / funding approved / business case processes (as evidence in the contract governance form).	Budget Holders, or Executive Directors, or Executive Director of Finance and Commercial, or Chief Executive Officer.	Note 1
b. Signing of contracts or documentation related to services that are delegated to another ICB to deliver on behalf of Essex ICB.	Executive Directors	
c. Signing of Leases	Chief Executive Officer Executive Director of Finance and Commercial Executive Director of Corporate Services	In accordance with the procedure for use of the Seal

Scheme of Reservation and Delegation

Provision	Who can authorise	Notes
7. Neighbourhood Health Committee / Primary Care Commissioning		
a. Investment in Primary Care Contractors (General Medical Services, Pharmacy, Optometry and Dentistry) within existing budgets or nationally defined entitlement:		
vii. < £250,000	Budget Holders	Director of Primary Care
viii. < £500,000	Executive Director for Neighbourhood Health or Director of Primary Care	
ix. £500,000 - £10,000,000	Executive Committee	
x. £10,000,000 - £30,000,000	CQR Committee	Note 5
xi. > £30,000,000	ICB Board	
b. Investment in Primary Care Contractors (General Medical Services, Pharmacy, Optometry and Dentistry) outside of existing budget:		
iv. < £5,000,000	Executive Committee	Providing endorsement from Executive
v. £5,000,000 - £20,000,000	CQR Committee	
vi. > £20,000,000	ICB Board	
c. Investment in Primary Care outside of contractual entitlements will require the relevant business case and financial approvals process described in sections 2 and 5 to be followed.	As per business case process (and reported back to the Primary Care Commissioning Committee.	Providing initial endorsement from NH Committee

Scheme of Reservation and Delegation

Provision	Who can authorise	Notes
8. Better Care Fund (see note 4)		
a. Approval of the ICB element of BCF investment within existing budgets:		
i. < £250,000	Executive Directors	
ii. £250,000 - £1,000,000	Executive Director of Neighbourhood Health AND Executive Director of Finance and Commercial	
iii. £1,000,000 - £3,000,000	2 x Executive Directors **AND** Executive Director of Finance and Commercial or Chief Executive Officer	
iv. > £3,000,000	To follow section 2 above.	
b. Approval of the ICB element of BCF investment outside of existing budgets.	To follow section 2 above.	

Scheme of Reservation and Delegation

Provision	Who can authorise	Notes
9. Continuing Healthcare		
a. Approving Continuing Healthcare packages of care:		
i. Up to agreed standard rate per week	CHC Business Manager	
ii. Up to annual equivalent £100,000	Operational Lead	
iii. Up to annual equivalent £150,000	Head of CHC / Deputy Chief Nurse	
iv. Over annual equivalent £200,000	Executive Director of Nursing	
b. Patient Transport (journeys outside of contract)	Any posts identified in 9a.	

Scheme of Reservation and Delegation

Provision	Who can authorise	Notes
10. Losses, Write Off and Compensation		
a. Losses due to theft, fraud, overpayment, fruitless payments, non-contracted activity, compensation payments:		
i. < £5,000	Executive Director of Finance and Commercial **OR** Chief Executive Officer	
ii. £5,000 - £25,000	Executive Director of Finance and Commercial **AND** Chief Executive Officer	
iii. £25,000 - £100,000	ICB Board	
iv. > £100,000	ICB Board	And reported to NHSE at year-end
b. Redress payments made in respect of Continuing Healthcare costs (except for routine reimbursement of care costs incurred due to delay in package set-up over permitted 20 days):		
i. < £10,000	Chief Executive Officer **OR** Executive Director of Finance and Commercial **AND** Executive Chief Nursing Officer	
ii. > £10,000	Chief Executive Officer **AND** Executive Director of Finance and Commercial **AND** Executive Chief Nursing Officer	
c. Write off of non-NHS debtors:		*All instances of losses or write off will be reported to the audit committee.*
i. < £500	Executive Directors	
ii. > £500	Chief Executive Officer **OR** Executive Director of Finance and Commercial	

Scheme of Reservation and Delegation

Provision	Who can authorise	Notes
d. Special severance or retention payments	Reserved by NHS England	

Scheme of Reservation and Delegation

Notes:

1. Limits for Budget Holders will be set on a case-by-case basis up to the maximum limits shown in the schedules.
2. Approval limits include commitment of expenditure (approval of business cases), authorising requisitions / order / invoice and the signing of contracts and grants.
3. Approval of commitment of expenditure relates to the total and aggregate value of any contracts over its full term.
4. At least 4 written quotations. Competitive quote procedure with a written specification and a detailed option appraisal.
5. Matters relating to Primary Care will follow the route set out at provision 7 within the detailed delegated financial limits.
6. Full application of the Procurement Act 2023. Must follow an appropriate procedure under the Procurement Act 2023 (open or competitive flexible). Seek support from the ICB's Procurement Advisors regarding the appropriate procedure.

Scheme of Reservation and Delegation

Definitions:

Full Title	Short Title	Description
Executive Directors	Exec Dir	All Executive Directors of the ICB with a line report to the Chief Executive Officer
ICB Chief Executive Officer	CEO	
Executive Director of Finance and Commercial	EDFC	The ICB Executive Director of Finance & Commercial
Executive Medical Director	EMD	The ICB Executive Medical Director
Executive Chief Nursing Officer	ECNO	The ICB Executive Director of Nursing
Deputy Director of Finance	DDoF	Named Directors and Deputy Directors of Finance within the Finance and Estates Directorate
Director of Primary Care	Dir PC	Director of Primary Care
Deputy Director for Primary Care Development	DD PC	Deputy Director for Primary Care Development
Deputy Chief Nursing Officer	Deputy CN	The ICB Director of Nursing reporting to the CN.
Head of Continuing Healthcare	Head of CHC	The Deputy Director for All Age Continuing Care
Continuing Healthcare Business Manager	CHC Business Manager	Nominated CHC Business Managers, CHC team to maintain register.
Operational Lead	Operational Lead	Nominated CHC Operational Leads. CHC team to maintain a register.
Budget Holder	Budget Holder	Any nominated budget holder. The limits in this SoDDFL are the maximum limits. Each budget holder will be granted a specific limit based on need and responsibility, see note 1.
Senior Finance Manager	SFM	Deputy Directors of Finance or their line reports. For allocation of new budget allocations (virements) where the use is specified and thus no decision on which are area the funding is to be allocated to is needed.
Nominated Deputy	ND	A deputy can be nominated by the authorising officer.
Committee Name:		
The ICB Board	Board	
Commissioning, Quality and Resource Committee	CQRC	
Audit, Risk and Compliance Committee	Audit	
Primary Care Commissioning Group	PCCG	
Remuneration Committee	RemCom	
Executive Committee	Exec	
Neighbourhood Health Committee	NHC	

Scheme of Reservation and Delegation

NHS
Essex
Integrated Care Board

2. Terms of Reference (TOR) and Management of Meetings

2.1. **Schedule of Committee Membership and review/approval Register [to follow]**

2.2. **Audit, Risk and Compliance Committee TOR**

2.3. **Remuneration Committee TOR**

2.4. **Executive Committee TOR**

2.5. **Commissioning, Quality and Resource Committee TOR**

2.6. **Neighbourhood Health Committee TOR**

2.7. **Essex Integrated Care Partnership TOR**

2.8. **Summary of meeting etiquette (Petitions, Questions, Role of Observers and Participants.)**

2.9. **Process for New Governance Group [to follow]**

2.10. **Guidance for Meeting Administration [to follow]**

NHS
Essex
Integrated Care Board

Audit, Risk and Compliance Committee

Terms of Reference

Status:	The Committee is a non-executive committee of the Board.
Accountable to:	The ICB Board.
Purpose:	Provide oversight and assurance to the Board on the adequacy of governance, risk management and internal control and compliance processes within the ICB, driven by organisational objectives and associated risks.
Membership:	Non-Executive Member (Audit Committee) Non-Executive Member Non-Executive Member *Neither the Chair of the Board nor employees of the ICB will be members of the Committee.*
Chair:	Non-Executive Member (Audit Committee) *Refer to ICB Constitution regarding rules for Audit Committee Chair.*
Vice Chair:	Non-Executive Member
Executive Sponsor:	Executive Director of Corporate Services
Attendees:	Executive Director of Finance and Commercial Executive Chief Nursing Officer Executive Director of Corporate Services Representatives of Internal and External Audit Individuals who lead on Risk Management and Counter Fraud Matters Chair and Chief Executive (invited to attend annually)
Frequency of Meetings:	At least 5 times per year. *Arranged quarterly with an additional meeting for the annual report and accounts.*
Quorum:	Minimum of two members (including Chair or Vice Chair).

Delegated Authority:	Approving on behalf of the ICB Board or endorsing new and/or significant amendments of policies and procedures within its remit.
Key Performance Indicators:	Mandatory training compliance – Data Security, Health and Safety, Manual Handling, Emergency Planning. Incidents ICB Risk Profile
Intelligent Board Data / Reporting Requirements:	[state the reporting requirements of the committee to enable it to discharge its responsibilities]
Sub Committees:	Information Governance Steering Group Health and Safety Group
Other Matters:	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 Committee.

Responsibilities of Committee

The responsibilities of the committee include:

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, ensure business is conducted in accordance with law and proper standards and to highlight any areas of weakness to the Board.
- To ensure that financial systems and governance are established which facilitate compliance with the Department of Health and Social Care (DHSC's) Group Accounting Manual.
- Ensure that governance and internal control systems reflect current procurement legislation, including compliance with the Provider Selection Regime (PSR).
- To review the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of the ICB's objectives and 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 (not system-wide performance management).

- To ensure that the ICB acts consistently with the principles and guidance established in HM Treasury's Managing Public Money.
- To seek reports and assurance from directors and managers as appropriate, concentrating on the ICB's 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 and provide assurance on processes to the Board, particularly in relation to organisational changes required following the Model ICB Blueprint and any subsequent legislative change.
- To review the adequacy and quality of information and assurance provided to support effective oversight in line with the Insightful ICB guidance.

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 and approving the internal audit service arrangements and the costs involved.
  - Endorsing the Internal Audit Charter.
  - 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 and in accordance with the new ICB role as strategic commissioner and payer function.
  - 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.
  - 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 (including having a clear policy for the engagement of External Auditors to supply non-audit services).

- 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.
- 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. This will be undertaken by reviewing the work of other committees in the ICB, whose work can provide relevant assurance to the Audit Committee's own areas of responsibility.
- To review the 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.
  - Reviews and reports issued by professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges and accreditation bodies).

Counter fraud

- To assure itself that the ICB has adequate arrangements in place for counter fraud, bribery and corruption (including cyber security) that meet NHS Counter Fraud Authority's (NHSCFA) standards and 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, counter fraud self-review assessment submissions and discuss NHSCFA quality assessment reports.
- To be responsible for ensuring that the counter fraud service submits an Annual Report and Counter Fraud Functional Standard return, outlining key work undertaken during each financial year to meet the Government Function Standard 013: Counter Fraud.
- To be responsible for ensuring that the ICB undertakes and submits a fraud risk assessment (reflected within he ICBs risk management system and risk registers) in accordance with the Government Functions Standard 013: Counter Fraud.
- To consider the impact of fraud risks associated with organisational restructuring and function transfers (for 2026/27 only).
- 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, including those relating to IT security and the annual (Cyber Assessment Framework aligned) Data Security and Protection toolkit (DSPT) audit.
- To review the annual Senior Information Risk Owner (SIRO) and Caldicott reports, the submission for the DSPT and relevant reports and action plans.
- To provide assurance to the Board that there is an effective framework in place for the management of risks associated with information governance.

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.
- Receive assurance that financial reporting reflects the ICB's role as strategic commissioner and payer, including allocation decisions and associated controls.
- 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.
    - Qualitative aspects of financial reporting.
- To review the assurance processes in place in relation to financial performance across the ICB including the completeness and accuracy of information provided.

Statutory Compliance

- In accordance with **Health and Safety** legislation, to receive assurances from the Health and Safety Group that the ICB fully complies with the Health and Safety Act and all other associated legislation, including the arrangements and systems in place to maintain the safety and security of staff, visitors and the public on the ICB premises.
- The Committee shall ensure that the ICB has adequate arrangements in place for **security** that meet NHS England/ NHS Protect standards and review the outcomes of work in these areas.
- The Committee will receive reports and have oversight of **statutory compliance** in relation to children's safeguarding, Special Education Needs and Disability, Serious Violence and Domestic Abuse and safeguarding.

Conflicts of Interest

- The chair of the Audit Committee will be the nominated Conflicts of Interest Guardian.
- The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.
- The Committee shall receive reports on compliance with the training requirements for conflicts of interest at least twice annually and ensure that processes are operating effectively that staff are adequately trained.

Emergency Preparedness, Resilience & Response (EPRR) and Business Continuity Management (including Cyber Security)

- The Committee shall seek assurance on implementation of Emergency Planning and Business Continuity arrangements. This shall be via management reporting and receipt of the EPRR core standards.
- The Committee shall seek assurance on the effectiveness of:
  - the systems and management arrangements established for addressing the risk of a Cyber Security attack; and
  - the associated Business Continuity planning and arrangements for maintaining corporate, operational, and clinical services in the event of a loss of either IT or data due to a cyber-attack.

Sustainability

- The Committee will seek assurance on the delivery of the Green Plan for Essex and associated actions to improve its carbon footprint and reduce the environmental impact of its services, including progress against the NHS Net Zero strategy.

Individual Funding Request Process

- The Committee shall seek assurance on the Individual Funding Request governance to ensure the process followed is robust and consistent.

Management

- To request and review reports and assurance from directors and managers on the overall arrangements for governance, risk management and internal control.
- To review emerging governance arrangements relating to changes in governance relating to transferring functions and delegation.
- 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 and retrospective expenditure approval, in order to provide assurance in relation to the appropriateness of decisions and to derive future learning.
- To note all losses and special payments (including special severance payments, as defined by NHS England).
- To receive reports on compliance with mandatory training.

Exclusions

Whilst the Audit, Risk and Compliance Committee has a significant remit to assure systems of internal control and compliance, areas of concern relating to performance and quality will not be overseen by the Committee. Instead, it will escalate to the appropriate Board sub-committee to address concerns.

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NHS
Essex
Integrated Care Board

Remuneration Committee

Terms of Reference

Status:	The Committee is a non-executive committee of the Board.
Accountable to:	The ICB Board.
Purpose:	To agree ICB policy on pay/pay framework and recommends Pay, terms and conditions for board members. Provides assurance to the Board on the discharge of this ICB statutory duty.
Membership:	Non-Executive Member (Remuneration Committee Chair) Non-Executive Member Non-Executive Member *Neither the Chair of the Audit Committee nor employees of the ICB will be members of the Committee.*
Chair:	Non-Executive Member (Remuneration Committee) *Refer to ICB Constitution regarding rules for Committee Chair.*
Vice Chair:	Non-Executive Member
Executive Sponsor:	Executive Director of Corporate Services
Attendees:	Executive Director of Corporate Services Chief Executive Officer Executive Director of Finance and Commercial Associate Director People and Organisational Development
Frequency of Meetings:	Twice per year, plus ad hoc as required
Quorum:	Minimum of two members (including Chair and Vice Chair)
Delegated Authority:	Approving on behalf of the ICB Board or endorsing new and/or significant amendments of policies and procedures within its remit.

Key Performance Indicators (KPIs):	National workforce KPIs relating to sickness, vacancies, agency use and appraisals and locally set mandatory training compliance Workforce Race Equality Standard Workforce Disability Equality Standards Gender Pay Gap Ethnicity Pay Gap
Intelligent Board Data / Reporting Requirements:	[state the reporting requirements of the committee to enable it to discharge its responsibilities]. A Remuneration Committee update report will be provided to confidential Part II Board meetings.
Sub Committees:	Lay Member Remuneration Panel
Conflicts of Interest:	No voting individual should be present during any discussion relating to any aspect of their own pay, or any aspects of the pay of others when it has an impact on them.

Responsibilities of Committee

The responsibilities of the committee are to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B of the NHS Act 2006, specifically to confirm the ICB's policy on pay including adoption of any pay frameworks for all employees including senior managers/directors (including Board members). This specifically includes:

Chief Executive, Executive Directors, Very Senior Managers (VSMs) and other senior employees (excluding the Chair and Non-Executive Members):

- Determine all aspects of remuneration including salary, performance related pay, bonuses, allowances, pensions and other contractual or non-contractual payments, taking account of national policy and benchmarking.
- Approve arrangements for termination of employment and any severance or special payments, ensuring compliance with national guidance.
- Oversee the process for executive recruitment, appointment and appraisal in line with the ICB Constitution and national role descriptors.
- Oversee succession planning for executive roles.

For other staff groups

- Confirm the ICB pay policy including the adoption of any pay frameworks for all employees, including clinical staff not covered by Agenda for Change.

- Oversee any payments outside of standard pay policies, such as on-call arrangements or non-Agenda for Change mechanisms.
- 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. Ensuring compliance with relevant national guidance on special and severance payments.

Governance, organisational change and transition

- Oversee organisational change programmes, including restructures in response to delivering the Model ICB Blueprint and 10 Year Health Plan, ensuring changes to executive structures, job design and VSM roles are appropriately governed.
- Provide oversight of workforce transition during functions transfers to ensure fair treatment of all staff and compliance with statutory duties.
- Ensure ICB workforce strategy is aligned to the NHS 10 Year Workforce Plan.
- Seek assurance as to the ICB's compliance with statutory people responsibilities and delivery of plans to strengthen associated internal controls, e.g. compliance with the Equality Act 2010 and Human Rights Act 1998.
- Approve policies within the remit of this committee on behalf of the ICB Board.

Oversight of contractual and non-standard arrangements

- Receive assurance that robust processes are in place, and are annually reviewed, to ensure the ICB's compliance with HMRC requirements relating to employment status determinations (e.g., IR35 and off-payroll engagements).
- Review and approve any special or novel contractual arrangements for senior staff.

Exclusions

The remuneration of the Chair is set by NHS England.

The remuneration of Non-Executive Members will be determined by a separate Lay Member Remuneration Panel comprising the ICB Chair, Chief Executive, and Executive Director of Corporate Services.

Policies relating to HR will ordinarily be approved by the Executive Committee, save where there may be conflicts of interest.

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NHS
Essex
Integrated Care Board

Executive Committee

Terms of Reference

Status:	The Committee is an executive committee of the Board.
Accountable to:	The ICB Board.
Purpose:	To provide oversight and assurance to the Board regarding operational management of the ICB and delivery of its strategic objectives, strategies and plans.
Membership:	Chief Executive Officer Executive Director of Finance and Commercial Executive Chief Nursing Officer Executive Medical Director Executive Director of Corporate Services Executive Director of Neighbourhood Health Executive Director of Strategy
Chair:	Chief Executive Officer
Vice Chair:	TBC
Attendees:	Chief of Staff Senior Business Manager
Frequency of Meetings:	Monthly Decision-Making (minuted) Weekly operational and development
Quorum:	Three Members
Delegated Authority:	Financial approval limits between £500k - £15m (budgeted), <£5m (unbudgeted). £2.5m - £5m for capital investments. Approving on behalf of the ICB Board or endorsing new and/or significant amendments of policies and procedures within its remit.
Key Performance Indicators:	Delivery of the Population Health Improvement Plan Delivery of ICB Financial Plan

	Freedom to speak up referrals and outcomes Equality metrics (WRES, WDES, Pay Gap)
Intelligent Board Data / Reporting Requirements:	Directorate and Executive KPIs Equality Indicators Compliance data
Sub Committees:	Strategic Delivery Group Senior Leadership Team ICB People Group Inclusion and Belonging Steering Group

Responsibilities of Committee

The Executive Committee is accountable for the delivery of statutory, regulatory and constitutional duties and responsible for providing multi-professional leadership, scrutiny and strategic alignment to ensure the effective operation of the Integrated Care Board (ICB) and the delivery of its objectives. In discharging its delegated authority, the Committee will:

1. **Strategic Leadership and Direction**
    - Establish, shape and oversee the strategic direction of the ICB, ensuring strategies and plans are developed for recommendation to and approval by the Board, including setting strategic commissioning intentions and the Population Health Improvement Plan.
    - Provide operational oversight of ICB operations.
    - Ensure consistent organisational messaging and alignment to strategic priorities, including the delivery of financial turnaround.
    - Ensure the ICB fulfils its statutory requirement to engage with stakeholders and the public; to ensure that system collaboration is effective and that the patient voice is heard.
    - Receive reports from Executives on the delivery of organisation objectives, including any escalations in relation to delivery.
2. **Delivery Oversight**
    - Empower and enable staff to deliver programmes and projects that support the achievement of ICB objectives.
    - Provide collective stewardship and early oversight of financial, quality, operational and contractual performance prior to scrutiny by Board sub-committees.

- Oversee the delivery, governance and benefits realisation of major transformation and improvement programmes.

3. **Organisational Development and Culture**
   - Ensure the ICB has a comprehensive and effective organisational development plan that supports capability, culture and change.
   - Provide leadership for the ICB's equality, diversity, inclusion and belonging agenda, ensuring compliance with statutory requirements and promotion of an inclusive culture.
   - Set expectations and model behaviours for effective matrix working across the organisation.
4. **Governance, Assurance and Risk**
   - Maintain oversight of the corporate risk register, ensuring risks are regularly reviewed, updated and that mitigation actions are actively managed.
   - Support the Board and its sub-committees to discharge their duties by providing clear, timely and accurate information, assurance and recommendations.
   - Provide advice, guidance and decision-making support to the Senior Leadership Team and Strategic Delivery Group.
5. **Financial Sustainability**
   - Support financial sustainability through robust decision-making within delegated authority as set out in the Scheme of Reservation and Delegation (SoRD).
   - Ensure collective executive ownership of financial stewardship and the embedding of financial discipline across the ICB (in conjunction with the Commissioning, Quality and Resource Committee).
6. **Regulatory and System Alignment**
   - Oversee the organisation's preparations for, and responses to, external regulatory reviews and inspections (e.g., NHS England, CQC).
   - Ensure that executive decisions and organisational priorities support the delivery of statutory duties and NHS constitutional commitments.
7. **Workforce, Digital and Resilience**
   - Oversee workforce planning and sustainability to ensure the ICB is equipped to meet its strategic ambitions.
   - Provide strategic direction for digital transformation.

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NHS
Essex
Integrated Care Board

Commissioning, Quality and Resource Committee

Terms of Reference

Status:	The Committee is a non-executive committee of the Board.
Accountable to:	The ICB Board.
Purpose:	To triangulate the ICBs approach to quality, finance and commissioning supporting the new role of the ICB as strategic commissioner providing the Board with clear oversight and assurance that the ICB is meeting its statutory functions by aligning commissioning intent with quality outcomes, financial sustainability and optimal use of resources, and ensuring the delivery of high-quality, value-driven healthcare within the resources available.
Membership:	Non-Executive Member Non-Executive Member Chief Executive Officer Executive Chief Nursing Officer Executive Director of Finance and Commercial Executive Director of Strategy
Chair:	Non-Executive Member X
Vice Chair:	Non-Executive Member X
Executive Sponsor:	Executive Director of Finance and Commercial, and Executive Chief Nursing Officer
Attendees:	Local Authority Representative Executive Director of Corporate Services Executive Director of Neighbourhood Health Director of Finance Assistant Directors of Finance Director of Commercial Director of Capital and Estates Director of Nursing

	Director of Quality Director of Medicines Management and Pharmacy Deputy Medical Director
Frequency of Meetings:	Quarterly
Quorum:	Four Members including one Non-Executive Member and one Executive Member.
Delegated Authority:	Financial approval limits between: • Revenue: £15m - £30m (budgeted), £5m - £15m (unbudgeted) • Capital: £5m - £10m Approving on behalf of the ICB Board or endorsing new and/or significant amendments of policies and procedures within its remit.
Key Performance Indicators:	Sustainable Hospital Services (Planned and Unplanned Care) – constitutional standards / improve UEC Mental health and Neurodiversity Services for Children and Adults Improved services for CYP Improved services for people with LDA Improved value and outcomes in AACC Strengthened quality oversight and safeguarding of commissioned services Deliver financial plan Outcome based contracting models Deliver Estates Strategy Sustainability of commissioned services Adherence to Procurement and Contracting Policy
Intelligent Board Data / Reporting Requirements:	[state the reporting requirements of the committee to enable it to discharge its responsibilities]
Sub Committees:	Medicines Commissioning Group Provider Selection Regime Review Group System Quality Group

	Estates and Capital Group Quality, Contracting and Performance Review Meetings

Responsibilities of Committee

The responsibilities of the committee include:

Strategic Commissioning:

- Oversee the ICB's commissioning strategy (Population Health Improvement Plan (PHIP)), ensuring alignment with:
  - The Strategic Commissioning Framework's four-stage cycle (needs assessment, long-term strategy, payor delivery, evaluation)
  - The 10-Year Health Plan and updated ICB operating model, emphasising outcomes, prevention, neighbourhood-level models and left-shift care approaches.
- Approve the commissioning intentions and associated resource plans.
- Ensure prioritisation decisions are transparent and supported by high-quality data, population segmentation and risk stratification.
- Set the ICB Quality Improvement Strategy in accordance with National Quality Board guidance and the PHIP to guide the achievement of the ICB's quality responsibilities.

Quality Governance

- Ensure appropriate frameworks exist and are effective to support quality planning, control and improvement.
- Receive assurance that the ICB discharges its statutory quality functions in line with National Quality Board recommendations, including those relating to:
  - Safety, clinical effectiveness, patient experience
  - Safeguarding children and adults
  - Infection prevention and control
  - Medicines optimisation safety
  - Maternity, children and young people, mental health (all ages), learning disability and autism services
  - Neurodiversity improvement
  - SEND statutory responsibilities
  - Equality, diversity and inclusion (as it applies to service users)
  - All Age Continuing Care provision
  - Primary Care quality (General Practice, Pharmacy, Optometry and Dental)

- Ensure quality considerations and outcome improvements, are embedded in all procurement, contracting and commissioning decisions, in line with NHSE quality duties for strategic commissioners.
- Receive assurance that robust governance has been established to manage impact assessments (quality, equality, health inequality) and that impact assessments are completed appropriate to inform ICB decision-making, improve quality performance and reduce health inequalities.
- Oversee and scrutinise the ICB's response to all relevant directives, regulations, national standards, policies, reports, review and best practice issued by regulatory and advisory bodies and the Department for Health and Social Care and Department of Education (for SEND responsibilities).
- Received assurance from the System Quality Group regarding progress and sustained delivery of quality improvement programmes and ensuring a lessons learned culture across the system.

Finance and Resources

- Oversee financial, capital and estates planning, forecasting and delivery of the ICB's financial duties.
- Review and recommend approval to the Board of the ICB medium and long-term-financial, capital and estates plans alongside annual budgets, which demonstrates ongoing value and recovery.
- Be assured that adequate financial and reporting frameworks are in place to deliver the financial duties and responsibilities of the ICB.
- Monitor financial performance and associated risks, reporting to the Board on overall financial management, performance against the financial strategy and national and local metrics, highlighting areas of concern.
- Monitor progress against the Estates and Capital Plan associated risks and changes.
- Scrutinise and approve procurements and business cases within delegated financial limits according to the needs of the ICB as set out within the PHIP.
- Monitor, hold to account and report to the Board on progress in delivering the ICB efficiency savings.
- To advise the Board on any changes to NHS and non-NHS funding regimes, oversee national level ICB financial submissions and receive assurance that adequate processes are in place delivering to and in accordance with national planning timelines and requirements.
- Receive assurance that the finance, capital and estates plans are aligned to the PHIP and delivery of neighbourhood plans.
- Approve capital investment (including scrutinising and supporting capital business cases) within the delegated remit of the committee, where the value exceeds that assigned to the Estates and Capital Group.

Performance Oversight

- Scrutinise performance against national, regional and locally mandated standards as set out in contractual arrangements, including constitutional standards and outcomes frameworks.
- Monitor delivery of annual and medium-term plans, including recovery trajectories.
- Escalate concerns to the Board where performance diverges from plan.
- Ensure adequate processes exist to ensure the ICB achieves return on investment / intended benefits of approved business case proposals / procurements.

Contracting and Market Management

- Provide strategic oversight of contract management (including Provider Accreditation), market stewardship, and provider performance ensuring the procurement programme and pipeline are in line with commissioning intentions and the priorities of the PHIP.
- Ensure contracts support outcome-based commissioning and incentivise quality improvement.
- Review procurement outcomes and award decisions in line with delegation.

Population Health, Data and Intelligence

- Ensure the ICB maintains effective intelligence functions, including integrated needs assessments using linked person-level data.
- Oversee evaluation frameworks measuring impact, outcomes, access and quality.

Risk Management

- Review and monitor Board Assurance Framework (BAF) and Corporate Risks related to commissioning, finance, performance and quality.
- Ensure mitigation plans are robust and timely.

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NHS
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Integrated Care Board

Neighbourhood Heath Committee

Terms of Reference

Status:	The Committee is a non-executive committee of the Board.
Accountable to:	The ICB Board.
Purpose:	The Committee provides oversight, assurance and strategic leadership for the design, commissioning and delivery of neighbourhood-level health and care models.
Membership:	Non-Executive Member Executive Director of Neighbourhood Health Executive Medical Director Primary Care Partner Member Locality GP Director of Commissioning (Primary Care) Director of Commissioning (Community) Director of Adult Social Care / Public Health Healthwatch representative (or successor body) VCSFE representative Acute Provider Partner Member Community Collaborative Representative
Chair:	Non-Executive Member
Vice Chair:	Primary Care Partner Member
Executive Sponsor:	Executive Director of Neighbourhood Health
Attendees: (as needed)	Executive Director of Corporate Services Executive Director of Strategy Director of Nursing Director of Finance Director of Capital and Estates Director of Commissioning (Acute)

	Associate Medical Director for Neighbourhood Health Contract Business Partner Childrens and Young People Commissioner Adult's Mental Health Commissioner Associate Director of Neighbourhood Health BCF Programme Leads Analytics, digital and workforce leads POD – for relevant items escalated from PCCG
Frequency of Meetings:	Quarterly
Quorum:	Four Members including a representative from Primary Care and an ICB Executive
Delegated Authority:	Financial approval limits aligned with SORD and covering oversight of programme budgets that are separate to the core allocation. Approving on behalf of the ICB Board or endorsing new and/or significant amendments of policies and procedures within its remit.
Key Performance Indicators:	Improved access to primary and community services More multi-disciplinary neighbourhood teams supporting frailty and long-term conditions. Increased community-based activity and reduced reliance on hospital care Reduced variation in service provision across Essex. Reduce unnecessary non-elective admissions and bed days Enable specialised support closer to home Outcomes and Population Health Experience and personalisation INT Maturity Primary Care Extended Access
Intelligent Board Data / Reporting Requirements:	See Dashboard

Sub Committees:	Primary Care Commissioning Group Health Inequalities Group 5 Alliances (Basildon & Brentwood, Mid Essex, North East Essex, South East Essex, and Thurrock, and the Health Care Partnership (sub-committee of PAH) acting as a West Essex Alliance will report into this Committee) Southend, Essex and Thurrock Better Care Fund Committees

1. Responsibilities of Committee

The Committee will support the ICB in fulfilling its statutory duties as a strategic commissioner by overseeing the development and delivery of the neighbourhood element of the Population Health Improvement Plan. This will oversee the development of a Neighbourhood health model consistent with national guidance and the emerging 10-Year Health Plan, with the aim to:

- Improve population health and reduce inequalities
- Integrate NHS, social care, public health and community-sector interventions
- Support delivery of care closer to home and improve access, experience and outcomes
- Address the needs of people with multiple and complex health and care needs.

The Committee will promote collaboration in guiding the development of neighbourhood health plans, expected nationally to be co-produced by local government, the NHS and partners under Health and Wellbeing Board leadership.

The Committee will ensure alignment between neighbourhood-level planning, primary care commissioning, partnership alliances, prevention and health inequalities workstreams and Better Care Fund-related joint commissioning.

The Committee will achieve this through the following key objectives:

1. **Strategic Neighbourhood Health Development**
    - Provide leadership and assurance for the implementation of the neighbourhood element of the Population Health Improvement Plan (PHIP) overseeing the implementation of neighbourhood health guidelines across the ICB, ensuring progress toward the model described in national policy for 2025-27, the model neighbourhood framework (awaited), neighbourhood planning framework, model system archetypes, model neighbourhood health centre archetypes. This includes delivery of the six ‘core components’ of integration, proactive care, multi-disciplinary working, personalised care, community assets, and outcomes-focused design.
    - Oversee the development and approval pathway for neighbourhood health plans in accordance with the PHIP and associated strategies, ensuring

they are outcomes-focussed, evidence-based, credible, multi-disciplinary as required nationally and focus on core priorities outlined in the PHIP for frailty and end of life care.

- Ensure neighbourhood health models incorporate prevention, early intervention and community-asset-based approaches.
- Ensure neighbourhood health models include workforce, digital and analytics capability development as reference in national guidance (e.g. integrated teams, shared care planning, and linked datasets for proactive care).

2. **Primary Care Commissioning**

   Through its Primary Care Commissioning Group (sub-committee):

   - Oversee operational commissioning decisions relating to primary medical, dental, community pharmacy and optometry services.
   - Ensure primary care commissioning is embedded within neighbourhood-level models and multidisciplinary teams.
   - Oversee contract performance, service redesign, workforce issues and primary care estates matters at neighbourhood level.

3. **Alliance Development and Locality Oversight**

   - Provide oversight of the five locality Alliances, ensuring they each:
     - Develop and deliver locality neighbourhood models
     - Reflect local population needs and priorities
     - Integrate NHS, social care, public health and VCSFE contributions
   - Ensure consistent governance, dashboards, performance expectations and accountability systems across Alliances.
   - Guide the evolving model of alliances to neighbourhood working.

4. **Health Inequalities and Prevention**

   - Oversee the Health Inequalities and Prevention Group, ensuring neighbourhood interventions address the risk factors and disparities identified in local Joint Strategic Needs Assessments (JSNAs).
   - Ensure segmentation and risk-stratification datasets are used to drive targeted prevention, as recommended in national guidance for neighbourhood health.
   - Monitor delivery of Core20PLUS5 and wider inequalities commitments at neighbourhood level.

5. **Integrated Commissioning and Better Care Fund**

   - Maintain a formal interface with Better Care Fund (BCF) governance under s75 agreements.

- Ensure neighbourhood health planning aligns with BCF priorities and joint commissioning intentions with local authorities.
- Support integrated commissioning of services delivered through neighbourhood teams.

6. **Performance and Assurance**
   - Oversee strengthened population health management in neighbourhoods, by monitoring performance of neighbourhood models, including access, outcomes, experience, workforce and integration metrics.
   - Monitor progress on national implementation programme expectations, including “test, learn, grow” requirements and evaluation cycles under the National Neighbourhood Health Implementation Programme (NNHIP).
   - Escalate material risks to the ICB Board.
7. **Engagement and Co-Production**
   - Ensure people with lived experience, VCSFE partners, local authorities and community organisations are integral to shaping neighbourhood design and evaluation, consistent with national guidance emphasising community asset-based models and shared leadership.

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NHS
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Integrated Care Board

Essex Integrated Care Partnership
Terms of Reference

Purpose

The Integrated Care Partnership (herein referred to as the ICP) is a partnership across Essex, established by the Essex Integrated Care Board and the three upper tier local authorities (Southend City Council, Essex County Council and Thurrock Council) as equal partners, with a focus on aligning purpose and ambitions to support the residents of Essex. It is formed as a joint committee between the Essex ICB and the upper tier local authorities.

The ICP will facilitate joint action to improve health and care outcomes, to influence the wider determinants of health and broader social and economic development.

Together, the Essex Integrated Care Board (EICB) and the Essex ICP form the new statutory Essex Integrated Care System (ICS).

The ICP has specific responsibility for developing the 10-year Essex Integrated Care Strategy for the whole population. The strategy will take forward the health and wellbeing strategies of our upper tier health and wellbeing boards, use the best available evidence and data, covering health and social care (both children's and adult's social care), and seek to address the wider determinants of health and wellbeing. The strategy will be built bottom-up from local assessments of needs and assets identified through our Alliances, district, borough, and city councils. The strategy will be focused on improving health and care outcomes, reducing inequalities, ensuring inclusion, and addressing the consequences of the pandemic for our communities.

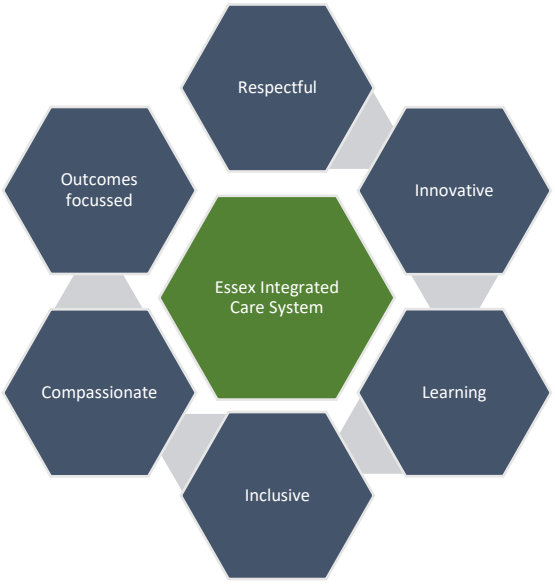
While the ICP has no formal delegated powers from its constituent organisations, it will provide leadership, oversight, and support for system-wide activities, playing a key role in ensuring joint accountability to our population.

The ICP builds on the existing Health & Care Partnership and will therefore be underpinned by the existing Partnership Memorandum of Understanding (MoU). These ToR should be read in conjunction with the MoU.

1 Our Beliefs and Values as an Integrated Care Partnership

- **Subsidiarity -** devolving planning and delivery to the lowest possible level.
- **Respect for sovereignty** of statutory organisations
- **Collaboration** to bring about improved Standards, Outcomes and the application of Common Clinical Policies
- **A shared agenda** driven and owned by partners working together with a focus on **reducing health inequality**
- **Data Driven:** serving the individual needs of our population, not organisations

- **Delivery of integrated care,** with meaningful engagement with our communities
- **Asset and strengths-based approaches**, delivering care according to people's preferences
- **A focus on healthy lives** – prioritising prevention and self-care
- **Clinical and Care Professional engagement** at the earliest opportunity
- **Empowering front line staff to do the right thing** – through distributed leadership
- **Pragmatic pluralism** – differing needs across our populations require different approaches. Not a one size fits all approach
- **Innovative - trying** new and innovative approaches, test and learn



2 Our Responsibilities as an Integrated Care Partnership

The ICPs responsibilities are to:

1. Develop the integrated care strategy for the population of Essex.
2. Design and oversee a joint accountability framework to ensure delivery of the integrated care strategy.
3. Ensure the integrated care strategy:
    a) Is focused on reducing the inequalities that our population faces.
    b) Uses the best available evidence and information, including the joint strategic needs assessments and health and wellbeing strategies of local authorities.
    c) Is built 'from the bottom up' taking account of health inequalities, challenges, assets and resources locally at neighbourhood and Alliance level.
    d) Expands the range of organisations and partners involved in strategy development and delivery.

e) Is underpinned by insights gained from our communities.
f) Benefits from strong clinical and professional input and advice.

4. Agree and monitor delivery of Alliance plans with a focus on shared learning and support.

5. Agree and have oversight of the statutory ICS health inequalities strategy.

6. Consider recommendations from partners and reach agreement on:
   - Priority work programmes and workstreams that would benefit from a cross-partnership approach.
   - The apportionment of transformation monies from national bodies aligned to the ICP.
   - The need to take joint action in relation to managing collective issues and challenges.

7. Commission specific advice as required.

8. Provide active support to the development of the Alliances across Essex, enabling local partnership arrangements, engagement and co-production, bringing together Local Authorities, voluntary and community groups, NHS partners and residents. Facilitate and support cross-Alliance working and sharing of best practice where this would benefit the population or provide efficiencies in our approach.

9. Ensure that the ICP has a greater focus on population health improvement, integration of health and care services around the needs of residents, and a focus on care provided in primary and community settings.

10. Provide a mechanism for joint action and joint decision-making for those issues which are best tackled on a wider scale.

For the avoidance of doubt, it is not a function of the ICP to duplicate the statutory functions of constituent organisations.

The Essex ICP will not perform a health scrutiny function and will itself be subject to scrutiny by the Health Scrutiny Committees as appropriate of Southend City Council, Essex County Council and Thurrock Council.

3 Chair and Vice Chair Arrangements

3.1 The Essex ICB will appoint a Chair and three vice-Chairs annually. The Chair and vice-chairs will hold office until they resign, cease to be a member of the Essex ICP, or cease to be a member of the organisation that appointed them to the ICP.

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

3.3 For the first year of operation, the Chair of Essex ICB will act as Chair of the ICP. The chairs of the three upper tier local authorities Health and Wellbeing Boards (Southend City Council, Essex County Council and Thurrock Council) will act as vice chairs.

4 Membership

4.1 The founding membership of the Essex ICP will be one member nominated by the ICB, and one member nominated by each of Southend City Council, Essex County Council, and Thurrock Council.

4.2 Subject to the agreement of the Essex ICP, the membership will be as set out in Appendix 2.

4.3 In addition to the membership outlined in Appendix 2, the Essex ICP may appoint such additional persons as it sees fit, either as co-opted voting members or as observers who shall be entitled to participate in discussion at meetings of the Essex ICP but shall not be entitled to vote.

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

4.5 Southend City Council, Essex County Council, and Thurrock Councils will not exercise Health and Wellbeing Board activity through the Essex ICP.

5 Deputies

5.1 If a member is unable to attend a meeting of the ICP, s/he will be responsible for identifying a suitable deputy to attend on their behalf. Such a deputy must have sufficient seniority and understanding of the issues to be considered to represent their organisation, Alliance, or group effectively. Deputies will be eligible to vote if required. The Chair of the Essex ICP must be informed in advance of the relevant meeting of the identity of a substitute.

6 Additional Attendees

6.1 At the discretion of the Chair, additional representatives may be requested to attend meetings from time to time to participate in discussions or report on particular issues.

7 Term of Office

7.1 The term of office of members shall end:

a) if rescinded by the organisation by whom they are appointed; or
b) if a Councillor appointed by a Council cease to be a member of the appointing Council.
c) if an ex officio member cease to be appointed in that role
d) if the individual changes role within an organisation and is no longer in the role that led to their appointment to the ICP.

8 Quorum

8.1 The quorum for meetings of the Essex ICP shall be the chair plus 1 voting member representing each of Southend City Council, Essex County Council, and Thurrock Council and the Essex ICB.

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

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

8.4 The Quorum provisions shall apply equally to virtual meetings.

9 Member Conduct

9.1 Members of the Essex ICP who are not Councillors shall comply with any code of conduct applicable to their professional body and/or the organisation they represent.

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

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

10 Conduct of Business

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

10.2 In the absence of the Chair at a meeting of the Essex ICB, one of the three Vice Chairs will preside over that meeting.

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

10.4 The manner of voting will be determined by the person chairing the meeting.

11 Notice of and Summons to Meetings

11.1 At least five clear working days before a meeting, a copy of the agenda and associated papers will be sent to every member of the ICP and made available to the public for meetings held in public. The agenda will give the date, time and confirmation regarding whether the meeting is in person or virtual and specify the business to be transacted and will be accompanied by such details as are available.

11.2 A minimum of five working days' notice will be given when calling an extraordinary meeting.

12 Participation at the Essex ICP

12.1 All members of the Essex ICP are entitled to speak and where necessary to vote (unless they have been co-opted as a non-voting member by the Essex ICP).

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

13 Public Questions

13.1 At a meeting of the Essex ICP any member of the public who is a resident or a registered local government elector of Southend City Council, Essex County Council, or Thurrock Council may ask a question about any matter over which the Essex ICP has power, or which directly affects the health and wellbeing of the population.

13.2 A member of the public who wishes to ask a question shall give written notice, including the text of the proposed question, within 2 working days of the meeting. Questions from the public should be sent to mseics.partnership@nhs.net

13.3 Unless the Chair otherwise agrees, a member of the public may only ask one question.

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

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

13.6 Answers given orally at the meeting shall be included in the minutes. Written replies shall be copied to all members of the Essex ICP.

13.7 For the purposes of 13.1 to 13.6 above and for the avoidance of doubt a County Councillor, or a District Councillor for a District Council in Essex, or a councillor of Southend City Council or Thurrock Council who, in either case, is not a member of the Essex ICP shall be regarded as a member of the public.

14 Voting

14.1 The ICP will generally operate on the basis of forming a consensus on issues considered and will attempt to resolve in good faith any issues between partners, as per the principles of the Partnership MoU. It will seek to make any decisions on a “Best for Essex” basis.

14.2 On the rare occasion that a vote is required to support a decision, for example, should that become necessary in respect of priorities for investment or apportionment of transformation funding, the ICP may make a decision provided that it is supported by a simple majority of ICP members present at the meeting. If notwithstanding a consensus decision cannot be achieved, the issue resolution process outlined in the MoU will be followed.

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

15 Accountability and Reporting

15.1 Minutes, and a summary of key messages arising from each meeting will be submitted to all members after each meeting and made available on the ICS website.

15.2 The ICP has no formal powers delegated by Partner organisations.

16 Conflicts of Interest

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

16.2 Where any ICP member has an actual or potential personal conflict of interest (in other words, one which is not related to the role they undertake for the partner organisation) in relation to any matter under consideration at any meeting, the Chair shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that member may participate and/or vote in meetings (or parts of meetings) in which the relevant matter is discussed.

16.3 Where the Chair decides to exclude a member, the relevant organisation represented by that member may send a deputy to take the place of the conflicted member in relation to that matter.

16.4 Each member must abide by the policies of the organisation they represent in relation to conflicts of interest.

17 Professional & Administrative Support

17.1 The secretariat function for the ICP will be provided by the Essex ICB in partnership with upper tier local authorities. A member of the team will be responsible for arranging meetings, recording notes and actions from each meeting and preparing agendas and ensuring these are agreed by the Chair and Vice Chairs.

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

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

18 Minutes

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

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

19 Interpretation of Terms of Reference

19.1 The ruling of the Chair of the Essex ICP as to the interpretation of these Terms of Reference shall be final.

20 Suspension of Terms of Reference

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

21 Review

21.1 The terms of reference and the membership of the ICP will be reviewed at least annually.

Appendix 1

East of England Leadership Compact

In working together as a leadership community, we will adopt the following behaviours and hold each other to account for upholding these:

- We will put people first – our patients, staff, and citizens.
- We will support each other to deliver excellence in quality and performance.
- We will respect and trust each other and share important information, so there are no surprises
- We will have inclusive robust, honest, and realistic conversations where all voices are heard, views respected, and differences resolved for the greater good of our population.
- We will be compassionate and caring, supporting each other, especially in difficult times.
- We will value each other's contributions, celebrate successes collectively and learn from failure
- We will ensure our collective decisions are transparent and inclusive and we will abide by them.
- We will agree expectations and hold each other to account.
- We will be ambitious to improve health and wellbeing, sharing expertise, talent, knowledge, best practice, innovation and learning for the benefit of our patients, staff, and citizens
- We will work together to have a strong, united external voice for our region.

Appendix 2

Essex ICP Membership

	Name
1.	Chair, Essex ICB (Chair)
2.	Chair, Southend City Council Health & Wellbeing Board (Vice Chair)
3.	Chair, Essex County Council Health & Wellbeing Board (Vice Chair)
4.	Chair, Thurrock Council Health & Wellbeing Board (Vice Chair)
5.	CEO, Essex ICB
6.	Chair of the Mid & South Essex Foundation Trust
7.	Chair of the Essex Partnership NHS Foundation Trust
8.	Chair of Provide CIC
9.	Chair of the North East London NHS Foundation Trust
10.	Lead Non-Executive Director of the East of England Ambulance Services Trust
11.	Director of Public Health, Southend City Council
12.	Director of Public Health, Essex County Council
13.	Director of Public Health, Thurrock Council
14.	Director of Adult Social Services, Southend City Council
15.	Director of Adult Social Services, Essex County Council
16.	Director of Adult Social Services, Thurrock Council
17.	Director of Children's Services, Southend City Council
18.	Director of Children's Services, Essex County Council
19.	Director of Children's Services, Thurrock Council
20.	Executive Director of Neighbourhood Health
21.	Associate Director of Neighbourhood Health
22.	Director of Commissioning (Primary Care & Neighbourhood)
23.	Associate Director of Community and Neighbourhood Health
24.	Associate Medical Director Neighbourhood Health
25.	Lead Officer, Basildon Council
26.	Lead Officer, Braintree District Council
27.	Lead Officer, Brentwood Council
28.	Lead Officer, Castle Point Council
29.	Lead Officer, Chelmsford City Council
30.	Lead Officer, Maldon District Council
31.	Lead Officer, Rochford Council
32.	CEO, Essex Local Medical Committee
33.	CEO, Healthwatch Southend
34.	CEO, Healthwatch Essex

Name
35. CEO, Healthwatch Thurrock
36. Representative of Essex Community & Voluntary Sector Organisations
37. Representative of Hospice Sector
38. Representative of Anglia Ruskin University
39. Representative of University of Essex
40. Representative of Writtle University College
41. Chief Constable, Essex Police
42. Locality Director, NHS England & Improvement
43. Executive Director of Corporate Services, Essex ICB
44. Executive Director of Strategy, Essex ICB
45. Executive Director of Finance & Commercial, Essex ICB
46. Executive Medical Director, Essex ICB
47. Executive Director of Nursing, Essex ICB
48. Associate Director of People and Organisational Development, Essex ICB
49. Associate Director of Comms and Engagement

Reviewed: 24 March 2026

Agreed: 1 April 2026

NHS
Essex
Integrated Care Board

Summary of Meeting Protocols, Conduct & Etiquette
For ICB Board Meetings

Role of Members, Attendees and Observers

Members as listed within the ICB Constitution (for ICB Board meetings) or in the Terms of Reference of the Committee are the individuals who will provide quoracy of the meeting and will be responsible for making decisions, if necessary, by voting in accordance with the Constitution and Standing Orders.

Deputies – With the permission of the Chair of the meeting, Executive Directors and the Partner Members of the Board may nominate a suitable deputy to attend if they are unable to. The deputy may speak but may not vote on their behalf at the ICB Board. Deputies at sub-committee meetings are able to vote and fully act on behalf of the member.

Participants/Attendees are invited by the Chair for either one off attendance or as a regular attendee and do not participate in decision making but may be invited to present papers or be asked to provide explanations and further information in relation to items for discussion.

Observers are members of the public and others not required to be present, but who are welcome to attend the meeting on the basis that they will respect the proceedings and the Chair's authority. Observers may ask questions where this is appropriate and at the discretion of the Chair as set out below.

Questions from the Public or Individual who are not 'Members'

ICB Board meetings are 'meetings held in public' not 'public meetings'. The arrangements are intended to promote transparency over the Board governance and decision-making processes. [However, the requirements of the Board and the conduct of its business are paramount].

Members of the public may be given an opportunity to pose questions at a specific point during the meeting, which should be submitted in writing three working days in advance of the meeting. The agenda time given over to Questions from the public will normally be confined to fifteen minutes. no individual question together with its response is expected to exceed five minutes.

A question should relate to an item considered by the Board Directors at the relevant meeting. Questions on matters not on the agenda of the Board can be resolved by letter or email to the Chief Executive's Office. The ICB postal address is NHS Essex ICB, Floor 1, Seax House, Victoria Road South, Chelmsford CM1 1QH, ceooffice.mseics@nhs.net.

To support the good conduct of business, each member of the public is requested to pose only one question and the number of questions responded to during the meeting will be at the discretion of the Chair. Where the Chair deems necessary, a written response to questions raised will be provided where a substantive response cannot be provided immediately. Questions dealt with at meetings will be documented within the relevant minutes.

Behaviour

- The Chair reserves the right to call the meeting to a stop and discharge the public in attendance where individuals' conduct is inappropriate or distracting.
- Aggressive behavior or abusive language (including heckling) will not be tolerated. Such behaviour will automatically result in the exclusion of any person(s) involved from the Board's meeting(s).

Petitions[1]

Members of the public are permitted, by agreement in advance, to formally present petitions to the Board. A petition is the expression of the views of the people who sign it and is an important mechanism for local people to have a voice on local health matters. [Such petitions may take digital or electronic form so long as they offer free and unfettered access to local residents]. To ensure that a range of voices are heard and in order to avoid giving undue prominence to particular or active lobby groups, petitions will be viewed as one piece of evidence and information contributing to an overall picture of public opinion.

Accordingly, the ICB will follow best practice and use a fair, transparent, and consistent approach to responding to petitions where decisions of the ICB Chair shall be deemed final. A valid petition must be signed by the person initiating the petition, plus at least five other supporting individuals, it may be in relation to an item of Board business or in relation to the provision of services for which the ICB is responsible for commissioning.

Meeting etiquette protocols

We ask participants and those in attendance at Board meetings to observe the following meeting etiquette:

- Please identify yourself and address the Chair when asking a question.
- Respect the decisions of the Chair in conducting the meeting.
- Please avoid interrupting anyone or talking over someone else, even if you disagree strongly.
- When contributing to proceedings, allow others to have their say. It is unfair to continue to address the meeting at the expense of others who would like to contribute.
- Avoid holding side conversations when someone else is talking.

Mobile Phone Protocol

The Board has responsibility for the health and care of 1.9m residents. It is essential therefore that Board and committee meetings have the full and focussed attention of members so that they can discharge their duties effectively and transparently. It is recognised that many Board members have senior responsibilities including clinical and professional accountabilities and/or on-call / emergency response duties; therefore, it is acceptable for phones to be present at meetings. Our policy is that

[1] A valid petition must be signed by the person initiating the petition, plus at least five other supporting individuals, it may be in relation to an item of Board business or in relation to the provision of services for which the ICB is responsible for commissioning.

any board member who is likely to be to be required to attend to a call or a message should avoid disrupting meetings by ensuring that:

- phones are always kept on silent/vibrate mode
- If an urgent call/message is received that requires immediate attention that this is signalled to the Chair and the member leaves the meeting room for the period required.

This will ensure that fellow Board members are not distracted, that the business of the Board can be conducted without interruption and to reassure the public that each and every member is focussed on their Board responsibilities during the meetings.

Members of the public or other attendees are also asked to turn mobile phones and other devices off or to vibrate.

Those in attendance have a responsibility to respect the role of Chair and to assist them in the delivery of the above. The underlying principles of the all the above reflect good manners, courtesy and consideration.

3. Financial Management

3.1. Standing Financial Instructions

NHS
Essex
Integrated Care Board

Standing Financial Instructions

Policy No: F006

Document Control:

Policy Name	Standing Financial Instructions
Policy Number	F006
Version	1.0
Status	Final Approved
Author / Lead	Finance Team
Responsible Executive Director	Executive Director of Finance & Commercial
Responsible Committee	Audit, Risk and Compliance Committee Commissioning, Quality and Resource Committee
Date Ratified by Responsible Committee	5 March 2026
Date Approved by Board/Effective Date	1 April 2026
Next Review Date	April 2028
Target Audience	All Staff
Stakeholders engaged in development of Policy (internal and external)	Finance Team Governance Team Internal Audit External Audit
Impact Assessments Undertaken *(State if not applicable)*	Equality Impact Assessment

Version History

Version	Date	Author (Name and Title)	Summary of amendments made
0.1	Dec 2025	Ashley King – Director Finance & Estates	First draft – base version MSEICB SFI Jan 24 Section 7 requires review once ICB governance agreed
0.2	Jan 2026	Nicola Adams	Updating governance sections
1.0	Apr 2026	Governance Senior Officer	Final – Approved version
1.1			
2.0			

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1. Introduction

1.1. From 1 April 2026, the Integrated Care Board (ICB) operates as the strategic commissioner for NHS services within its statutory footprint, responsible for long-term population health improvement, reducing inequalities, and ensuring value from the NHS budget.
These Standing Financial Instructions support the delivery of the 10-Year Health Plan, the Strategic Commissioning Framework, and the statutory duties of the ICB.

1.2. This is a controlled document. Whilst this document may be printed (please consider if this is necessary) the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the website (or requested from the Governance Lead/Team) to ensure the most up-to-date version is used.

2. Purpose and Statutory Framework

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

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

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

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

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

2.6. Each ICB is 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.

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

2.8. Should any difficulties arise regarding the interpretation or application of any of these SFIs, the advice of the Chief Executive or the Executive Director of Finance & Commercial (EDFC) must be sought before acting.

2.9. Failure to comply with the SFIs may result in disciplinary action in accordance with the ICBs applicable disciplinary policy and procedure in operation at that time.

3. Scope

3.1. All officers of the ICB, without exception, are within the scope of the SFIs without limitation. The term officer includes, permanent employees, secondees and contract workers.

3.2. Within this document, words imparting any gender include any other gender. Words in the singular include the plural and words in the plural include the singular.

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

3.4. Unless a contrary intention is evident, or the context requires otherwise, words or expressions contained in this document, will have the same meaning as set out in the applicable Act.

4. Definitions

There are no definitions to include.

5. Roles and Responsibilities

5.1. Integrated Care Board

5.1.1. The ICB Board remains accountable for the financial stewardship of the ICB and ensuring it complies with legislation and statutory requirements.

5.2. Audit Risk & Compliance Committee

5.2.1. The Board and Accountable Officer should be supported by an Audit, Risk & Compliance 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.

5.3. Commissioning, Quality and Resource Committee

5.3.1. The Commissioning, Quality and Resource Committee is responsible for ensuring that this governance document is followed, along with other relevant governance policies, when making commissioning decisions.

5.3.2. The Committee will also hold accountability for the financial stewardship of the ICB and ensuring it meets its financial statutory duties.

5.4. Other Committees'

5.4.1. The ICB Board may create other committees to discharge its responsibilities as set out and defined within the scheme of reservation and delegation. Where such committee's exist and have delegated responsibility for decision making, they shall also ensure this governance document is followed.

5.5. Chief Executive

5.5.1. The ICB constitution provides for the appointment of the Chief Executive by the ICB chair. The Chief Executive is the Accountable Officer for the ICB and is personally accountable to NHS England for the stewardship of the ICB's allocated resources.

5.5.2. The Executive Director of Finance & Commercial (EDFC)) reports directly to the ICB Chief Executive and is professionally accountable to the NHS England regional finance director.

5.5.3. The Chief Executive will delegate to the EDFC 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 the ICB meets its financial plan requirements and associated financial duties

- ensuring that there is an effective financial control framework in place to support accurate financial reporting, safeguard assets and minimise risk of financial loss
- meeting statutory requirements relating to taxation
- ensuring that there are suitable financial systems in place (see Section 6)
- meets the financial targets set for it by NHS England
- use of incidental powers such as management of ICB assets, entering commercial agreements
- the Governance statement and annual accounts & reports are signed
- planned budgets are approved by the relevant Board; developing the funding strategy for the ICB to support the board in achieving ICB objectives, including consideration of place-based budgets
- making use of benchmarking to make sure that funds are deployed as effectively as possible
- executive members, partner members and non-executive members, and other officers are notified of and understand their responsibilities within the SFIs
- specific responsibilities and delegation of authority to specific job titles are confirmed
- financial leadership and financial performance of the ICB
- identification of key financial risks and issues relating to robust financial performance and leadership and working with relevant providers and partners to enable solutions, and
- the EDFC 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.

5.6. All Staff

5.6.1. All ICB Officers are severally and collectively, responsible to their respective employer(s) for:

- abiding by all conditions of any delegated authority
- the security of the statutory organisations property and avoiding all forms of loss
- ensuring integrity, accuracy, probity, and value for money in the use of resources, and
- conforming to the requirements of these SFIs.

6. Policy Detail

6.1. Management accounting and business management

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

6.1.2. The EDFC will delegate the budgetary control responsibilities to budget holders through a formal documented process.

6.1.3. The EDFC 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
- 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 10-Year Health Plan objectives.

6.1.4. In addition, the EDFC should have financial leadership responsibility for the following statutory duties:

- the duty of the ICB to perform its functions so 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.

6.1.5. The EDFC 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.

6.2. Income, Banking Arrangements and Debt Recovery

Income

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

6.2.2. The EDFC is responsible for:

- ensuring order to cash practices are designed and operated to support, efficient, accurate and timely invoicing and receipting of cash. The processes and procedures should be standardised and harmonised across the NHS System by working cooperatively with the Shared Services provider, and
- ensuring the debt management strategy reflects the debt management objectives of the ICB and the prevailing risks.

Banking

6.2.3. The EDFC 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.

6.2.4. The EDFC 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

6.2.5. The EDFC is responsible for the ICB debt management strategy.

6.2.6. 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.

6.3. Financial Systems and Processes

Provision of Finance Systems

6.3.1. The EDFC is responsible for ensuring systems and processes are designed and maintained for the recording and verification of finance transactions such as payments and receivables for the ICB.

6.3.2. The systems and processes will ensure, inter alia, that payment for goods and services is made in accordance with the provisions of these SFIs, related procurement guidance and prompt payment practice.

6.3.3. As part of the contractual arrangements for ICBs officers will be granted access where appropriate to the Integrated Single Financial Environment (“ISFE”). This is the required accounting system for use by ICBs, Access is based on single access log on to enable users to perform core accounting functions such as to transacting and coding of expenditure/income in fulfilment of their roles.

6.3.4. The EDFC 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 EDFC shall periodically seek assurances that adequate controls are in operation.

6.4. Procurement and Purchasing

6.4.1. The EDFC 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.

6.4.2. The ICB must ensure that procurement activity is in accordance with the Public Contracts Regulations 2015 (PCR) for non-healthcare services as defined by the Common Procurement Vocabulary (CPV) codes and associated statutory requirements whilst securing value for money and sustainability.

6.4.3. The ICB must ensure that healthcare services procurement is in accordance with the Health Care Services (Provider Selection Regime) Regulations 2023 (PSR) as defined in Schedule 1 and section 150(1) of the Health and Social Care Act 2012.

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

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

6.4.6. All revenue and non-pay expenditure must be approved, in accordance with the ICB decision making policy, prior to an agreement being made with a third party that enters a commitment to future expenditure.

6.4.7. 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.

6.4.8. 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.

6.4.9. Undertake any contract variations or extensions in accordance with PCR 2015 for non-healthcare services, PSR for healthcare services and the ICB procurement policy.

6.4.10. Retrospective expenditure approval should not be permitted. Any such retrospective breaches require approval from any committee responsible for approvals before the liability is settled. Such breaches must be reported to the audit, risk and compliance committee.

6.5. Staff Costs and Staff Related non-Pay Expenditure

Executive Director of Corporate Services

6.5.1. The Executive Director of Corporate Services [EDCS] will lead the development and delivery of a people strategy to deliver the requirements of the 10-year workforce plan (due 2026).

6.5.2. Operationally the EDCS 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.

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

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

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

6.6. Annual Reporting and Accounts

6.6.1. The EDFC 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 strategy and capital resource use plan, and
    - review any steps that the board has taken to implement any joint local health and wellbeing strategy.

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

6.6.3. The ICB must give a copy of its annual report to NHS England by the date specified by NHS England in a direction and publish the report.

6.7. Internal Audit

6.7.1. 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 EDFC to ensure that:

- all internal audit services provided under arrangements proposed by the EDFC are approved by the Audit, Risk and Compliance 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, Risk and Compliance 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, Risk and Compliance Committee meetings and have a right of access to all audit, risk and compliance committee members, the Chair and Chief Executive of the ICB, and

- 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.

6.8. External Audit

6.8.1. The EDFC 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, 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.

6.9. Losses and Special Payments

6.9.1. HM Treasury approval is required if a transaction exceeds the delegated authority, or if transactions will set a precedent, are novel, contentious or could cause repercussions elsewhere in the public sector.

6.9.2. The EDFC 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.

6.9.3. NHS England has the statutory power to require an integrated care board to provide NHS England with information. The information, is not limited to losses and special payments, must be provided in such form, and at such time or within such period, as NHS England may require.

6.9.4. As part of the compliance and control procedures, ICBs must submit an annual assurance statement confirming the following:

- details of all exit packages (including special severance payments, as defined by NHS England) that have been agreed and/or made during the year
- that NHS England and HM Treasury approvals have been obtained before any offers, whether verbally or in writing, are made, and
- adherence to the special severance payments guidance as published by NHS England.

6.9.5. All losses and special payments (including special severance payments as defined by NHS England) must be reported to the ICB Audit, Risk and

Compliance Committee and NHS England noting that ICBs do not have a delegated limit to approve losses or special payments.

6.9.6. For detailed operational guidance on losses and special payments, please refer to the ICB losses and special payment guide.

6.10. Fraud, Bribery and Corruption (Economic Crime)

6.10.1. The ICB is committed to identifying, investigating, and preventing economic crime.

6.10.2. The ICB EDFC 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, Risk and Compliance Committee, and defined roles and accountabilities for those involved as part of the process of providing assurance to the board. These arrangements should comply with the NHS Requirements the Government Functional Standard 013 Counter Fraud as issued by NHS Counter Fraud Authority and any guidance issued by NHS England and NHS Improvement.

6.11. Capital Investments & Security of Assets and Grants

6.11.1. The EDFC 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 Integrated Care Board(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 EDFC is responsible for ensuring there are processes in place to ensure that a business case is produced.

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

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

6.11.3. Advice should be sought from the EDFC or nominated officer if there is any doubt as to whether any proposal is a capital commitment requiring formal approval.

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

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

- ensure the ICB asset portfolio supports its business objectives, and
- comply with NHS England policies and directives and with this standard.

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

Grants

6.11.7. The EDFC 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.

6.11.8. 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.

6.12. Legal and Insurance

6.12.1. This section applies to any legal cases threatened or instituted by or against the ICB. The ICB should have policies and procedures detailing:

- engagement of solicitors / legal advisors
- approval and signing of documents which will be necessary in legal proceedings, and
- Officers who can commit or spend ICB revenue resources in relation to settling legal matters.

6.12.2. ICBs are advised not to buy commercial insurance to protect against risk unless it is part of a risk management strategy that is approved by the accountable officer.

7. Monitoring Compliance

7.1. Compliance with this policy will be monitored by the finance team and reported to the Audit, Risk and Compliance Committee and the Commissioning, Quality and Resource Committee according to their terms of reference.

7.2. Both Internal and External Auditors will also review compliance with the policy and provide feedback to respective committees via their audit reports.

8. Staff Training

8.1. There is no general staff training required. However, finance staff will be professionally qualified as required by their role description.

8.2. This policy will be shared with staff to ensure their understanding and 'on the job' support will be provided by the finance team where needed.

9. Arrangements for Review

9.1.1. This policy will be reviewed no less frequently than every two years. An earlier review will be carried out in the event of any relevant changes in legislation, national or local policy/guidance, organisational change or other circumstances which mean the policy needs to be reviewed.

9.2. The sponsoring Committee has authority to make these changes without referral to the Integrated Care Board. If more significant or substantial changes are required, the policy will need to be approved by the relevant committee, and will be notified to the Integrated Care Board.

10. Associated Policies, Guidance and Documents

Associated Policies

- Scheme of Reservation and Delegation
- Standing Orders
- Decision Making Policy
- Procurement and Contracting Policy

11. References

- ICB Constitution

- National Health Service Act 2006, as amended by the Health and Care Act 2022.

12. Equality Impact Assessment

12.1. The EIA has identified no equality issues with this policy.

12.2. The EIA has been included as Appendix A.

Appendix A - Equality Impact Assessment

INITIAL INFORMATION

Name of policy and version number: Standing Financial Instructions v1.0	**Directorate/Service**: Finance
Assessor's Name and Job Title: Ashley King – Director of Finance & Estates	**Date:** 22/12/2025

OUTCOMES
Briefly describe the aim of the policy and state the intended outcomes for staff
To govern financial processes. This document ensures that staff follow statutory guidance and ICB Policy.
EVIDENCE
What data / information have you used to assess how this policy might impact on protected groups?
General assessment.
Who have you consulted with to assess possible impact on protected groups? If you have not consulted other people, please explain why?
This is a financial procedure that has no impact on protected characteristics.

ANALYSIS OF IMPACT ON EQUALITY

The Public Sector Equality Duty requires us to **eliminate** discrimination, **advance** equality of opportunity and **foster** good relations with protected groups. Consider how this policy / service will achieve these aims.

N.B. In some cases it is legal to treat people differently (objective justification).

- ***Positive outcome*** *– the policy/service eliminates discrimination, advances equality of opportunity and fosters good relations with protected groups*
- ***Negative outcome*** *– protected group(s) could be disadvantaged or discriminated against*
- ***Neutral outcome*** *– there is no effect currently on protected groups*

Please tick to show if outcome is likely to be positive, negative or neutral. Consider direct and indirect discrimination, harassment and victimisation.

Protected Group	Positive outcome	Negative outcome	Neutral outcome	Reason(s) for outcome
Age			X	
Disability (Physical and Mental/Learning)			X	
Religion or belief			X	
Sex (Gender)			X	
Sexual Orientation			X	
Transgender / Gender Reassignment			X	
Race and ethnicity			X	
Pregnancy and maternity (including breastfeeding mothers)			X	
Marriage or Civil Partnership			X	

MONITORING OUTCOMES
Monitoring is an ongoing process to check outcomes. It is different from a formal review which takes place at pre-agreed intervals.
What methods will you use to monitor outcomes on protected groups?
The impact of financial decisions are monitored as per individual decisions and not as part of this policy.

REVIEW
How often will you review this policy / service?
Every 2 years as a minimum and earlier if there are any significant changes in legislation, policy or good practice.
If a review process is not in place, what plans do you have to establish one?
N/A

NHS
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Integrated Care Board

4. Policy Management Framework

4.1. **Policy for developing policies (including Policy Template)**

4.2. **Policy Framework (Register of Policies)**

4.3. **Risk Management Policy**

4.4. **Standards of Business Conduct Policy (Including Management of Conflicts of Interest, Gifts and Hospitality, Outside Employment, Commercial Sponsorship and other situations where conflicts might arise)**

4.5. **Decision Making Policy [to follow]**

4.6. **Patient and Public Engagement Framework [to follow]**

NHS
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Integrated Care Board

Policy for the development, ratification and implementation of policies

Policy No: C001

Document Control:

Document Control Information	Details
Policy Name	Policy for the development, ratification and implementation of policies
Policy Number	C001
Version	1.0
Status	Final - Approved
Author / Lead	Sara O'Connor, Senior Manager Corporate Services
Responsible Executive Director	The Chief Executive has delegated responsibility to the Executive Director of Corporate Services for the management of policies
Responsible Committee(s)	Executive Committee Essex Joint Committee
Date Approved by Responsible Committee	6 January 2026 22 January 2026
Date Ratified by Board	1 April 2026
Next Review Date	April 2028
Target Audience	All ICB Board members and staff (including temporary/bank/agency/work experience staff, students and volunteers)
Stakeholders engaged in development of Policy (internal and external)	• Governance Team • Executive Committee • Audit Committee
Impact Assessments Undertaken *(State if not applicable)*	• Equality and Health Inequalities Impact Assessment - completed • Quality Impact Assessment – N/A • Privacy Impact Assessment – N/A

Version History

Version	Date	Author (Name and Title)	Summary of amendments made
0.1	06/01/26	Senior Manager Corp Svcs	Draft Policy
1.0	19/01/26	Corp Svcs & Gov Support Officer	Final – Approved version

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1. Introduction

1.1. To ensure robust governance, organisations need formal written documents, such as policies, which communicate standard corporate organisational ways of working. These help to clarify current legislation, guidelines and best practice, strategic and operational requirements and ensure consistency within day-to-day practice. In addition, they can improve the quality of work, increase the successful achievement of objectives and support patient safety, quality and experience. All policies will undergo an Equality Impact Assessment (**Appendix A**) and website accessibility checks to support the ICB's equality, diversity and inclusion agenda. It is recognised that systems need to be in place to ensure policies are user friendly, up-to-date and easily accessible.

1.2. A common format and approval structure for policies will reinforce corporate identity. More importantly, this will help to ensure that policies and related procedures in use are current and reflect an organisational approach. It will also avoid confusion and assist employees to readily access information within the document in a consistent manner.

1.3. This is a controlled document. Whilst this document may be printed (please consider if this is necessary) the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the website (or requested from the Governance Lead/Team) to ensure the most up-to-date version is used.

2. Purpose

2.1. Essex Integrated Care Board (the ICB) intends that its organisational policies should provide a clear understanding of what is expected of employees and Board members.

2.2. Whilst this document is particularly relevant to staff who are responsible for writing or reviewing policies, it is equally important that all Board members and employees understand the relevance of having these in place.

2.3. Occasionally policies will be developed through partnership working and may have a different format than that described here. In these instances, the policy itself will be adopted but will still be quality-assured against the criteria of this document to ensure that when presented for final approval it meets the ICB's requirements.

2.4. This document outlines the process for policy development from inception through to ratification, implementation and evaluation.

2.5. A flow chart detailing this process is shown at **Appendix B**.

3. Scope

This policy applies to all ICB Board members and staff (including temporary/bank/agency/work experience staff, students and volunteers).

4. Definitions

- **Policy** - an organisation wide corporate policy is a ratified plan of action which applies to all relevant staff as a 'must do' requirement. The formal policy document is legally binding between employer and employee. A policy says '*what you must know or do*.'
- **Procedure** - an organisation wide procedure is a standardised series of actions taken to achieve a task in an agreed and consistent manner to attain a safe and effective outcome. A procedure is a formal document that must be complied with as it may be used to support an individual or the ICB during legal action. A procedure tells you '*how it must be done*.'
- **Strategy** - a strategy is a document that defines a process of moving towards an ideal situation, generally over the long-term, implementing actions or compliance with a policy. A strategy tells you '*how we will get from A to B*.'

5. Roles and Responsibilities

5.1. Integrated Care Board

5.1.1. The ICB Board has overall responsibility for ensuring that the organisation has a robust system in place for the development, approval and regular review of policies covering all corporate activities.

5.1.2. The ICB Board will receive formal confirmation from the committee sponsoring the policy that it meets the requirements of the Policy for Policies and has been approved by the committee via regular policy updates at Board meetings. The ICB Board is responsible for providing formal approval of all new ICB policies and those which have been subject to substantial or significant revisions, having received this assurance.

5.2. Committees

The responsibility of the ICB's main committees is to review and approve policies that are new or have been subject to substantial or significant revisions since the previous version.

NB: Minor amendments that do not change the intention of a policy, e.g. typographical errors, can be made by policy authors/governance team and noted in the version control table.

Responsibility for policies is set out in committee terms of reference and summarised in the table below:

Committee	Policy responsibility
Audit, Risk and Compliance Committee	• Standards of Business Conduct/Conflicts of Interest/Fraud, Bribery & Corruption • Health & Safety • Information Technology/Digital • Information Governance • Emergency Planning/Business Continuity/Security • Corporate communications (media/social media)
Executive Committee	• People Policies (except those relating to pay/terms & conditions) • The Executive Team will also review new/revised policies prior to approval by other main committees.
Neighbourhood Health Committee	• Primary Care • Communications and Engagement with stakeholders
Remuneration Committee	• People policies relating to pay and terms and conditions.
Commissioning, Quality and Resource Committee	• Commissioning • Finance • Contracting / Procurement • Quality and Safety

5.3. Chief Executive

5.3.1. The Chief Executive Officer of the ICB has overall accountability for implementing the Policy for Policies.

5.4. Executive Director of Corporate Services

5.4.1. The Chief Executive has delegated operational responsibility for implementation of this policy to the Executive Director of Corporate Services.

5.5. Policy Authors

5.5.1. Policy authors are responsible for reviewing and updating the policies within their remit on an annual basis or should legislation, guidance, organisational change or other circumstances necessitate an earlier review.

5.6. Governance Lead

5.6.1. The Associate Director of Governance supported by the Governance and Risk Manager (referred to in this policy as the Governance Lead) will provide support with policy development by:

- Offering support and advice to policy authors.
- Testing the rationale for the need for an ICB policy.
- Logging the policy on the relevant policy register.
- Identifying possible overlap/conflict with any other policies that have been ratified or are in development.
- Identifying whether the document is a policy or a local procedure or guidance.
- Identifying and confirming the correct ratification route.
- Confirming that a draft policy meets the requirements of the Policy Development Checklist (**Appendix C**) before it is submitted to the ratifying committee.
- Liaising with the Communications and Engagement Team to upload ratified policies to the intranet and internet.
- Maintaining the register of active policies.
- Archiving old policies.
- Advising policy leads when policies are due for review.

5.7. Line Managers

5.7.1. Line Managers are responsible for:

- Identifying when a new or amended policy may be required for business areas within their remit.
- Ensuring that new members of staff are made aware of key policies as part of their induction.
- Highlighting new and amended policies within their team briefings.
- Monitoring the implementation of policies within their team, by identifying risks and key performance indicators to indicate/measure the effectiveness or a policy, auditing compliance and addressing any failures to follow agreed processes.

5.8. All Staff

5.8.1. All staff need to ensure they are aware of the system for policy development, ratification and implementation. This includes a requirement on receipt of new policies to review their contents and assess the relevance to their role.

5.8.2. All staff should be aware that wilful or negligent disregard of any policy will be investigated and potentially treated as a disciplinary offence.

6. Policy Detail

6.1. Style and format

6.1.1. All policies and any related procedures should be developed using the Policy Template appended to this policy (**Appendix D**). Requirements in respect of style and format are detailed on the template itself.

6.1.2. The Policy Template has been designed to be accessible in accordance with the requirements of the Equality Act 2010 and the Public Sector Bodies (Websites and Mobile Applications) Accessibility Regulations 2018. The Equality and Human Rights Commission is responsible for enforcing the regulations. It is imperative, therefore, that policy authors use the template provided and do not attempt to modify its format. Accessibility checks **must** be performed **by the policy author** and any issues addressed prior to approval of a new or revised policy.

6.2. Key features of a well-written policy

6.2.1 Each policy must be compliant with all current legal and statutory requirements that are relevant to their development. A well written policy should:

- Be clear, concise, jargon free and written in straightforward language, with flowcharts or diagrams where these aid understanding
- Explain abbreviations or acronym the first time they are used.
- Take account of the relevant views of stakeholders where appropriate.
- Be sound / evidence based.
- Have clear objectives.
- Specify how it will be implemented, monitored and audited.
- Describe a consequence of any breaches.

6.3. Development of new and revised policies

6.3.1 It is important that the development of policies and related procedures are linked to service priorities and that they do not duplicate other work either nationally or locally. Therefore, the author must ensure that they have researched the background and available evidence prior to consultation and ratification.

6.3.2 An author may be requested to develop a new policy based on ICB

needs, changes in legislation or national requirements.

6.3.3 An author who is reviewing an existing policy is expected to review the contents of the current version for their continued relevance and maintaining continuity between versions. The author will also be responsible for checking that any hyperlinks remain valid and undertaking a new Equality Impact Assessment which must be included in each policy as an Appendix

6.3.4 Whilst writing the policy, the author should use the Policy Development Checklist (**Appendix C**) to confirm whether it meets necessary requirements.

6.4. Consultation

6.4.1 Consultation should be undertaken to secure the support and experience from all relevant individuals and groups, for example Staff Side (unions) for HR policies. Advice on consulting with Staff Side can be obtained from the ICB's Human Resources Lead.

6.4.2 It is vital to the success of the implementation of any policy that the expertise and experience of all relevant parties has been considered, particularly those who will be expected to implement its requirements.

6.4.3 The consultation process is an opportunity to influence the policy content and should not be considered only as an exercise to satisfy the checklist requirements.

6.4.4 A draft policy when sent out to stakeholders should be as near to the 'final' draft version as possible and include all relevant references with details of associated documentation. This will help to ensure that the stakeholders are able to review and make appropriately informed comments. Sufficient time should be given to enable a thorough review by stakeholders.

6.4.5 A list of all staff and stakeholders consulted during the policy development should be included in the relevant section.

6.5. Preparation for approval

6.5.1. Once the policy has been fully consulted upon and comments considered, it is ready for formal agreement and ratification.

6.5.2. It is the author's responsibility to contact the Governance Lead to request that the policy be added to the agenda of the next appropriate committee meeting, although the governance team will track and remind policy authors when policies are due for review.

6.5.3. The author should submit the draft policy, completed Policy Development Checklist and a summary of the purpose of the policy (if new) or of the key changes that have been to the existing policy (if amended) to the Governance Lead/Team.

6.5.4. The Governance Lead/Team will review the policy and associated documents and advise the policy author if any changes or additional information is needed before it is submitted to the ratifying committee.

6.5.5. The policy author may be invited to attend the committee meeting to present the policy and respond to any queries.

6.5.6. If the policy is not deemed to be ready for formal ratification, the committee will agree with the author where amendment or clarification is required. The author will then re-submit to the next meeting if appropriate. If the policy is deemed ready for final approval (with or without minor amendments), then it will be approved by the relevant committee(s) and ratified by the ICB Board, or, in the case of new or significantly amended policies, approved by the ICB Board.

6.6. Fastrack policy approval process

6.6.1. There will be occasions due to urgency or immediacy where the process of formal ratification needs to be accelerated, but this should be on an exceptional basis only. In these circumstances, committee Terms of Reference allow for urgent decisions to be taken outside of their normal meeting schedule. If necessary, the policy can then be formally approved by the ICB Board under the exercise of Emergency Powers.

6.7. Dissemination and communication to staff and the public

6.7.1. The Governance Team will liaise with the Communications and Engagement Team to arrange for all ratified policies to be added to the staff intranet and external website in accessible HTML format, and staff will be notified of all policy activity through the ICB's internal communication system.

6.7.2. Policies must be provided in alternative formats upon request, such as larger print, easy read, braille, audio format and different languages.

6.8. Document control including archiving arrangements

6.8.1. The Governance team will hold a central register of all current policy documents, together with a master file of electronic copies, including archived documents.

7. Monitoring Compliance

7.1. Performance indicators will be used to monitor effectiveness of this and other policies. These may include compliance with associated mandatory training, the RAG rating of associated risks, complaints, claims and incidents and the outcome of audits to identify where failure to follow policy may have impacted on commissioning, service delivery, regulatory compliance or corporate governance.

7.2. The monitoring compliance section of each policy should identify the intelligent data sources (where available) that should be reported to the

sponsoring committee that indicate whether or not the policy is being adhered to / delivered. These will form part of the intelligent Board reports from the sponsoring committee to the ICB Board.

7.3. The relevant sponsoring committee will be responsible for ensuring that policies submitted to them for approval are compliant with this policy.

8. Implementation and Staff Training

8.1 There is a requirement as part of local induction to ensure that staff are made aware of the importance of policies and procedures and their adherence to them.

8.2 All policies must identify training requirements associated with them and the frequency with which this training is required. Policy authors should contact Human Resources for any e-Learning available via ESR relevant to the policy.

9. Arrangements for Review

9.1. This policy will be reviewed no less frequently than every two years. An earlier review will be carried out in the event of any relevant changes in legislation, national or local policy/guidance, organisational change or other circumstances which mean the policy needs to be reviewed.

9.2. If only minor changes are required, the sponsoring committee has authority to make these changes without referral to the ICB Board. If more significant or substantial changes are required, the policy may need to be ratified by the relevant committee before final approval by the ICB Board. The Governance Lead will provide advice on the correct approval route if required.

10. Associated Policies, Guidance and Documents

10.1 The author is required to provide details of supporting or linked strategy, policy, procedural or other documents within the ICB that may need to be read in conjunction with the policy or for staff to be aware of their existence.

10.2 For this policy the associated documentation is:

- Policy Template.
- Policy Checklist.

Associated Policies

This policy is relevant to all ICB Policies.

11. References

11.1. The author should provide references to any documents that have been used to develop the policy as evidence that it has been based on best practice and guidance.

11.2. For this policy the references are:

- Equality Act 2010.
- Public Sector Bodies (Websites and Mobile Applications) (No. 2) Accessibility Regulations 2018.

12. Equality Impact Assessment

12.1. An Equality Impact Assessment (EIA) of this policy has been undertaken and it has identified no equality issues.

12.2. The EIA has been included as **Appendix A**.

Appendix A - Equality Impact Assessment

INITIAL INFORMATION

Name of policy: Policy for Policies **Version number (if relevant): 1.0**	**Directorate/Service**: CEO's office / Governance
Assessor's Name and Job Title: Sara O'Connor, Senior Manager Corporate Services	**Date:** 17/12/2025

OUTCOMES
Briefly describe the aim of the policy and state the intended outcomes for staff
This policy provides a framework for the development of staff and public policies to ensure that they are user friendly, up-to-date and easily accessible.
EVIDENCE
What data / information have you used to assess how this policy might impact on protected groups?
This policy acknowledges that circa 25% of people in the UK have a disability and many more have a temporary disability. Additionally, circa 36% of people of working-age people report having at least one long-term health condition. The policy template has therefore been developed to meet the accessibility requirements of the Equality Act 2010 and the Public Sector Bodies (Websites and Mobile Applications) Accessibility Regulations 2018.
Who have you consulted with to assess possible impact on protected groups? If you have not consulted other people, please explain why?
• Governance Lead • Executive Committee • Audit Committee (will be asked to formally approve the policy)

ANALYSIS OF IMPACT ON EQUALITY

The Public Sector Equality Duty requires us to **eliminate** discrimination, **advance** equality of opportunity and **foster** good relations with protected groups. Consider how this policy / service will achieve these aims.

N.B. In some cases it is legal to treat people differently (objective justification).

- ***Positive outcome*** *– the policy/service eliminates discrimination, advances equality of opportunity and fosters good relations with protected groups*
- ***Negative outcome*** *– protected group(s) could be disadvantaged or discriminated against*
- ***Neutral outcome*** *– there is no effect currently on protected groups*

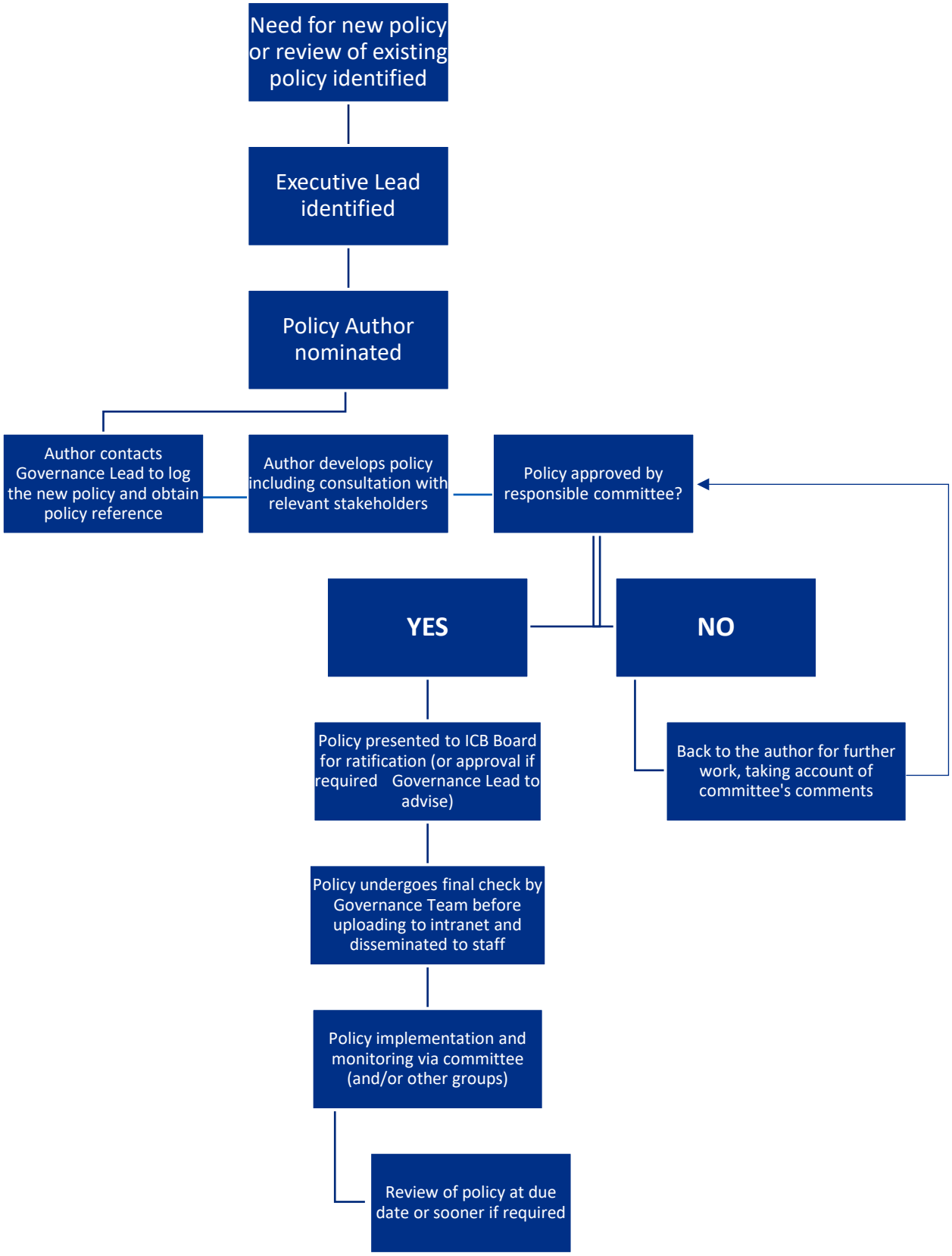
Please tick to show if outcome is likely to be positive, negative or neutral. Consider direct and indirect discrimination, harassment and victimisation.

Protected Group	Positive outcome	Negative outcome	Neutral outcome	Reason(s) for outcome
Age			X	No impact identified
Disability (Physical and Mental/Learning)			X	No impact identified. Policies will be made available in alternative formats on request. All final policies undergo website accessibility checks and will be uploaded to the ICB website in accessible HTML format.
Religion or belief			X	No impact identified
Sex (Gender)			X	No impact identified
Sexual Orientation			X	No impact identified
Transgender / Gender Reassignment			X	No impact identified
Race and ethnicity			X	No impact identified. Policies will be made available in alternative formats on request.
Pregnancy and maternity (including breastfeeding mothers)			X	No impact identified
Marriage or Civil Partnership			X	No impact identified

MONITORING OUTCOMES
Monitoring is an ongoing process to check outcomes. It is different from a formal review which takes place at pre-agreed intervals.
What methods will you use to monitor outcomes on protected groups?
Performance indicators will be used to monitor effectiveness of this and other ICB policies. These will include mandatory training compliance, risk RAG ratings/scores, outcomes of audits, complaints, claims and incidents to identify where failure to follow policy may have impacted on commissioning, service delivery, regulatory compliance or corporate governance. Sponsoring committees which review new/revised policies often query issues relating to equality and request policy authors to update policies to address any issues identified.

REVIEW
How often will you review this policy / service?
Every 2 years as a minimum and earlier if there are any significant changes in legislation, policy or good practice.
If a review process is not in place, what plans do you have to establish one?
N/A

Appendix B – Key Stages of the Policy Process



Appendix C - Policy Development Checklist

Policy title:			
Criteria for Compliance	**Author Yes/No**	**Author's Comments**	**Reviewer's Comments**
Could this policy be incorporated within an existing policy?		If no explain why	
If a new policy, has the Governance Team been notified so a policy reference can be allocated?			
Does this policy follow the style and format of the agreed template?			
Has the Document Control table been completed?			
Has the Version Control table been completed?			
Is there an appropriate review date?		Explain if less or more than 2 years	
Have key performance indicators (or other arrangements) been identified to monitor effectiveness of the policy?			
Have all relevant associated policies, references and hyperlinks been included and checked?			
Have all appropriate stakeholders (including where necessary Staff Side, the Local Counter Fraud Specialist or Local Security Management Specialist) been consulted and identified on the stakeholder list?			
Are all appendices referred to in the correct order, included within the policy (they must not be embedded) and their headings formatted correctly so they appear in the Contents list?			

Policy title:			
Criteria for Compliance	**Author Yes/No**	**Author's Comments**	**Reviewer's Comments**
Has the Contents page been updated to show correct page numbers and hyperlinks to each section?			
Has an Equality Impact Assessment (EIA) been undertaken/updated? (NB: The EIA is within the Policy template and should be included as Appendix A of the policy)			
Has the policy been amended to address any negative impacts identified from the EIA?			
Is a Quality Impact Assessment (QIA) or Privacy Impact Assessment required? *NB: Seek advice from Quality Team or Information Governance Team if required.*			
Is there a clear indication of how the policy will be implemented?			
Have job titles/responsibilities been updated to reflect the current ICB structure.			
Has the 'Footer' of the policy been updated to reflect correct name, version and page numbers?			
If the policy includes tables, flowcharts or diagrams, do these align with the content of the policy and meet website accessibility standards?			
Has a website accessibility check been undertaken and any issues addressed?			

Appendix D – Policy Template

SEE NEXT PAGE

LOGO

[Insert Policy Name]

Policy No: EICB XXX

Document Control:

Document Control Information	Details
Policy Name	
Policy Number	
Version	
Status	
Author / Lead	
Responsible Executive Director	
Responsible Committee	
Date Approved by Responsible Committee	
Date Ratified by the ICB Board/Effective Date	
Next Review Date	
Target Audience	
Stakeholders engaged in development of Policy (internal and external)	
Impact Assessments Undertaken *(State if not applicable)*	• Equality and Health Inequalities Impact Assessment • Quality Impact Assessment • Privacy Impact Assessment

Version History

Version	Date	Author (Name and Title)	Summary of amendments made

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5.1. Integrated Care Board XX

5.2. XXXX Committee XX

5.3. XXXX Committee (Repeat as necessary) XX

5.4. Chief Executive XX

5.5. Policy Authors XX

5.6. Arden and GEM Commissioning Support Unit (AGEMCSU) XX

5.7. Governance Lead XX

5.8. Line Managers XX

5.9. All Staff XX

6. Policy Detail XX

6.1. Subheading XX

7. Monitoring Compliance XX

8. Staff Training XX

9. Arrangements For Review XX

10. Associated Policies, Guidance And Documents XX

11. References XX

12. Equality Impact Assessment XX

Appendix A - Equality Impact Assessment XX

Appendix B – Title XXX XX

1. Introduction

1.1. Insert text

1.2. This is a controlled document. Whilst this document may be printed (please consider if this is necessary), the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the website (or requested from the Governance Lead/Team) to ensure the most up-to-date version is used.

2. Purpose / Policy Statement

2.1. Insert text Insert statement of policy

2.2. Insert narrative for bullet list:

- Bullet list (remove if not using)

3. Scope

3.1. E.g. This policy applies to all ICB Board members and staff (including temporary/bank/agency/work experience staff, students and volunteers).

4. Definitions

- State Word – Provide Definition
- State Word – Provide Definition
- State Word – Provide Definition

5. Roles and Responsibilities

5.1. Integrated Care Board

5.1.1. Insert narrative for ICB Board responsibilities.

5.2. XXXX Committee

5.2.1. Insert narrative for Committee responsibilities.

5.3. XXXX Committee

5.3.1. Insert narrative for XXX Committee responsibilities (if applicable – repeat as necessary).

5.4. Chief Executive

5.4.1. Insert narrative for what the Chief Executive is accountable for.

5.5. Executive Director of XXX

5.5.1. Insert narrative for what the Executive Director lead is accountable for.

5.6. Policy Authors

5.6.1. Insert narrative for what the Policy Authors are accountable for.

5.7. Governance Lead

5.7.1. Insert narrative for what the Governance Lead is accountable for (if applicable).

5.8. Line Managers

5.8.1. Insert narrative for what Line Managers are accountable for.

5.9. All Staff

5.10. Insert narrative for what all staff are accountable for.

6. Policy Detail

6.1. Subheading

6.1.1. Insert text. Additional headings can be added instead of subheadings if this aids comprehension.

7. Monitoring Compliance

7.1. Insert text regarding KPIs or other data sources evidencing the policy is effective, such as associated risks and their RAG rating/scores, that will be used by committees or other groups to monitor compliance with the policy.

7.2. Insert text regarding the committees / groups responsible for monitoring compliance.

8. Implementation and Staff Training

8.1. State how the policy will be implemented including mandatory or other training requirements. Contact Human Resources to check any e-Learning available via ESR.

9. Arrangements for Review

9.1.1. This policy will be reviewed no less frequently than every two years *[this may be reduced to one year if necessary, for example if required by a relevant standard, or extended to three years as long as this can be justified and explained within the policy].* An earlier review will be carried out in the event of any relevant changes in legislation, national or local policy/guidance, organisational change or other circumstances which mean the policy needs to be reviewed. Policy reviews should seek input from relevant stakeholders, including Staff Side/Staff Engagement Group for HR policies, and other appropriate fora including the Executive Team.

9.2. If only minor changes are required, the sponsoring Committee has authority to make these changes without referral to the Integrated Care Board. If more significant or substantial changes are required, the policy will be ratified by the relevant committee before final approval by the Integrated Care Board.

10. Associated Policies, Guidance and Documents

- List supplementary documents (if applicable)

Associated Policies (A hyperlink to the policies webpage will be added once the new EICB website goes live).

- List here the relevant associated ICB policies

11. References

- Provide a list of references of the documents that have informed or contributed to this policy.

12. Equality Impact Assessment

12.1. State either – the EIA has identified no equality issues with this policy OR Issues identified in the EIA were XXX and they have been addressed by XXX.

12.2. The EIA has been included as **Appendix A**.

Appendix A - Equality Impact Assessment

INITIAL INFORMATION

Name of policy and version number:	**Directorate/Service**:
Assessor's Name and Job Title:	**Date:**

OUTCOMES
Briefly describe the aim of the policy and state the intended outcomes for staff
EVIDENCE
What data / information have you used to assess how this policy might impact on protected groups?
Who have you consulted with to assess possible impact on protected groups? If you have not consulted other people, please explain why?

ANALYSIS OF IMPACT ON EQUALITY

The Public Sector Equality Duty requires us to **eliminate** discrimination, **advance** equality of opportunity and **foster** good relations with protected groups. Consider how this policy / service will achieve these aims.

N.B. In some cases it is legal to treat people differently (objective justification).

- ***Positive outcome*** *– the policy/service eliminates discrimination, advances equality of opportunity and fosters good relations with protected groups*
- ***Negative outcome*** *– protected group(s) could be disadvantaged or discriminated against*
- ***Neutral outcome*** *– there is no effect currently on protected groups*

Please tick to show if outcome is likely to be positive, negative or neutral. Consider direct and indirect discrimination, harassment and victimisation.

Protected Group	Positive outcome	Negative outcome	Neutral outcome	Reason(s) for outcome
Age				
Disability (Physical and Mental/Learning)				
Religion or belief				
Sex (Gender)				
Sexual Orientation				
Transgender / Gender Reassignment				
Race and ethnicity				
Pregnancy and maternity (including breastfeeding mothers)				
Marriage or Civil Partnership				

MONITORING OUTCOMES
Monitoring is an ongoing process to check outcomes. It is different from a formal review which takes place at pre-agreed intervals.
What methods will you use to monitor outcomes on protected groups?

REVIEW
How often will you review this policy / service?
Every 2 years as a minimum and earlier if there are any significant changes in legislation, policy or good practice.
If a review process is not in place, what plans do you have to establish one?
N/A

Implementing the Policy/Service

Negative outcomes – action plan

If there are no negative outcomes, please remove this section.

An Equality Impact Assessment cannot be signed off until negative outcomes are addressed. What actions you have taken/plan to take to remove/reduce negative outcomes?

1. Action taken/to be taken	2. Date	~~3.~~ Person Responsible

If a negative outcome(s) remain explain why you think implementation is justified.

Insert response here.

Signed off by:

Date:

Appendix B – Title XXX

Insert other appendices as appropriate – please use the same format as the heading above for each additional appendix.

To do this, click/highlight the above heading, then click on the ‘Format Painter’ icon (within the ‘Home’ menu tab), then highlight the new appendix heading). This ensures all appendix headings appear in the contents page.

Essex Integrated Care Board Policy Framework

Directorate / Business Area	Policy Name
Coporate Governance	Policy for Policies
Corporate Governance	Standards of Business Conduct Policy, including Conflicts of Interest, Gifts and Hospitality, etc
Corporate Governance	Counter-Fraud, Bribery & Corruption Policy
Corporate Governance	Decision Making Policy and Procedure
Corporate Governance	Health & Safety Policy (including Fire Safety, First Aid and Manual Handling)
Corporate Governance	Impact Assessment Policy and Guidance (including Quality, Health Inequalities, Equality)
Corporate Governance	Incident Reporting Policy
Corporate Governance	Legal Services Policy
Corporate Governance	Lone Working Policy
Corporate Governance	Management of Violence and Aggression and Vexatious Behaviour Policy
Corporate Governance	Risk Management Policy
Emergency Planning Resilie	Emergency Preparedness, Resilience and Response and Business Continuity Management Policy
Emergency Planning Resilie	On Call Director Policy
Emergency Planning Resilie	Security and Lockdown Policy
Communications	Media Policy
Communications	Social Media Policy
Human Resources	Absence Management Policy
Human Resources	Annual Leave Policy
Human Resources	Appraisal Policy
Human Resources	Close Personal Relationships at Work Policy
Human Resources	Cycle to Work Policy
Human Resources	Dignity at Work Policy
Human Resources	Disciplinary Policy
Human Resources	Disclosure and Barring Policy
Human Resources	Domestic Violence and Abuse Policy
Human Resources	Equality in Employment Policy
Human Resources	Flexible Working Policy
Human Resources	Fostering Policy
Human Resources	Freedom to Speak Up (Whistleblowing) Policy
Human Resources	Grievance Policy
Human Resources	Hybrid Working Policy
Human Resources	Job Matching and Evaluation Policy
Human Resources	Learning & Development Policy
Human Resources	Lease Car Scheme Policy
Human Resources	Management of Leavers Policy
Human Resources	Managing Performance Policy
Human Resources	Maternity, Paternity & Adoption Leave Policy
Human Resources	Menopause at Work Policy
Human Resources	Nurse Revalidation Policy
Human Resources	Organisational Change Policy
Human Resources	Parental Leave Policy
Human Resources	Pay Protection Policy
Human Resources	Probation Policy
Human Resources	Professional Registration Policy
Human Resources	Recruitment & Selection Policy
Human Resources	Reimbursement of Staff Expenses Policy (including Travel).
Human Resources	Sexual Misconduct Policy
Human Resources	Shared Parental Leave Policy
Human Resources	Special Leave Policy
Human Resources	Staff Volunteering Policy
Human Resources	Stress Management Policy
Human Resources	Under / Overpayments Policy
Information Governance	Access to Information Policy
Information Governance	Forensic Readiness Policy
Information Governance	Information and Cyber Security Policy
Information Governance	Information Governance Management & Framework Policy
Information Governance	Information Sharing Policy
Information Governance	Records Management & Information Lifecycle Policy
Finance & Commercial	Accounting and Financial Management
Finance & Commercial	Banking and Cashflow Management Policy
Finance & Commercial	Creditors and Purchase Policy

Directorate / Business Area	Policy Name
Finance & Commercial	Debtors and Sales Order Policy
Finance & Commercial	Procurement and Contracting Policy
Finance & Commercial	Provider Accreditation Policy
Finance & Commercial	Standing Financial Instructions
Medical	Commissioning Policy (Service Restriction)
Medical	Defining Boundaries Between NHS and Private Healthcare
Medical	Individual Funding Request Policy
Medical	Patient Choice Policy
Nursing	All Age Continuing Care Policy
Nursing	Communicable Disease Outbreak and Incident Management Policy
Nursing	Complaints, Compliments and Concerns Management Policy
Nursing	Mental Capacity Act 2005 and Deprivation of Liberty Policy
Nursing	MSE Cross System Response Policy
Nursing	Patient Safety Incident Response Framework (PSIRF) Policy
Nursing	Personal Health Budgets: Ethos, Practice and Guidance Policy
Nursing	Prevent Policy
Nursing	Quality Assurance Visits Policy
Nursing	Safeguarding Adults and Children (including Children in Care/Looked After Children) Policy
Nursing	Safeguarding Supervision Policy
Nursing	Serious Incidents Process Policy

NHS
Essex
Integrated Care Board

Risk Management Policy and Strategy

Policy No: C003

Document Control:

Document Control Information:	Details:
Policy Name	Risk Management Policy and Strategy
Policy Number	C003
Version	1.0
Status	Final - Approved
Author / Lead	Associate Director of Governance
Responsible Executive Director	Executive Director of Corporate Services
Responsible Committee	Audit, Risk and Compliance Committee
Date Ratified by Responsible Committee	24 March 2026
Date Approved by Board/Effective Date	1 April 2026
Next Review Date	April 2027
Target Audience	• Integrated Care Board (ICB) members and staff (including temporary/bank/agency/voluntary/work experience staff). • Contractors engaged by the ICB. • Staff from other organisations who are members of ICB Committees/Sub-Committees and other groups.
Stakeholders engaged in development of Policy (internal and external)	• Governance Leads. • Audit, Risk and Compliance Committee. • Executive Committee
	• Equality Impact Assessment

Version History

Version	Date	Author (Name and Title)	Summary of amendments made
0.1	21/03/26	Nicola Adams, Associate Director of Corporate Services	First draft of ICB Risk Management Policy and Strategy
1.0	24/03/26	Helen Chasney, Senior Governance Officer	Final – Approved version

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1. Introduction

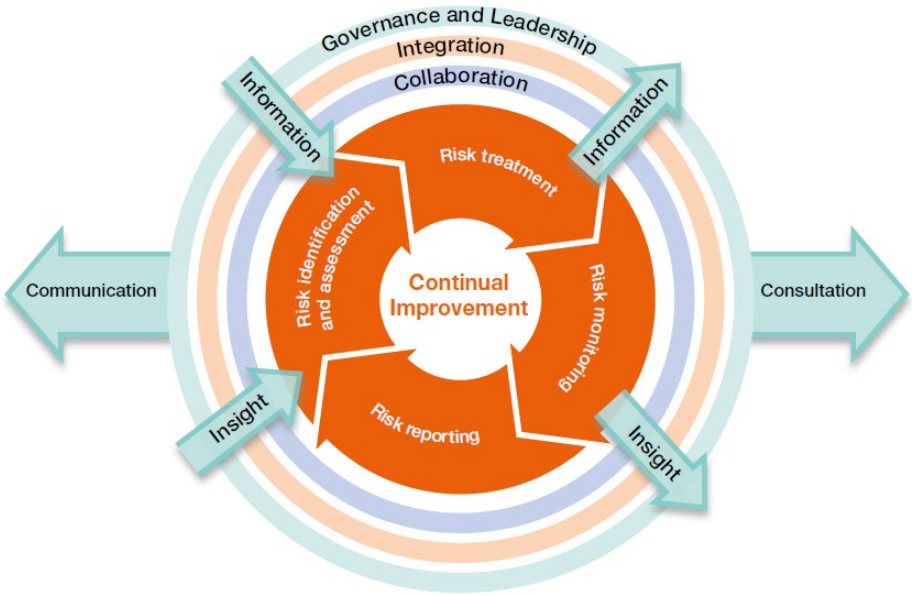
1.1. From 1 April 2026, the new Essex Integrated Care Board ('the ICB') assumes its role as the statutory strategic commissioning body for NHS services for the population of Essex. The ICB is responsible for ensuring that risks which may impact the achievement of its corporate objectives (derived from and set out in greater detail in the Population Health Improvement Plan), statutory duties, or commissioning responsibilities are identified, assessed, managed in a consistent and transparent way and form the bedrock of decision-making and reporting across the ICB. This policy and strategy set out how the ICB will establish and manage its risk framework to that end, across all areas of its work.

1.2. The ICB recognises that commissioning high-quality, sustainable healthcare services inherently involves risk. Taking well-managed and informed risks can also create opportunities to innovate, improve outcomes and reduce inequalities. The ICB does not seek to operate in a risk-free environment; rather, it aims to ensure that risk is routinely identified, understood and managed through proportionate and embedded structures, processes and behaviours.

1.3. Risk is defined as the effect of uncertainty on objectives, whether representing a potential opportunity or a threat. Effective risk management involves identifying and assessing risks (including inherent risks), implementing controls and mitigations, monitoring their effectiveness, and taking action where further intervention is necessary. A structured and systematic approach enables the ICB to avoid exposure to extreme or unmanaged risks, and to support efficient, evidence-based decision-making.

1.4. An effective framework must support continuous learning. The ICB will ensure that risks are identified, analysed, prioritised, mitigated and reported at all appropriate levels, including through its committees and the Board. Regular reporting enables the Board to understand changes in the ICB's risk profile and provides assurance on whether internal control systems are operating effectively.

1.5. The way in which those accountable for risk engage with the risk management process reflects principles set out in HM Treasury's Orange Book: Management of Risk – Principles and Concepts (2023), depicted below, and the NHS England Risk Management Framework (v4.0, 2025). This framework underpins how the ICB balances strategic oversight with operational accountability and ensures a coherent approach to risk management across the organisation.



1.6. The Board Assurance Framework (BAF) and Corporate Risk Register (CRR) are central components of this approach. The BAF focuses on strategic risks that may affect the delivery of the ICB's objectives, while the CRR captures operational risks owned by Directorates. A defined escalation process ensures that material risks that may affect strategic delivery are escalated to Board level.

1.7. This is a controlled document. Whilst this document may be printed (please consider if this is necessary), the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the website (or requested from the Governance Lead/Team) to ensure the most up-to-date version is used.

2. Purpose / Policy Statement

2.1. Purpose

2.1.1. This policy sets out the overarching framework for identifying, assessing, managing, reporting and escalating risks across the Essex ICB. It supports the Board, committees, staff and risk owners in fulfilling their roles and responsibilities in managing risk effectively.

2.1.2. The purpose of the strategy is twofold. Firstly, to set the direction as to how the maturity of the risk framework will evolve over time, seeking consistent and continual improvement. Secondly, once the framework has been established, it seeks to enact meaningful change that will better manage risk over time and thus support delivery of the Population Health

Improvement Plan to make health services better in Essex, meaning that the ICB will:

- Establish a consistent service offer.
- Reduce long waits for care.
- Implement evidenced-based practice
- Improve public perception of NHS Services.
- Make the best use of public money.
- Act in cases of poor performance.

2.2. Policy Statement

2.2.1. The ICB acknowledges that commissioning NHS services is inherently risky and that well-managed risk-taking can enable innovation, improvement and better outcomes. The ICB therefore aims to create an environment in which risk is identified and considered routinely and managed proportionately, not avoided.

2.2.2. Effective risk management supports the ICB in providing safer, more efficient commissioning environment in realising opportunities, and in achieving its strategic objectives and delivering the Population Health Improvement Plan. The ICB is committed to embedding risk management into its organisational culture, governance processes and planning cycles, ensuring that responsibility for risk is understood and accepted at every level.

2.2.3. While the ICB engages constructively with partners and stakeholders, its risk management responsibilities relate to its own statutory functions as a strategic commissioner, rather than to whole-system or system-wide oversight. Collaborative working remains important to understand shared risks, but the ICB will only hold and manage risks that fall within its defined scope of accountability.

2.2.4. The ICB's specific objectives for embedding a mature and integrated approach to risk management include:

- Maintaining an up-to-date and effective Risk Management Policy and Strategy.
- Strengthening ownership of risks across Directorate and at Board level.
- Ensuring staff and Board members receive appropriate training and support.
- Routinely reviewing and improving the maturity of the ICB's risk processes.
- Revisiting the Board Assurance Framework and Corporate Risk Register to establish the approach for Essex ICB.
- Ensuring that risks are regularly reviewed, updated and escalated where necessary and that risk is the primary driver of decision-making.

- Ensuring that assurances, internal and external, clearly align to risks and support the Annual Governance Statement.
- Supporting committees to discharge delegated risk-related responsibilities effectively.

3. Scope

3.1. The ICB's risk management arrangements apply to all ICB staff (including temporary/agency/voluntary/work experience staff), Board members, and persons acting on behalf of the ICB, including contractors.

3.2. While the ICB works collaboratively with NHS and non-NHS partners, its accountability for risk lies within its own statutory remit as strategic commissioner. The ICB no longer holds system-wide responsibility for risk; however, it will remain an active participant in relevant partnership forums to ensure that shared risks affecting commissioning decisions are understood and appropriate reflected in ICB risk processes where required.

3.3. The resources available for managing risks are finite. The ICB will therefore prioritise its response to risk in accordance with its evaluation of likelihood and impact, striking a balance between cost and benefit. Through the annual review of the ICBs risk appetite, the Board will determine the level of risk it is willing to accept and/or tolerate in pursuit of its strategic objectives.

4. Definitions

- **Assurances** – evidence relied upon by the organisation to provide it with a level of assurance that its controls are effective (positive assurance) or ineffective (negative assurance). Sources of assurance can be internal or external, with the latter considered to provide a higher level of assurance. Drawn from the Three Lines Model (management oversight, functional oversight and independent audit).

- **Board Assurance Framework (BAF)** – the key document used to record and report to the Board significant risks (strategic risks) to achieving its strategic objectives. It is used to support the Governance Statement that the Chief Executive is required to sign-off at the end of each financial year.

- **Controls** - measures implemented to reduce risk and prevent harm. These include systems and structures, processes, policies, guidelines, professional practice, and training.

- **Corporate Risk Register** – contains the red rated risks of directorate risk registers that are then owned by the Executive Committee.

- **Datix** – is the system used by the ICB to record, categorise, assess and manage its risks and produce reports for committees and the Board.

- **Directorate Risk Register** – is the register of risks relating to a specific directorate, whereby risks can be escalated to the corporate risk register where they are deemed to be a red rated risk that could impact the achievement of corporate objectives. Risks can also be downgraded to a team risk register where they no longer affect directorate objectives.

- **Hazard** - any source (incident/event/circumstances) of potential damage, harm or adverse effect on someone, something, the organisation or the environment.

- **Inherent Risk** - the level of exposure arising from a specific risk before any action has been taken to manage it. This is often referred to as the 'initial risk rating'

- **Integrated Risk Management** - the management of risk across the organisation at varying levels via a range of processes. In addition to the maintenance of the risk register and BAF, this includes undertaking specific risk assessments, performance reporting and the management of incidents, complaints, and claims. Taking an integrated risk management approach enables the triangulation of data/findings and the sharing of learning.

- **Operational Risks** – a risk that is most likely to impact on an organisation's ability to undertake its day-to-day internal functions in a safe and efficient manner. These risks tend to affect one department or a specific area of business and are often held on a team risk register.

- **Project Risks** – These are risks that relate specifically to an individual project and are unlikely to have an impact beyond the project's scope of lifespan. Risks and issues identified during the course of a project should be assessed in the context of that project. As such, even where a project risk is scored as high, it may not warrant inclusion on the directorate or corporate risk register or BAF. However, project managers must ensure that any significant risks which could compromise the successful delivery of the project are escalated to the Director accountable for that project. The Director will determine whether the risk should be added to the corporate/directorate risk register, seeking advice from the Governance Lead as necessary.

- **Residual Risk** - is the level of exposure arising from a specific risk after mitigating action has been taken to manage it.

- **Responsible Executive Director** - the Executive Director with overall responsibility for managing risks within their remit. These individuals will be identified on the risk register and BAF.

- **Risk** – the potential of a situation or event to impact on the achievement of specific objectives. Risks can arise in many ways and include clinical, non-clinical, financial, environmental, workforce, equality and diversity and reputational risks. In the Orange Book, risk is defined as the "uncertainty of outcome, whether positive opportunity or negative threat, of actions and events".

  Risk is characterised by two factors, being a combination of the

  - **consequences/impact** of a hazard and the
  - **likelihood** of occurrence.

- **Risk Appetite** – the amount and type of risk the Board is willing accept in pursuit of its objectives. This will also consequently define the 'target risk rating'.

- **Risk Lead** – the operational lead (i.e., a senior manager or workstream lead) who has been delegated responsibility for managing specific risks. These individuals will be identified on the risk register and BAF and are responsible for ensuring action is taken to mitigate risks and for providing updates on their status for inclusion on the risk register and BAF.

- **Risk Management** - a coordinated set of activities to identify, assess and control risks to support decision-making and achieve objectives.

- **Risk Materialisation** – the time at which a hazard or adverse circumstances thought possible occur. This may also trigger an 'issue' that needs urgent attention to address or mitigate.

- **Risk Profile** - the documented overall assessment of the range/type, number and rating of risks faced by the organisation.

- **Risk Rating** - the level of risk at a particular point in time (i.e. initial, current or target risk rating) expressed by calculating the risk rating score by using the impact and likelihood assessment tables at **Appendices C and D** and the risk rating matrix at **Appendix E**. Depending on the score, risks will be categorised as Red, Amber, or Green (often referred to as the 'RAG' rating).

- **Risk Register** - a document detailing all risks identified by the organisation. The ICB will maintain a central repository/database of all risks, registered on the Datix system, to enable risk registers to be produced for directorates, committee and Board meetings.

- **Risk Tolerance** – the acceptable level of variation from the risk appetite.

- **Strategic Objectives –** the main objectives (aims) agreed by the ICB as set out in the Population Health Improvement Plan, against which all risks are mapped. The ICB's current strategic objectives are set out in **Appendix B** and will be reviewed annually.
- **Strategic Risk** - a risk with the potential to have significant impact upon the achievement of strategic objectives affecting the whole or several areas of the organisation (as opposed to one department). These risks have the highest potential for external impact. Red rated/extreme risks will be recommended by the Responsible Director/Committee to the Board for consideration as strategic risks and inclusion on the BAF.
- **Team Risk Register** – a register of risks to the achievement of team objectives, which are not considered to impact on directorate objectives.

5. Roles and Responsibilities

5.1. ICB Board

5.1.1. The Board is accountable and responsible for ensuring that the ICB has an effective risk framework in place for managing risks that might compromise the achievement of its strategic objectives and statutory duties.

5.1.2. The Board reserves authority to set and review the ICB's risk appetite annually and to approve and review the Board Assurance Framework.

5.1.3. The Board will seek regular assurance via the Board Assurance Framework (BAF), from its committees and other sources regarding the effectiveness of the risk framework and internal controls and will ensure further mitigating action is taken where necessary.

5.2. All ICB Committees, Sub-Committees and Groups

5.2.1. All ICB committees, sub-committees or groups have responsibility for identifying, assessing, reviewing and monitoring specific risks within their remit, ensuring systems are established to mitigate/manage risks and for providing regular assurance to the ICB Board (or in the case of sub-committees, to the relevant committee) that systems of internal control to manage risks are effective, and for the escalation of significant risks where necessary.

5.2.2. All risks will identify committees, sub-committees and/or groups who will be responsible for overseeing the risk, according to their remit. Risk registers will be produced and presented to relevant Board sub-committees and groups as necessary to facilitate their review and enable scrutiny of the risks. This will enable Board sub-committees to provide assurance to the Board accordingly.

5.2.3. ICB committees will make recommendations regarding the management of risks and how they should be graded, downgraded or escalated.

5.3. Audit, Risk and Compliance Committee

5.3.1. The Audit, Risk and Compliance Committee provides independent oversight and scrutiny aligned to the third line model. It's provides assurance on the effectiveness of internal control and the risk framework, as well as overseeing internal and external audit findings, and other independent sources of assurance on the ICB systems of internal control.

5.3.2. The Audit, Risk and Compliance Committee has responsibility 'as the sponsoring committee' for monitoring the ICB's compliance with this policy.

5.3.3. The Audit, Risk and Compliance Committee will seek assurance that risks are being appropriately and robustly managed via receipt of a report on the BAF, the minutes of other ICB committee meetings and other reports on specific issues requested by the committee.

5.3.4. The Audit, Risk and Compliance Committee will review the outcome of the annual internal audit of governance and risk management arrangements which, along with other assurances received, will enable the committee to recommend the Governance Statement is signed-off by the Chief Executive at the end of each financial year.

5.3.5. The Audit, Risk and Compliance Committee also has responsibility for reviewing and monitoring any specific risks within its remit and for providing regular assurance to the ICB Board, including escalation of significant risks where necessary.

5.4. The Executive Committee

5.4.1. The Executive Committee shall have oversight of the Corporate Risk Register, approving new risks and de-escalation of risks to directorate risk registers. The Committee will ensure that corporate risks are appropriately managed and will have oversight of BAF reporting to the Board.

5.4.2. The Executives are collectively responsible for the delivery of actions to manage risks and ensure those actions are effective to reduce risks to their target level. Providing 'first and second lines of defence' assurance to committees and the Board through reports and BAF updates.

5.5. Chief Executive

5.5.1. The Chief Executive has overall accountability for effective risk management within the ICB in line with legislation and guidance issued by NHS England, the Department for Health and Social Care and HM Treasury.

5.5.2. The Chief Executive will report annually to the ICB Board on the adequacy of internal control and risk management within the Governance Statement that forms part of the Annual Report and Accounts.

5.6. Executive Director of Corporate Services

5.6.1. The Chief Executive has delegated overarching responsibility for risk management to the Executive Director of Corporate Services, supported by the Associate Director of Governance, with each Executive Director being responsible for risks aligned to their functions.

5.7. Executive Director of Finance and Commercial

5.7.1. The Executive Director of Finance and Commercial has delegated responsibility for financial risk management and will ensure:

- The effectiveness of the ICB's financial control systems.
- Significant financial risks faced by the ICB are identified and managed effectively.
- Audit, Risk and Compliance Committee and Internal Audit effectively perform their roles in assuring the ICB's system of internal control.
- Robust counter fraud arrangements are in place and comply with NHS standards in relation to counter fraud.

5.7.2. The Executive Director of Finance and Commercial also acts as the ICB Senior Information Risk Owner.

5.8. Executive Chief Nursing Officer

5.8.1. The Executive Chief Nursing Officer has lead responsibility for the safety and quality of services and is accountable for safeguarding children and adults, working in partnership with responsible local authorities and other key agencies to ensure that the ICB's statutory safeguarding duties are met.

5.8.2. The Executive Chief Nursing Officer provides assurance to the Board within their remit and in line with local and national legislation and guidance and will ensure that any associated risks are appropriately captured on the risk register and escalated to the Board and BAF where necessary.

5.8.3. The Executive Chief Nursing Officer also acts as the ICB Caldicott Guardian.

5.9. All Executive Directors, and other Managers

5.9.1. All Executive Directors and other managers are responsible for ensuring that appropriate and effective risk management processes are in place within their designated areas and scope of responsibility and that they comply with the requirements of the ICB's risk management arrangements, including regularly reviewing risks with their staff at directorate/departmental meetings and reporting risks to the appropriate Committee or Board, including making recommendations to add, close or re-categorise risks as appropriate.

5.9.2. They are responsible for ensuring that all members of their staff are aware of risks relevant to their area of work and of their personal responsibilities as set out in section 5.13 of this policy. They must ensure their staff receive appropriate information, instruction, and training to enable them to undertake their roles effectively and safely.

5.9.3. Responsible Executive Directors may delegate the management of some of the operational risk management processes to an appropriate senior manager, who will be named as the 'Risk Lead' on the risk register/BAF.

5.10. Policy Author

5.10.1. The policy author will have responsibility for developing and updating the policy in line with Section 9.

5.11. Governance and Risk Manager

5.11.1. The Governance and Risk Manager, reporting to the Associate Director of Governance has responsibility for managing the risk management process, including liaising with risk leads for updates, production of the BAF and risk registers for Board/Committee meetings, provision of risk management training and having oversight of risks.

5.12. Business Managers

5.12.1. Business Managers will ensure that their directorate risk registers are up to date and that risks are discussed monthly at senior team meetings. Business Managers will provide administrative support updating risks recorded on Datix.

5.12.2. Business Managers will ensure that all staff within their directorate have undergone appropriate risk management training.

5.13. All Members of ICB Staff

5.13.1. All members of staff are individually responsible for:

- Familiarising themselves with the content of this policy and associated procedures and following these.
- Identifying, assessing, and putting systems in place to mitigate any risks to the achievement of the ICB's strategic objectives and those within their remit, to ensure risks are managed and escalated where appropriate through the risk register and associated processes.
- Reporting incidents/accidents and near misses using the ICB incident reporting procedure.
- Being aware of their duty under legislation to maintain safe working practices and to take reasonable care of their own health, safety, and welfare and that of others by complying with all relevant ICB policies, procedures and guidance.
- Being aware of any emergency procedures relevant to their role and place of work, e.g., security/lockdown and fire safety procedures.
- Completing their mandatory training and attending risk management training and development events relevant to their role.

6. Policy Detail

6.1. Overview of Risk Management Process

6.1.1. The ICB has adopted the Australia/New Zealand risk management model, advocated within the Orange Book, which sets out the following stages to manage risk:

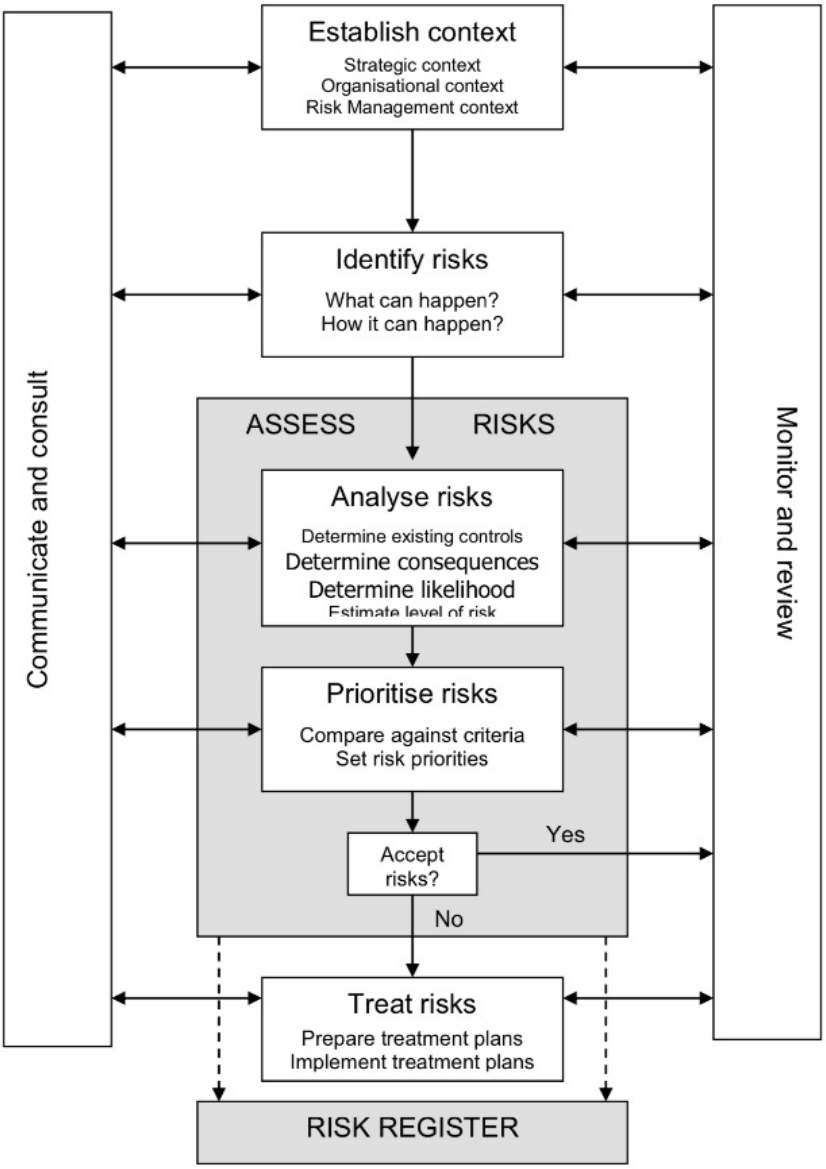
1. Establish the context
2. Identification of hazards
3. Analyse risk
4. Prioritise risk
5. Treat risk
6. Monitor and review
7. Communicate and Consult.

6.1.2. Each stage of the risk management process should be documented in order to:

- Demonstrate the process is conducted properly
- Provider evidence of systematic approach
- Provide a record of risk and develop the ICBs knowledge of risk
- Provide relevant decision makers with a risk management plan for approval etc.
- Provide an accountability mechanism and tool

- Facilitate review and monitoring
- Provide an audit trail
- Share and communicate information.

6.1.3. This will be achieved through recording risks and how we manage them on the Datix system. The diagram below and paragraphs 6.2 – 6.11 summarises this model:



6.2. Establishing the Context

6.2.1. Establishing the context is the first step in the risk management process. It defines the scope within which risks will be identified, assessed and

managed, and ensures that all risk activity is anchored to the ICB's purpose and strategic direction.

6.2.2. For Essex ICB, the context for risk management is set by our Population Health Improvement Plan, which is the organisation's primary strategy. This plan establishes the ICB's key objectives, outlines the outcomes we aim to achieve for our population, and provides the framework through which we discharge our statutory duties as a strategic commissioner.

6.2.3. The ICB's strategic objectives for 2026/27 have been defined as:

- Health inequalities narrowing year on year.
- A decisive shift towards neighbourhood care delivery and prevention.
- Timely access and excellent outcomes across services.
- Financially and clinically sustainable services across Essex which are safe and high quality.
- An organisation that is up to the job, good to work for and good to partner with.

6.2.4. The ICB's risk management arrangements provide the Board with assurance that these objectives are being delivered safely, effectively and within our defined risk appetite. They also enable senior leaders to identify and manage threats or opportunities that could affect delivery of the Population Health Improvement Plan or the wider statutory responsibilities of the ICB.

6.2.5. The ICB's strategic objectives are therefore derived directly from the Population Health Improvement Plan and reflect the organisation's core commissioning responsibilities, financial duties, and governance requirements. By setting a clear strategic context, the ICB ensures that all risks – whether strategic, operational, financial, performance-related or quality-related, are assessed consistently and managed in a way that supports the achievement of those objectives.

6.2.6. The risk management programme is the primary system by which the Board can gain assurance that the ICB is delivering its objectives, functions and duties.

6.3. Identifying Risks

6.3.1. Identifying risks is the first step in building the ICB's risk profile. The purpose is to generate a clear, comprehensive view of events or conditions that could support or impede achievement of the ICB's strategic objectives, particularly those set out in the Population Health Improvement Plan.

6.3.2. Essex ICB will use a combined top-down and bottom-up approach to ensure risk identification is thorough and embedded across the

organisation. This aligns with Orange Book expectations for collaborative, informed, and structured risk processes.

6.3.3. **Top-down identification -** Senior leaders, through Executive discussions, Board development sessions and regular review of the Board Assurance Framework, identify strategic risks related to the ICB's statutory functions, commissioning responsibilities and strategic objectives. This ensures emerging and horizon-scanned risks are recognised at the earliest opportunity.

6.3.4. **Bottom-up identification -** Directorates, teams and workstreams identify risks associated with their operational objectives, performance, quality, and delivery responsibilities. Staff are encouraged to raise risks that may affect delivery, patient experience, safety, or workforce wellbeing. This ensures that operational insight informs the overall risk picture.

6.3.5. **Proactive and reactive identification -** Risk identification will use:

- Reactive learning from past experience, incidents, complaints, audits and performance issues.
- Proactive horizon scanning, recognising potential future risks before they materialise. This is consistent with Orange Book guidance on anticipating uncertainty.

6.3.6. **Recording risks -** All identified risks must be recorded on Datix, using the ICB's standard risk template. Risks are mapped to the relevant Directorate or strategic objective to ensure consistent ownership and alignment with the ICB's organisational structure.

6.3.7. Once identified, each risk is assessed to understand its likelihood and impact, producing an inherent and residual risk score. Risks are then prioritised for escalation, mitigation and monitoring in line with the ICB's risk management framework.

6.4. Assessing/Analysing Risks

6.4.1. Risk assessment helps the ICB understand the nature, scale and urgency of each risk so that appropriate decisions can be made about mitigation, escalation and monitoring. It is carried out consistently across the organisation and recorded on Datix.

6.4.2. **Risk Analysis -** Risk analysis involves understanding the causes, potential consequences and interdependencies of the risk. This includes identifying whether the risk could lead to multiple outcomes; positive or negative; and considering how it interacts with other risks or organisational priorities.

6.4.3. The following categories are included on Datix to classify the area potentially impacted by the risk:

- Acute Hospital Demand
- Claims & Complaints
- Finance
- Health Inequality
- Patient Experience
- Patient Safety & Harm
- Primary Care Demand
- Regulator Penalties
- Reputational Damage
- Safeguarding
- Service Delivery
- Human Resources / Organisational Development capacity
- Data Quality / Information Governance
- Community Demand
- Workforce – Capacity / availability of staff

6.4.4. The analysis must also consider the effectiveness of existing controls, assessing whether they are adequate and operating as intended.

6.4.5. **Defining the Risk -** A clearly defined risk is essential for accurate assessment. Risks should be described using a simple **Event / Cause / Impact** structure, consistent with Orange Book guidance, to link:

- Event (There is a risk that…)
- Cause (This is caused by…)
- Impact on objectives (This could lead to…)

6.4.6. The following table provides an example to assist in the defining of risks:

Objective: to travel by train from A to B for a meeting at a certain time	
Failure to get from A to B on time for the meeting	X This is simply the converse of the objective
Being late and missing the meeting	X This is a statement of the impact of the risk and not the risk itself
There is no buffet on the train so I get hungry	X This does not impact on the achievement of the objective

Missing the train (the event) causes me to be late (cause) and miss the meeting (impact)	✓ This is a risk which can be controlled by making sure I allow plenty of time to get to the station
Severe weather (cause) prevents the train from running (event) and me from getting to the meeting (impact)	✓ This is a risk which I cannot control, but against which I can make a contingency plan

Source: The Orange Book: Management of Risk – Principles and Concepts, October 2004

6.4.7. Risks must always be expressed in relation to ICB objectives, particularly those set out in the Population Health Improvement Plan.

6.4.8. **Risk Evaluation (Scoring) -** Each risk is scored to determine its inherent and residual rating:

- Inherent rating: the level of risk before controls
- Residual rating: the level of risk after controls

6.4.9. Both **impact** and **likelihood** are assessed using the ICB's standard 5×5 risk matrix, as set out in Appendices C and D. Impact (what the outcome would be should the risk materialise) is evaluated across relevant domains such as quality, performance, finance, workforce, reputation and delivery, whereas likelihood (how probable it is that the risk will materialise) considers inherent likelihood (naturally how it might occur), as well as the controls and resources in place to manage likelihood and key performance indicators that could signal where likelihood changes. Scoring must be:

- Structured
- Evidence-based
- Consistently applied across Directorates

6.4.10. Any changes to scores must be explained clearly in Datix and, for strategic risks, on the Board Assurance Framework (BAF). Governance Leads will support risk owners to apply the scoring approach consistently.

6.4.11. **Prioritising Risks -** Risk prioritisation ensures that the most significant risks receive appropriate attention and resource. Prioritisation is based primarily on the risk rating, but also considers:

- Legal and regulatory requirements
- Alignment with strategic objectives
- Dependencies with other risks or programmes
- Potential impact on patient outcomes, financial performance or organisational resilience

6.4.12. Based on the impact and likelihood assessment, risks will be rated as follows:

- **Extreme risk (red), those rated 15 or above**: Immediate action is required. The Responsible Executive Director and Risk Lead must take responsibility for development and implementation of an appropriate risk action plan and ensure progress against this is reported to the relevant committee and ICB Board. Risks rated 'red/extreme' will be recommended by the Responsible Executive Director/Committee for inclusion on the corporate risk register or potentially to the ICB Board for inclusion on the BAF where appropriate, noting that strategic risks on the BAF may cover one or more risk on the risk register.

- **High risk (amber), those rated between 8 and 12:** Within one month an appropriate action plan must be agreed, usually with a deadline for completion within 6 months. To be reported to the relevant committee. However, if within the ICB risk appetite / target risk score, monitoring action and some adjustment of controls to improve management of the risk if possible, are required.

- **Medium risk (yellow), those rated between 4 and 6:** If within the ICB risk appetite / target risk score, monitoring action only is required. In addition, the risk could be recommended for removal from Datix or downgraded to a 'team' risk.

- **Low risk (green), those rated between 1 and 3:** Acceptable risk. Periodic monitoring and review to be undertaken at Directorate/Departmental level to ensure that risk has not escalated, and controls remain effective. Alternatively, risk could be recommended for removal from Datix.

6.4.13. Highly rated risks are escalated in line with the ICB's governance structure:

- Strategic risks → BAF and Board
- Operational risks → Corporate Risk Register and Directorate oversight

6.4.14. Lower-level risks may still be addressed promptly where quick mitigation is possible or where inaction could allow escalation.

6.4.15. **Continuous Review -** Risk scores, controls and improvement actions must be reviewed regularly to ensure they reflect the current operating environment. As recommended by the Orange Book, risk assessment is a dynamic process, supporting timely decisions and providing assurance that risks are being managed effectively.

6.5. Treatment of Risks

6.5.1. Once a risk has been assessed, the ICB will determine the most appropriate response to reduce the likelihood and/or impact of the risk, or to take advantage of potential opportunities. Decisions about risk treatment must align with the ICB's risk appetite, statutory responsibilities and the strategic aims set out in the Population Health Improvement Plan. Essex ICB will use the following four recognised approaches to managing risk:

6.5.2. **Tolerate -** The ICB may decide to accept a risk where:

- it falls within the ICB's agreed risk appetite,
- further mitigation is not feasible or proportionate, or
- the cost of additional controls outweighs the benefits.

6.5.3. Where a risk is tolerated, contingency plans must be in place to manage the consequences should the risk materialise.

6.5.4. **Treat -** Most risks will be treated by introducing new controls or strengthening existing ones to reduce the risk to an acceptable level. Controls may relate to:

- governance and decision-making,
- workforce capability and supervision,
- policies and procedures,
- performance monitoring,
- contracting and financial controls, or
- improvements in processes, data quality or oversight.

6.5.5. Treatment plans must be proportionate, achievable and recorded clearly in Datix, with designated owners and target completion dates.

6.5.6. **Transfer -** Some risks may be shared or transferred to another organisation (e.g., through insurance, commissioning arrangements, or contractual mechanisms).

6.5.7. However, certain risks—such as those linked to statutory duties, governance responsibilities or reputational harm—cannot be fully transferred. Where risks are transferred, the ICB must:

- maintain effective oversight of the receiving organisation, and
- ensure that accountability, performance and assurance arrangements are clearly defined.

6.5.8. **Terminate –** where appropriate, the ICB may seek to eliminate a risk entirely by stopping or changing the activity that gives rise to it (e.g., decommissioning a service or discontinuing a specific function).

6.5.9. Given the NHS context, termination is often a last resort and must be considered carefully, with full assessment of the impact on patients, finances and statutory duties. Actions to terminate a risk will generally also require consultation or engagement with stakeholders and members of the public (refer to ICB policy on communications and engagement).

6.5.10. **Action planning and documentation –** once the treatment option is agreed a clear action plan must be developed, implemented and monitored. This could involve the need to complete one or more impact assessments e.g., a quality, or health inequalities impact assessment. This must be carried out in accordance with the ICB policy on undertaking impact assessments.

6.5.11. Progress and changes in implementing actions must be updated in Datix and reflected in the corporate risk register or BAF where relevant. Documentation must demonstrate a systematic and auditable approach, supporting learning, assurance and decision-making.

6.6. Controls and Assurances

6.6.1. Controls and assurances are central to understanding how effectively risks are being managed across the ICB. Each risk recorded on Datix must include a clear description of the controls currently in place, along with the sources of assurance that demonstrate whether those controls are operating as intended.

6.6.2. Managers and risk owners are responsible for routinely assessing control effectiveness as part of the ICB's monitoring and review processes. This includes identifying any gaps, weaknesses or overdue actions, and determining whether new or strengthened controls are required, taking into account the ICB's risk appetite and the cost–benefit of further mitigation. Where gaps are identified, appropriate improvement actions must be recorded in Datix with named owners and delivery timescales.

6.6.3. Assurance over controls is provided through the ICB's application of the Three Lines Model. Operational management provides first-line assurance that controls are implemented and effective; corporate functions provide second-line oversight, challenge and triangulated testing; and Internal Audit and other external reviews provide independent third-line assurance. Data plays an important role in this process, offering evidence of performance, quality, workforce or financial trends that can confirm the operation of controls or indicate a change in risk likelihood or impact.

6.6.4. Where a risk does not reach its target score and remains static over three consecutive review cycles on the Corporate Risk Register or the Board Assurance Framework, the relevant Director or risk owner may be required to attend the appropriate committee or the Board. They will be asked to

explain the barriers to progress and provide assurance on the actions being taken to address outstanding gaps.

6.6.5. Together, these arrangements ensure that the ICB maintains a consistent and evidence-based approach to evaluating control effectiveness, securing appropriate assurance, and taking timely corrective action where needed.

6.7. Risk Escalation

6.7.1. Risk escalation ensures that risks are managed at the appropriate organisational level and that significant threats to the ICB's objectives are visible to senior leaders. Escalation follows a structured process, beginning at team level and progressing through directorate, corporate and Board oversight as required. All risks at any stage of escalation must be recorded and updated within Datix.

6.7.2. **Team-Level Risk Registers -** Team or service-level risk registers capture operational risks relating to day-to-day activities, processes or local objectives. These risks are owned and monitored by team managers.

6.7.3. A risk should remain at team level where:

- it can be managed locally with available controls and resources,
- the impact is limited to the team or service area, and
- the likelihood and consequence remain within the ICB's defined risk appetite for operational activities.

6.7.4. A risk must be considered for escalation to the Directorate Risk Register if:

- its potential impact extends beyond the team,
- it requires intervention or resources from the wider Directorate,
- controls at team level are insufficient or cannot be strengthened locally,
- the risk score increases and approaches agreed escalation thresholds, or
- the risk relates to recurrent or systemic issues.

6.7.5. **Directorate Risk Registers** - Directorate Risk Registers hold risks that affect the wider Directorate or require senior oversight to mitigate effectively. Directorate leads are responsible for ensuring risks are reviewed, challenged and updated regularly.

6.7.6. A risk should be escalated from directorate level to the Corporate Risk Register where:

- it has cross-directorate implications,
- it may impact delivery of the Population Health Improvement Plan objectives,

- the Directorate cannot reasonably manage or mitigate the risk alone,
- the risk score is high or increasing despite controls,
- additional organisational-level actions, investment or decisions are required, or
- there is a potential impact on quality, safety, financial sustainability or ICB statutory duties.

6.7.7. Directorate leads must review risks regularly and identify those requiring Executive consideration.

6.7.8. **Corporate Risk Register (CRR) -** The Corporate Risk Register holds organisation-wide operational risks that require Executive oversight. Escalation to the CRR occurs via the Executive Team, who review proposed escalations submitted through Directorate leads and the Governance Team.

6.7.9. The Executive Team will accept a risk onto the CRR where:

- the risk may significantly affect organisational performance, finances, workforce, reputation or legal compliance,
- coordinated, cross-Directorate action is required,
- the risk could impact delivery against NHS England oversight frameworks or statutory duties, or
- the risk score meets corporate escalation thresholds.

6.7.10. Once accepted, an Executive lead is assigned as the risk owner, with clear expectations for monitoring, mitigation and reporting.

6.7.11. **Board Assurance Framework (BAF) -** Risks are escalated from the CRR to the Board Assurance Framework when they represent threats to the ICB's strategic objectives or delivery of the Population Health Improvement Plan.

6.7.12. Only strategic risks sit on the BAF. These are risks that:

- could materially impact achievement of the ICB's strategic objectives,
- remain highly rated even after controls,
- require Board-level visibility, assurance and oversight, or
- relate to statutory functions, governance, system partnerships or strategic commissioning.

6.7.13. Executive risk owners present BAF risks to the Board and its committees, ensuring there is a clear articulation of:

- the risk,

- the controls in place,
- sources of assurance,
- gaps in assurance, and
- required actions.

6.7.14. Continuous Review and De-escalation - All risks must be reviewed regularly. As controls become effective or the risk profile changes, risks may be de-escalated to a lower level of oversight. De-escalation follows the same pathway in reverse:

BAF → CRR → Directorate Register → Team Register

6.7.15. This ensures ongoing ownership while promoting proportionate, responsive risk management.

6.8. Monitor and Review

6.8.1. Monitoring and review ensure that risks, controls and assurances remain accurate, effective and aligned with the ICB's strategic objectives. All risks must be kept up to date in Datix so that the organisation has a reliable and current risk profile.

6.8.2. Directorates are expected to review their Directorate Risk Registers monthly as part of their Senior Leadership Team meetings, ensuring that risk scores, controls and actions remain appropriate and that any risks requiring escalation are identified promptly. The Executive Team will review the Corporate Risk Register on a monthly basis to provide organisational oversight, ensure consistency of scoring, and determine whether any risks warrant escalation to the Board Assurance Framework. In addition, sponsoring committees will review their relevant risks on a quarterly basis, for example, finance and quality risks will be overseen by the Commissioning, Quality and Resource Committee, so that risks within their remit receive focused scrutiny and assurance at appropriate intervals. All risks can be updated on an ad hoc basis whenever new information, incidents, performance data or changes in context indicate that the likelihood, impact or control effectiveness has changed.

6.8.3. Monitoring includes reviewing the effectiveness of controls and ensuring that assurances are credible, timely and proportionate. The ICB's approach follows the **Three Lines Model:** operational teams provide day-to-day management and control of risks; corporate oversight functions such as Governance, Quality, Finance and Workforce provide support, challenge and triangulation; and Internal Audit and other independent reviewers provide third-line assurance on the robustness of the overall system of internal control.

6.8.4. Data plays a central role in risk monitoring and assurance across all three lines. Relevant performance, workforce, quality or financial data may be uploaded or referenced within Datix, enabling risk owners to demonstrate the effectiveness of controls and to identify whether the likelihood or impact of a risk is increasing or decreasing. Where data indicates a change in exposure, risk owners must update the risk promptly and consider whether escalation is required.

6.8.5. Risk management will continue to be embedded in governance processes across the ICB by ensuring that meeting agendas routinely include consideration of relevant risks, and by ensuring that reporting templates used across committees and programme boards are risk-driven. Embedding these approaches strengthens risk culture across the organisation, supports effective decision-making, and reinforces the expectation that risk management is an integral part of everyday practice.

6.9. Reporting

6.9.1. Risk reporting is delivered through the processes described in the *Risk Escalation* and *Monitoring and Review* sections, ensuring that risks recorded on Datix flow from teams to Directorate SLTs, the Executive Team, oversight committees and the Board via the Corporate Risk Register and the Board Assurance Framework. Reports draw on the controls, assurances and data described in earlier sections, providing senior leaders with timely and accurate insight into the organisation's risk profile. These reporting arrangements ensure that decision-making remains informed, transparent and aligned with the ICB's strategic objectives and governance requirements.

6.10. Communicate and Consult

6.10.1. Effective communication and consultation are essential components of the ICB's risk management approach. They ensure that risks are understood, shared and managed collaboratively across all levels of the organisation. Communication supports informed decision-making, while consultation ensures that those involved in or affected by risks contribute their knowledge, experience and insight to the process.

6.10.2. The ICB will communicate risk information clearly and consistently through established reporting mechanisms, including Directorate Senior Leadership Teams, the Executive Team, committees, and the Board. Risk-related discussions will form a routine part of governance business, enabling leaders to understand the organisation's risk profile, emerging issues and the effectiveness of current controls and assurances. Risk reports will be produced in an accessible and meaningful format so that decision-makers can quickly identify significant risks, understand their implications, and determine whether further action is required.

6.10.3. Consultation is equally important. Staff at all levels are encouraged to raise and discuss risks openly within their teams and with senior leaders. Directorates will engage with their teams to gather intelligence, test assumptions, and identify changes in risk exposure. Corporate functions—such as Governance, Quality, Finance, Workforce and Digital—will provide expert advice to support risk owners in refining risk definitions, analysing controls and interpreting assurance information. This collaborative approach ensures that risks are assessed using the best available information and from multiple perspectives.

6.10.4. The ICB will also ensure that relevant external partners, regulators or providers are engaged where their insight or actions are necessary to manage a risk effectively. This may include sharing risk information where appropriate, seeking clarification on control arrangements, or working jointly on mitigations that require cooperation across organisational boundaries. Although the ICB is not accountable for system-wide risks, engagement with partners remains important where external factors influence the ICB's commissioning responsibilities or strategic objectives.

6.10.5. Communication and consultation are continuous activities that occur throughout the life of a risk. They support transparency, foster a culture of openness, and help embed good risk management across the organisation. By ensuring that risks are well-understood, clearly articulated and openly discussed, the ICB can make informed decisions, allocate resources effectively and maintain confidence in its systems of internal control.

6.11. Risk Appetite and Tolerance

6.11.1. The ICB's risk appetite describes the level of risk that the organisation is willing to accept in pursuit of its strategic objectives. It provides a framework for making informed decisions, prioritising risks, and ensuring that the ICB's approach to uncertainty is consistent with its strategic ambitions and responsibilities. Risk tolerance represents the degree of variation from this appetite that the organisation is willing to operate within during the management of a risk.

6.11.2. The ICB will adopt the Good Governance Institute (GGI) Risk Appetite Maturity Model and Risk Appetite Matrix as the basis for defining its appetite across key domains. The GGI model sets out six appetite levels: *None, Minimal, Cautious, Open, Seek,* and *Significant,* each describing the extent to which the organisation is willing to accept uncertainty, variation or potential impact. These appetite levels provide a shared language to support decision-making and enable alignment between the Board, Executive Team, and the wider organisation.

6.11.3. The ICB will determine its risk appetite through a structured annual process, including a Board seminar, Board survey and facilitated Executive discussion. These activities will consider strategic priorities, statutory

responsibilities, risk maturity, operational capacity, external context and learning from audit and assurance. The outcome of this process will be a formally agreed Risk Appetite Statement that sets out the appetite for each risk category used within the organisation. The GGI appetite levels will then be translated into corresponding target risk scores within the ICB's 5×5 risk matrix, enabling risk appetite to be applied directly through the Corporate Risk Register and the Board Assurance Framework.

6.11.4. Each risk recorded in Datix will include a target score that reflects the agreed appetite for its category. Risk owners will be expected to develop mitigation plans aimed at reducing the residual risk to within the agreed appetite. Once a risk reaches its target score, the responsible committee and Executive lead will determine whether it should be closed, de-escalated or retained for continued monitoring. Where a risk remains above the agreed appetite, additional controls or assurance may be required, and progress will be monitored through the governance processes set out in this policy.

6.11.5. Risk tolerance will guide judgements about short-term fluctuations in risk ratings. Temporary movements above or below appetite may occur due to external pressures, changes in performance data, or evolving operational conditions. Tolerance provides the flexibility needed to operate safely while still maintaining a clear boundary for unacceptable risk exposure.

6.11.6. The ICB's agreed risk appetite levels across each category will be set out in **Appendix F** and reviewed annually or sooner if significant changes in strategy, national policy or risk exposure occur. This ensures that Essex ICB maintains a dynamic, informed and mature approach to risk-taking that supports delivery of its Population Health Improvement Plan and statutory duties.

Risk Management Strategy - Risk Management Maturity Assessment and strategic improvement

6.12. Purpose and Strategic Intent

6.12.1. As part of its Risk Management Strategy, Essex ICB is committed to developing a mature, consistent and transparent approach to managing risk, creating a positive risk culture that underpins all aspects of the ICBs approach to risk management.

6.12.2. To support the development of a robust and continuously improving risk management system, Essex ICB will adopt a *three-strand approach* to assessing its current level of risk maturity. This approach comprises:

(1) an internal self-assessment using the HM Treasury Risk Management Assessment Framework;

(2) an independent maturity review undertaken by Internal Audit using the Institute of Internal Auditors (IIA) Risk Maturity Model; and

(3) an annual assessment of the ICB's overall risk profile.

6.12.3. Together, these strands provide a comprehensive picture of the ICB's current maturity and risk exposure and form the basis for targeted improvement actions designed to strengthen risk capability, enhance the organisation's risk profile over time, and support effective delivery of the Population Health Improvement Plan.

6.13. Primary Maturity Assessment Method – HM Treasury RMAF

6.13.1. The ICB will undertake an annual assessment of its risk management maturity using the HM Treasury Risk Management Assessment Framework (RMAF), a model derived from the European Foundation for Quality Management (EFQM) Excellence Framework and designed to evaluate the effectiveness of risk systems across public bodies.

6.13.2. This assessment forms a central component of the ICB's strategy to continually strengthen organisational risk capability and improve its risk profile year on year, in line with the ICB's statutory responsibilities and the ambitions set out in the Population Health Improvement Plan.

6.13.3. This framework evaluates capability across seven key domains: Leadership, Strategy and Policies, People, Partnerships, Processes, Risk Handling and Outcomes. The RMAF uses a five-level maturity scale, where Level 1 represents early awareness and Level 5 represents a fully embedded, high-performing and continuously improving risk management system.

6.13.4. Each year, the ICB will conduct a structured assessment using the RMAF, drawing on evidence from Datix, the Corporate Risk Register, the Board Assurance Framework, performance and quality data, committee scrutiny, and staff input. This will establish the ICB's current maturity position and define the improvement trajectory for the year ahead.

6.13.5. The results will be used to update the ICB's Risk Management Improvement Plan, which outlines clear actions designed to strengthen maturity across the seven domains, embed best practice, and enhance how the organisation anticipates, manages and learns from risk.

6.14. Independent Maturity Opinion – IIA Risk Maturity Model

6.14.1. While the RMAF provides the ICB with an internal, capability-focused assessment, the ICB also recognises the importance of independent scrutiny. Therefore, the ICB's Internal Auditors will undertake an annual review using the Institute of Internal Auditors (IIA) Risk Maturity Model,

which is widely adopted across the NHS and used by Internal Audit to benchmark organisational risk maturity.

6.14.2. This model assesses governance, culture and assurance arrangements across five levels (Risk Naïve to Risk Enabled) and provides an external viewpoint on how well the organisation is embedding risk processes and applying risk information in decision-making. The Internal Audit maturity opinion is presented to the Audit Committee, offering objective assurance that supports Board oversight and the continuous improvement cycle.

6.14.3. Together, the RMAF and IIA models provide a comprehensive and balanced maturity picture:

- RMAF → assesses organisational capability and integration of risk across functions
- IIA → independently evaluates governance, behaviour and assurance maturity

6.15. Annual Review of the ICB's Risk Profile

6.15.1. In addition to assessing maturity, the ICB will annually review its overall risk profile. Once established, this profile will be analysed to identify themes, patterns and areas of strategic exposure across the Corporate Risk Register and Board Assurance Framework. The review will consider the external environment, performance data, emerging national policy, regulatory intelligence, and internal learning.

6.15.2. This risk profile analysis will then be used to determine strategic actions required to improve the organisation's exposure to risk over time, such as:

- strengthening internal controls and assurance patterns
- improving commissioning oversight
- addressing cross-cutting risks impacting multiple directorates
- refining risk appetite and tolerance
- enhancing capability and training
- improving the quality and consistency of risk information

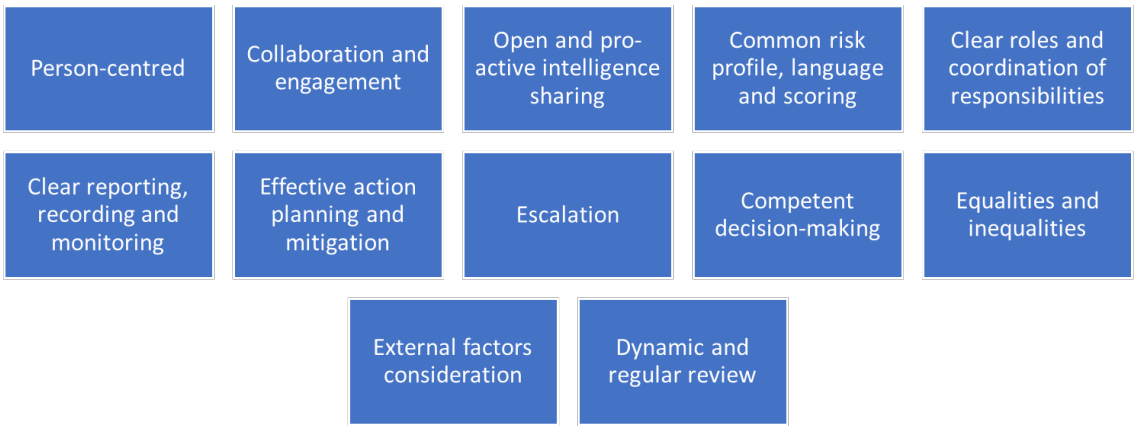
6.15.3. These actions will be integrated into the annual Risk Management Improvement Plan, monitored through the Executive Team and Audit Committee, ensuring the ICB systematically improves both its risk maturity and its overall risk exposure.

6.15.4. The improvement plan will identify areas of risk where the ICB will need to focus to improve its risk profile. It is accepted that these will generally be areas of risk that span across multiple NHS and other organisations. In order to address such risks, the ICB will implement the National Quality Board Principles for Assessing and Managing Risks across Integrated Care

Systems. This will foster the National Quality Board shared commitments for care that is safe, effective and provides a personalised experience, delivered in a way that is well-led, sustainable and addresses inequalities.



6.15.5. The approach will incorporate the 12 Principles for assessing risks as shown below.



6.15.6. To achieve this the ICB will arrange a multi-disciplinary risk summit of all key partners and stakeholders to assess risks, it will ensure:

- The patient voice is at the centre of the assessment, so all partners understand patient experience.
- Accurate, visible and timely data will enable partners to understand current performance, in the context of patient experience.

- The patient pathway will be mapped to understand the full patient experience and where performance weakens and gaps in service provision, access or quality exist.
- All partners will work together to own and implement clear action plans to enact a step change in the existing and emerging risks.

6.16. Commitment to Continuous Improvement

6.16.1. By combining the HM Treasury RMAF for internal assessment, the IIA model for independent assurance, and annual strategic review of the ICB's risk profile, Essex ICB commits to a continuous cycle of evaluation, learning and improvement. This ensures that risk management remains an enabler of effective strategic commissioning, robust governance, and the delivery of improved outcomes for the population

6.17. Risk Culture

6.17.1. A positive risk culture underpins all aspects of the ICB's Risk Management Strategy and reflects the attitudes, behaviours and values that shape how individuals and teams identify, discuss and manage risk.

6.17.2. The ICB is committed to fostering a culture in which staff at every level are encouraged to raise risks early, speak openly about uncertainty, and engage constructively in actions to mitigate or escalate risks as required and there is a collaborative approach to addressing risks among its staff and with its partners.

6.17.3. This culture is supported by clear leadership expectations, transparent reporting processes, and an emphasis on learning rather than blame. Through regular communication, training, committee scrutiny and reinforcement of the Three Lines Model, the ICB aims to embed risk awareness into everyday decision-making so that risks are understood, well-managed and aligned to the organisation's strategic objectives. Developing and maintaining a mature risk culture is therefore a core part of the ICB's continuous improvement journey and fundamental to achieving an effective, proactive and resilient risk management system.

7. Monitoring Compliance

7.1.1. The Governance Lead is responsible for monitoring the ongoing compliance with this policy and ensuring that an appropriate risk management culture is embedded across the ICB.

7.1.2. The Audit, Risk and Compliance Committee is accountable to the Board for ensuring that the risk management process is effective and will ensure that the Annual Internal Audit Plan incorporates yearly assurance to the Board

on the robustness of the ICB's risk management arrangements to support completion of the Governance Statement.

8. Implementation and Staff Training

8.1.1. All staff will be made aware of the Risk Management Policy as part of their local induction by their line manager including their role and the forms of support available to them. Line managers will be responsible for ensuring that employees' ongoing risk management training needs are assessed during induction and reviewed annually via the staff appraisal process. The ICB risk management training needs assessment has been included in Appendix G.

8.1.2. The Governance Lead will provide ongoing risk management support to relevant staff and will offer one-to-one meetings with all Risk Leads or attendance at team meetings to assist in the review of their risks prior to each Board or Committee meeting.

9. Arrangements For Review

9.1.1. This policy will be reviewed annually. Additional reviews will be carried out in the event of any relevant changes in legislation, national or local policy/guidance, organisational change or other circumstances which mean the policy needs to be reviewed.

9.1.2. If only minor changes are required, the responsible Committee has authority to make these changes without referral to the Integrated Care Board. If more significant or substantial changes are required, the policy will need to be ratified by the relevant committee before final approval by the Integrated Care Board.

10. Associated Policies, Guidance and Documents

10.1. Associated Documents

- Board Assurance Framework
- Risk Registers
- Risk Management Training Slides
- General Risk Assessment Template

10.2. Associated Policies

- Anti-Fraud, Bribery and Corruption Policy
- Health & Safety Policy
- Information Governance Policy

- Management of Conflicts of Interest Policy (including Gifts and Hospitality, Commercial Sponsorship and Outside Employment)
- Raising Concerns Policy
- Standards of Business Conduct Policy
- Impact Assessments Policy

11. References and Sources of Further Information

- The Orange Book: Management of Risk – Principles and Concepts; HM Treasury, October 2004.
- Risk Management Assessment Framework: a tool for departments: HM Treasury, July 2009
- NHS England: Risk Management Policy and Process Guide
- National Patient Safety Agency: Risk Assessment Programme Overview
- Department of Finance and Personnel: Policy and Framework for Risk Management
- HM Treasury: Managing Risks with Delivery Partners
- HM Treasury: Thinking about Risk (Managing your risk appetite: A Practitioner's Guide)
- COSO: Enterprise Risk Management – Integrated Framework
- COSO: ERM Risk Assessment in Practice
- COSO: Enterprise Risk Management – Understanding and Communicating Risk Appetite
- COSO: Internal Control – Integrated Framework.

12. Equality Impact Assessment

12.1. The EIA has identified a positive impact and is included at **Appendix A**.

Appendix A - Equality Impact Assessment

INITIAL INFORMATION

Name of policy and version number: Risk Management Policy **Version:** 1.0	**Directorate/Service**: Corporate Services
Assessor's Name and Job Title: Nicola Adams, Associate Director of Governance	**Date:** 23 March 2026

OUTCOMES
Briefly describe the aim of the policy and state the intended outcomes for staff
The Risk Management Policy and Strategy will support the organisation and staff to achieve a consistent method for identifying and managing/mitigating risks which threaten to achieve the organisation's strategic and other objectives.
EVIDENCE
What data / information have you used to assess how this policy might impact on protected groups?
The ICB regularly monitors the make-up of its workforce, including protected groups.
Who have you consulted with to assess possible impact on protected groups? If you have not consulted other people, please explain why?
The policy has been shared with the ICB Governance Leads and Audit, Risk and Compliance Committee members/attendees, including internal audit.

ANALYSIS OF IMPACT ON EQUALITY

The Public Sector Equality Duty requires us to **eliminate** discrimination, **advance** equality of opportunity and **foster** good relations with protected groups. Consider how this policy / service will achieve these aims.

N.B. In some cases it is legal to treat people differently (objective justification).

- ***Positive outcome*** *– the policy/service eliminates discrimination, advances equality of opportunity and fosters good relations with protected groups*
- ***Negative outcome*** *– protected group(s) could be disadvantaged or discriminated against*
- ***Neutral outcome*** *– there is no effect currently on protected groups*

Please tick to show if outcome is likely to be positive, negative, or neutral. Consider direct and indirect discrimination, harassment, and victimisation.

Protected Group	Positive outcome	Negative outcome	Neutral outcome	Reason(s) for outcome
Age	X			The policy refers to equality and diversity risks and makes it

Protected Group	Positive outcome	Negative outcome	Neutral outcome	Reason(s) for outcome
				clear that all staff are able to raise risks that might affect their work life.
Disability (Physical and Mental/Learning)	X			As above
Religion or belief	X			As above
Sex (Gender)	X			As above
Sexual Orientation	X			As above
Transgender / Gender Reassignment	X			As above
Race and ethnicity	X			As above
Pregnancy and maternity (including breastfeeding mothers)	X			As above
Marriage or Civil Partnership	X			As above

MONITORING OUTCOMES
Monitoring is an ongoing process to check outcomes. It is different from a formal review which takes place at pre-agreed intervals.
What methods will you use to monitor outcomes on protected groups?
Regular review of the BAF and risk registers, which include risks relating to equality and diversity and workforce and ensuring that appropriate mitigating action is taken to address these risks.

REVIEW
How often will you review this policy / service?
Annually and earlier if there are any significant changes in legislation, policy or good practice.
If a review process is not in place, what plans do you have to establish one?
N/A

Appendix B – Strategic Objectives

1. Health inequalities narrowing year on year
2. A decisive shift towards neighbourhood care delivery and prevention
3. Timely access and excellent outcomes across services
4. Financially and clinically sustainable services across Essex which are safe and high quality
5. An organisation that is up to the job, good to work for and good to partner with

Appendix C – Impact Assessment Table

Level	Objectives / Projects	Clinical / Injury	Patient Experience	Complaints / Claims	Service / Business Interruption	Staffing and Competence / HR / OD	Financial / Materiality	Adverse Publicity / Reputation
1 Low	Insignificant cost increase / schedule slippage Barely noticeable reduction in scope or quality.	Minor Injury not requiring first aid.	Unsatisfactory patient experience not directly related to patient care.	Locally resolved complaint.	Loss / interruption > 1 hour.	Short term low staffing level temporarily reduces service quality (<1 day)	< £50k	Rumours
2 Medium	Less than 5% over budget / schedule slippage. Minor reduction in quality / scope.	Minor injury or illness, first aid treatment needed.	Unsatisfactory patient experience partly related to patient care – readily resolvable.	Justified complaint peripheral to clinical care.	Loss / interruption > 8 hours.	On-going low staffing level reduces service quality.	£50k – < £100K	Local media – Short-term. Minor effect on staff morale / service.
3 High	5-10% over budget / schedule slippage. Reduction in quality or scope.	Moderate injury or illness, requiring first aid or medical treatment i.e. fractures. RIDDOR / Agency Reportable.	Mismanagement of patient care.	Below excess claim. Justified complaint involving lack of appropriate care.	Loss / interruption > 1 day.	Late delivery of key objective / service due to lack of staff. Minor error due to poor training. On-going unsafe staffing level.	£100K – < £500K	Local media – Long-term. Significant effect on staff morale / Service.
4 Major	10-25% over budget / schedule slippage.	Major injuries, or long-term incapacity / disability (loss of limb)	Serious mismanagement of patient care.	Claim above excess level. Multiple justified complaints.	Loss / interruption > 1 week.	Uncertain delivery of key objective / service due to lack of staff.	£500K - < £1m	National Media - < 3 days.

Level	Objectives / Projects	Clinical / Injury	Patient Experience	Complaints / Claims	Service / Business Interruption	Staffing and Competence / HR / OD	Financial / Materiality	Adverse Publicity / Reputation
	Doesn't meet secondary objectives.					Serious error due to poor training.		
5 Critical	>25% over budget / schedule slippage. Doesn't meet primary objectives.	Death or major permanent incapacity.	Totally unsatisfactory patient outcome or experience.	Multiple claims or singe major claim.	Permanent loss of service or facility.	Non delivery of key objective / service due to lack of staff. Loss of key staff. Critical error due to insufficient training.	>£1m	National media - > 3 days. MP Concern (questions in House)

Appendix D – Likelihood Assessment Table

Level	Description	Controls	Resources	KPIs/Output
1 Rare	The event **may** only happen in **exceptional circumstances**. < 20% chance or occurrence Could occur within 5 to 10 years	System controls are **sound** and **working effectively.** Policies and procedures established and followed.	**Stable** staff environment. **Good** training & development (T&D). **Positive** staff morale. **Suitable** premises / working environment	KPIs established and met. Full reporting to mgt & board. Accurate / valid mgt info
2 Unlikely	The event **could** occur (recur) at **some time**. 20% - 40% chance of occurrence Could occur within 1 to 5 years	System controls are **essentially sound** but minor weaknesses may still exist. Policies and procedures in place, but may not always by followed.	**Fairly stable** staff environment. **Some** T&D issues. **Generally positive** staff morale. Premises suitable, but a **little restrictive**.	KPIs generally established / met. Reporting to mgt / board generally good. Mgt info generally accurate / valid, may be some errors.
3 Possible	The event **may well** occur (recur) at some time, **but may not**. 40% - 60% chance of occurrence Could occur within 1 year	Some systems control **may be missing** or **applied inconsistently.** Policies and procedures generally exist, some may be missing or they may not be followed in a number of cases.	**Some** staff turnover / sickness. T&D **could be improved**. Staff morale **indifferent.** Premises in need of **some repair** / larger premises required	KPIs established, but not always met / monitored. Mgt info available, not always reported to mgt / board, sometimes unreliable.
4 Likely	The event **will occur** (recur) in **most circumstances**. (Could probably happen) 60% - 80% chance of occurrence Could occur within 6 months	A number of key controls **are missing** or controls are **not followed.** Policies and procedures generally lacking.	**Medium** staff turnover / sickness. **Lack** of T&D. **Low** staff morale. Premises requires **high level of repair** or is highly inappropriate (i.e. size)	Lack of appropriate KPIs or clear fall in performance. Lack of reports to mgt / Board. Data generally unreliable in most cases.
5 Almost Certain	The event is **expected to occur** (recur) in **all circumstances**. (Will happen, just a matter of when) 80% - 100% chance of occurrence Could occur within 1 month	Serious **lack of controls.** No policies / procedures established.	**Unstable** staff environment (i.e. high turnover / sickness). High use of agency staff. **Poor** T&D. **Negative** staff morale. **Unsuitable** premises / working environment.	KPIs not established / met. Lack of reporting to mgt / board. Unreliable management information.

Appendix E – Risk Rating Matrix

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

Appendix F –Risk Appetite

To be completed

Appendix G –Risk Training Needs Analysis

To be inserted

NHS
Essex
Integrated Care Board

Standards of Business Conduct Policy

(Including Management of Conflicts of Interest, Gifts and Hospitality, Outside Employment, Commercial Sponsorship and other situations where conflicts might arise)

Policy No: C002

Document Control:

	Standards of Business Conduct Policy
	C002
Version	1.0
	Final - Approved
Policy Lead	Associate Director of Governance
	Executive Director of Corporate Services
Responsible Committee	Audit, Risk and Compliance Committee
Date Approved by Responsible Committee	5 March 2026
Date Ratified by EICB Board	1 April 2026
Next Review Date	April 2027
Target Audience	• Essex Integrated Care Board (EICB) members and staff (including temporary/bank/agency/ voluntary/work experience staff). • Contractors engaged by the ICB. • Staff from other Essex Integrated Care Partnership (ICP) organisations who are members of EICB committees/sub-committees and other groups.
Stakeholders engaged in development of original Policy (internal and external)	• Governance Team • Kevin Edwards, Associate Director, Attain. • Director of Pharmacy, Medicines and Clinical Policies • Staff Engagement Group. • Staff Side • ICB Executive Team • Audit Committee
Impact Assessments Undertaken	• Equality Impact Assessment (see Appendix A)

Version History

Version	Date	Author (Name and Title)	Summary of amendments made
0.1	03/02/26	Michael Watson	First draft
0.2	20/06/23	Sara O'Connor	Draft policy added to agreed EICB policy template and other updates
1.0	05/03/26	Senior Governance Officer	Final – Approved version

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1. Introduction

1.1. This is a controlled document. Whilst this document may be printed (please consider if this is necessary), the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the website (or requested from the Governance Lead/Team) to ensure the most up-to-date version is used.

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

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

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

1.5. ICBs were created to give statutory NHS providers, local authority and primary medical services nominees a role in decision-making. These individuals will be expected to act in accordance with the first principle (as described in paragraph 1.3 above), and whilst it should not be automatically assumed that they are personally or professionally conflicted just by virtue of being an employee, director, partner or otherwise holding a position with one of these organisations, the possibility of actual and perceived conflicts of interests arising will remain. For all decisions, ICBs will need to carefully consider whether an individual's role in another organisation could result in actual or perceived conflicts of interest and whether that outweighs the value of the knowledge they bring to the process.

1.6. The personal and professional interests of all ICB board members, ICB committee members and ICB staff who are involved in the marking of decisions within this ICB need to be declared, recorded and managed appropriately. Declarations must be made as soon as practicable after the person becomes aware of the conflict or potential conflict and, in any

event, within 28 days of the person becoming aware. This includes being clear and specific about the nature of any interest, and about the nature of any conflict that may arise regarding a particular decision.

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

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

1.9. Actions to mitigate a conflict of interest should be proportionate and should seek to preserve the spirit of collective decision-making wherever possible. Mitigation should take account of a range of factors including the perception of any conflicts and how a decision may be received if an individual with a perceived conflict is involved in that decision, and the risks and benefits of having a particular individual involved in making the decision. Potential options in relation to mitigation are outlined in section 6.25.24 below.

i. Including a conflicted person in the discussion but not in decision making;

ii. Excluding a conflicted person from both the discussion and the decision making;

iii. Including a conflicted person in the discussion and decision where there is a clear benefit to them being included in both – however, including the conflicted person in the actual decision should be done after careful consideration of the risk and with proper mitigation in place. The rationale for inclusion should also be properly documented and included in minutes.

iv. Excluding the conflicted individual and securing technical or local

expertise from an alternative, unconflicted source

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

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

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

2. Purpose

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

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

3. Scope

3.1. This policy applies to, including and without limitation, whether permanent, temporary, seconded, students/trainees/apprentices or contracted-in (either as an individual or through an agency/third party supplier):

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

(b) members of the Board, committees/sub-committees and practice representatives involved in the ICB's policy-making processes (including co-opted members, appointed deputies, temporary appointments, members of committees/groups from other organisations and 'regular attendees' of these meetings.
(c) self-employed consultants.

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

- Board and sub-committee members
- Place based directors
- Executive and senior managers as outlined in the Scheme of Reservation and Delegation and Standing Financial Instructions
- Level 4 Patient and Public Voice partners

4. Definitions and Categories of Interests

4.1. **Commercial Sponsorship** - An arrangement where the ICB receives financial support or support in kind for staff, research, training, equipment, premises or conferences.

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

A conflict of interest may be:

- **Actual** - there is a material conflict between one or more interests, or
- **Potential** – there is the possibility of a material conflict between one or more interests in the future.

Individuals 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 imputation of improper conduct.

'Interests' can arise in a number of different contexts. A benefit may arise from the making of a gain or the avoidance of a loss.

4.3. **Financial interest -** Where an individual may get direct financial benefit (this may be a financial gain, or avoidance of a loss) from the consequences of a decision they are involved in making.

4.4. **Gifts** - Any item of cash or goods, or any service, which is provided for personal benefit, free of charge or less than its commercial value.

4.5. **Hospitality** - Food, drink, travel, accommodation, or entertainment offered or provided in the nature of the organisation's business by anyone other than the employer.

4.6. **'Material interest'** – is an interest which a reasonable person would take into account when making a decision regarding the use of taxpayers' money because the interest has relevance to that decision. Consequently, all such interests should be declared and assessed as appropriate for inclusion in the ICB's register of interests.

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

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

4.9. **Indirect interests:** Where an individual has a close association[1] with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making. These associations may arise through relationships with close family members and relatives, close friends and associates, and business partners.
A common-sense approach should be applied to these terms. It would be unrealistic to expect staff to know of all the interests that people in these classes might hold. However, if staff do know of material interests (or could be reasonably expected to know about these) then these should be declared. Further guidance on how to interpret these categories can be found in Appendix B.

4.10. **Decision-Making Staff:** Those staff in roles who are more likely than others to have a decision-making influence on the use of taxpayers' money, because of the requirements of their role. The ICB considers decision-making staff to be:

- Executive, non-executive and partner members of the ICB Board (or equivalent roles) who have decision making roles which involve the spending of taxpayers' money (equivalent roles in different organisations carry different titles and these should be considered on a case-by case basis).

[1] A common sense approach should be applied to the term 'close association'. Such an association might arise, depending on the circumstances, through relationships with close family members and relatives, close friends and associates, and business partners.

- Members of advisory groups which contribute to direct or delegated decision making on the commissioning or provision of taxpayer funded services.
- Staff at Agenda for Change band 8d and above (reflecting guidance issued by the Information Commissioner's Office with regard to freedom of information legislation).
- Administrative and clinical staff who have the power to enter into contracts on behalf of their organisation.
- Administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment, and formulary decisions.

4.11. **Improper Performance:** Under the Bribery Act 2010 improper performance is defined in summary as 'performance which amounts to a breach of an expectation that a person will act in good faith, impartially, or in accordance with a position of trust.' The offence applies to bribery relating to any function of a public nature, connected with a business, performed during a person's employment or performed on behalf of a company or another body of persons. Therefore, bribery in both the public and private sectors is covered by the Act.

NB: It is an offence for a person to offer, promise or give a financial or other advantage to another person in one or two cases:

Case One applies where that person intends the advantage to bring about the improper performance by another person of a relevant function or activity or to reward such improper performance.

Case Two applies where the person knows or believes that the acceptance of the advantage offered, promised, or given in it constitutes the improper performance or a relevant function or activity.

4.12. **Joint Working** - Situations where, for the benefit of patients, organisations pool skills, experience and/or resources for the joint development and implementation of patient centred projects and share a commitment to successful delivery. Joint working agreements and management arrangements are conducted in an open and transparent manner.

Joint working differs from sponsorship, where pharmaceutical companies simply provide funds for a specific event or work programme.

4.13. **Openness** – Means that there should be transparency about NHS activities to promote confidence between the ICB and its employees, service users and the public.

4.14. **Pharmaceutical Industry** - Includes:

- Companies, partnerships or individuals involved in the manufacturing, sale, promotion or supply of medicinal products subject to the licensing provision of the Medicines Act 196816.

- Companies, partnerships or individuals involved in the manufacture, sale, promotion or supply of medical devices, appliances, dressings, and nutritional supplements which are used in the treatment of patients within the NHS.
- Trade associations and agencies representing companies involved with such products.
- Companies, partnerships or individuals who are directly concerned with research, development or marketing of a medicinal product, device, appliance, dressing or supplement that is being considered by, or would be influenced by, decisions taken by the ICB.
- Pharmaceutical industry related industries, including companies, partnerships or individuals directly concerned with enterprises that may be positively or adversely affected by decisions taken by the ICB.

4.15. **Probity** – Means that 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 affecting service users, employees, and suppliers and in the use of information acquired in the course of NHS duties.

4.16. **VCFSE** - Voluntary, community, faith and social enterprise.

5. Roles and Responsibilities

5.1. ICB Board

In the context of this policy members of the Board are:

- required to comply with all relevant elements of this policy
- ensure that the ICB's policies and procedures reflect best practice particularly in relation to the procurement of services
- ensure that arrangements for audit and reporting are open, robust and effective.

5.2. Chief Executive

The Chief Executive Officer of the ICB has overall accountability for managing conflicts of interest within the ICB and is responsible for:

- ensuring that the ICB has processes in place to enable individuals to declare and manage conflicts of interest.
- creating a culture in which ICB employees feel able and supported to report any conflicts of interest concerns as part of their day-to-day activities.

5.3. Executive Director of Corporate Services

The Chief Executive has delegated responsibility for the organisation's compliance with this policy to the Executive Director of Corporate Services including investigation into any breaches of this policy.

5.4. Audit, Risk and Compliance Committee

5.4.1. The Audit, Risk and Compliance Committee will have responsibility for

- Overseeing the arrangements for the management of conflict of interest, gifts, hospitality and commercial sponsorship, and advise the Board as required.
- Receive a Decision Register report on a quarterly basis which will include all decisions made by the Board and Board Committees inclusive of any declaration of interests made against each decision and how those conflicts were managed.
- Ensure that the registers of interests and gifts, hospitality and sponsorship are reviewed regularly and updated as necessary.
- Ensure that for every interest declared, arrangements are in place to manage the conflict of interests or potential conflict of interests, to ensure the integrity of the ICB's decision making process.
- The arrangements will confirm the following:
  - When an individual should withdraw from a specified activity, on a temporary or permanent basis.
  - Monitoring of the specified activity undertaken by the individual, either by a line manager, colleague or other designated individual.

5.5. Conflicts of Interest Guardian

5.5.1. The Chair of the Audit, Risk and Compliance Committee will be the ICB's Conflict of Interest Guardian and, in collaboration with the ICB Governance Lead, will:

- Act as a conduit and safe point of contact for staff, members of the public and healthcare professionals who have any concerns with regards to conflicts of interest.
- Be a safe point of contact for employees or workers of the ICB to raise any concerns in relation to this policy, ensuring that concerns are treated with appropriate confidentiality and that explanations are provided for any decisions taken.
- Support the rigorous application of this and associated policies.
- Provide independent advice and judgement to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation.
- Provide advice on minimising the risks of conflicts of interest.

5.5.2. Contact details for the Audit, Risk and Compliance Committee Chair/Conflicts of Interest Guardian are at **Appendix D**.

5.6. Policy Author

5.6.1. The policy author will have responsibility for reviewing and updating the policy in line with Section 9 below.

5.7. Associate Director of Governance (ICB Governance Lead)

5.7.1. The ICB Governance Lead, with the support of other governance team staff, is responsible for:

- Ensuring the ICB has a conflicts of interest policy in place which is accessible to staff.
- Ensuring a formal review of all individuals' declarations of interest is undertaken annually.
- Providing staff and other relevant individuals with advice, support, and guidance to enable them to manage conflicts of interest.
- Maintaining the register of interest, register of gifts and hospitality and other records relating to the management of conflicts of interest
- Ensuring that registers of interest and registers of gifts and hospitality are published on the ICB's public website.
- Ensuring that appropriate administrative arrangements are in place to effectively manage and record/report any issues relating to breaches of this or associated policies.
- Supporting the Conflicts of Interest Guardian to enable them to effectively carry out their responsibilities.
- Maintain the Decision Register of all decisions made by the Board and Board Committees inclusive of any declarations made against each action, provide to Audit, Risk and Compliance Committee meetings on a quarterly basis and subsequently published on the ICB public website, unless exempt due to reasons of commercial sensitivity or personal confidentiality.
- Ensuring that senior managers provide adequate, appropriate and transparent reporting to the ICB Board, its committees, stakeholders and the public as required by the Health and Social Care Act 2012 and the Health and Care Act 2022.

5.8. Executive Director of Finance and Commercial

5.8.1. The Executive Director of Finance and Commercial is a designated contact to whom any suspicious of fraud may be reported, as per the Counter Fraud, Bribery and Corruption Policy, and is also the lead Executive Director for procurement.

5.9. Line Managers

5.9.1. Line managers are responsible for upholding and promoting high standards in relation to the management of conflicts of interest, gifts, hospitality and commercial sponsorship, ensuring staff reporting to them understand their responsibilities and are supported to adhere to the

requirements of this policy and for providing adequate, appropriate and transparent reporting to the ICB Board and its committees, stakeholders and the public.

5.9.2. Line managers should be the first point of contact if a member of staff is unsure whether to declare an interest or to accept/decline a gift and should work with their staff to ensure their declarations of interests and declarations of gifts and hospitality are up to date, including during annual appraisal of members of their team.

5.10. Local Counter Fraud Specialist

5.10.1. The ICB Local Counter Fraud Specialist should be contacted in the first instance if you have any genuine suspicions or concerns over fraud or bribery, in accordance with the ICB Counter Fraud Bribery and Corruption Policy.

5.10.2. The LCFS is responsible for investigating allegations of fraud, bribery, and corruption. In consultation with the Executive Director of Finance and Commercial, the LCFS will report any case to the NHS Counter Fraud Authority and / or the police, as agreed, in accordance with the NHS Counter Fraud manual. The LCFS is responsible for taking forward all counter fraud work locally in accordance with national standards and in consultation with the Executive Director of Finance and Commercial.

5.11. All ICB Employees, Committee members and Contractors.

The ICB uses the skills of many different people, all of whom are vital to our work. This includes people on differing employment terms, who for the purposes of this policy are collectively referred to as 'staff' and are listed below:

- All Board members and salaried employees.
- All prospective employees who are part-way through recruitment.
- Contractors and sub-contractors.
- Agency/bank staff.
- Committee, sub-committee and advisory group members (who may not be directly employed or engaged by the organisation, for example staff employed/engaged by member organisations of the Essex Integrated Care Partnership).

As a member of staff you should:

- Familiarise yourself with this policy and associated policies, including the Counter Fraud and Bribery and Corruption Policy and follow them.
- Refer to NHSE/I guidance on managing conflicts of interest for the rationale behind this policy.
- Use your common sense and judgement to consider whether the interests you have could affect the way taxpayers' money is spent.

- Regularly consider what interests you have and declare these as they arise. If in doubt, declare. (NB: There may be occasions where staff declare an interest but upon closer consideration it is clear it is not material and so does not give rise to the risk of a conflict of interest. The governance lead/team will decide whether it is necessary to transfer such declarations to the ICB's registers of interests).
- **NOT** misuse your position to further your own interests or those close to you.
- **NOT** be influenced or give the impression that you have been influenced by outside interests.
- **NOT** allow your outside interests to inappropriately affect the decisions you make when using taxpayers' money.
- Seek clarification from your line manager on any points which are not clear.
- Speak up if you have any concerns about how conflicts of interest are being managed.
- Support others to identify and manage conflicts of interest.
- Undertake mandatory online conflicts of interest training.
- Report any suspicions of fraud, bribery, or corruption in accordance with the ICB's Counter Fraud, Bribery, and Corruption Policy by referral to the ICB's Local Counter Fraud Specialist (LCFS), Executive Director of Finance and Commercial, or to the NHS Counter Fraud Authority (NHS CFA).

6. Standards of Business Conduct

6.1. Principles of Good Business Conduct

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

- The Seven Principles of Public Life (the 'Nolan Principles').
- The Good Governance Standards for Public Services (CIPFA 2004)
- The seven key principles of the NHS in England
- The Equality Act 2010
- The UK Corporate Governance Code 2024
- Guidance on Integrated Care Board Constitutions and Governance

6.1.2. In addition, as an ICB we will:

- Do business appropriately: conflicts of interest become much easier to identify, avoid and/or manage when the processes for needs assessments, consultation mechanisms, commissioning strategies and procurement procedures are right from the outset, because the

rationale for all decision-making will be clear and transparent and should withstand scrutiny.

- Be proactive, not reactive: commissioners should seek to identify and minimise the risk of conflicts of interest at the earliest possible opportunity.
- Be balanced and proportionate: rules should be clear and robust but not overly prescriptive or restrictive. They should ensure that decision-making is transparent and fair whilst not being overly constraining, complex or cumbersome.
- Be transparent: document clearly the approach and decisions taken at every stage in the commissioning cycle so that a clear audit trail is evident.
- Create an environment and culture where individuals feel supported and confident in declaring relevant information and raising any concerns.

6.1.3. The ICB recognises that:

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

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

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

6.2. Identification & Declaration of Interests

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

6.2.2. The definition of 'conflict of interest' and the types/categories are defined in Section 4 above and within the Declaration of Interest Form at **Appendix B**. A common-sense approach should be applied to these terms. It would be unrealistic to expect staff to know of all the interests that people in these categories might hold. However, if staff do know of

material interests (or could be reasonably expected to know about them) then these should be declared.

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

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

6.2.5. All staff must identify and declare material interests at the earliest opportunity, and by law within 28 days after the interest arises/is known. The ICB also expects individuals to declare new interests they are pursuing.

6.2.6. Declarations received may be checked against publicly accessible sites including those hosted by Companies House, Disclosure UK, and social media - with particular focus being directed to Board members and other individuals holding decision making roles within the ICB. The annual audit of conflicts of interest will also include checks against random sample declarations of interests.

6.2.7. If staff are in any doubt as to whether an interest is material, they should declare it, or seek advice from the Governance Lead so it can be considered.

6.2.8. Declarations should be made, using the declaration of interest form available at **Appendix B** and as a separate document on the ICB's intranet, as below:

- On appointment with the organisation, or as a member of an ICB committee/sub-committee or other group/forum – the ICB will implement appropriate arrangements to facilitate this.

- Annually when prompted by the ICB and/or during the staff appraisal process. Because of its role in spending taxpayers' money, the ICB will ensure that, at least annually, staff are prompted to update their declarations of interests or make/confirm a nil return where there are no interests or changes to declare.

- During meetings by inclusion of declarations of interest as a standing item on each meeting's agenda.

- All board or committee members are required to declare any interests in agenda items in advance of the meeting. The Governance Team will assist with identification of relevant interests. During Board and other meetings, members/attendees are required to declare their interests as a standing agenda before the item is discussed. Even if an interest has been recorded in the register of interests, it should still be declared in meetings where matters relating to that interest are discussed. Declarations of interest and how they were managed must be recorded in minutes of meetings.

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

- When staff move to a new role or their responsibilities change significantly.

- At the beginning of a new project/piece of work/procurement process/contract monitoring: Conflicts of interest must be managed appropriately throughout the whole commissioning cycle and then within the ongoing management of existing contracts. You must complete a declaration of interest form at the outset of any commissioning process, even if you have nothing to declare, and a record of this should be made available to relevant stakeholders as per the ICB policy around register of interests. Where a potential conflict of interest has been identified, you must take steps to declare this as soon as possible and work with the commissioning lead and/or the Governance Lead to agree the extent to which it is appropriate for you to be involved in the ongoing process and, in some circumstances, whether it is appropriate to be involved at all. Similarly, should your circumstances change at any point during the commissioning cycle, you must declare any potential conflict of interest as soon as possible and follow steps identified in this policy.

  Please also refer to the ICB's Procurement and Contracting Policy which has specific requirements for managing conflicts of interest.

- Whenever an individual's role, responsibility or circumstances change in a way that affects the individual's interests (e.g. where an individual takes on a new role outside the ICB or enters a new business or relationship), a further declaration must be made to reflect the change in circumstances as soon as possible, and in any event within 28 days. This could involve a conflict of interest ceasing to exist or a new one materialising. The onus is on the individual to make this declaration, rather than waiting to be asked

6.2.9. Where an interest is declared, the individual's line manager should review the form and agree any mitigating action required to manage any conflicts

which should be recorded on the form for transferring to the appropriate register.

6.2.10. Declarations of Interest forms submitted outside of recruitment processes should be returned to the Governance team for inclusion on the register of interests.

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

6.3. Appointment of board members, committee members and senior employees.

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

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

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

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

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

6.3.6. This would prevent, for example, directors of private healthcare companies or significant stakeholders of private healthcare companies

from sitting on any board, committee or sub-committee exercising ICB commissioning functions.

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

6.4. Proactive Review of Interests

6.4.1. The ICB will require all staff to formally review and, if necessary, update their declaration of interest annually.

6.4.2. Reminders for staff to review and update their declarations of interest will be provided in several ways, including reminders based on the anniversary of the last declaration and via the staff appraisal process.

6.4.3. The ICB will implement arrangements to prompt ICB Board members and other decision-making staff to review and update their declarations of interest on a regular basis by:

- Including 'declarations of interest' on meeting agendas.
- Providing a register to each meeting of the ICB Board and its main committees/groups setting out the interests of relevant members and regular attendees.
- Implementing arrangements to ensure that staff participating in projects, new pieces of work and procurement processes are required to declare relevant interests.

6.5. Maintenance of Records

6.5.1. The ICB will maintain the following registers:

- Register of Interests.
- Register of Gifts and Hospitality.
- Register of Commercial Sponsorship.
- Register of Procurement Decisions.

6.5.2. All declared interests that are material will be promptly transferred to the register by the Governance team.

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

6.6. Publication

6.6.1. The ICB will publish the interests declared by decision-making staff in the relevant registers available on the ICB website.

6.6.2. This information will be refreshed at least annually.

6.6.3. Registers of interests for publicly held Board or committee meetings will be made available within meeting papers available on the ICB website.

6.6.4. Registers will also be made available for inspection, by emailing mseicb-thu.icbgovernanceteam@nhs.net to make an appointment with the Governance team, at Seax House, Victoria Road South, Chelmsford, Essex CM1 1QH.

6.6.5. If decision-making or other staff have substantial grounds for believing that publication of their interests should not take place, they should contact the ICB Governance Lead to explain why. In exceptional circumstances, for instance where publication of information might cause the member of staff or somebody else substantial damage or distress or put a member of staff at risk of harm, with the agreement of the Conflicts of Interest Guardian (who will seek appropriate legal advice where required), information may be withheld or redacted on public registers. However, this would be the exception, and information will not be withheld or redacted merely because of a personal preference. In these circumstances a confidential unredacted record will be maintained.

6.7. Wider Transparency Initiatives

6.7.1. The ICB fully supports wider transparency initiatives in healthcare and encourages staff to engage actively with these.

6.7.2. Relevant staff are strongly encouraged to give their consent for payments they receive from the pharmaceutical industry to be disclosed as part of the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative. These “transfers of value” include payments relating to:

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

6.7.3. Further information about the scheme can be found on the ABPI website.

6.8. Management of Interests - General

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

6.8.2. If an interest is declared but there is no risk of a conflict arising then no action is warranted. However, if a material interest is declared then the general management actions that could be applied include:

- Restricting staff involvement in associated discussions and excluding them from decision making.
- Removing staff from the whole decision-making process.
- Removing staff responsibility for an entire area of work.
- Removing staff from their role altogether if they are unable to operate effectively in it because the conflict is so significant.

6.8.3. Each case will be different and context-specific, and the ICB will always clarify the circumstances and issues with the individuals involved to assess issues and risks. Staff should maintain a written audit trail of information considered and actions taken.

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

6.8.5. The ICB Governance Lead and/or the Conflicts of Interest Guardian will provide advice on possible disputes about the most appropriate management action to ensure that interests do not (and do not appear to) affect the integrity of the ICB's decision-making process

6.9. Managing conflicts of interests at meetings

6.9.1. The chair of a meeting of the ICB's Board or any of its committees, sub-committees or groups has ultimate responsibility for deciding whether there is a conflict of interest and for taking the appropriate course of action to manage the conflict.

6.9.2. The chair, with support of the ICB's Governance Lead or their representative, should proactively consider ahead of meetings what conflicts are likely to arise and how they should be managed, including taking steps to ensure that supporting papers for particular agenda items of private sessions/meetings are not sent to conflicted individuals in advance of the meeting where relevant. This also applies to the minutes of discussions held relating to relevant item(s).

6.9.3. On circulation of the meeting agenda, delegates should be asked to confirm in writing prior to the meeting whether they believe themselves to be conflicted or potentially conflicted regarding one or more of the agenda items.

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

6.9.5. Any new offers of gifts or hospitality (whether accepted or not) which are declared at a meeting must be included on the ICB's register of gifts and hospitality to ensure it is up-to-date.

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

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

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

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

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

6.10. Managing conflicts when making joint decisions with other partners.

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

6.10.2. Appropriate governance arrangements must be put in place that ensure that conflicts of interest are identified and managed. Where independent

providers (including the voluntary sector) hold contracts for services (for example, community services) it would be appropriate and reasonable for the body to involve them in discussions (for example, about pathway design and service delivery, particularly at place-level). However, this would be clearly distinct from any considerations around contracting and commissioning, from which they would be excluded.

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

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

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

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

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

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

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

- Remain and participate - Noting the interest and ensuring that all attendees are aware of the nature and extent of the interest but

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

6.10.5. At the start of meetings, the chair should summarise all interests received prior to the meeting and call for any other interests in respect of the agenda items. Just prior to individual agenda items being discussed, the chair should confirm any declarations of interest referred to earlier in the meeting. The chair, in discussion with meeting attendees if appropriate, should agree on a course of action to manage those conflicts. This very much depends on an assessment of the facts at the time but several options are available to the chair of the meeting:

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

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

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

6.11. Minutes of meetings

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

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

6.12. Management of Interests – Common Situations

6.12.1. The following sections set out the principles and rules to be adopted by staff in common situations, and what information should be declared.

6.13. Gifts

6.13.1. This policy prohibits the offer or receipt of gifts, hospitality, payment or expenses whenever these could affect or be perceived to affect the outcome of business transactions and are not reasonable and bona fide expenditure. All staff should be aware that gifts and hospitality can be used as a subterfuge for bribery and, if this is suspected it should be reported immediately to the Local Counter Fraud Specialist.

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

6.13.3. Staff should not accept gifts that may affect, or be seen to affect, their professional judgement. If you are in any doubt as to whether to accept a gift, it is better to politely decline the offer.

6.13.4. Gifts from suppliers or contractors:

- Gifts from suppliers or contractors doing business (or likely to do business) with the organisation should always be declined, whatever their value.
- Low cost branded promotional aids such as pens or post-it notes may, however, be accepted where they are under the value of £6 in total and need not be declared. The £6 value has been selected with reference to existing industry guidance issued by the Association of the British Pharmaceutical Industry (ABPI).

6.13.5. Gifts from other sources (e.g. patients, families, service users):

- Staff must not ask for any gifts.
- Personal gifts 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) to individuals must always be declined whatever their value and whatever their source, and the offer which has been declined must be declared and recorded on the register.
- Gifts valued at over £50 should be treated with caution and only be accepted on behalf of behalf of the ICB and not in a personal capacity. These should be declared by staff, providing a clear reason as to why it was considered permissible to accept the gift, alongside the actual or estimated value, to the ICB Governance Lead in order to agree how these should be used, for example, donated to a local charity.
- Modest gifts accepted under a value of £50 do not need to be declared.

6.13.6. 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).

6.13.7. Multiple gifts from the same source over a twelve-month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50.

6.13.8. The acceptance or rejection of gifts should be declared on the form provided at **Appendix C,** which summarises the above rules, and submitted to the Governance Team.

6.14. Hospitality (including Meals, Refreshments, Travel and Accommodation)

6.14.1. 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, 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.

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

6.14.3. Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement.

6.14.4. Hospitality must only be accepted when there is a legitimate business reason, and it is proportionate to the nature and purpose of the event.

6.14.5. Caution must be exercised when hospitality is offered by actual or potential suppliers or contractors. This can be accepted, and must be declared, if modest and reasonable, but caution should be exercised if a contract re-tender is imminent. Advice should be sought from the Governance Lead and prior approval by the relevant Executive Director must be obtained.

6.14.6. Meals and refreshments:

- Under a value of £25 - may be accepted and need not be declared.
- Of a value between £25 and £75 - may be accepted and must be declared. The £75 value has been selected with reference to existing industry guidance issued by the ABPI.
- Over a value of £75 - should be refused unless (in exceptional circumstances) prior approval by the relevant Director is given. A clear reason should be recorded on the organisation's register(s) of interest as to why it was permissible to accept.

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

- 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).

6.14.7. Travel and accommodation:

- Modest offers to pay some or all travel and accommodation costs related to attendance at events may be accepted and must be declared.

- Offers which go beyond modest or are of a type that the organisation itself might not usually offer should be politely refused. However, there might be some **limited and exceptional circumstances** where accepting these types of hospitality may be contemplated. In these circumstances, prior approval by the relevant Director is required and must be declared.

- A clear reason should be recorded on the organisation's register(s) of interest as to why it was permissible to accept travel and accommodation of this type. A non-exhaustive list of examples includes:

  - hospitality of a value above £75 per attendee.

  - offers of business class or first-class travel and accommodation (including domestic travel).

  - offers of foreign travel and accommodation.

6.14.8. The acceptance or rejection of hospitality should be declared on the form provided at **Appendix C,** which summarises the above rules, and submitted to the Governance Team.

6.14.9. With regard to the provision of hospitality by the Integrated Care Board, The Code of Conduct: Code of Accountability in the NHS advises that the use of NHS monies for hospitality and entertainment, including hospitality at conferences or seminars, should be carefully considered. Expenditure on these items should be capable of justification, as reasonable in the light of general practice in the public sector. The provision of hospitality or entertainment is open to challenge by auditors and ill-considered actions can damage public perception and respect for the NHS.

6.15. Outside Employment

6.15.1. 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.

6.15.2. Outside employment means employment and other engagements, outside of formal ICB employment arrangements. This can include employment within another NHS organisation, 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 the ICB.

6.15.3. The ICB requires employees, committee members, contractors and others engaged under a contract with the ICB to declare if they are employed or engaged in any employment, business, consultancy, or voluntary role in addition to their work with the ICB.

6.15.4. Staff must declare any existing outside employment/engagement on their appointment and any new outside employment/engagement when it arises.

6.15.5. Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks.

6.15.6. Where contracts of employment or terms and conditions of engagement permit, staff will be required to seek prior approval from the ICB to engage in outside employment.

6.15.7. The ICB may also have legitimate reasons within employment law for knowing about outside employment of staff, even when this does not give rise to risk of a conflict. Nothing within this policy prevents such enquiries being made.

6.15.8. The ICB requires that individuals obtain prior written permission from a director to engage in outside employment. The ICB reserves the right to implement appropriate arrangements to manage any conflict(s) and to refuse permission for outside employment where it believes a conflict will arise which cannot be effectively managed.

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

6.15.10. Trading on official premises is prohibited, whether for personal gain or on behalf of others. Canvassing/advertising by, or on behalf of, outside bodies or firms (including non-ICB interests of staff or their relatives) is also prohibited. Official ICB email accounts and documentation such as

letter headed paper / logos should not be used for private enterprise and may constitute an offence of fraud.

6.15.11. The ICB will implement arrangements to facilitate the declaration of outside employment by new staff upon their appointment by completion of the Declaration of Interest form at Appendix B. This process will be managed by the ICB's Human Resources and Governance Teams with relevant outside employment interests being recorded within the register of interest.

6.16. Shareholdings and other ownership issues

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

6.16.2. Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the ICB or member organisations of the wider Integrated Care Partnership.

6.16.3. Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

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

6.16.5. Shareholdings and other ownership issues should be declared on the form provided at Appendix B and will be recorded within the register of interests.

6.17. Patents

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

6.17.2. Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by the organisation.

6.17.3. Staff should seek prior permission from the ICB before entering into any agreement with bodies regarding product development, research, work on pathways etc, where this impacts on the ICB's time, or uses its equipment, resources or intellectual property.

6.17.4. 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.

6.17.5. Relevant patents must be declared on the form provided at Appendix B and submitted to the Corporate Governance Team for recording within the register of interests.

6.18. Loyalty Interests

6.18.1. Conflicts of interest can arise when decision making is influenced through association with colleagues or organisations out of loyalty to the relationship they have, rather than through an objective process.

6.18.2. 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 an organisation spends taxpayers' money.
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.
- Are aware that the ICB does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

6.18.3. Where holding loyalty interests gives rise to a conflict of interest then the general management actions outlined in this guidance should be considered and applied to mitigate risks

6.18.4. Loyalty interests must be declared on the form provided at **Appendix B** and submitted to the Governance Team for recording within the register of interests.

6.19. Donations

6.19.1. 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. Staff will, in their private lives, undertake voluntary work or

fundraising activities for charity. A supportive environment across the NHS and charitable sector should be promoted. However, conflicts of interest can arise.

6.19.2. Donations made by suppliers or bodies seeking to do business with the ICB should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.

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

6.19.4. Staff must obtain permission from the ICB if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the organisation's own.

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

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

6.19.7. The ICB will maintain records in line with the above principles and rules and relevant obligations under charity law.

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

6.20. Commercial Sponsorship

6.20.1. This section should be read in conjunction with section 6.28, Joint working with the pharmaceutical industry.

6.20.2. ICB staff, the Board and committee members may be offered commercial sponsorship for events such as courses, conferences, post/project funding, meetings and publications in connection with the activities which they carry out for or on behalf of the ICB. All such offers (whether accepted or declined) must be declared so that they can be included on the ICB's register of gifts, hospitality and commercial sponsorship, and the Head of Governance should provide advice on whether or not it would be appropriate to accept any such offers. If such offers are reasonably justifiable then they may be accepted, with the written approval of a director or the Governance Lead.

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

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

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

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

6.20.7. 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.

6.20.8. For further information on what to do if offered sponsorship, see **Appendix C.**

6.21. Sponsored events

6.21.1. Line manager and governance advice must be sought before accepting any type of sponsorship as this can be a controversial issue.

6.21.2. 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.

6.21.3. In the case of sponsored events, sponsorship should never be accepted from organisations whose business would not be seen as being compatible with the ethos of the NHS, e.g. organisations that are associated with:

- matters that are damaging to health or associated with gambling, alcohol, vaping, tobacco, illegal drugs, weight control or politics.
- the promotion of prescription-only drugs to the general public, or other promotion that contravenes that ABPI Code of Practice to the Pharmaceutical Industry.
- Pornography or other companies involved in the sexual exploitation of adults or children.
- The manufacture of firearms or other weapons.
- Legal services which overtly promote compensation and personal injury services and claims management companies acting on their behalf.

This list is not exhaustive and if there is any doubt, please contact your line manager and/or a senior member of the Governance Team.

6.21.4. Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit to the ICB and the NHS.

6.21.5. During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.

6.21.6. No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.

6.21.7. 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.

6.21.8. The involvement of a sponsor in an event should always be clearly identified in the interest of transparency.

6.21.9. Staff within the organisation involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.

6.21.10. Staff arranging sponsored events must declare this to the organisation by using the form at **Appendix C**.

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

6.22. Sponsored Research

6.22.1. 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.

6.22.2. Funding sources for research purposes must be transparent.

6.22.3. Any proposed research must go through the relevant health research authority or other approvals process.

6.22.4. 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.

6.22.5. The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service.

6.22.6. Staff should declare involvement with sponsored research to the ICB by using the form at **Appendix C**.

6.22.7. The ICB will retain written records of sponsorship of research, in line with the above principles and rules.

6.23. Sponsored Posts

6.23.1. 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.

6.23.2. External sponsorship of a post requires prior approval from the ICB. Requests should be submitted to the Executive Chief People Officer.

6.23.3. Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and withdraw if appropriate.

6.23.4. 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. This should be audited for the duration of the sponsorship. 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.

6.23.5. Sponsored post holders must not promote or favour the sponsor’s products, and information about alternative products and suppliers should be provided.

6.23.6. 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.

6.23.7. The ICB will retain written records of sponsorship of posts, in line with the above principles and rules.

6.23.8. 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.

6.24. Clinical Private Practice

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

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

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

- Where they practise (name of private facility).
- What they practise (specialty, major procedures).
- When they practise (identified sessions/time commitment).
- Hospital consultants are already required to provide their employer with this information by virtue of paragraph 3, schedule. 9 of Terms and conditions – consultants (England)
- Action taken to mitigate against a conflict, including details of any approvals given to depart from the terms of this policy.

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

- Seek prior approval of the ICB before taking up private practice.
- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private

work.2 (these provisions already apply to hospital consultants by virtue of paragraphs 5 and 20, schedule 9 of the Terms and conditions – consultants (England).
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines: Non-Divestment_Order_amended.pdf

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

6.24.6. Staff should declare involvement with clinical private practice to the ICB by using the form at **Appendix B** which should be submitted to the Governance Team for inclusion on the relevant register.

6.25. Strategic Decision Making Groups

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

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

6.25.2. The interests of those who are involved in these groups should be well known (as highlighted on registers of interests provided to each meeting) so that they can be managed effectively. For this organisation these groups include:

- The ICB Board
- The ICB's main Committees as set out in its Constitution
- Essex Medicines Optimisation Committee

6.25.3. These groups should adopt the following principles:

- Chairs should consider any known interests of members in advance and begin each meeting by asking for declaration of relevant material interests.
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.
- Any new interests identified should be added to the appropriate register.

[2] These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf)

- The vice chair (or other non-conflicted member) should chair all or part of the meeting if the chair has an interest that might prejudice their judgement.
- Terms of reference for such groups should refer to the organisation's policy and procedures for managing conflicts of interest and should set out any specific requirements which apply to the group.

6.25.4. If a member has an actual or potential interest the chair should consider the following approaches and ensure that the justification and reason for the chosen action is documented in the minutes of the meeting and (where appropriate) other records:

- Requiring the member to not attend the meeting.
- Excluding the member from receiving meeting papers relating to their interest.
- Excluding the member from all or part of the relevant discussion and/or decision and where necessary, securing technical or local expertise from an alternative unconflicted source.
- Including a conflicted person in the discussion and decision where there is a clear benefit to them being included in both – however, including the conflicted person in the actual decision should be done after careful consideration of the risk and with proper mitigation in place. The rationale for inclusion should also be properly documented and included in minutes.
- Noting the nature and extent of the interest but judging it appropriate to allow the member to remain and participate.
- Removing the member from the group or process altogether.
- Consider using a sub-committee to remove potential conflict from core committee membership.

6.25.5. The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. Good judgement is required to ensure proportionate management of risk.

6.25.6. The Chair of a meeting has ultimate decision-making responsibility regarding how conflicts of interest are managed.

6.26. Procurement

6.26.1. Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour which is against the interest of patients and the public.

6.26.2. Those involved in procurement exercises for and on behalf of the organisation should keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of

procurement processes. At every stage of procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process.

6.26.3. 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.

6.26.4. The procedure for managing conflicts of interest during procurements is set out in the ICB's Procurement and Contracting Policy. Further information about the PSR, including about the management of conflicts of interest, can be found within the PSR statutory guidance.

6.27. Contract management

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

6.27.2. The individuals involved in the monitoring of a contract should not have any direct or indirect financial, professional, or personal interest in the incumbent provider or in any other provider that could prevent them, or be perceived to prevent them, from carrying out their role in an impartial, fair and transparent manner.

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

6.28. Joint working with the pharmaceutical industry

6.28.1. This section should be read in conjunction with section 6.20, Commercial sponsorship.

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

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

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

6.28.5. This section of the policy is intended to:

6.28.6. Ensure transparency for all our stakeholders on our approach to joint working with the pharmaceutical industry.

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

6.28.8. Joint working can be defined as “situations where, for the benefit of patients, one or more pharmaceutical companies and the NHS pool skills, experience and/or resources for the joint development and implementation of patient centred projects and share a commitment to successful delivery”.The key requirements from this definition are:

- Any joint working project must be focused on benefits to patients
- There must be a “pooling” of resources between the pharmaceutical company or companies and the NHS organisation(s) involved. Each party must, therefore, make a significant contribution to the Joint Working project to avoid the arrangement being construed as merely a gift, benefit in kind, donation or some other non-promotional/commercial practice. Resources may come in various forms, including people, expertise, equipment, communication channels, information technology and finance.

6.28.9. Other principles to be applied to any instances of joint working and sponsorship are:

- All joint working and sponsorship will support projects that address local and national priorities and will maintain the freedom of clinicians to prescribe the most clinically appropriate and effective treatment for individual patients.
- Joint working and sponsorship will be conducted in an ethical, open and transparent manner.
- Joint working will take place at a corporate (organisational) level, and not with individual healthcare professionals or NHS administrative staff.
- Joint working contracts will be negotiated on fair and reasonable terms, in line with NHS values.
- Confidentiality of information received in the course of the joint working arrangement will be respected and never used outside the scope of the project. All patient identifiers will be removed from data to preserve and respect patient confidentiality in line with the Data Protection Act 2018.
- In the interests of transparency, the overall arrangements for joint working and sponsorship must be made public via the ICB website.
- Joint working and sponsorship is based on mutual trust and respect. Pharmaceutical companies must comply with the ABPI Code at all times. All NHS employed staff should comply with NHS, the ICB and relevant professional body codes of conduct at all times.

- Clinical and prescribing policies or guidelines must be based upon principles of evidence-based medicine and cost effectiveness. They will be consistent with national recommendations including the National Institute for Health and Clinical Excellence (NICE), expert bodies such as the Royal College of General Practitioners (RCGP) and local guidance.
- The Pharmaceutical industry should not have undue influence.
- Sponsorship must not provide personal benefit.

6.28.10. Any Joint Working/Sponsorship must ensure that all arrangements are neutral, free from preference regarding the use of the company's product over other more clinically appropriate or cost-effective products or services. In addition, arrangements must be in keeping with local guidelines and formularies.

6.28.11. The ICB will act in a transparent, objective manner, never endorsing any individual company or product through such agreements.

6.28.12. Where joint working is being contemplated, full consideration of the proposal must be given before any agreement is made. Advice should be sought from the Pharmacy and Medicines Optimisation Team and the Governance Lead. Legal advice may also be necessary.

6.28.13. There must be a specific agreement for each joint working project which contains information on:

- The name of the joint working project, the parties to the agreement, the date and the term of the agreement.
- The expected benefits for patients, the NHS and the pharmaceutical company.
- How the success of the project will be measured, when and by whom. A set of baseline measurements must be established at the outset of the project to track and measure the success of the project aims, particularly patient outcomes. For longer term projects (>1 year) patient outcomes should be analysed at least every six months as a minimum to ensure that anticipated patient benefits are being delivered.
- An outline of the financial arrangements.
- The roles and responsibilities of the ICB and the pharmaceutical company. All aspects of input from the company should be included such as training, support for service redesign, business planning, data analysis etc.
- The agreement should specify criteria that result in high certainty that both parties can meet their commitments. For example, both parties should be able to demonstrate that they have the capability, resource or track record to deliver on the commitments they are making.
- The planned publication of any data or outcomes.
- Procedures for dealing with Freedom of Information Act requests.
- If a pharmaceutical company enters into a joint working agreement on the basis that its product is already included in an appropriate place on

the local formulary, a clear reference to this should be included in the joint working agreement so that all the parties are clear as to what has been agreed.

- The agreement should include contingency arrangements to cover possible unforeseen circumstances such as changes to summaries of product characteristics and updated clinical guidance. Agreements should include a dispute resolution clause and disengagement/exit criteria including an acknowledgement by the parties that the project might need to be amended or stopped if a breach of the ABPI Code is ruled.

6.28.14. Approval must be obtained from the Commissioning Committee or relevant sub-group before the project proceeds. This will allow a full evaluation of the joint working agreement including governance issues and the overall impact of the joint working to be assessed in relation to healthcare priorities.

6.28.15. Joint Working offers of any kind from pharmaceutical companies must be declared and registered whether refused or accepted and be available for public scrutiny on request.

6.28.16. The ICB will encourage competitor companies to collaborate on any such ventures. If several companies are able to provide the same arrangements they should all – or at least a selection – be approached to ascertain their willingness to undertake joint working. If willing to do so, they could then share a joint working arrangement.

6.28.17. Any joint working arrangements will be reported to the Audit, Risk and Compliance Committee.

6.28.18. A primary care rebate scheme (PCRS) is an agreement between an ICB and a pharmaceutical company that provides an economic benefit to the commissioner and, in theory, may increase the volume sales of a company's product. These are different to national patient access schemes which are negotiated nationally by the Department of Health to enable patient access for very high-cost drugs that have clear clinical benefits. PCRS could be seen to undermine national pricing agreements between the Department of Health and Industry.

- The ICB believes that the pharmaceutical industry should supply medicines to the NHS using transparent pricing mechanisms, wherever possible.
- The ICB does accept rebates from pharmaceutical companies. The decision as to whether to accept a rebate is made by the Pharmacy & Medicines Optimisation Team based on the PrescQIPP operating model.

6.29. Prevention of Fraud and Bribery

6.29.1. The ICB is committed to preventing fraud and bribery and encourages staff with concerns or reasonably held suspicion about potentially fraudulent activity or practice to report these immediately to the ICB's Local Counter Fraud Specialist (LCFS), whose contact details can be obtained via the ICB's intranet. Suspicions may also be reported to the Executive Director of Finance and Commercial, or to the ICB Chair or ICB Chief Executive Officer where it would not be appropriate to report to the Executive Director of Finance and Commercial.

6.29.2. Suspicions of fraud can also be reported directly and confidentially to the NHS Fraud and Corruption Reporting Line on 0800 028 4060 or via https://cfa.nhs.uk/reportfraud.

6.30. Identifying and Reporting Breaches

6.30.1. There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as 'breaches'.

6.30.2. Staff who are aware about actual breaches of this policy, or who are concerned that there has been, or might be, a breach, should report these concerns to one of the officers listed below, whose contact details are set out on **Appendix D**:

- The ICB's Local Counter Fraud Specialist (who is the first point of contact for any genuine suspicions or concerns regarding fraud or bribery, as per the ICB's Counter Fraud, Bribery and Corruption Policy).
- National Fraud and Corruption Line 0300 123 2040
- The Executive Director of Corporate Services
- The ICB Governance Lead.
- The Conflicts of Interest Guardian.
- The Executive Director of Finance and Commercial.

6.30.3. To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Every individual has a responsibility to do this. For further information about how concerns should be raised please refer to the ICB's Freedom to Speak Up (Whistleblowing) Policy.

6.30.4. The ICB will investigate each reported breach according to its own specific facts and merits and give relevant parties the opportunity to explain and clarify any relevant circumstances.

6.30.5. Following investigation, the ICB will:

- Decide if there has been or is potential for a breach and, if so, what the severity of the breach is.
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum.
- Consider who else inside and outside the organisation should be made aware
- Take appropriate action as set out in the next section.

6.31. Taking Action in Response to Breaches

6.31.1. Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of the organisation and could involve organisational leads for staff support (e.g. Human Resources), fraud (e.g. Local Counter Fraud Specialist), members of the management or executive teams and auditors.

6.31.2. Any potential breach of the conflicts of interest elements of this policy will be investigated and actual breaches published on the ICB website. This includes the treatment of service contracts where a breach of conflicts of interest was identified.

6.31.3. Potential breaches highlighted during the course of ICB business, reported to the Conflicts of Interest Guardian or identified in any other way, will be documented by the Executive Director of Corporate Services and investigated.

6.31.4. Each breach needs to be investigated and judged on its own merits, and this should start with those involved having the opportunity to explain and clarify any relevant circumstances.

6.31.5. A conflict of interest panel will be assembled by the Executive Director of Corporate Services. The panel will be chaired by a non-executive board member and a minimum of two other non-executive board members will be members of the panel.

6.31.6. All documented evidence will be compiled by the Executive Director of Corporate Services or their representative and circulated to panel members at least five working days prior to the panel meeting.

6.31.7. There is an expectation that the individual being investigated will respond to questions and provide evidence sought in a timely manner to reduce possible delay.

6.31.8. The ICB recognises that receiving requests as part of the investigative process could be distressing for the individuals, and therefore HR will be approached to provide or sign-post relevant support.

6.31.9. Witnesses and the individual being investigated may be invited to the meeting if appropriate.

6.31.10. The panel meeting will be minuted by the Executive Director of Corporate Services, or their representative. and minutes will be kept on file for a minimum of six years.

6.31.11. The role of the panel is to assess whether an actual breach has occurred and to decide on a course of action to reflect the consequences of that breach.

6.31.12. Legal or other appropriate advice may be sought prior to imposing sanctions which could have serious consequences for those involved, Appendix 5 outlines the 'Potential Sanctions' (as per NHS England Managing Conflicts of Interest Guidance 2024).

6.31.13. Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process and procedures.
- Consideration as to whether HR/employment law/contractual action should be taken against staff or others.
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS Counter Fraud Authority, the Police, statutory health, or social care bodies (such as NHS England, Care Quality Commission, Local Government Association, and/or health professional regulatory bodies.

6.31.14. Inappropriate or ineffective management of interests can have serious implications for the organisation and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches in accordance with the ICB's Disciplinary Policy.

6.31.15. Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the ICB can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach. This includes:

- Employment law action against staff, which might include
- Informal action (such as reprimand or signposting to training and/or guidance).
- Formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal).
- Reporting incidents to the external parties/regulators described above for them to consider what further investigations or sanctions might be.
- Where the individual is not a direct employee, review of their appointment to the role that has given rise to the conflict.

- Civil/contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach, e.g. a claim for misfeasance in public office.
- Criminal sanctions such as investigation and prosecution under fraud, bribery, and corruption legislation, i.e. the Fraud Act 2006 and Bribery Act 2010.

6.31.16. Statutorily regulated healthcare professionals who work for, or are engaged by, the ICB are under professional duties imposed by their relevant regulator to act appropriately with regard to conflicts of interest. The ICB will report statutorily regulated healthcare professionals to their regulator if they believe that they have acted improperly, so that these concerns can be investigated. Statutorily regulated healthcare professionals should be made aware that the consequences for inappropriate action could include fitness to practise proceedings being brought against them, and that they could, if appropriate, be struck off by their professional regulator as a result. and

6.32. Transparency Concerning Breaches

6.32.1. Anonymised reports on breaches, the impact of these, and actions taken will be considered by the Audit, Risk and Compliance Committee and any other relevant committee/group.

6.32.2. To aid transparency the ICB will consider whether anonymised information on breaches and action taken in response should be prepared and published on its website.

7. Monitoring Compliance

7.1. Compliance with this policy will be monitored in the following ways:

- As part of the routine monitoring undertaken by the ICB Governance Lead.
- Monitoring completion rates of mandatory training relating to the management of conflicts of interest and taking action where necessary to improve completion rates, which must be a minimum of 90% compliance as of 31 March each year.
- Annual Audit of arrangements to manage conflicts of interest undertaken by the ICB's auditors, including an annual review by Counter Fraud as part of requirement 12 Government Functional Standards.
- The Audit, Risk and Compliance Committee will monitor compliance with this policy and the declaration of interest process via reporting as identified in the committee's workplan.
- Anonymised reporting on breaches and significant issues relating to the management of conflicts of interest to the Audit, Risk and Compliance Committee or other relevant committee.

- Identification and monitoring of any associated risks.
- By submission of any returns required by NHSE/I in relation to the management of conflicts of interest, which will be signed-off by the Conflicts of Interest Guardian.

8. Implementation and Staff Training

8.1. Induction training must be provided to all employees, Board members and members of ICB committees and sub-committees on the management of conflicts of interest. This is to ensure staff and others within the ICB understand what conflicts are and how to manage them effectively.

8.2. Induction training will cover the following:

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

8.3. All ICB staff will be required to undertake training deemed to be mandatory by NHSE/I or the ICB on the management of conflicts of interest available via the Electronic Staff Record (ESR). As a minimum, all staff will be required to complete Module 1, with Modules 2 and 3 to be completed by senior staff/Board members as identified on the ICB's mandatory training matrix.

8.4. The ICB will also implement arrangements to ensure that non-ICB staff who are members of the Board or its committees have undergone suitable

training on the management of conflicts of interests.

8.5. Those staff with responsibility for decision-making or providing advice and support regarding the management of conflicts of interest (including the ICB Governance Lead, other governance staff and the Conflicts of Interest Guardian) will be required to undertake appropriate additional training relating to the management of conflicts of interest.

8.6. Additional training needs may be identified, for example, where a breach has occurred or to provide a member of staff with additional knowledge to undertake their role effectively.

8.7. Completion of mandatory training will be monitored and action taken to address completion rates where necessary.

9. Arrangements For Review

9.1. This policy will be reviewed annually. An earlier review will be carried out in the event of any relevant changes in legislation, national or local policy/guidance, organisational change or other circumstances which mean the policy needs to be reviewed.

9.2. Views and input from relevant stakeholders will be sought when the policy is reviewed, including those of the ICB's Local Counter Fraud Specialist and procurement advisers.

9.3. If only minor changes are required, the sponsoring committee (Audit, Risk and Compliance Committee) has authority to make these changes without referral to the ICB Board. If significant or substantial changes are required, the policy will need to be ratified by the relevant committee before final approval by the ICB Board.

10. Associated Policies, Guidance And Documents

10.1. Associated Guidance and Legislation

- Managing Conflicts of Interest in the NHS, 17 September 2024
- Managing Conflicts of Interest Mandatory Training Modules 1, 2 and 3, available via Electronic Staff Record.
- Guidance on integrated care board constitutions and governance, 26 July 2024
- www.england.nhs.uk/ourwork/coi
- Freedom of Information Act 2000
- ABPI: The Code of Practice for the Pharmaceutical Industry (2021)
- ABHI Code of Ethical Business Practice https://www.abhi.org.uk/membership/code-of-ethical-business-practice/
- NHS Code of Conduct and Accountability (July 2004)
- The Provider Selection Regime (PSR) Statutory Guidance

- Economic Crime and Corporate Transparency Act (ECCT).
- NHS Fit and Proper Person Test
- General Medical Council: Identifying and Managing Conflicts of Interest
- Transparency and doctors with competing interests – guidance from the British Medical Association February 2025

10.2. Associated ICB Policies

- MSEICB 003 Procurement and Contracting Policy
- MSEICB 023 Freedom to Speak Up Policy
- MSEICB 026 Counter-Fraud, Bribery and Corruption Policy
- MSEICB 045 Disciplinary Policy

11. References

This policy is primarily based on:

Managing Conflicts of Interest in the NHS, 17 September 2024

12. Equality Impact Assessment (EIA)

12.1. The EIA (**Appendix A**) identified no equality issues with this policy.

Appendix A - Equality Impact Assessment

INITIAL INFORMATION

Name of policy: Conflicts of Interest Policy **Version number (if relevant): 1.0**	**Directorate/Service**: Corporate Services
Assessor's Name and Job Title: Sara O'Connor, Senior Manager Corporate Services	**Date:** 6 February 2026

OUTCOMES
Briefly describe the aim of the policy and state the intended outcomes for staff
This policy is designed to enable the ICB and its staff and partner organisations to effectively manage conflicts of interest in situations where conflicts might arise (e.g. during decision making/procurement processes, offers of gifts and hospitality, commercial sponsorship and outside employment).
EVIDENCE
What data / information have you used to assess how this policy might impact on protected groups?
The ICB monitors the composition of its workforce under the nine protected equality characteristics and reports on this annually. This information helps the ICB to assess the potential impact of its policies upon staff.
Who have you consulted with to assess possible impact on protected groups? If you have not consulted other people, please explain why?
The policy is based on the NHS England/Improvement Policy template for managing conflicts. The Staff Engagement Group have been consulted on the policy and their feedback will be considered before the policy is finalised.

ANALYSIS OF IMPACT ON EQUALITY

The Public Sector Equality Duty requires us to **eliminate** discrimination, **advance** equality of opportunity and **foster** good relations with protected groups. Consider how this policy / service will achieve these aims.

N.B. In some cases it is legal to treat people differently (objective justification).

- ***Positive outcome*** *– the policy/service eliminates discrimination, advances equality of opportunity and fosters good relations with protected groups*
- ***Negative outcome*** *– protected group(s) could be disadvantaged or discriminated against*
- ***Neutral outcome*** *– there is no effect currently on protected groups*

Please tick to show if outcome is likely to be positive, negative or neutral. Consider direct and indirect discrimination, harassment and victimisation.

Protected Group	Positive outcome	Negative outcome	Neutral outcome	Reason(s) for outcome
Age			X	The onus is on every individual to declare their interests. However, there is a risk that staff from protected groups may be reluctant to use the policy to raise concerns because of fear of discrimination, harassment or victimisation. However it is considered that this risk will be minimised by the assurances given in the associated Freedom to Speak Up Policy and reference within the Conflicts of Interest Policy that employees will not be penalised for raising honest concerns and by the regular monitoring of reported cases.
Disability (Physical and Mental/Learning)			X	As above.
Religion or belief			X	As above
Sex (Gender)			X	As above
Sexual Orientation			X	As above
Transgender/Gender Reassignment			X	As above
Race and ethnicity			X	As above
Pregnancy and maternity (including breastfeeding mothers)			X	As above
Marriage or Civil Partnership			X	As above

MONITORING OUTCOMES
Monitoring is an ongoing process to check outcomes. It is different from a formal review which takes place at pre-agreed intervals.
What methods will you use to monitor outcomes on protected groups?
An anonymised summary of breaches will be provided to the Audit Committee. If pertinent, the summary will identify where an individual's protected group status was relevant to the circumstances investigated and identify any lessons learned in this respect.

REVIEW
How often will you review this policy / service?
Annually
If a review process is not in place, what plans do you have to establish one?
N/A

Appendix B – Declarations of Interest Form

Declaration of Interest form (for ICB Board members, Employees/Bank/Agency Staff/Contractors, GPs and members of ICB Committee/Sub-Committees/Groups)

To be completed and signed even if a 'Nil' Return

Name:		**Email Address:**	
		Tel No:	
Position within, or relationship with, the ICB			
Name & Position of Head of Service/Senior ICB Manager: (who will sign-off form where an interest is declared)			

Please list below details of actual or potential interests held by you, or state 'Nil' if there are no interests that need to be declared. Interests declared by those staff considered to be 'decision-makers', as defined within the ICB's Management of Conflicts of Interest Policy, will be included within the publicly available Register of Interests posted on the ICB website unless an objection to publication is received (see below).

Declared Interest (Name of the Organisation and nature of business)	**Type of Interest** (see guidance notes below – please mark 'X')			**Is the interest direct or indirect?** (see guidance notes below)	**Nature of Interest**	**Date of Interest**		**Action taken to mitigate risk** Action to be agreed with Head of Service (with support from ICB Governance Lead if required) who must sign p2 of this form
	Financial Interest	**Financial Professional Interest**	**Professional Personal Interest**			**From**	**To** (Insert end date if interest is time limited. Advise ICB Gov Lead when interest ceases)	

NB: The names of individuals who make a 'Nil' declaration will not be included in the publicly available register of interests (except where they are Board members).

Fair Processing Statement

This information submitted will be held by the ICB for the reasons specified on this form and to comply with the NHS Act 2006 (section 14O(1)), the ICB's Constitution and the ICB's policies. This information may be held in both manual and electronic form, in accordance with the Data Protection Act 2018. The information will be held securely by the ICB, but, as per the NHS Act 2006 (section 14O(2)), will be made available to the public on request and, as per NHSE/I mandatory guidance on managing conflicts of interest, in the case of Governing Body members and other staff/individuals who have declared an interest, published on the ICB website.

Declaration

I confirm the information provided above is complete and correct. I acknowledge that any changes in this declaration 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 I may be committing an offence under the Fraud Act 2006, which may result in civil, criminal, and / or internal disciplinary investigation and action, including prosecution.

I **do / do not [delete as applicable]** object to my name and details of declared interests being published on registers that the ICB holds.

If you are raising an objection, please give reasons and a decision will be made by the ICB's Conflict of Interests Guardian whether to redact this information from the publicly available register(s).

Signed: _____ **Date**:_____
(Individual making the declaration of interest(s)

'Nil' declarations do not need to be signed-off by the Head of Service/Senior ICB Manager. Where one or more interests have been declared, individuals must discuss and agree how these interests will be managed with their Head of Service/Senior ICB Manager, who must then sign this form before submission to the ICB Governance Lead. Agreed action taken to mitigate the risk must be recorded in the last column of the table on the first page of this form. Declarations from non-ICB employees, will be signed-off by the ICB Governance Lead.

Signed: _____ Position: _____

Date:_____
(Head of Service/Senior ICB Manager)
Please return to: Corporate Governance Team (mseicb-thu.icbgovernanceteam@nhs.net)

DEFINITION OF AN INTEREST

A conflict of interest may be “actual” or “potential”.

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

It should be noted that a benefit may arise from the making of a gain or the avoidance of a loss. Interests fall into four categories as set out in the table below (not exhaustive). It is also important to avoid any ‘**perception**’ that a conflict of interest has occurred. Therefore, if you have any doubt as to whether an interest should be declared, please seek advice from the ICB Governance Lead.

Interest	Description
Direct Financial Interests	This is where an individual may get direct financial benefits from the consequences of a commissioning decision. This could, for example, include being: • A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations. This includes involvement with a potential provider of a new care model. • A shareholder (or similar owner interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations. • A management consultant for a provider; • A provider of clinical private practice; • 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).
Direct Non-Financial	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:

Interest	Description
Professional Interests	• An advocate for a particular group of patients; • A GP or other clinician with special interests e.g., in dermatology, ophthalmology, 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) or a medical defence organisation would not usually by itself amount to an interest which needed to be declared); • An advisor for Care Quality Commission (CQC) or National Institute for Health and Care Excellence (NICE); • Engaged in a research role (including sponsored research). • 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 and practice managers or other practice staff who are members of the ICB governing body or committees of the ICB, should declare details of their roles and responsibilities held within their GP practices.
Direct Non-Financial Personal Interests	This is where an individual may benefit (a benefit may arise from the making of gain or avoiding loss) 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 and care.
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 would include: Spouse / partner Close family member or relative e.g., parent, grandparent, child, grandchild or sibling, aunt/uncle/niece nephew etc. Close friend or associate; or Business partner. 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.

Appendix C – Gifts and Hospitality Declaration Form

Declaration of Gifts, Hospitality, and Sponsored Events Form

Name of member of staff offered gift(s) or hospitality:		**Email Address:**	
		Tel No:	
Position within, or relationship with, the Integrated Care Board			

GIFT(S) AND/OR HOSPITALITY – please see table below (pages 3 and 4) for guidance on what can be accepted (in some cases with prior approval) or must be refused, and what must be declared. Please refer to Section 6.15 of the Conflicts of Interest Policy regarding Sponsored Events.

Date of Offer	Date of Receipt (if applicable)	Details of Gift / Hospitality / Sponsorship	Estimated Value	Supplier / Offeror Name and Nature of Business	Details of Previous Offers or Acceptance by this Offeror/ Supplier/Sponsor	Declined or Accepted?	Reason for Accepting or Declining

REVIEW BY HEAD OF SERVICE	
Name and Position of Manager reviewing and signing-off acceptance/rejection of gift or hospitality.	
Reason for recommending acceptance/rejection, where applicable (see guidance below).	
Signature of Manager	
Date:	

Fair Processing Statement

The information submitted will be held by the ICB for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that the ICB holds. The Data Protection Officer can be contacted at Jane.marley@nhs.net.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in this declaration must be notified to the ICB as soon as practicable and no later than 28 days after I am aware that changes are required. I am aware that if I do not make full, accurate and timely declarations then I may be committing an offence under the Fraud Act 2006, which may result in civil, criminal, and / or internal disciplinary investigation and action, including prosecution may result

I do / do not (delete as applicable) object to this information being included on registers that the ICB holds and publishes on its website.
NB: *If you are raising an objection, please give reasons and a decision will be made by the ICB's Conflict of Interests Guardian whether to redact this information from the publicly available register(s).*

Signed: _____ **Date:** _____

Please return completed and signed form to Jane.King8@nhs.net

GUIDANCE ON ACCEPTING, REFUSING AND DECLARING GIFTS, HOSPITALITY AND SPONSORSHIP

Gifts

A 'gift' is defined as any item of cash or goods, or any service, which is provided for personal benefit, free of charge or at less than its commercial value. ICB staff should not ask for any gifts. ICB staff should also not accept any unsolicited offers of gifts or hospitality that may affect, or be seen to affect, their professional judgement. The rules for accepting, refusing, and declaring gifts and hospitality are summarised below.

If the actual value of a gift is unknown, a 'common sense' approach should be applied to the valuing of such gifts, by using an estimated amount that a reasonable person would make as to its value. Multiple gifts from the same source over a twelve-month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50. For further information, please refer to the ICB's Conflicts of Interest Policy(Including Gifts and Hospitality, Outside Employment, Commercial Sponsorship and other situations where conflicts might arise).

Hospitality

'Hospitality' means offers of meals, refreshments, travel, accommodation. and other expenses in relation to attendance at meetings, conferences, education/training or other events. ICB staff, or others working on behalf of the ICB, 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.

Relevant Paragraph within G&H Policy	Types of Gifts and Hospitality and thresholds for acceptance/refusal.	Accept or Refuse?	Must I Declare the Offer/Gift/Hospitality?
6.8.2	Gifts made by suppliers or contractors linked (currently or prospectively) to the ICB's business. However, see exception below.	**Refuse**	**Yes** – all such offers must still be declared.
6.8.2	Low cost branded promotional aids from suppliers or contractors may be accepted and not declared where they are under the value of a common industry standard of £6.	**Acceptable**	**No**
6.8.3	Cash or cash equivalents (including vouchers, tokens, offers of remuneration to attend meetings whilst in a capacity working for or representing the ICB) whatever their value and whatever their source;	**Refuse**	**Yes** – all such offers must still be declared.
6.8.3	Items of low value such as diaries, calendars, stationery and other gifts acquired from meetings, events or conferences and modest gifts such as flowers and small tokens of appreciation from patients, families and members of the public to staff for work well done may be accepted where the notional value is under £50. These gifts do not have to be declared.	**Acceptable**	**No**

Relevant Paragraph within G&H Policy	Types of Gifts and Hospitality and thresholds for acceptance/refusal.	Accept or Refuse?	Must I Declare the Offer/Gift/Hospitality?
6.8.3	Gifts offered from other sources (i.e. other than suppliers or contractors) and valued at over £50 should be treated with caution and only be accepted on behalf of the ICB (i.e. to the ICB's charitable funds) not in a personal capacity and must be declared.	**Acceptable** (but treat with caution)	**Yes** – all such offers must still be declared.
6.8.3	Gifts offered from other sources (i.e. other than suppliers or contractors) should be declined if accepting them might give rise to perceptions of bias or favouritism, and a common-sense approach should be adopted as to whether or not this is the case. All such gifts should be declared to a Line Manager, and the Head of Corporate Governance, who will recommend refusal or acceptance.	**Refuse** if there could be a perception of bias/favouritism.	**Yes** – all such offers must still be declared.
6.9.4	Modest hospitality, under the value of £25, provided in normal and reasonable circumstances may be acceptable, although it should be on a similar scale to that which the ICB might offer in similar circumstances (e.g. tea, coffee, light refreshments at meetings). A common-sense approach should be adopted as to whether hospitality offered is modest or not.	**Acceptable**	**Yes** – if offered by suppliers or contractors linked (currently or prospectively) to the ICB's business **No** – if offered from other sources.
6.9.4	Offers of hospitality of a value between £25 and £75.	**Acceptable**	**Yes** – all such offers must still be declared.
6.9.4	Hospitality (including meals, refreshments, travel, accommodation) of a value above £75 unless (in exceptional circumstances) senior prior approval is given (a clear reason should be recorded on the gifts & hospitality register as to why it was permissible to accept).	**Refuse** (unless senior prior approval given in exceptional circumstances)	**Yes – all such offers must still be declared.**
6.15 – 6.17	**Sponsorship** Line manager and governance advice must be sought before accepting any type of sponsorship as this can be a controversial issue. In the cases of sponsored events, sponsorship should **never** be accepted from organisations whose business would not be seen as being compatible with the ethos of the NHS, e.g. organisations that are associated with:	**Discuss with Line Manager and obtain Governance advice regarding acceptance or refusal.**	**Yes – all sponsorship must be declared.**

Relevant Paragraph within G&H Policy	Types of Gifts and Hospitality and thresholds for acceptance/refusal.	Accept or Refuse?	Must I Declare the Offer/Gift/Hospitality?
	• Matters that are damaging to health or associated with gambling, alcohol, tobacco, weight control or politics. • The promotion of prescription-only drugs to the general public, or other promotion that contravenes that ABPI Code of Practice to the Pharmaceutical Industry. • Pornography or other companies involved in the sexual exploitation of adults or children. • The manufacture of firearms or other weapons • Legal services which overtly promote compensation and personal injury services and claims management companies acting on their behalf		

Appendix D – Contact Details of Officers referred to within the Policy

Corporate Governance Team contacts – Nicola Adams or mseicb-thu.icbgovernanceteam@nhs.net

Audit Committee Chair: TBC

Conflicts of Interest Guardian: TBC

Executive Director Finance – Jennifer Kearton

Local Counter Fraud Specialist – Hannah Wenlock, Anti-Crime Specialist (ACS). Email: hannah.wenlock@nhs.net, Telephone: 07919 595930

5. Principles of Governance

5.1. **NHS Constitution – The NHS Constitution for England**

5.2. **Nolan Principles**

5.3. **Our People Promise - NHS The Promise (england.nhs.uk)**

Guidance t

HS Constitution for England

Upda ed 17 Augus 2023

Appli s to England

Con en s

In roduc ion t o he NHS Cons i u ion
Principles ha guide he NHS
NHS values
igh s and h NHS pledges o you
Pa ien s and he public: your responsib li ies
igh s and NHS pledges o you
S aff: your responsib l ies t

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T s ubl cat on s l censed under t e terms of t e O en Government L cence v3 0 exce t w ere ot erw se stated To v ew t s l cence, v s t nat onalarc ves ov uk/doc/o en- overnment-l cence/vers on/3 or wr te to t e Informat on Pol c Team, T e Nat onal Arc ves, Kew, London TW9 4DU, or ema l: s @nat onalarc ves ov uk

W here we ave dent fied an t rd art co r t nformat on ou w ll need to obta n erm ss on from t e co r t olders concerned

T s ubl cat on s ava lable at tt s://www ov uk/ overnment/ ubl cat ons/t e-n s-const tut on-for-en land/t e-n s-const tut on-for-en land .

Introduct on to t HS Const tut on

The NHS belongs to the people

It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health It touches our lives at times of basic human need, when care and compassion are what matter most

The NHS is founded on a common set of principles and values that bind together the communities and people it serves – patients and public – and the staff who work for it

This Constitution establishes the principles and values of the NHS in England It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively The Secretary of State for Health, all NHS bodies, private and voluntary sector providers supplying NHS services, and local authorities in the exercise of their public health functions are required by law to take account of this Constitution in their decisions and actions References in this document to the NHS and NHS services include local authority public health services, but references to NHS bodies do not include local authorities Where there are differences of detail these are explained in the Handbook to the Constitution

The Constitution will be renewed every 10 years, with the involvement of the public, patients and staff It is accompanied by the Handbook to the NHS Constitution, to be renewed at least every 3 years, setting out current guidance on the rights, pledges, duties and responsibilities established by the Constitution These requirements for renewal are legally binding They guarantee that the principles and values which underpin the NHS are subject to regular review and re-commitment; and that any government which seeks to alter the principles or values of the NHS, or the rights, pledges, duties and responsibilities set out in this Constitution, will have to engage in a full and transparent debate with the public, patients and staff

Pr nc pl s t at gu d t HS

Seven key principles guide the NHS in all it does They are underpinned by core NHS values which have been derived from extensive discussions with staff, patients and the public These values are set out in the next section of this document .

1. The NH ides a c mp ehensi e se ice, a ailable t all

It is availa le to all irrespective of gender, race, disa ility, age, sexual orientation, religion, elief, gender reassignment, pregnancy and maternity or marital or civil partnership status. The service is designed to improve, prevent, diagnose and treat oth physical and mental health pro lems with equal regard. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.

2. Access t NH se ices is based n clinical need, n t an indi idual's ability t ay

NHS services are free of charge, except in limited circumstances sanctioned y Parliament.

3. The NH as i es t the highest standa ds f excellence and fessi nalism

It provides high quality care that is safe, effective and focused on patient experience; in the people it employs, and in the support, education, training and development they receive; in the leadership and management of its organisations; and through its commitment to innovation and to the promotion, conduct and use of research to improve the current and future health and care of the population. Respect, dignity, compassion and care should e at the core of how patients and staff are treated not only ecause that is the right thing to do ut ecause patient safety, experience and outcomes are all improved when staff are valued, empowered and supported.

4. The atient will be at the hea t f e e ything the NH d es

It should support individuals to promote and manage their own health. NHS services must reflect, and should e coordinated around and tailored to, the needs and preferences of patients, their families and their carers. As part of b

this, the N i e sure that i i e ith the Armed Forces Cove a t, those i the armed forces, reservists, their fami ies a d vetera s are ot disadva taged i accessi g hea th services i the area they reside. Patie ts, ith their fami ies a d carers, here appropriate, i be i vo ved i a d co su ted o a decisio s about their care a d treatme t. he N i active y e courage feedback from the pub ic, patie ts a d staff, e come it a d use it to improve its services.

5. The NHS works across organisational boundaries

It orks i part ership ith other orga isatio s i the i terest of patie ts, oca commu ities a d the ider popu atio . he N is a i tegrated system of orga isatio s a d services bou d together by the pri cip es a d va ues ref ected i the Co stitutio . he N is committed to orki g joi t y ith other oca authority services, other pub ic sector orga isatio s a d a ide ra ge of private a d vo u tary sector orga isatio s to provide a d de iver improveme ts i hea th a d e bei g.

6. The NHS is committed to providing best value for taxpayers' money

It is committed to providi g the most effective, fair a d sustai ab e use of fi ite resources. Pub ic fu ds for hea thcare i be devoted so e y to the be efit of the peop e that the N serves.

7. The NHS is accountable to the public, communities and patients that it serves

he N is a atio a service fu ded through atio a taxatio , a d it is the gover me t hich sets the frame ork for the N a d hich is accou tab e to Par iame t for its operatio . o ever, most decisio s i the N , especia y those about the treatme t of i dividua s a d the detai ed orga isatio of services, are right y take by the oca N a d by patie ts ith their c i icia s. he system of respo sibi ity a d accou tabi ity for taki g decisio s i the N shou d be tra spare t a d c ear to the pub ic, patie ts a d staff. he gover me t i e sure that there is a ays a c ear a d up-to-date stateme t of N accou tabi ity for this purpose. T

NHS valu

ien s, public nd s ff h ve helped develop his expression of v lues h inspire p ssion in he N S nd h should underpin every hing i does. Individu l org nis ions will develop nd build upon hese v lues, iloring hem o heir loc l needs. The N S v lues provide common ground for co-oper ion o chieve sh red spir ions, ll levels of he N S.

Working tog th r for pati nt

ien s come firs in every hing we do. We fully involve p ien s, s ff, f milies, c rers, communi ies, nd profession ls inside nd ou side he N S. We pu he needs of p ien s nd communi ies before org nis ion l bound ries. We spe k up when hings go wrong.

R p ct and dignity

We v lue every person – whe her p ien , heir f milies or c rers, or s ff – s H n individu l, respec heir spir ions nd commi men s in life, nd seek o unders nd heir priori ies, needs, bili ies nd limi s. We ke wh o hers h ve o s y seriously. We re hones nd open bou our poin of view nd wh we c n nd c nno do.

Commitm ent to quality of car

We e rn he rus pl ced in us by insis ing on qu li y nd s riving o ge he b sics of qu li y of c re – s fe y, effec iveness nd p ien experience – righ every ime. We encour ge nd welcome feedb ck from p ien s, f milies, c rers, s ff nd he public. We use his o improve he c re we provide nd build on our successes.

Compa ion

We ensure h comp ssion is cen r l o he c re we provide nd respond wi h hum ni y nd kindness o e ch person's p in, dis ress, nxie y or need. We H

search f r he h s we ca d , h wever small, ve c mf r a d rel eve suffer . We f d me f r pa e s, he r fam l es a d carers, as well as h se we w rk al s de. We d wa be asked, because we care.

Improv ng l ves

We s r ve mpr ve heal h a d wellbe a d pe ple's exper e ces f he NHS. We cher sh excelle ce a d pr fess al sm wherever we f d – he everyday h s ha make pe ple's l ves be er as much as cl cal prac ce, serv ce mpr veme s a d va . We rec se ha all have a par play mak urselves, pa e s a d ur c mmu es heal h er.

Everyone counts

We max m se ur res urces f r he be ef f he wh le c mmu y, a d make sure b dy s excluded, d scr m i a ed a a s r lef beh d. We accep ha s me pe ple eed m ore help, ha d ff cul dec s s have be ake – a d ha whe we was e res urces we was e pp r u es f r hers.

Pat ents and the publ c: your r ghts and the NHS pledges to you

Every e wh uses he NHS sh uld u ders a d wha le al r h s hey have. F r h s reas , mp r a le al r h s are summar sed h s C i s u a d expla ed m ore de a l he Ha db k he NHS C s u , wh ch als expla s wha y u ca d f y u h k y u have rece ved wha s r h fully y urs. Th s summary d es al er y ur le al r h s.

The C s u als c a s pled es ha he NHS s c mmi ed ach eve. Pled es ab ve a d bey d le al r h s. Th s mea s ha pled es are le ally b d bu represe a c mmi me by he NHS i pr v de c mprehe s ve h h qual y serv ces.

Access to he th se ces

You ghts

You have the right to receive NHS ervice free of charge, apart from certain limited exception anctioned by Parliament.

You have the right to acce NHS ervice . You will not be refu ed acce on unrea onable ground .

You have the right to receive care and treatment that i appropriate to you, meet your need and reflect your preference .

You have the right to expect your NHS to a e the health requirement of your community and to commi ion and put in place the ervice to meet tho e need a con idered nece ary, and in the ca e of public health ervice commi ioned by local authoritie , to take tep to improve the health of the local community.

You have the right to authori ation for planned treatment in the EU under the UK EU Trade and Cooperation Agreement where you meet the relevant requirement .

You al o have the right to authori ation for planned treatment in the EU, Norway, Iceland, Lichten tein or Switzerland if you are covered by the Withdrawal Agreement and you meet the relevant requirement .

You have the right not to be unlawfully di criminated again t in the provi ion of NHS ervice including on ground of gender, race, di ability, age, exual orientation, religion, belief, gender rea ignment, pregnancy and maternity or marital or civil partner hip tatu .

You have the right to acce certain ervice commi ioned by NHS bodie within maximum waiting time , or for the NHS to take all rea onable tep to offer you a range of uitable alternative provider if thi i not po ible. The waiting time are de cribed in the Handbook to the NHS Con titution.

NHS p edges

The NHS pledge to:

- provide convenient, ea y acce to ervice within the waiting time et out in the Handbook to the NHS Con titution
- make deci ion in a clear and tran parent way, o that patient and the public can under tand how ervice are planned and delivered
- make the tran ition a mooth a po ible when you are referred between ervice , and to put you, your family and carer at the centre of deci ion that affect you or them s

Quality a and nvi nment

Y u ights

You have the ri ht to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or re istered or anisation that meets required levels of safety and quality.

You have the ri ht to be cared for in a clean, safe, secure and suitable environment.

You have the ri ht to receive suitable and nutritious food and hydration to sustain ood health and wellbein .

You have the ri ht to expect NHS bodies to monitor, and make efforts to improve continuously, the quality of healthcare they commission or provide. This includes improvements to the safety, effectiveness and experience of services.

NHS pl dg

The NHS also pled es to identify and share best practice in quality of care and treatments.

Nati nally app v d t atments, d ugs and p g ammes

Y u ights

You have the ri ht to dru s and treatments that have been recommended by NICE for use in the NHS, if your doctor says they are clinically appropriate for you.

You have the ri ht to expect local decisions on fundin of other dru s and treatments to be made rationally followin a proper consideration of the evidence. If the local NHS decides not to fund a dru or treatment you and your doctor feel would be ri ht for you, they will explain that decision to you.

You have the ri ht to receive the vaccinations that the Joint Committee on Vaccination and Immunisation recommends that you should receive under an NHS-provided national immunisation pro ramme.

NHS pl dg

The NHS also commits to provide screenin pro rammes as recommended by the UK National Screenin Committee. g

Respect, c se t c i e ti lity

Y ur rights

You have the ri ht to be treated with di nity and respect, in accordance with your human ri hts.

You have the ri ht to be protected from abuse and ne lect, and care and treatment that is de radin .

You have the ri ht to accept or refuse treatment that is offered to you, and not to be iven any physical examination or treatment unless you have iven valid consent. If you do not have the capacity to do so, consent must be obtained g from a person le ally able to act on your behalf, or the treatment must be in your best interests.

You have the ri ht to be iven information about the test and treatment options available to you, what they involve and their risks and benefits.

You have the ri ht of access to your own health records and to have any factual inaccuracies corrected.

You have the ri ht to privacy and confidentiality and to expect the NHS to keep g your confidential information safe and secure.

You have the ri ht to be informed about how your information is used.

You have the ri ht to request that your confidential information is not used beyond your own care and treatment and to have your objections considered, and where your wishes cannot be followed, to be told the reasons includin the le al basis.

NHS ple ges

The NHS also pled es:

- to ensure those involved in your care and treatment have access to your health information so they can care for you safely and effectively
- that if you are admitted to hospital, you will not have to share sleepin accommodation with patients of the opposite sex, except where appropriate, in line with details set out in the Handbook to the NHS Constitution
- to anonymise the information collected durin the course of your treatment and use it to support research and improve care for others
- where identifiable information has to be used, to ive you the chance to object wherever possible
- to inform you of research studies in which you may be eli ible to participate
- to share with you any correspondence sent between clinicians about your care g

Informed o e

our r g ts

You have the right to choose your P practice, and to be accepted by that practice unless there are reasonable grounds to refuse, in which case you will G be informed of those reasons.

You have the right to express a preference for using a particular doctor within G P your practice, and for the practice to try to comply.

You have the right to transparent, accessible and comparable data on the quality of local healthcare providers, and on outcomes, as compared to others nationally.

You have the right to make choices about the services commissioned by NHS bodies and to information to support these choices. The options available to you will develop over time and depend on your individual needs. Details are set out in the Handbook to the NHS Constitution.

NHS pledges

The NHS also pledges to:

- inform you about the healthcare services available to you, locally and nationally
- offer you easily accessible, reliable and relevant information in a form you can understand, and support to use it. This will enable you to participate fully in your own healthcare decisions and to support you in making choices. This will include information on the range and quality of clinical services where there is robust and accurate information available

Involvement n your ealt are and t e NHS

our r g ts

You have the right to be involved in planning and making decisions about your health and care with your care provider or providers, including your end of life care, and to be given information and support to enable you to do this. Where appropriate, this right includes your family and carers. This includes being given the chance to manage your own care and treatment, if appropriate.

You have the right to an open and transparent relationship with the organisation providing your care. You must be told about any safety incident relating to your care which, in the opinion of a healthcare professional, has caused, or could G

still caus si i ica t harm or d ath. You must b iv th acts a apolo y a d a y r aso abl support you d.

You hav th ri ht to b i volv d dir ctly or throu h r pr s tativ s i th pla i o h althcar s rvic s commissio d by NHS bodi s th d v lopm e t a d co sid ratio o proposals or cha s i th way thos s rvic s ar provid d a d i d cisio s to b mad a cti th op ratio o thos s rvic s.

NHS ledges

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Com laint and redress

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Your rights

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You hav th ri ht to tak your complai t to th i d p d t Parliam e tary a d H alth S rvic Ombudsma (http://www.ombudsma .or .uk/) or Local Gov r m e t Ombudsma (http://www.l o.or .uk/) i you ar ot satis i d with th way your complai t has b d alt with by th NHS. **p**

You have he h o ke a cla fo jud c al ev ew f you h nk you have been d ec ly affec ed by an unlawful ac o dec s on of an NHS body o local au ho y.

You have he h o co ens a on whe e you have been ha d by ne l en ea n . e

NH pledges

The NHS also pled es o:

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- ensu e ha when s akes happen o f you a e ha d w h le ece v n heal h ca e you ece ve an app op a e explana on and apolo y, del ve ed w h sens v y and eco n on of he au yo a have expe enced, and know ha lessons w ll be lea ned o help avo d a s la nc den occu n a a n
- ensu e ha he o an sa on lea ns lessons f o co la ps and cla ans **S** uses hese o ove e NHS se v ces

Patients and the public: your responsibilities

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Please e sure ha h se cl ses y u are aware f y ur w shes ab u rga d a .

Please g ve feedback – b h p s ve a d ega ve – ab u y ur exper e ces a d he rea e a d care y u have rece ved, clud g a y adverse reac s y u y have had. Y u ca f e pr v de feedback a y usly a d g v g feedback w ll affec adversely y ur care r h w y u are rea ed. If a fa ly er br s e e y u are a carer f r s a pa e a d u able pr v de feedback, y u are e c uraged g ve feedback ab u he r exper e ces he r behalf. eedback w ll help r ve e NHS serv ces f r all.

Staff: your rights and NHS pledges to you

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The C s u appl es all s aff, d g cl cal r -cl cal NHS w rk – clud g publ c heal h – a d he r e l yprs. I c vers s aff wherever hey are w rk g, whe her publ c, pr va e r v lu ary sec r rga sa s.

Your rights

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Constitution. n ition in ivi u l contr cts of employment cont in terms n con itions giving st ff further rights.

The rights re there to help ensure th t st ff:

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- c n be involve n represente in the workpl ce
- h ve he lthy n s fe working con itions n n environment free from h r ssment bullying or violence
- re tre te f irly equ lly n free from iscrimin tion
- c n in cert in circumst nces t ke compl int bout their employer to n mployment Tribun l
- c n r ise ny concern with their employer whether it is bout s fety m alpr ctice or other risk in the public interest.

NHS pledges

n ition to these leg l rights there re number of ple ges which the NHS is committe to chieve. Ple ges go bove n beyon your leg l rights. This me ns th t they re not leg lly bin ing but represent commitment by the NHS to provi e high-qu lity working environments for st ff. E

The NHS ple ges to:

- provi e positive working environment for st ff n to promote supportive open cultures th t help st ff o their job to the best of their bility
- provi e ll st ff with cle r roles n responsibilities n rew r ing jobs for te ms n in ivi u ls th t m ake ifference to p tients their f milies n c rers n communities
- provi e ll st ff with person l evelopment ccess to ppropri te e uc tion E n tr ining for their jobs n line m an gement support to en ble them to fulfil their potenti l
- provi e support n opportunities for st ff to m aint in their he lth wellbeing n s fety
- eng ge st ff in ecisions th t ffect them n the services they provi e in ivi u lly through represent tive org nis tions n through loc l p rtnership working rr ngements. All st ff will be empowere to put forw r w ys to eliver better n s fer services for p tients n their f milies (ple ge)
- to h ve process for st ff to r ise n intern l griev nce (ple ge)
- encour ge n support ll st ff in r ising concerns t the e rliest re son ble opportunity bout s fety m alpr ctice or wrong oing t work respon ing to E

and, whe e ne e a , nve t gat ng the on e n a ed and a t ng on tentl w th the Emplo ment R ght A t 1996 y

Staff: our responsibilities

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- follow all gu dan e, tanda d and ode elevant to ou ole, ubje t to an mo e pe f equ ement of ou emplo e
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- f nd alte nat ve ou e of a e o a tan e fo pat ent , when ou a e unable to p ov de th (n lud ng fo tho e pat ent who a e not e e v ng y

basic care e e eir eeds)

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- raise a y ge ui e c cer ay u y ave ab u a risk, lpra c ice r wr gd i g a w rk (suc as a risk pa ie safe y, fraud r breac es f pa ie c fide iali y), w ic y affec pa ie s, e public, er s aff r e rga isa i i self, a e earlies reas able pp r u i y
- i v lve pa ie s, eir fa lies, carers r represe a ives fully i decisi s ab u preve i , diag sis, a d eir i dividual care a d rea e
- be pe wi pa ie s, eir fa lies, carers r represe a ives, i cludi g if a y i g g es wr g; welc g a d lis e i g feedback a d addressi g c cer s pr ly a d i a spiri f c - pera i
- c ribu e a cli e w ere e ru ca be eard, e rep r i g f, a d lear i g fr , err rs is e c uraged a d c lleagues are supp r ed w ere err rs are ade
- view e services y u pr vide fr ' e s a dp i f a pa ie , a d i v lve pa ie s, eir fa lies ia d carers i e services y u pr vide, w rki g wi e e, r c i ies aud er rga isa i s, a d ki g i clear w is resp sible f r eir care
- ake every appr pria e pp r u i y e c urage a d supp r pa ie s a d c lleagues i r v e eir eal a d wellbei g
- c ribu e wards pr vidi g fair a d equi able services f r all a d play y ur par , w erever p ssible, i elpi g reduce i equali ies i experie ce, access r u c s b e wee differi g gr ups r sec i s f s cie y requiri g eal care
- i f r pa ie s ab u e use f eir c fide ial i f r i a a d rec rd eir bjec i s, c se r disse
- pr vide access a pa ie s i f r i a er releva pr fessi als, always d i g s securely, a d ly w ere ere is a legal a d appr pria e ' basis d s .

↑ Back p

OGL

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Nolan principles - The Seven Principles of Public Life

The Committee on Standards in Public Life was established in 1994, initially to deal with concerns about unethical conduct amongst MPs, including accepting financial incentives for tabling Parliamentary questions, and issues over procedures for appointment to public bodies. As an independent advisory body to the Government it monitors, reports and makes recommendations on all issues relating to standards in public life.

The seven principles are:

- **Selflessness** - Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.
- **Integrity** - Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
- **Objectivity** - In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.
- **Accountability** - Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.
- **Openness** - Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.
- **Honesty** - Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
- **Leadership** - Holders of public office should promote and support these principles by leadership and example.



NHS

People Promise

We are more than 1.3 million strong.
We are all walks of life, all kinds of experiences.
We are the NHS.

We are **compassionate** and **inclusive**

We are **recognised** and **rewarded**

We each have **a voice that counts**

We are **safe** and **healthy**

We are **always learning**

We work **flexibly**

We are **a team**

People Promise

This is a promise we must all make to each other – to work together to improve the experience of working in the NHS for everyone.

The themes and words that make up Our People Promise have come from those who work in the NHS. People in different healthcare roles and organisations have made it clear what matters most to them, and what would make the greatest difference in improving their experience in the workplace.

For many, some parts of the Promise will already match their current experience. For others, it may still feel out of reach. We must all pledge to work together to make these ambitions a reality for all of us, within the next four years.

The people best placed to say when progress has been made are those who work in the NHS. From 2021 the annual NHS Staff Survey will be redesigned to align with Our People Promise.

The NHS is an extraordinary, world-class service – thanks to every single one of us who contributes to it. Our service, training, skills and commitment are admired across the world. Together we have achieved the extraordinary – and together we continue to do so.

We feel the pressure of workload and not always having enough colleagues. We all want more time to support one another and provide great care. And we are often so busy with the daily demands of our work that we lack the time and energy to find new and better ways of doing it. But we know that the NHS always rises to the challenge, and we have seen its resilience, teamwork and innovation.

We want to continue to bring out the very best in one another – inspiring each and every person and unleashing potential. We do this by making the culture of the NHS one that's compassionate and inclusive, and addressing our workforce and workload challenges.



We are compassionate and inclusive

We are kind and respectful. We all feel the pressure at times, but we care for each other, as we care for our patients. We don't tolerate any form of discrimination, bullying or violence, and call out inappropriate behaviour.

We are open and inclusive. We understand, encourage and celebrate diversity, making the NHS a place where we all feel we belong.

We are recognised and rewarded

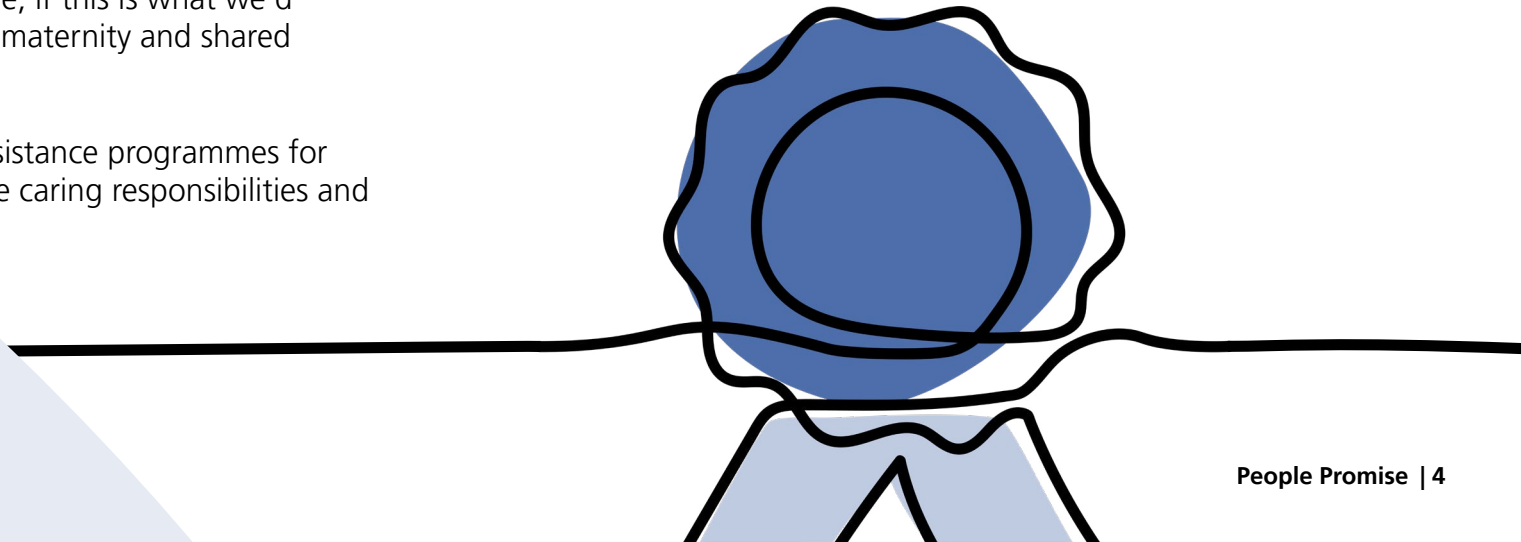


We are recognised and appreciated – whether a simple thank you for our day-to-day work, or formal recognition for our dedication, such as every decade of service to the NHS.

We have a fair salary, competitive pension, and an attractive package of extended benefits, whatever our role.

We have more choices. We can buy and sell unused holiday and arrange unpaid leave, if this is what we'd prefer. We also enjoy enhanced maternity and shared parental leave.

We have access to employee assistance programmes for advice and support on issues like caring responsibilities and financial wellbeing.





We each have a voice that counts

We all feel safe and confident when expressing our views. If something concerns us, we speak up, knowing we will be listened to and supported. Our teams are safe spaces where we can work through issues that are worrying us.

If we find a better way of doing something, we share it. We use our voices to shape our roles, workplace, the NHS, and our communities, to improve the health and care of the nation.

We take the time to really listen – beyond the words – to understand the hopes and fears that lie beneath them. We help one another through challenges, during times of change, and to make the most of new opportunities.

We are safe and healthy



We're considerate of each other's time and mindful of each other's workload and the physical and emotional impact this can have. While we may choose to go the extra mile to deliver exceptional care, we still look after ourselves and each other.

Wellbeing is our business and our priority. We stay mentally and physically fit and healthy through working hour limits, healthier food choices and access to schemes to help us stay in shape.

And if we're unwell ourselves, we are supported to get the help we need, take the time to recover, and return to work at our own pace.

Our occupational health and wellbeing services are there for us when we need them, with rapid access to help with work-related mental and physical injury and illness.

We have clean safe spaces to rest and reflect, and access to hot food and drinks, including fresh water. These are the basics, but they really matter and can't be underestimated.

We have the technology and equipment we need to keep us safe, deliver the best possible care, and make the best use of our time and our skills.





We are always learning

Opportunities to learn and develop while working for the NHS are plentiful. Our management and supervision are first class – with regular reviews of workload, and opportunities for two-way feedback and appraisals – to ensure we are able to realise our potential.

We are supported to invest in our careers, through formal and informal training, to reach our personal and professional goals. We have the time, space and funding to do this.

The many career options mean we can experience a variety of health and care settings, skills and practice, and progress to different roles. There are opportunities to take advantage of shadowing and secondments, coaching and mentoring, and contribute towards research and teaching. We exchange our skills and knowledge across the local health and care system, and beyond.

We all have equal access to opportunities – with fair and transparent selection processes that attract, develop and retain talented people from all backgrounds.

We work flexibly



Our work doesn't mean we have to sacrifice family, friends or interests. Predictable working patterns and hours, that we have a say in agreeing, make a real difference to our lives and our wellbeing. That's why we have access to new rostering technology that lets us take more control over when we work.

We can work flexibly, doing whatever work pattern fits our needs, regardless of the type of role we're in. As a modern and model employer, flexible and less than full-time working isn't a barrier to progress in the NHS – it is commonplace.

As more people are recruited to the NHS across many areas, and roles are adapted to make everyone's workload more manageable, we feel better supported and the demands of work are more sustainable.

And if we have unpaid caring duties, we are supported and helped to return to work if we take time off to look after someone.

We are able to come back to the NHS even after we retire, if we still want to contribute our expertise.



We are a team

The NHS is first and foremost one huge team. Regardless of our role, experience or background, if we work for the NHS, we are part of that team. We are united by a desire to provide the very best care and support not just to those using our services, but to each other.

We're also part of a growing team, with people from many different professions and roles, working together in a flexible way to respond to the changing needs of our patients. Being in a diverse team gives us a chance to learn from each other's experience, specialisms and skills, working with a shared purpose.

Our work is fulfilling – it makes a real difference and is rewarding. We give one another the space to innovate, we support each other when times are tough, and we take time to celebrate successes, small and large.

People Promise

Together we make the
NHS the best place to work.
We are the NHS.



Cambridge University
Hospitals NHS Foundation Trust

Thank you to all our NHS people featured here.
Some of their images were captured prior to the Covid-19 pandemic.

June 2021
Publication reference: 0067

NHS
Essex
Integrated Care Board

6. Board Nomination and Selection Process

6.1. NEM Recruitment Application Pack

6.2. Partner Application Pack

6.3. Nomination Letters [to follow]

6.4. List of eligible nominating PMS (GMS/APMS) Providers [to follow]

Designate Non-Executive Members
For proposed Essex Integrated Care Board

Applicant information pack

We value and promote diversity and are committed to equality of opportunity for all. We believe that the best boards are those that reflect the communities they serve.

We prioritise Equality, Diversity and Inclusion, team health and wellbeing and the principles of kind leadership in our 'ways of working'. All postholders will have a key role in nurturing this culture.

Appointment will be made on merit after a fair and open process so that the best people, from the widest possible pool of applicants, are appointed.

Regulated by
The Commissioner for
Public Appointments

Context

The NHS is in the midst of one of its most significant periods of change—reshaping Integrated Care Boards (ICBs) to ensure they have the scale, clarity of purpose and strategic focus needed to meet the ambitions set out nationally. Publications from NHS England and the government, including the Model ICB Blueprint and the 10 Year Health Plan, set the direction for the next generation of ICBs: organisations that are lean, strategic and focused on improving population health, prevention and digital transformation.

In the East of England, this has meant moving from six ICBs to three larger footprints, with one of these being the proposed Essex ICB—bringing together Mid and South Essex, West Essex and North East Essex. This new configuration was confirmed through NHS England and government merger plans, with implementation beginning from April 2026.

To prepare for this transition, the existing ICBs across Essex—Mid and South Essex (MSE), Suffolk and North East Essex (SNEE), and Hertfordshire and West Essex (HWE)—established the Essex Joint Committee (EJC). The EJC was created through delegated authority to support shared decision-making across the Essex geography and to align priorities and governance during the transition period. Formal public meetings of the committee began in November 2025, focusing on preparing the ground for a single Essex ICB

These arrangements marked the start of “working as Essex” ahead of the statutory change, enabling the three ICBs to collaborate more closely, streamline commissioning decisions and build the foundations for a unified, strategic commissioning organisation from April 2026.

As the new Essex ICB takes shape, it will inherit this strong platform of collaboration and shared purpose. The future organisation will operate at scale, able to lead long-term health improvement, reduce inequalities and shape a sustainable, integrated health and care system for the communities it serves. This is an exciting moment to join the board—helping to shape a new ICB that is designed from the outset to be forward-looking, ambitious and aligned with the NHS’s long-term vision for healthier communities.

Introduction from our Chair (designate), Essex ICB



Across Essex—serving communities in Basildon, Braintree, Brentwood, Castle Point, Chelmsford, Colchester, Epping Forest, Harlow, Maldon, Rochford, Southend-on-Sea, Tendring, Thurrock and Uttlesford —we have seen what’s possible when partners work with purpose and pace. Over recent years we have built a strong foundation of joint working and begun to reshape how care is delivered. We also face realities we must confront with clarity and resolve: people are living longer, but too many of those added years are not spent in good health; inequalities persist and, for some, have widened; and, as everywhere in the NHS, demand and waiting times across primary, community, mental health and hospital services have grown.

The pandemic exposed the depth of health inequalities in our communities—but it also showed how quickly we can innovate when we align around what matters most. We learned to use data and digital tools more intelligently, to make decisions faster, and to deliver together. Those lessons continue to equip us to take the next step with greater discipline, clearer accountability and a sharper focus on outcomes.

From April 2026 (subject to confirmation), we will establish the Essex Integrated Care Board—a unified commissioning organisation with a clear purpose, fresh ambition and a way of working grounded in trust, openness and collaboration. This is not a simple merger of structures; it is the chance to bring the best of our legacy organisations into a single, coherent approach. No one culture will dominate—we are building something new, together.

Our mission is clear: to work with our population to achieve their best health through equitable care, delivering maximum value from every pound spent. We will do this by being a highly effective team of commissioners—inclusive, fair, responsive and innovative—combining the benefits of scale with a deep connection to the distinct needs of our neighbourhoods. We will use insight-rich data, transparent prioritisation and practical innovation to design care that works for people and delivers measurable improvement.

Guided by the NHS Long Term Plan and our statutory duties under the Health and Social Care Act 2022, the ICB will assume full accountability for:

- improving outcomes in population health and healthcare;
- tackling inequalities in outcomes, experience and access;
- enhancing productivity and value for money; and
- supporting broader social and economic development.

We will deliver these objectives by driving three major shifts:

- **From treatment to prevention:** acting earlier, supporting people closer to home and personalising care around what matters to them.
- **From hospital to community**: strengthening primary, community and mental health services, integrating around neighbourhood teams and simplifying pathways.
- **From analogue to digital**: enabling interoperable data, proven technologies and real-time insight to improve quality, safety and experience.

The Board, led by the Chair and Chief Executive, will oversee the Model ICB Blueprint transition, translating strategy into delivery through disciplined commissioning, robust assurance and purposeful partnership. Our approach is simple but powerful: catalyse, don't control; equip, don't fix; sustain, don't substitute. We will succeed not by doing everything ourselves, but by enabling partners and communities to lead change, reducing unwarranted variation, improving access and creating a fairer, more integrated system.

We will hold ourselves to the Nolan Principles of Public Life: Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty and Leadership. These are more than words; they are the standards we live by, shaping how we work with colleagues, partners and the public so that everyone feels heard, respected and valued.

To those considering joining us: this is a pivotal moment to shape a new organisation with a clear mandate and the momentum of a county ready to move forward. If you are driven by equity, partnership and impact; if you bring curiosity, courage and a commitment to delivery; if you believe that better health is possible for all, then we would be delighted to work with you.

Together, we will build a culture of trust, respect and forward momentum, always centred on the people we serve, and always focused on delivering better health and better value for Essex.

Professor Michael Thorne
Chair (Designate), Essex Integrated Care Board

The opportunity

We are seeking Non-Executive Members who will work closely with the Chair (designate) to help shape a future-focussed Essex Integrated Care Board as it transitions towards the ambitions set out in the NHS Model ICB Blueprint. While the new ICB will be established regardless of forthcoming legislation, changes to the statutory framework are expected to realign Board composition and strengthen the commissioning focus required for the next decade. Successful candidates will play a key role in overseeing this evolution, guiding the shift from legacy arrangements to a more disciplined, outcomes-driven mode, and will bring the

insight, independence and leadership needed to steer the organisation through both the immediate priorities and the future legislative changes that will refine how the Board operates.

We are looking for four suitably qualified individuals to join the ICB Board and fulfil the following roles:

- Chair of the Remuneration Committee (statutory role)
- Chair of the Audit, Risk and Compliance Committee (statutory role) (and conflicts of interest guardian)
- Chair of the Neighbourhood Health Committee
- Chair of the Commissioning, Quality and Resource Committee

In addition, Non-Executive Members will be selected to additional fulfil the following:

- To act as Deputy Chair
- To act as Senior Independent Member
- To lead a portfolio of responsibilities covering:
  - Equality, Diversity and Inclusion.
  - Children, and Young People
  - Digital Change Management
  - Left shift transformation and prevention

Non-Executive Members are statutory voting members of the ICB Board providing independent oversight, constructive challenge, and strategic leadership to ensure the organisation delivers its objectives for all communities across Essex. They play a central role in the Board's governance, holding the ICB to account for robust, evidenced-based decision making across commissioning, contracting, workforce, neighbourhood health and financial sustainability, ensuring that choices are transparent, withstand scrutiny and service the best interests of our 1.9 million residents.

The key priorities for the roles will be to:

- Establish effective working relationships with ICB Board members
- Establish clear terms of reference and governance processes for each committee
- Establish strategic priorities and key milestones for reporting requirements
- Ensure that the ICB is effectively fulfilling its statutory requirements in terms of reporting and delivery
- Ensure that the population voice is effectively captured and used to inform the priorities and strategies of the ICB
- Ensure that the theme of inclusion and reducing inequalities runs through the work of the ICB at every level

The ICB needs diverse, inclusive and compassionate leaders who not only reflect the community they serve and the staff employed but have the leadership style and breadth of perspective to make good collective decisions.

We are really interested in receiving applications from people with different backgrounds, skills and experience.

About us

Essex is a populous and diverse county in the east of England, home to around 1.9 million people. It includes three cities: Chelmsford, Colchester and Southend-on-Sea, making Essex one of a small number of English counties with multiple cities outside the larger metropolitan regions.

Our communities range from dense urban centres such as Basildon, Buckhurst Hill, and Harlow; commuter towns with close links to London including Epping and Thurrock; rural villages like Stansted Mountfitchet and the Colne Valley; and coastal areas such as Shoeburyness, Leigh-on-Sea, Clacton and Harwich. This

diversity of place and population shapes the health and care needs of residents and highlights the importance of services that are equitable, locally responsive and future-facing.

Essex's location in the south-east, with strong transport links into London and neighbouring counties, means many residents live and work across different parts of the region. The county is also home to London Stansted Airport, one of the busiest airports in England, bringing significant economic contribution as well as unique health, transport and emergency planning considerations. Essex includes several densely populated districts and fast-growing urban centres, particularly in areas with close links to London and major employment hubs.

Health and care needs across the county

Our geography creates a broad spectrum of health and care needs:

- In urban and commuter areas, health demand is shaped by population growth, ageing, long-term conditions and pressures on primary, community and mental health services.
- Rural communities may face challenges such as service accessibility, transport barriers and gaps in local support.
- Coastal towns, while rich in community identity, often have higher levels of deprivation and poorer health outcomes, including lower life expectancy and greater prevalence of long-term illness than the England average.

Across Essex, there are marked health inequalities between communities. For example, healthy life expectancy can differ significantly between neighbourhoods, with some areas seeing people live many more years in good health than others. These inequalities are often linked to socio-economic factors such as income, employment, education, housing and access to services. Access to, and quality of, clinical care contributes just 20% to the wider determinants of health, and that's why we need to work together with our Partners.



SOURCE: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute in US to rank countries by health status

Working in partnership

We work with partners across Essex to plan and deliver care that meets the needs of all residents. Our footprint includes:

- 3 acute hospital trusts providing emergency, specialist and planned care
- 10 community hospitals offering rehabilitation, recovery and outpatient services

- 6 community diagnostic centres improving access to tests and early detection
- 5 urgent treatment centres providing same-day urgent care
- 1 ambulance trust coordinating emergency response and transport
- 207 GP practices and 41 Primary Care Networks delivering primary and preventive care
- 308 community pharmacies supporting medicines advice and health promotion
- 203 NHS dental practices and 180 optical practices supporting oral and eye health

We also work with an extensive partnership network including 15 local authorities, Essex Police, Essex County Fire and Rescue, Healthwatch and the voluntary sector.

Essex ICB Footprint

3 Acute Hospital Trusts
10 Community Hospitals
6 Community Diagnostic Centres
5 Urgent Treatment Centres
1 Ambulance Trust
207 GP Practices
41 Primary Care Networks
308 Community Pharmacies
203 Dental practices (with an NHS contract)
180 Optical practices

Partners:
3 upper tier local authorities*
12 district councils*
3 Healthwatch organisations*
11 VCSE infrastructure organisations

** Current configuration subject to change*



Role priorities and accountabilities

Priorities

The non-executive members will:

- Work collaboratively to shape the long-term, viable plan for the delivery of the functions, duties and objectives of the ICB and for the stewardship of public money.
- Ensure that the Board is effective in all aspects of its role and appropriately focused on the four core purposes, to: improve outcomes in population health and healthcare; tackle inequalities in outcomes, experience and access; enhance productivity and value for money and help the NHS support broader social and economic development.
- Be champions of new governance arrangements, collaborative leadership and effective partnership working, including with local government, NHS bodies and the voluntary sector.
- Play a key role in how the ICB will evolve to continue to meet statutory arrangements, that may change, whilst delivering the asks of the model blueprint ICB and 10-year health plan, building strong partnerships and governance arrangements.

Accountabilities

The Non-Executive Members:

- Are accountable to the ICB Chair.
- Have designated areas of responsibilities as agreed with the ICB Chair.
- Have a collective responsibility with the other members of the ICB to ensure corporate accountability for the performance of the organisation, ensuring its functions are effectively and efficiently discharged and its financial obligations are met.

Role responsibilities and competencies

Role descriptions for the two statutory committee chair roles, and lead on equality, diversity and inclusion are included in the Annexes below.

You will work alongside the Chair, other non-executives, executive directors and partner members and as equal members of a unitary board. You will be responsible for specific areas relating to board governance and oversight:

- Bringing independent and respectful challenge to the plans, aims and priorities of the ICB.
- Promoting open and transparent decision-making that facilitates consensus aimed to deliver exceptional outcomes for the population.

As an NHS leader, you will demonstrate a range of leadership competencies outlined below. Corporately, as members of a unitary board, you will contribute to a wide range of areas, including:

Strategy and transformation

- Setting the vision, strategy and clear objectives for the ICB in delivering on the four core purposes of the ICB, the triple aim of improved population health, quality of care and cost-control.
- Aligning partners in delivering the 10 Year Health Plan and the forthcoming refreshed 10 Year Workforce Plan (due 2026)
- Providing oversight and constructive challenge to ensure the ICB transitions care into community settings, accelerates digital transformation, and embeds prevention at scale, in line with the 10-year Health Plan.
- Providing oversight of safe, effective data use and digital transformation, ensuring digital investment directly improves outcomes, user experience and workforce productivity.

Partnerships and communities

- Promoting dialogue and consensus with local government and broader partners, to ensure effective joint planning and delivery for collaborative working and mutual accountability.
- Supporting the operation of the ICP in line with current statutory requirements, while remaining response to any future legislative changes arising from national reforms, developing strong relationships between the ICB Board, Voluntary, Community, Faith and Social Enterprise (VCFSE), Local Authority and other stakeholders
- Supporting the success of the ICP/collaboration with stakeholders/working at neighbourhood level in establishing shared strategic priorities within the NHS, in partnership with local government, to tackle population health challenges and enhance services across health and social care.

Social justice and health equalities

- Advocating diversity, health equality and social justice to close the gap on health inequalities and achieve the service changes that are needed to improve population health.

- Ensuring the ICB is responsive to people and communities and that public, patient and carer voices are embedded in all of the ICB's plans and activities.
- Embedding co-production with communities and lived-experience voices in strategic design.
- Ensuring strategies follow the principle of proportionate universalism – universal actions with scale and intensity proportionate to need.
- Promoting the values of the NHS Constitution and modelling the behaviours embodied in Our People Promise and forthcoming replacement guidance to ensure a collaborative, inclusive and productive approach across the system.

Sustainable outcomes

- Oversight of purposeful arrangements for effective leadership of clinical and professional care throughout the ICB.
- Fostering a culture of research, innovation, learning and continuous improvement to support the delivery of high-quality services for all.
- Ensuring the NHS plays its part in social and economic development and achieving environmental sustainability, including the Carbon Net Zero commitment. Overseeing the integration of greener clinical pathways, sustainable estates and low-carbon models of care.

Governance and assurance

- Collectively ensuring that the ICB is compliant with its constitution and contractual obligations, holding other members of the ICB to account through constructive, independent and respectful challenge.
- Maintaining oversight of the delivery of ICB plans, ensuring expected outcomes are delivered in a timely manner through the proportionate management of risks.
- Ensuring that the ICB operates to deliver its functions in line with all of its statutory duties, and that compliance with the expected standards of the regulatory bodies is maintained.
- Providing steady, values-based leadership during significant system restructuring, ensuring continuity of services and safeguarding population health outcomes.

People, workforce and culture

- Supporting the development of other board members to maximise their contribution.
- Providing visible leadership in developing a healthy and inclusive culture for the organisation, which promotes diversity, encourages and enables system working and which is reflected and modelled in their own and the Board's behaviour and decision-making.
- Ensuring the Board acts in accordance with the highest ethical standards of public service and that any conflicts are appropriately resolved.
- Lead inline with our leadership way and the NHS Management and Leadership Framework (2025).
- Ensuring compliance with the new national NHS Leadership and Management Framework (2025), including the Code of Practice, national standards and leadership appraisal requirements.
- Supporting workforce transformation, including growing local workforce pipelines and reducing dependence on international recruitment in line with the national workforce strategy.

Designate ICB non-executive member: person specification

Competency	Knowledge, Experience and Skills required
Setting strategy and delivering long-term transformation	• Knowledge of health, care, local government landscape and/ or the voluntary sector • A capacity to thrive in a complex and politically charged environment of change and uncertainty • Experience leading change at a senior level to bring together disparate stakeholder interests
Building trusted relationships with partners and communities	• An understanding of different sectors, groups, networks and the needs of diverse populations • Exceptional communication skills and comfortable presenting in a variety of contexts • Highly developed interpersonal and influencing skills, able to lead in a creative environment which enables people to thrive and collaborate • Experience working collaboratively across agency and professional boundaries
Leading for Social Justice and health equality	• An awareness and appreciation of social justice and how it might apply within an ICS • Record of promoting equality, diversity and inclusion in leadership roles • Life experience and personal motivation that will add valuable personal insights
Driving high quality, sustainable outcomes	• Problem solving skills and the ability to identify issues and areas of risk, leading stakeholders to effective resolutions and decisions
Providing robust governance and assurance	• An understanding of good corporate governance • Ability to remain neutral to provide independent and unbiased leadership with a high degree of personal integrity • Experience contributing effectively in complex professional meetings at a very senior level
Creating a compassionate and inclusive culture for our people	• Models respect and a compassionate and inclusive leadership style with a demonstrable commitment to equality, diversity and inclusion in respect of boards, patients and staff • Creates and lives the values of openness and transparency embodied by the principles-of-public-life and in Our People Promise

Additional requirements for Chair of the Audit, Risk and Compliance Committee. You will:

- Have recent, relevant finance experience in a large and complex organisation, preferably with a financial qualification
- Have experience operating at senior or board level
- Have an excellent working knowledge of audit committee practices and risk management frameworks
- Demonstrate independent and proactive leadership with confidence and integrity
- Champion open, frank and disciplined discussion and be prepared to ask the difficult questions

Additional requirements for Chair of the Remuneration Committee. You will:

- Demonstrate independent and proactive leadership with confidence and integrity
- Bring expertise of workforce development, people practices and / or leading organisational and cultural change
- Champion open, frank and disciplined discussion and be prepared to ask the difficult questions

Additional requirements for Equality, Diversity and Inclusion lead. You will

- Demonstrate a proven track record of working within a complex environment to champion and effect change around equality, diversity and inclusion
- Have an understanding of the demographics of the ICB population, in order to ensure that any proposals around interventions are fit for purpose and tailored to the specific needs of the population
- Bring expertise of best practice and up to date thinking in the EDI agenda
- Demonstrate independent and proactive leadership with confidence and integrity
- Champion open, frank and disciplined discussion and be prepared to ask the difficult questions

Eligibility

You will be able to demonstrate that you meet eligibility criteria for Board Members as set out in the NHSE England Model Constitution (included at Annex 2), meet the requirements of the fit and proper person test and that you have no substantial conflicts of interests that would interfere with your ability to be independent and offer an impartial perspective.

All appointments will be made in accordance with the eligibility and exclusion criteria set out in the ICB Constitution, re-stated in Annex 2. These criteria cover matters relating to existing roles or public office. Applicants should review Annex 2 carefully to understand the conditions that apply to appointment before applying.

Applicants should have strong connections with the area served by the ICB, but do not necessarily need to reside within it.

Given the significant public profile and responsibility members of NHS boards hold, it is vital that those appointed inspire confidence of the public, patients and NHS staff at all times. We will undertake a number of specific background checks to ensure that those we appoint are “fit and proper” people to hold these important roles. More information can be found on our website.

Applications will be assessed on merit, as part of a fair and open process, from the widest possible pool of candidates. The information provided by applicants will be relied on to assess whether sufficient personal responsibility and competence have been demonstrated in previous/other roles, to satisfy the experience, skills and values being sought.

We value and promote diversity and are committed to equality of opportunity for all. We believe that the best boards are those that reflect the communities they serve.

- 51% of the working age population and 76% of the NHS workforce are women
- 10% of the working age population and 28.6% of the NHS workforce are from ethnic minorities
- 17.7% of the population and 5% of the NHS workforce are disabled
- 2.5% of the population over 16 and 3% of the NHS workforce identify as LGBT
- 60.5% of working age adults and 79% of the NHS workforce are under 55[1]

We want to increase the diversity of our NHS leadership and encourage applications from groups we know are all under-represented in these important roles. We prioritise Equality, Diversity and Inclusion, team health and wellbeing and the principles of kind leadership in our 'ways of working'. The successful applicants will have a key role in nurturing this culture.

Terms of appointment

This section may be subject to change.

The remuneration: £18,000 per annum and working requirement will be 3 days per month

Term of appointment: Non-Executive Member appointment is usually for 3 years per term, however, some appointments will be made for 2 years to enable succession planning and minimise risks to stability of the Board.

You will have considerable flexibility to decide how you manage the time needed to undertake this role. On average, it will require a minimum 2 - 3 days a month, including preparation time, the occasional evening engagement and events designed to support your continuous development.

All NHS board members are required to comply with the Nolan Principles of Public Life and meet the Fit and Proper Persons requirements.

More information

Support in preparing your application

Onboarding support, sources of information, useful reading

View all current chair and non-executive vacancies

Sign up to receive email alerts on the latest vacancies

The ICB respects your privacy and is committed to protecting your personal data. We will only use personal data where we have your consent or where we need to comply with a legal or statutory obligation. It is important that you read our *privacy notice* so that you are fully aware of how and why we are using your data.

[1] Population data source gov.uk/ons.gov.uk (2021 Census). NHS source: Workforce NHS Digital – NHS workforce statistics (November 2025), NHS Providers (2024)

Making an application

More Information

For more information, you can get in touch with:

Michael Watson, Executive Director of Corporate Services.

✉ **michael.watson9@nhs.net**

☎ **07960085266**

Making an Application

If you wish to be considered for one of the ICB Non-Executive Member roles, please provide:

- Confirmation of the Non-Executive Role you are applying for. You may apply for more than one role if you meet the criteria, but we strongly advise that you tailor and submit individual applications to be competitive.
- A CV that includes your address and preferred contact details, highlighting and explaining any gaps in your employment history
- A supporting statement that highlights your skills and experience and allows insights on your values and motivations for applying for the role. You should outline your personal responsibility and achievement within previous roles that demonstrates you have the knowledge, skills and competencies to deliver this role, as outlined in the person specification
- The names, positions, organisations and contact details for three referees. Your referees should be individuals in a line management capacity (or senior stakeholders), and cover your most recent roles and employer, any regulated health or social care activity or where roles involved children or vulnerable adults. Your references will be taken prior to interview and may be shared with the selection panel
- A completed monitoring information form which accompanies this pack
- A completed self-declaration form confirming that you do not meet any of the criteria that would disqualify you from appointment

The closing date for applications is midday 20 February 2025.

Interviews are planned on the 26 and 27 February, subject to confirmation.

Applications should be sent to mseicb-me.essexhr-recruitment@nhs.net Reference Essex ICB and include both your CV, Supporting Statement and a covering letter.

The application process

Preliminary selection: information provided by applicants will be relied on to assess whether sufficient personal responsibility and competence have been demonstrated in previous/other roles, to satisfy the experience, skills and values outlined in the person specification. Long-listed applicants may be invited for a short preliminary interview. Feedback from any preliminary assessment will be given to the selection panel who will agree the applicants invited to interview.

Shortlisting: the selection panel will use the information provided by the applicants and feedback from any preliminary assessment to agree applicants invited to interview. Assessment will be based on merit against the competencies experience, skills and values outlined in the person specification.

Interviews: applicants will be asked to make a 5 - 10 minute presentation to help the selection panel draw out the competencies, experience, skills and values outlined in the person specification. The formal interview will be 45 mins to an hour of open questions from the selection panel to showcase past experience and explore applicant's values, motivations, creativity and ability.

Appointment: Selection panels will be asked to identify appointable candidates based on merit against the competencies experience, skills and values outlined in the person specification. The panel will recommend a preferred candidate for approval by the Chair of the ICB.

Commencement: Successful candidates will be appointed from 1 April and will be required to attend the inaugural meeting of the ICB on 1 April. Successful candidates may attend the Essex Joint Committee meeting held in public on 19 March should they so wish.

Annex 1. Chair of the Audit, Risk and Compliance Committee – model role description

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

The role of the audit, risk and compliance committee is to seek assurance that financial reporting and internal control principles are applied, and to maintain an appropriate relationship with the auditors, both internal and external. The audit committee provides advice to the board about the reliability and robustness of internal control processes. This includes the power to review the work of any other committee, including in relation to quality, and to provide assurance to the board with regard to internal controls.

Audit, risk and compliance committee chairs share the roles and responsibilities of the other non-executive members and in addition have responsibilities to:

- Provide leadership and vision to the audit, risk and compliance committee to ensure that it is effective in its role and that robust internal control systems are in place and operating effectively;
- Bring independent financial acumen to the work of the audit, risk and compliance committee across its governance, risk management, assurance and internal control functions;
- Ensure the committee identifies key risks in implementing its strategy; determine its approach and attitude to providing effective oversight of those risks and ensure there are prudent controls to assist in managing risk;
- Set an integrated agenda relevant to the current operating environment, taking full account of the important strategic issues it faces and aligning with the annual planner for the board and other committees
- Build and maintain relationships with key committee stakeholders, such as the board chair, the chief executive, finance director and internal and external auditors, including regular meetings with each as part of the process of developing the agenda and preparing for each committee meeting;
- Lead and support a constructive dynamic within the committee, enabling grounded debate with contributions from all, ensuring the committee sees itself as a team, has the right balance and diversity of skills, knowledge and perspectives, and the confidence to challenge on all aspects of the agenda
- Guard the committee's independence as a source of assurance to the board and lead the committee in establishing effective and ethical decision-making processes;
- Ensure that the committee receives accurate, high quality, timely and clear information, that the related assurance systems are fit for purpose and that there is a good flow of information between the committee, the board and senior management;
- Ensure safeguards are in place to allow staff and other individuals, where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. These processes should also reassure individuals raising concerns that they will be protected from potential negative repercussions.
- Develop a committee that is genuinely connected to and assured about staff and patient experience, as demonstrated by appropriate feedback and other measures; and
- Oversee the professional development of the members and ensuring that they have the right information to perform their roles.

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

- Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest;

- Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest;
- Support the rigorous application of conflict of interest principles and policies;
- Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation;
- Provide advice on minimising the risks of conflicts of interest.

Chair of the Remuneration Committee – model role description

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

The Remuneration Committee Chair shares the roles and responsibilities of the other non-executive members and in addition has responsibilities to:

- Provide leadership and vision to the remuneration committee to ensure that it is effective in its role and that robust internal control systems are in place and operating;
- Lead and support a constructive dynamic within the committee, enabling grounded debate with contributions from all, ensuring the committee sees itself as a team, has the right balance and diversity of skills, knowledge and perspectives, and the confidence to challenge on all aspects of the agenda
- Guard the committee's independence as a source of assurance to the board and leading the committee in establishing effective and ethical decision-making processes;
- Ensure that the committee receives accurate, high quality, timely and clear information, that the related assurance systems are fit for purpose and that there is a good flow of information between the committee, the board and senior management;
- Develop a committee that is genuinely connected to and assured about staff and patient experience, as demonstrated by appropriate feedback and other measures; and
- Oversee the professional development of the members and ensuring that they have the right information to perform their roles.

Equality, Diversity and Inclusion Lead – model role description

This member will promote matters relating to health inequalities.

The Inequalities/EDI lead shares the roles and responsibilities of the other non-executive members and in addition has responsibilities to:

- Provide leadership and vision to the Inequalities/EDI committee to ensure that it is effective in its role and that robust internal control systems are in place and operating;
- Ensure that the decisions made by relevant Committee's are grounded in robust qualitative and quantitative data
- Lead and support a constructive dynamic within the ICB, enabling grounded debate with contributions from all, ensuring the committee sees itself as a team, has the right balance and diversity of skills, knowledge and perspectives, and the confidence to challenge on all aspects of the agenda
- Be an independent source of assurance to the board and in establishing effective and ethical decision-making processes;
- Work to ensure the ICB is genuinely connected to and assured about staff and patient experience, as demonstrated by appropriate feedback and other measures; and
- Oversee the professional development of the members and ensuring that they have the right information to perform their roles.

Annex 2. Eligibility Criteria

The following criteria has been included within the Constitution and sets the eligibility criteria for Board Membership. Anyone who doesn't meet the eligibility criteria or who does meet any of the disqualification criteria should not apply to a Non-Executive Member position.

Eligibility criteria for board membership

Each member of the ICB must:

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

Disqualification criteria for board membership

- A Member of Parliament.
- A person whose appointment as a board member ("the candidate") is considered by the person making the appointment as one which could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.
- A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted:

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

- A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, Part 13 of the Bankruptcy (Scotland) Act 2016 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).
- A person who has been dismissed within the period of five years immediately preceding the date of the proposed appointment, otherwise than because of redundancy, from paid employment by any Health Service Body.
- A person whose term of appointment as the Chair, a Member, a Director or a Governor of a health service body, has been terminated on the grounds:

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

- A Healthcare Professional, meaning an individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002, or other professional person who has at any time been subject to an investigation or proceedings, by any body which regulates or licenses the profession concerned ("the regulatory body"), in connection with the person's fitness to practise or any alleged fraud, the final outcome of which was:

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

- A person who is subject to:

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

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

  a) Section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities), or
  b) Section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).

Designate Partner Members
For proposed Essex Integrated Care Board

Information pack for Nominations and Selection

We value and promote diversity and are committed to equality of opportunity for all. We believe that the best boards are those that reflect the communities they serve.

We prioritise Equality, Diversity and Inclusion, team health and wellbeing and the principles of kind leadership in our 'ways of working'. All postholders will have a key role in nurturing this culture.

Appointment will be made on merit after a fair and open process so that the best people, from the widest possible pool of applicants, are appointed.

Regulated by
The Commissioner for
Public Appointments

Context

The NHS is in the midst of one of its most significant periods of change—reshaping Integrated Care Boards (ICBs) to ensure they have the scale, clarity of purpose and strategic focus needed to meet the ambitions set out nationally. Publications from NHS England and the government, including the Model ICB Blueprint and the 10 Year Health Plan, set the direction for the next generation of ICBs: organisations that are lean, strategic and focused on improving population health, prevention and digital transformation.

In the East of England, this has meant moving from six ICBs to three larger footprints, with one of these being the proposed Essex ICB—bringing together Mid and South Essex, West Essex and North East Essex. This new configuration was confirmed through NHS England and government merger plans, with implementation beginning from April 2026.

To prepare for this transition, the existing ICBs across Essex—Mid and South Essex (MSE), Suffolk and North East Essex (SNEE), and Hertfordshire and West Essex (HWE)—established the Essex Joint Committee (EJC). The EJC was created through delegated authority to support shared decision-making across the Essex geography and to align priorities and governance during the transition period. Formal public meetings of the committee began in November 2025, focusing on preparing the ground for a single Essex ICB

These arrangements marked the start of “working as Essex” ahead of the statutory change, enabling the three ICBs to collaborate more closely, streamline commissioning decisions and build the foundations for a unified, strategic commissioning organisation from April 2026.

As the new Essex ICB takes shape, it will inherit this strong platform of collaboration and shared purpose. The future organisation will operate at scale, able to lead long-term health improvement, reduce inequalities and shape a sustainable, integrated health and care system for the communities it serves. This is an exciting moment to join the board—helping to shape a new ICB that is designed from the outset to be forward-looking, ambitious and aligned with the NHS’s long-term vision for healthier communities.

National legislation governing ICBs is expected to change over the coming years. Emerging proposals which may take affect no earlier than April 2027, could alter the statutory composition of ICB boards including the potential removal of partner member roles. While the detail and timing remain uncertain, the Essex ICB will continue to adapt its governance arrangements in line with national requirements as they are confirmed.

Introduction from our Chair (designate), Essex ICB



Across Essex—serving communities in Basildon, Braintree, Brentwood, Castle Point, Chelmsford, Colchester, Epping Forest, Harlow, Maldon, Rochford, Southend-on-Sea, Tendring, Thurrock and Uttlesford —we have seen what’s possible when partners work with purpose and pace. Over recent years we have built a strong foundation of joint working and begun to reshape how care is delivered. We also face realities we must confront with clarity and resolve: people are living longer, but too many of those added years are not spent in good health; inequalities persist and, for some, have widened; and, as everywhere in the NHS, demand and waiting times across primary, community, mental health and hospital services have grown.

The pandemic exposed the depth of health inequalities in our communities—but it also showed how quickly we can innovate when we align around what matters most. We learned to use data and digital tools more intelligently, to make decisions faster, and to deliver together. Those lessons continue to equip us to take the next step with greater discipline, clearer accountability and a sharper focus on outcomes.

From April 2026 (subject to confirmation), we will establish the Essex Integrated Care Board—a unified commissioning organisation with a clear purpose, fresh ambition and a way of working grounded in trust, openness and collaboration. This is not a simple merger of structures; it is the chance to bring the best of our legacy organisations into a single, coherent approach. No one culture will dominate—we are building something new, together.

Our mission is clear: to work with our population to achieve their best health through equitable care, delivering maximum value from every pound spent. We will do this by being a highly effective team of commissioners—inclusive, fair, responsive and innovative—combining the benefits of scale with a deep connection to the distinct needs of our neighbourhoods. We will use insight-rich data, transparent prioritisation and practical innovation to design care that works for people and delivers measurable improvement.

Guided by the NHS Long Term Plan and our statutory duties under the Health and Social Care Act 2022, the ICB will assume full accountability for:

- improving outcomes in population health and healthcare;
- tackling inequalities in outcomes, experience and access;
- enhancing productivity and value for money; and
- supporting broader social and economic development.

We will deliver these objectives by driving three major shifts:

- **From treatment to prevention:** acting earlier, supporting people closer to home and personalising care around what matters to them.
- **From hospital to community**: strengthening primary, community and mental health services, integrating around neighbourhood teams and simplifying pathways.
- **From analogue to digital**: enabling interoperable data, proven technologies and real-time insight to improve quality, safety and experience.

The Board, led by the Chair and Chief Executive, will oversee the Model ICB Blueprint transition, translating strategy into delivery through disciplined commissioning, robust assurance and purposeful partnership. Our approach is simple but powerful: catalyse, don’t control; equip, don’t fix; sustain, don’t substitute. We will succeed not by doing everything ourselves, but by enabling partners and communities to lead change, reducing unwarranted variation, improving access and creating a fairer, more integrated system.

We will hold ourselves to the Nolan Principles of Public Life: Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty and Leadership. These are more than words; they are the standards we live by, shaping how we work with colleagues, partners and the public so that everyone feels heard, respected and valued.

To those considering joining us: this is a pivotal moment to shape a new organisation with a clear mandate and the momentum of a county ready to move forward. If you are driven by equity, partnership and impact; if you bring curiosity, courage and a commitment to delivery; if you believe that better health is possible for all, then we would be delighted to work with you.

Together, we will build a culture of trust, respect and forward momentum, always centred on the people we serve, and always focused on delivering better health and better value for Essex.

Professor Michael Thorne
Chair (Designate), Essex Integrated Care Board

The opportunity

We are seeking Partner Members who will work closely with the Chair (designate) to help shape a future-focussed Essex Integrated Care Board as it transitions towards the ambitions set out in the NHS Model ICB Blueprint. While the new ICB will be established regardless of forthcoming legislation, changes to the statutory framework are expected to realign Board composition and strengthen the commissioning focus required for the next decade. Successful candidates will play a key role in overseeing this evolution, guiding the shift from legacy arrangements to a more disciplined, outcomes-driven mode, and will bring the insight, independence and leadership needed to steer the organisation through both the immediate priorities and the future legislative changes that will refine how the Board operates. It is expected that the expected legislative changes will remove the requirement for Partner Members on the ICB Board and thus, subject to those changes being enacted, we are seeking to recruit for a short-term period of 18-months.

We are seeking Partner members from:

- Upper Tier Local Authorities in Essex (3 members)
- NHS Trust and Foundation Trusts in Essex (3 members)
  - 1 Member – Mental Health
  - 1 Member – Acute
  - 1 Member – Community
- Primary Care GP (1 member)

In addition, the Board Partner members may be asked to join or attend the following committees:

- Remuneration Committee
- Audit, Risk and Compliance Committee
- Commissioning, Quality and Resource Committee
- Neighbourhood Health Committee
- Primary Care Commissioning Group
- Alliance Groups
- Provider Selection Regime Review Group
- Health Inequalities and Prevention Group
- Quality Improvement Group

Provider Members (as a representative of their sector) are statutory voting members of the ICB Board providing independent oversight, constructive challenge, and strategic leadership to ensure the organisation delivers its objectives for all communities across Essex. They play a central role in the Board's governance, holding the ICB to account for robust, evidenced-based decision making across commissioning, contracting, workforce, neighbourhood health and financial sustainability, ensuring that choices are transparent, withstand scrutiny and service the best interests of our 1.9 million residents.

The key priorities for the roles will be to:

- Establish effective working relationships with ICB Board members.
- Contribute to the operation of the ICB Board.
- Bring their expertise and experience of their sector to inform decision making as part of the ICB.
- Work collaboratively to shape the long-term, viable plan for the delivery of the functions, duties and objectives of the ICB and for the stewardship of public money.
- Ensure that the Board is effective in all aspects of its role and appropriately focused its core purposes.
- Be champions of new governance arrangements, collaborative leadership, and effective partnership working, including with local government, NHS bodies and the voluntary sector.
- Play a key role in establishing new statutory arrangements for the ICB when legislation changes.

The ICB needs diverse, inclusive and compassionate leaders who not only reflect the community they serve and the staff employed but have the leadership style and breadth of perspective to make good collective decisions.

We are really interested in receiving applications from people with different backgrounds, skills and experience.

About us

Essex is a populous and diverse county in the east of England, home to around 1.9 million people. It includes three cities: Chelmsford, Colchester and Southend-on-Sea, making Essex one of a small number of English counties with multiple cities outside the larger metropolitan regions.

Our communities range from dense urban centres such as Basildon, Buckhurst Hill, and Harlow; commuter towns with close links to London including Epping and Thurrock; rural villages like Stansted Mountfitchet and the Colne Valley; and coastal areas such as Shoeburyness, Leigh-on-Sea, Clacton and Harwich. This diversity of place and population shapes the health and care needs of residents and highlights the importance of services that are equitable, locally responsive and future-facing.

Essex's location in the south-east, with strong transport links into London and neighbouring counties, means many residents live and work across different parts of the region. The county is also home to London Stansted Airport, one of the busiest airports in England, bringing significant economic contribution as well as unique health, transport and emergency planning considerations. Essex includes several densely populated districts and fast-growing urban centres, particularly in areas with close links to London and major employment hubs.

Health and care needs across the county

Our geography creates a broad spectrum of health and care needs:

- In urban and commuter areas, health demand is shaped by population growth, ageing, long-term conditions and pressures on primary, community and mental health services.
- Rural communities may face challenges such as service accessibility, transport barriers and gaps in local support.
- Coastal towns, while rich in community identity, often have higher levels of deprivation and poorer health outcomes, including lower life expectancy and greater prevalence of long-term illness than the England average.

Across Essex, there are marked health inequalities between communities. For example, healthy life expectancy can differ significantly between neighbourhoods, with some areas seeing people live many more years in good health than others. These inequalities are often linked to socio-economic factors such as income, employment, education, housing and access to services. Access to, and quality of, clinical care contributes just 20% to the wider determinants of health, and that's why we need to work together with our Partners.



SOURCE: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute in US to rank countries by health status

Working in partnership

We work with partners across Essex to plan and deliver care that meets the needs of all residents. Our footprint includes:

- 3 acute hospital trusts providing emergency, specialist and planned care
- 10 community hospitals offering rehabilitation, recovery and outpatient services
- 6 community diagnostic centres improving access to tests and early detection
- 5 urgent treatment centres providing same-day urgent care
- 1 ambulance trust coordinating emergency response and transport
- 207 GP practices and 41 Primary Care Networks delivering primary and preventive care
- 308 community pharmacies supporting medicines advice and health promotion
- 203 NHS dental practices and 180 optical practices supporting oral and eye health

We also work with an extensive partnership network including 15 local authorities, Essex Police, Essex County Fire and Rescue, Healthwatch and the voluntary sector.

Essex ICB Footprint

3 Acute Hospital Trusts
10 Community Hospitals
6 Community Diagnostic Centres
5 Urgent Treatment Centres
1 Ambulance Trust
207 GP Practices
41 Primary Care Networks
308 Community Pharmacies
203 Dental practices (with an NHS contract)
180 Optical practices

Partners:
3 upper tier local authorities*
12 district councils*
3 Healthwatch organisations*
11 VCSE infrastructure organisations

** Current configuration subject to change*



Accountabilities

The Partner Members:

- Are accountable to the ICB Chair.
- Have designated areas of responsibilities as agreed with the ICB Chair.
- Have a collective responsibility with the other members of the ICB to ensure corporate accountability for the performance of the organisation, ensuring its functions are effectively and efficiently discharged and its financial obligations are met.

Role responsibilities and competencies

You will work alongside the Chair, non-executives, executive directors and other partner members as equal members of a unitary board.

As a senior leader in Essex, you will demonstrate a range of leadership competencies outlined below. Corporately, as members of a unitary board, you will contribute to a wide range of areas, including:

Strategy and transformation

- Setting the vision, strategy and clear objectives for the ICB in delivering on the four core purposes of the ICB, the triple aim of improved population health, quality of care and cost-control.
- Aligning partners in delivering the 10 Year Health Plan and the forthcoming refreshed 10 Year Workforce Plan (due 2026)
- Providing oversight and constructive challenge to ensure the ICB transitions care into community settings, accelerates digital transformation, and embeds prevention at scale, in line with the 10-year Health Plan.
- Providing oversight of safe, effective data use and digital transformation, ensuring digital investment directly improves outcomes, user experience and workforce productivity.

Partnerships and communities

- Promoting dialogue and consensus with local government and broader partners, to ensure effective joint planning and delivery for collaborative working and mutual accountability.
- Supporting the operation of the ICP in line with current statutory requirements, while remaining response to any future legislative changes arising from national reforms, developing strong relationships between the ICB Board, Voluntary, Community, Faith and Social Enterprise (VCFSE), Local Authority and other stakeholders
- Supporting the success of the ICP/collaboration with stakeholders/working at neighbourhood level in establishing shared strategic priorities within the NHS, in partnership with local government, to tackle population health challenges and enhance services across health and social care.

Social justice and health equalities

- Advocating diversity, health equality and social justice to close the gap on health inequalities and achieve the service changes that are needed to improve population health.
- Ensuring the ICB is responsive to people and communities and that public, patient and carer voices are embedded in all of the ICB's plans and activities.
- Embedding co-production with communities and lived-experience voices in strategic design.
- Ensuring strategies follow the principle of proportionate universalism – universal actions with scale and intensity proportionate to need.
- Promoting the values of the NHS Constitution and modelling the behaviours embodied in Our People Promise and forthcoming replacement guidance to ensure a collaborative, inclusive and productive approach across the system.

Sustainable outcomes

- Oversight of purposeful arrangements for effective leadership of clinical and professional care throughout the ICB.
- Fostering a culture of research, innovation, learning and continuous improvement to support the delivery of high-quality services for all.
- Ensuring the NHS plays its part in social and economic development and achieving environmental sustainability, including the Carbon Net Zero commitment. Overseeing the integration of greener clinical pathways, sustainable estates and low-carbon models of care.

Governance and assurance

- Collectively ensuring that the ICB is compliant with its constitution and contractual obligations, holding other members of the ICB to account through constructive, independent and respectful challenge.
- Maintaining oversight of the delivery of ICB plans, ensuring expected outcomes are delivered in a timely manner through the proportionate management of risks.
- Ensuring that the ICB operates to deliver its functions in line with all of its statutory duties, and that compliance with the expected standards of the regulatory bodies is maintained.
- Providing steady, values-based leadership during significant system restructuring, ensuring continuity of services and safeguarding population health outcomes.

People, workforce and culture

- Supporting the development of other board members to maximise their contribution.
- Providing visible leadership in developing a healthy and inclusive culture for the organisation, which promotes diversity, encourages and enables system working and which is reflected and modelled in their own and the Board's behaviour and decision-making.
- Ensuring the Board acts in accordance with the highest ethical standards of public service and that any conflicts are appropriately resolved.
- Lead inline with our leadership way and the NHS Management and Leadership Framework (2025).

- Ensuring compliance with the new national NHS Leadership and Management Framework (2025), including the Code of Practice, national standards and leadership appraisal requirements.
- Supporting workforce transformation, including growing local workforce pipelines and reducing dependence on international recruitment in line with the national workforce strategy.

Designate Partner member: person specification

Competency	Knowledge, Experience and Skills required
Setting strategy and delivering long-term transformation	• Knowledge of health, care, local government landscape and/ or the voluntary sector • A capacity to thrive in a complex and politically charged environment of change and uncertainty • Experience leading change at a senior level to bring together disparate stakeholder interests • Ability to influence partner organisations
Building trusted relationships with partners and communities	• An understanding of different sectors, groups, networks and the needs of diverse populations • Exceptional communication skills and comfortable presenting in a variety of contexts • Highly developed interpersonal and influencing skills, able to lead in a creative environment which enables people to thrive and collaborate • Experience working collaboratively across agency and professional boundaries
Leading for Social Justice and health equality	• An awareness and appreciation of social justice and how it might apply within an ICS • Record of promoting equality, diversity and inclusion in leadership roles • Life experience and personal motivation that will add valuable personal insights
Driving high quality, sustainable outcomes	• Problem solving skills and the ability to identify issues and areas of risk, leading stakeholders to effective resolutions and decisions
Providing robust governance and assurance	• An understanding of good corporate governance • Ability to remain neutral to provide independent and unbiased leadership with a high degree of personal integrity • Experience contributing effectively in complex professional meetings at a very senior level
Creating a compassionate and inclusive culture for our people	• Models respect and a compassionate and inclusive leadership style with a demonstrable commitment to equality, diversity and inclusion in respect of boards, patients and staff • Creates and lives the values of openness and transparency embodied by the principles-of-public-life and in Our People Promise

Nominees will:

- Bring the skills and experience of their sector but not act as delegates or representatives of their organisation.
- Demonstrate a proven track record of working within a complex environment to champion and effect change around equality, diversity and inclusion
- Have an understanding of the demographics of the ICB population, in order to ensure that any proposals around interventions are fit for purpose and tailored to the specific needs of the population
- Demonstrate independent and proactive leadership with confidence and integrity
- Champion open, frank and disciplined discussion and be prepared to ask the difficult questions

The term of office for these Partner Members will be up to 2 years pending the passage of legislation that will change the composition of the ICB Board.

Eligibility

You will be able to demonstrate that you meet eligibility criteria for Board Members as set out in the NHSE England Model Constitution (included at Annex 2), meet the requirements of the fit and proper person test and that you have no substantial conflicts of interests that would interfere with your ability to be independent and offer an impartial perspective.

All appointments will be made in accordance with the eligibility and exclusion criteria set out in the ICB Constitution, re-stated in Annex 2.

Given the significant public profile and responsibility members of NHS boards hold, it is vital that those appointed inspire confidence of the public, patients and NHS staff at all times. We will undertake a number of specific background checks to ensure that those we appoint are “fit and proper” people to hold these important roles. More information can be found on our website.

We value and promote diversity and are committed to equality of opportunity for all. We believe that the best boards are those that reflect the communities they serve.

- 51% of the working age population and 76% of the NHS workforce are women
- 10% of the working age population and 28.6% of the NHS workforce are from ethnic minorities
- 17.7% of the population and 5% of the NHS workforce are disabled
- 2.5% of the population over 16 and 3% of the NHS workforce identify as LGBT
- 60.5% of working age adults and 79% of the NHS workforce are under 55[1]

The nomination, selection and appointment process will encourage diversity of our NHS leadership. Those appointed will have a key role in nurturing this culture.

All NHS board members are required to comply with the Nolan Principles of Public Life and meet the Fit and Proper Persons requirements.

Nomination and Selection

The nominations and selection process for each category of Partner Member are set out in Annex 2.

The Chief Executive Officer of the ICB will write to the Chief Executive Officers of eligible Partner Members

[1] Population data source gov.uk/ons.gov.uk (2021 Census). NHS source: Workforce NHS Digital – NHS workforce statistics (November 2025), NHS Providers (2024)

for of Acute Trusts, Foundation Trusts and Local Authorities to commence the nomination process for those partners.

The Chief Executive Officer of the ICB will engage with the GP Provider Collaborative for Essex to facilitate the nomination and selection process for the GP Partner Member.

Assessment & Selection

Received and eligible nominations will be submitted to nominating organisations to demonstrate the requirement for joint nominations.

If, as set out in the Constitution, the number of nominations is equal to the number of partner member roles, there will be a confirmation process with the ICB Chair to ensure that the nominated partner member meets the criteria for board membership including the requirements of the role description and person specification and the disqualification criteria.

In the event that there is more than one suitable nominee for each of the partner member roles, the full list of nominees will be considered by a panel convened by the Chief Executive. The panel will assess the suitability of the nominees against the requirements of the role and will confirm that shortlisted nominees meet the requirements set out in the constitution.

The Chair will determine whether to approve the appointment of the most suitable nominee.

Timetable

13 February 2026 – CEO writes to eligible Partner Members CEOs and GP Collaborative to commence process and packs issued to eligible partners for nomination

27 February 2026 (midday) – Deadline for nominations to be received

3 March 2026 – Lists of nominations to be submitted to partners for confirmation (jointly nominated requirement)

4 – 6 March 2026 – Panel interviews / Chair confirmation

19 March 2026 – Essex Joint Committee Meeting – new members of Essex ICB welcome to attend.

Commitment

You will have flexibility to decide how you manage the time needed to undertake this role. On average, it will require a minimum 2 - 3 days a month, including preparation time, the occasional evening engagement and events designed to support your continuous development.

There is an expectation of commitment to the Board and thus continued absence from Board meetings could result in removal from office according to section 3.13 of the Constitution, restated at Annex 1.

Remuneration

Membership on the Board is not generally a funded position. Appointees participate on the basis that their contribution is supported by, and undertaken as part of, their existing organisational role. In contrast, the GP Partner Member will be remuneration for their Board duties, reflecting the need to release clinical time. The level of remuneration will be confirmed and agreed as part of the appointment arrangements.

More information

For more information, you can get in touch with:

Michael Watson, Executive Director of Corporate Services.

✉ **michael.watson9@nhs.net**

☎ **07960085266**

The ICB respects your privacy and is committed to protecting your personal data. We will only use personal data where we have your consent or where we need to comply with a legal or statutory obligation. It is important that you read our *privacy notice* so that you are fully aware of how and why we are using your data.

Annex 1. Eligibility, Disqualification Criteria and Removal from Office

The following criteria has been included within the Constitution and sets the eligibility criteria for Board Membership. Anyone who doesn't meet the eligibility criteria or who does meet any of the disqualification criteria will not be appointed to the Board.

Eligibility criteria for board membership

Each member of the ICB must:

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

Disqualification criteria for board membership

- A Member of Parliament.
- A person whose appointment as a board member ("the candidate") is considered by the person making the appointment as one which could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.
- A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted:

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

- A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, Part 13 of the Bankruptcy (Scotland) Act 2016 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).
- A person who has been dismissed within the period of five years immediately preceding the date of the proposed appointment, otherwise than because of redundancy, from paid employment by any Health Service Body.
- A person whose term of appointment as the Chair, a Member, a Director or a Governor of a health service body, has been terminated on the grounds:

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

- A Healthcare Professional, meaning an individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002, or other professional person who has at any time been subject to an investigation or proceedings, by any body which regulates or licenses the profession concerned ("the regulatory body"), in connection with the person's fitness to practise or any alleged fraud, the final outcome of which was:

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

- A person who is subject to:

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

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

    a) Section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities), or
    b) Section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).

Board Members: Removal from Office

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

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

a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this constitution, regulations or guidance.
b) If they fail to attend two consecutive meetings to which they are invited or show a pattern of absence (unless such absence has been agreed with the Chair in extenuating circumstances). A subsequent meeting with the Chair shall take place to determine whether the individual is able to continue to hold office.
c) If they are deemed to not meet the expected standards of performance at their annual appraisal.
d) If they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the ICB and is likely to bring the ICB into disrepute. This includes but it is not limited to dishonesty; misrepresentation (either knowingly or fraudulently); defamation of any member of the ICB (being slander or libel); abuse of position; non-declaration of a known conflict of

interest; seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise.

e) If they are deemed to have failed to uphold the Nolan Principles of Public Life.
f) Are subject to disciplinary proceedings by a regulator or professional body.

Annex 2. Nomination and Selection Process

Partner Member, NHS Trusts and Foundations Trusts (Section 3.6 of the Constitution)

These Partner Members are jointly nominated by the NHS trusts and/or FTs that provide services for the purposes of the health service within the ICB's area and meet the Forward Plan Condition or (if the Forward Plan Condition is not met) the Level of Services Provided Condition:

a) East of England Ambulance Service NHS Trust.
b) Essex Partnership University NHS Foundation Trust.
c) Mid and South Essex NHS Foundation Trust.
d) North East London NHS Foundation Trust.
e) The Princess Alexandra Hospital NHS Trust

These members must fulfil the eligibility criteria and also the following additional eligibility criteria:

a) Be a CEO or Executive Director of one of the NHS Trusts or FTs within the ICB's area.
b) One member must provide current and on-going experience of the acute hospital sector.
c) One member must provide current and on-going knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.
d) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.
e) One member shall have specific knowledge, skills and experience of the provision of community services.

Individuals will not be eligible if:

a) Any of the disqualification criteria set apply.
b) Any other disqualification criteria prescribed through NHS England guidance or supporting legislation apply.
c) A conflict of interest is evident, as determined by the Chair of the ICB board appointment panel, which results in the individual being unable to fulfil the role.

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

The appointment process will be as follows:

a) Joint Nomination:
    - When a vacancy arises, each eligible organisation listed above will be invited to make one nomination for each role.
    - Eligible organisations may nominate individuals from their own organisation or another organisation.
    - All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 10 working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.
b) Assessment, selection, and appointment subject to approval of the Chair under c):
    - If the number of nominations is equal to the number of partner member roles, there will be a confirmation process with the ICB Chair to ensure that the nominated partner member meets the

criteria for board membership including the requirements of the role description and person specification and the disqualification criteria.

- In the event that there is more than one suitable nominee for each of the partner member roles, the full list of nominees will be considered by a panel convened by the Chief Executive.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clauses herein.
- The panel will select the most suitable nominee for appointment via the shortlisting, interview, and selection process set out in the Governance Handbook.

c) Chair's approval:

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

Partner Member, Providers of Primary Medical Services (Section 3.7 of the Constitution)

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

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

This member must fulfil the eligibility criteria and also the following additional eligibility criteria:

a) Be registered with the General Medical Council.
b) Be a practising provider of primary medical services within the ICB area.
c) Work as a GP in the ICB area for a minimum of 1 session per week.
d) Fulfil the requirements relating to the relevant experience, knowledge, skills and attributes set out in a role specification.

Individuals will not be eligible if:

a) Any of the disqualification criteria apply.
b) A conflict of interest is evident, as determined by the Chair or the ICB board appointment panel, which results in the individual being unable to fulfil the role.

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

The appointment process will be as follows:

a) Joint Nomination:
   - When a vacancy arises, each eligible organisation listed in the Governance Handbook will be invited to make one nomination.
   - Each nomination must be seconded by one of the other eligible organisations listed in the Governance Handbook.
   - Eligible organisations may nominate an individual from their own organisation or another organisation.
   - All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 10 working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.
b) Assessment, selection, and appointment subject to approval of the Chair under c):
   - If the number of nominations is equal to the number of partner member roles, there will be a confirmation process with the ICB Chair to ensure that the nominated partner member meets the criteria for board membership including the requirements of the role description and person specification and the disqualification criteria.
   - In the event that there is more than one suitable nominee for the role, the full list of nominees will be considered by a panel convened by the Chief Executive.
   - The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clauses herein.

- The panel will select the most suitable nominee for appointment via the shortlisting, interview, and selection process set out in the Governance Handbook.

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

Partner Members, Local Authorities (Section 3.8 of the Constitution)

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

a) Essex County Council
b) Southend on Sea City Council
c) Thurrock Council

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

a) Be the Chief Executive or hold a relevant Executive level role of one of the bodies listed at 3.8.1.
b) The ICB is seeking knowledge and experience covering the full breadth of the ICB geography, its range of health and care services and professions.
c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.
b) A conflict of interest is evidence, as determined by the Chair or the ICB board appointment panel, which results in the individual being unable to fulfil the role.

This member will be recommended for appointment by the ICB Chief Executive subject to the approval of the Chair.

The appointment process will be as follows:

a) Joint Nomination:
   - When a vacancy arises, each eligible organisation listed at 3.8.1 will be invited to make one nomination for each role.
   - Eligible organisations may nominate individuals from their own organisation or another organisation.
   - All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 10 working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.
b) Assessment, selection, and appointment subject to approval of the Chair under c):
   - If the number of nominations is equal to the number of partner member roles, there will be a confirmation process with the ICB Chair to ensure that the nominated partner member meets the criteria for board membership including the requirements of the role description and person specification and the disqualification criteria.
   - In the event that there is more than one suitable nominee for each of the partner member roles, the full list of nominees will be considered by a panel convened by the Chief Executive.
   - The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.8.2 and 3.8.3.
   - The panel will select the most suitable nominee for appointment via the shortlisting, interview and selection process set out in the Governance Handbook.
c) Chair's approval:

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

7. Summary Delegation Arrangements

7.1 Primary Care Medical Services, Dental Services, Ophthalmic Services and Pharmaceutical Services Delegation Agreement

7.2 Specialised Commissioning Services Delegation Agreement

Dated 1 April 2026

(1) **NHS ENGLAND**

- and -

(2) **NHS ESSEX INTEGRATED CARE BOARD**

Delegation Agreement in Respect of

(i) Primary Medical Care Services
(ii) Primary Dental Services and Prescribed Dental Services
(iii) Primary Ophthalmic Services
(iv) Pharmaceutical Services and Local Pharmaceutical Services

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DELEGATION AGREEMENT FOR SPECIFIED FUNCTIONS

1. **PARTICULARS**

1.1 This Agreement records the particulars of the agreement made between NHS England and the Integrated Care Board (ICB) named below.

Integrated Care Board	**NHS Essex Integrated Care Board**
Area	**Area of the ICB as defined in it's Constitution**
Date of Agreement	**The date stated on the front page of this document**
ICB Representative	**Tom Abell**
ICB Email Address for Notices	**Nicola.adams15@nhs.net**
NHS England Representative	**Clare Panniker**
NHS England Email Address for Notices	**Alex.green-wilkes@nhs.net**

1.2 **The following Delegated Functions are included in this Agreement[1]:**

Delegated Functions	Schedule	Included	Effective Date of Delegation
Primary Medical Services Functions	Schedule 2A –	Yes	1 July 2022
Primary Dental Services and Prescribed Dental Services Functions	Schedule 2B –	Yes	1 April 2023
Primary Ophthalmic Services Functions	Schedule 2C –	Yes	1 April 2023
Pharmaceutical Services and Local Pharmaceutical Services Functions	Schedule 2D –	Yes	1 April 2023

1.3 This Agreement comprises:

1.3.1 the Particulars (clause 1);

[1] This table must be completed to indicate which services are included in the Delegation.

1.3.2 the Terms and Conditions (clauses 2 to 31);

1.3.3 the Schedules; and

1.3.4 the Mandated Guidance

Signed by **NHS England**



Clare Panniker

Regional Director East of England

(for and on behalf of NHS England)

Signed by **NHS Essex Integrated Care Board**

Tom Abell

Chief Executive Officer

(for and on behalf of NHS Central East Integrated Care Board)

TERMS AND CONDITIONS

2. **INTERPRETATION**

2.1 This Agreement is to be interpreted in accordance with Schedule 1 (Definitions and Interpretation).

2.2 If there is any conflict or inconsistency between the provisions of this Agreement, that conflict or inconsistency must be resolved according to the following order of priority:

2.2.1 the Particulars and Terms and Conditions (clauses 1 to 31);

2.2.2 all Schedules excluding Local Terms;

2.2.3 Mandated Guidance; and

2.2.4 Local Terms.

2.3 This Agreement constitutes the entire agreement and understanding between the Parties relating to the Delegation and supersedes all previous agreements, promises and understandings between them, whether written or oral, relating to its subject matter.

2.4 Where it is indicated that a provision in this Agreement is not used, that provision is not relevant and has no application in this Agreement.

2.5 Where a particular clause is included in this Agreement but is not relevant to the ICB because that clause relates to matters which do not apply to the ICB (for example, if the clause only relates to functions that are not Delegated Functions in respect of the ICB), that clause is not relevant and has no application to this Agreement.

3. **BACKGROUND**

3.1 By this Agreement NHS England delegates the Delegated Functions to the ICB under section 65Z5 of the NHS Act while retaining the Reserved Functions.

3.2 Arrangements made under section 65Z5 may be made on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the ICB.

3.3 This Agreement sets out the terms that apply to the exercise of the Delegated Functions by the ICB and the Parties' associated responsibilities and measures required to ensure the effective and efficient exercise of the Delegated Functions and Reserved Functions.

4. **TERM**

4.1 This Agreement has effect from the Date of Agreement set out in the Particulars and will remain in force unless terminated in accordance with clause 26 *(Termination)* below.

5. **PRINCIPLES**

5.1 In complying with the terms of this Agreement, NHS England and the ICB must:

5.1.1 at all times have regard to the Triple Aim;

5.1.2 at all times act in good faith and with integrity towards each other;

5.1.3 have regard to the intention that commissioning functions in respect of Primary Medical Services, Primary Dental Services and Primary Ophthalmic Services will in future be directly conferred on the ICB;

5.1.4 consider how it can meet its legal duties to involve patients and the public in shaping the provision of services, including by working with local

communities, under-represented groups and those with protected characteristics for the purposes of the Equality Act 2010;

5.1.5 consider how in performing their obligations they can address health inequalities;

5.1.6 at all times exercise functions effectively, efficiently and economically;

5.1.7 act in a timely manner;

5.1.8 share information and best practice, and work collaboratively to identify solutions and enhance the evidence base for the commissioning and provision of health services, eliminate duplication of effort, mitigate risk and reduce cost; and

5.1.9 have regard to the needs and views of the other Party and as far as is lawful and reasonably practicable, take such needs and views into account.

6. DELEGATION

6.1 In accordance with its statutory powers under section 65Z5 of the NHS Act, NHS England hereby delegates the exercise of the Delegated Functions to the ICB to empower it to commission a range of services for its Population, as further described in this Agreement ("**Delegation**").

6.2 The Delegated Functions are the functions described as being delegated to the ICB as have been identified as included in clause 1 (*Particulars*) and included as a Schedule to this Agreement.

6.3 The Delegation in respect of each Delegated Function has effect from the relevant Effective Date of Delegation.

6.4 NHS England may by Contractual Notice allocate Contracts to the ICB such that they are included as part of the Delegation. The Delegated Functions must be exercised both in respect of the relevant Contract and any related matters concerning any Provider that is a party to Contract or Arrangement.

6.5 Subsequent to the Effective Date of Delegation and for the duration of this Agreement, unless otherwise agreed any new Contract entered into in respect of the Delegated Functions shall be managed by the ICB in accordance with the provisions of this Agreement.

6.6 NHS England may by Contractual Notice add or remove Contracts to or from the list of those allocated to the ICB for the purposes of this Agreement. In particular, NHS England may add or remove Contracts where this is associated with an extension or reduction of the scope of the Delegated Functions.

6.7 Decisions of the ICB in respect of the Delegated Functions and made in accordance with the terms of this Agreement shall be binding on NHS England and the ICB.

6.8 Unless expressly provided for in this Agreement, the ICB is not authorised by this Agreement to take any step or make any decision in respect of Reserved Functions. Any such purported decision of the ICB is invalid and not binding on NHS England unless ratified in writing by NHS England in accordance with the NHS England Scheme of Delegation and Standing Financial Instructions. NHS England may, acting reasonably and solely to the extent that the decision relates to the Delegated Functions, substitute its own decision for any decision which the ICB purports to make where NHS England reasonably considers that the impact of the ICB decision could, in relation to the Delegated Functions, cause the ICB to be acting unlawfully, in breach of this Agreement including Mandated Guidance, or in breach of any Contract. The ICB must

provide any information, assistance and support as NHS England requires to enable it to determine whether to make any such decision.

6.9 The terms of clause 6.8 are without prejudice to the ability of NHS England to enforce the terms of this Agreement or otherwise take action in respect of any failure by the ICB to comply with this Agreement.

7. EXERCISE OF DELEGATED FUNCTIONS

7.1 The ICB agrees that it will exercise the Delegated Functions in accordance with:

7.1.1 the terms of this Agreement including Mandated Guidance;

7.1.2 any Contractual Notices;

7.1.3 all applicable Law and Guidance;

7.1.4 the ICB's constitution;

7.1.5 the requirements of any assurance arrangements made by NHS England, and;

7.1.6 Good Practice.

7.2 In exercising the Delegated Functions, the ICB must comply with the Mandated Guidance set out at Schedule 9 (*Mandated Guidance)* or otherwise referred to in the Schedules to this Agreement and such further Mandated Guidance as may be issued by NHS England from time to time, including on the Direct Commissioning Guidance Webpage.

7.3 NHS England may, at its discretion, issue Contractual Notices from time to time relating to the manner in which the Delegated Functions must be exercised by the ICB. Contractual Notices will have effect as variations to this Agreement.

7.4 The ICB must establish effective, safe, efficient and economic arrangements for the discharge of the Delegated Functions.

7.5 The ICB must give due consideration to whether any of the Delegated Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act.

7.6 The ICB must develop an operational scheme(s) of delegation defining those individuals or groups of individuals, including committees, who may discharge aspects of the Delegated Functions. For the purposes of this clause, the ICB may include the operational scheme(s) of delegation within its general organisational scheme of delegation.

7.7 Subject to clauses 7.1 to 7.6, the ICB may determine the arrangements for the exercise of the Delegated Functions.

7.8 The ICB must perform the Delegated Functions:

7.8.1 in such a manner as to ensure NHS England's compliance with NHS England's statutory duties in respect of the Delegated Functions and to enable NHS England to fulfil its Reserved Functions; and

7.8.2 having regard to NHS England's accountability to the Secretary of State and Parliament in respect of both the Delegated Functions and Reserved Functions.

8. PERFORMANCE OF THE RESERVED FUNCTIONS

8.1 NHS England will exercise the Reserved Functions, including but not limited to those set out in the relevant Schedules to this Agreement.

8.2 For the avoidance of doubt, the Parties acknowledge that the Delegation may be amended, and additional functions may be delegated to the ICB, in which event consequential changes to this Agreement shall be agreed with the ICB pursuant to clause 25 (*Variations*) of this Agreement.

8.3 Where appropriate NHS England will work collaboratively with the ICB when exercising the Reserved Functions.

8.4 If there is any conflict or inconsistency between functions that are named as Delegated Functions and functions that are named as Reserved Functions, then such functions shall be interpreted as Reserved Functions unless and until NHS England confirms otherwise. In the event that an ICB identifies such a conflict or inconsistency it will inform NHS England as soon as is reasonably practicable.

8.5 The Parties acknowledge that where the ICB shall provide administrative and management services to NHS England in relation to certain Reserved Functions these shall be as set out in clause 9.14. and Schedule 10 *(Administrative and Management Services*).

8.6 The Parties further acknowledge that NHS England may ask the ICB to provide certain administrative and management services to NHS England in relation to other Reserved Functions.

8.7 Notwithstanding any arrangement for or provision of administrative or management services in respect of certain Reserved Functions, NHS England shall retain and be accountable for the exercise of such Reserved Functions.

9. FINANCE

9.1 Without prejudice to any other provision in this Agreement, the ICB must comply with such financial processes as required by NHS England for the management, reporting and accounting of funds used for the purposes of the Delegated Functions.

9.2 The ICB acknowledges that it will receive funds from NHS England in respect of the Delegated Functions (the "Delegated Funds") and that these are in addition to the funds allocated to it within its Annual Allocation.

9.3 Subject to clause 9.4 and any provisions in the Schedules or Mandated Guidance, the ICB may use:

9.3.1 its Annual Allocation and the Delegated Funds in the exercise of the Delegated Functions; and

9.3.2 the Delegated Funds and its Annual Allocation in the exercise of the ICB's functions other than the Delegated Functions.

9.4 The ICB's expenditure on the Delegated Functions must be no less than that necessary to:

9.4.1 ensure that NHS England is able to fulfil its functions, including without limitation the Reserved Functions, effectively and efficiently;

9.4.2 meet all liabilities arising under or in connection with all Contracts allocated to the ICB in accordance with clauses 6.4 to 6.6 in so far as they relate to the Delegated Functions;

9.4.3 meet national commitments from time to time on expenditure on specific Delegated Functions including, without limitation, the Community Pharmacy Contractual Framework.

9.5 NHS England may increase or reduce the Delegated Funds in any Financial Year, by sending a notice to the ICB of such increase or decrease:

9.5.1 in order to take into account any monthly adjustments or corrections to the Delegated Funds that NHS England considers appropriate, including without limitation adjustments following any changes to the Delegated Functions, changes in allocations, changes in Contracts, to implement Mandated Guidance under Clause 7.4 or otherwise;

9.5.2 in order to comply with a change in the amount allocated to NHS England by the Secretary of State pursuant to section 223B of the NHS Act;

9.5.3 to take into account any Losses of NHS England for which the ICB is required to indemnify NHS England under clause 15;

9.5.4 to take into account any adjustments that NHS England considers appropriate (including without limitation in order to make corrections or otherwise to reflect notional budgets) to reflect funds transferred (or that should have been transferred) to the ICB in respect of the Delegated Functions and/or funds transferred (or that should have been transferred) to the ICB and in respect of which the ICB has management or administrative responsibility under Schedule 10 of this Agreement; or

9.5.5 in order to ensure compliance by NHS England with its obligations under the NHS Act (including without limitation, Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State in respect of NHS England under the NHS Act.

9.6 NHS England acknowledges that the intention of paragraph 9.5 is to reflect genuine corrections and adjustments to the Delegated Funds and may not be used to change the allocation of the Delegated Funds unless there are significant or exceptional circumstances that would require such corrections or adjustments.

9.7 The ICB acknowledges that it must comply with its statutory financial duties, including those under Part 11 of the NHS Act to the extent that these sections apply in relation to the receipt of the Delegated Funds.

9.8 NHS England may in respect of the Delegated Funds:

9.8.1 notify the ICB regarding the required payment of sums by the ICB to NHS England in respect of charges referable to the valuation or disposal of assets and such conditions as to records, certificates or otherwise;

9.8.2 by notice, require the ICB to take such action or step in respect of the Delegated Funds, in order to ensure compliance by NHS England of its duties or functions under the NHS (including without limitation, Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State under the NHS Act.

9.9 The Schedules to this Agreement identify further financial provisions in respect of the exercise of the Delegated Functions including but not limited to Schedule 5 (*Financial Provisions and Decision Making Limits*).

9.10 NHS England may issue Mandated Guidance in respect of the financial arrangements in respect of the Delegated Functions.

Payment and Transfer

9.11 NHS England will pay the Delegated Funds to the ICB using the revenue transfer process as used for the Annual Allocation or using such other process as notified to the ICB from time to time.

9.12 Without prejudice to any other obligation upon the ICB, the ICB agrees that it must use its resources for the purposes of the Delegated Functions in accordance with:

9.12.1 the terms and conditions of this Agreement including any Mandated Guidance issued by NHS England from time to time in relation to the use of resources for the purposes of the Delegated Functions (including in relation to the form or contents of any accounts);

9.12.2 the business rules as set out in NHS England's planning guidance or such other documents issued by NHS England from time to time;

9.12.3 any Capital Investment Guidance; and

9.12.4 the HM Treasury guidance *Managing Public Money* (dated September 2022)

9.13 Without prejudice to any other obligation upon the ICB, the ICB agrees that it must provide:

9.13.1 all information, assistance and support to NHS England in relation to the audit and/or investigation (whether internal or external and whether under Law or otherwise) in relation to the use of or payment of resources for the purposes of the Delegated Functions and the discharge of those functions;

9.13.2 such reports in relation to the expenditure on the Delegated Functions as set out in Mandated Guidance, the Schedules to this Agreement or as otherwise required by NHS England.

Administrative and/or Management Services

9.14 The provisions of Schedule 10 (*Administrative and Management Services)* in relation to Administrative and/or Management Services shall apply.

Pooled Funds

9.15 Subject to the provisions of this Agreement, the ICB may, for the purposes of exercising the Delegated Functions under this Agreement, establish and maintain a pooled fund in respect of any part of the Delegated Funds with:

9.15.1 NHS England in accordance with sections 13V or 65Z6 of the NHS Act;

9.15.2 one or more ICBs in accordance with section 65Z6 of the NHS Act as part of a Further Arrangement; or

9.15.3 NHS England and one or more ICBs in accordance with section 13V of the NHS Act; and

9.15.4 NHS England and one or more ICBs in accordance with section 65Z6 of the NHS Act.

9.16 At the date of this Agreement, details of the pooled funds (including any terms as to the governance and payments out of such pooled fund) of NHS England and the ICB are set out in the Local Terms.

10. INFORMATION, PLANNING AND REPORTING

10.1 The ICB must provide to NHS England:

10.1.1 all information or explanations in relation to the exercise of the Delegated Functions (including in relation to this Agreement), (and in such form) as requested by NHS England from time to time; and

10.1.2 all such information (and in such form), that may be relevant to NHS England in relation to the exercise by NHS England of its other duties or functions including, without limitation, the Reserved Functions.

10.2 The provisions of this clause 10 are without prejudice to the ability of NHS England to exercise its other powers and duties in obtaining information from and assessing the performance of the ICB.

Forward Plan and Annual Report

10.3 Before the start of each Financial Year, the ICB must describe in its joint forward plan prepared in accordance with section 14Z52 of the NHS Act how it intends to exercise the Delegated Functions.

10.4 The ICB must report on its exercise of the Delegated Functions in its annual report prepared in accordance with section 14Z58 of the NHS Act.

Risk Register

10.5 The ICB must maintain a risk register in respect of its exercise of the Delegated Functions and periodically review its content. The risk register must follow such format as may be notified by NHS England to the ICB from time to time.

11. FURTHER ARRANGEMENTS

11.1 The ICB must give due consideration to whether any of the Delegated Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act.

11.2 The ICB may only make arrangements with another person (a "Sub-Delegate") concerning the exercise of the Delegated Functions ("Further Arrangements"), including without limitation arrangements under section 65Z5 and section 75 of the NHS Act, with the prior written approval of NHS England.

11.3 The approval of any Further Arrangements may:

11.3.1 include approval of the terms of the proposed Further Arrangements; and

11.3.2 require conditions to be met by the ICB and the Sub-Delegate in respect of that arrangement.

11.4 All Further Arrangements must be made in writing.

11.5 The ICB must not:

11.5.1 terminate Further Arrangements; or

11.5.2 make any material changes to the terms of Further Arrangements,

11.5.3 without the prior written approval of NHS England.

11.6 If the ICB enters into a Further Arrangement it must ensure that the Sub-Delegate does not make onward arrangements for the exercise of any or all of the Delegated Functions without the prior written approval of NHS England.

11.7 The terms of this clause 11 do not prevent the ICB from making arrangements for assistance and support in the exercise of the Delegated Functions with any person, where such arrangements reserve the consideration and making of any decision in respect of a Delegated Function to the ICB.

11.8 NHS England requires the ICB to make arrangements for assistance and support in the exercise of the Delegated Functions with those persons described in the Schedules including, but not limited to Schedule 6 (*Mandated Assistance and Support*) and with such other persons as NHS England may require from time to time.

11.9 Where Further Arrangements are made, and unless NHS England has otherwise given prior written agreement, any positive obligation or duty on the part of the ICB under this Agreement that is relevant to those Further Arrangements shall also require the ICB to ensure that all Sub-Delegates comply with that positive obligation or duty and support the ICB in doing so. In the same way, any negative duty or obligation on the part of the ICB under this Agreement that is relevant to Further Arrangement shall also require the ICB to ensure that all Sub-Delegates comply with that negative obligation or duty and support the ICB in doing so.

12. STAFFING AND WORKFORCE

12.1 The Staffing Model in respect of each Delegated Function shall at the Effective Date of Delegation be as approved by the relevant National Moderation Panel.

12.2 Where the staffing arrangements include the deployment of NHS England Staff to the ICB for the purposes of carrying out the relevant Delegated Functions then the provisions of Schedule 8 (*Deployment of NHS England Staff to the* ICB) shall apply.

12.3 The ICB must comply with any Mandated Guidance issued by NHS England from time to time in relation to the NHS England Staff.

12.4 For the avoidance of doubt, any breach by the ICB of the terms of this clause 12 (Staffing), including any breach of any Mandated Guidance issued in accordance with clause 12.3 above, will be a breach of the terms and conditions of this Agreement for the purposes of clauses 9.5 and 15.2.

13. BREACH

13.1 If the ICB does not comply with the terms of this Agreement, then NHS England may:

13.1.1 exercise its rights under this Agreement; and/or

13.1.2 take such steps as it considers appropriate in the exercise of its other functions concerning the ICB.

13.2 Without prejudice to clause 13.1, if the ICB does not comply with the terms of this Agreement (including if the ICB exceeds its delegated authority under the Delegation), NHS England may (at its sole discretion):

13.2.1 waive its rights in relation to such non-compliance in accordance with clause 13.3;

13.2.2 ratify any decision in accordance with clause 6.8;

13.2.3 substitute a decision in accordance with clause 6.9;

13.2.4 revoke the whole or part of the Delegation and terminate this Agreement in accordance with clause 26 *(Termination)* below;

13.2.5 exercise the Escalation Rights in accordance with clause 14 *(Escalation Rights)*; and/or

13.2.6 exercise its rights under common law.

13.3 NHS England may waive any non-compliance by the ICB with the terms of this Agreement provided that the ICB provides a written report to NHS England as required by clause 13.4 and, after considering the ICB's written report, NHS England is satisfied that the waiver is justified.

13.4 If:

13.4.1 the ICB does not comply (or, based on the risk register maintained by the ICB in accordance with clause 10.5 or any other information available to it the ICB considers that it may not be able to comply) with this Agreement; or

13.4.2 NHS England notifies the ICB that it considers the ICB has not complied, or may not be able to comply with, this Agreement,

then the ICB must provide a written report to NHS England within ten (10) Operational Days of the non-compliance (or the date on which the ICB considers that it may not be able to comply with this Agreement) or such notification pursuant to clause 13.4.2 setting out:

13.4.3 details of and reasons for the non-compliance (or likely non-compliance) with the Agreement and/or the Delegation; and

13.4.4 a plan for how the ICB proposes to remedy the non-compliance.

14. ESCALATION RIGHTS

14.1 If the ICB does not comply with this Agreement, NHS England may exercise the following Escalation Rights:

14.1.1 NHS England may require a suitably senior representative of the ICB to attend a review meeting within ten (10) days of NHS England becoming aware of the non-compliance; and

14.1.2 NHS England may require the ICB to prepare an action plan and report within twenty (20) days of the review meeting (to include details of the non-compliance and a plan for how the ICB proposes to remedy the non-compliance).

14.2 Nothing in clause 14 *(Escalation Rights)* will affect NHS England's right to substitute a decision in accordance with clause 6.9, revoke the Delegation and/or terminate this Agreement in accordance with clause 26 *(Termination)* below.

15. LIABILITY AND INDEMNITY

15.1 NHS England is liable in respect of any Losses arising in respect of NHS England's negligence, fraud, recklessness or deliberate breach in respect of the Delegated Functions and occurring after the Effective Date of Delegation and, if the ICB suffers any Losses in respect of such actions by NHS England, NHS England shall make such adjustments to the Annual Allocation (or other amounts payable to the ICB) in order to reflect any Losses suffered by the ICB (except to the extent that the ICB is liable for such Losses pursuant to clause 15.3).

15.2 For the avoidance of doubt, NHS England remains liable for a Claim relating to facts, events or circumstances concerning the Delegated Functions before the Effective Date of Delegation.

15.3 The ICB is liable to (and shall pay) NHS England for any Losses suffered by NHS England that result from or arise out of the ICB's negligence, fraud, recklessness or breach of the Delegation (including any actions that are taken that exceed the authority

conferred by the Delegation) or this Agreement and, in respect of such Losses, NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB or make such adjustments to the Delegated Funds pursuant to clause 9.5. The ICB shall not be liable to the extent that the Losses arose prior to the Effective Date of Delegation.

15.4 Each Party acknowledges and agrees that any rights acquired, or liabilities (including liabilities in tort) incurred, in respect of the exercise by the ICB of any Delegated Function are enforceable by or against the ICB only, in accordance with section 65Z5(6) of the NHS Act.

15.5 The ICB indemnifies NHS England and shall keep it indemnified on a continuing basis from and against any and all Losses which NHS England may incur by reason of any claim by any NHS England Staff:

15.5.1 arising out of a breach of duty by the ICB (whether under common law, statute or otherwise) to the extent that such claim is not met by either the ICB's or NHS England's insurance or indemnity cover;

15.5.2 under the Equality Act 2010 or Part V of the Employment Rights Act 1996 arising out of acts or omissions by the ICB (or any of its employees, directors or officers);

15.5.3 arising from any acts or omissions by the ICB resulting in the termination of their employment, including any claim arising from any instruction by the ICB to NHS England to discipline or dismiss any person.

15.6 Each Party shall co-operate with the other in making all reasonable efforts to minimise any liabilities and Losses in connection with the employment of NHS England Staff in Delegated Functions.

15.7 Each Party will at all times take all reasonable steps to minimise and mitigate any Losses or other matters for which one Party is entitled to be indemnified by or to bring a claim against the other under this Agreement.

16. CLAIMS AND LITIGATION

16.1 Nothing in this clause 16 *(Claims and Litigation)* shall be interpreted as affecting the reservation to NHS England of the Reserved Functions.

16.2 Except in the circumstances set out in clause 16.5 and subject always to compliance with this clause 16 *(Claims and Litigation)*, the ICB shall be responsible for and shall retain the conduct of any Claim.

16.3 The ICB must:

16.3.1 comply with any policy issued by NHS England from time to time in relation to the conduct of or avoidance of Claims and/or the pro-active management of Claims;

16.3.2 if it receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim, immediately notify NHS England and send to NHS England all copies of such correspondence;

16.3.3 co-operate fully with NHS England in relation to such Claim and the conduct of such Claim;

16.3.4 provide, at its own cost, to NHS England all documentation and other correspondence that NHS England requires for the purposes of considering and/or resisting such Claim; and/or

16.3.5 at the request of NHS England, take such action or step or provide such assistance as may in NHS England's discretion be necessary or desirable having regard to the nature of the Claim and the existence of any time limit in relation to avoiding, disputing, defending, resisting, appealing, seeking a review or compromising such Claim or to comply with the requirements of the provider of an Indemnity Arrangement in relation to such Claim.

16.4 Subject to clauses 16.3 and 16.5 and Schedule 5 (*Financial Provisions and Decision Making Limits*) the ICB is entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit.

NHS England Stepping into Claims

16.5 NHS England may, at any time following discussion with the ICB, send a notice to the ICB stating that NHS England will take over the conduct of the Claim and the ICB must immediately take all steps necessary to transfer the conduct of such Claim to NHS England unless and until NHS England transfers conduct back to the ICB. In such cases:

16.5.1 NHS England shall be entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit, provided that if NHS England wishes to invoke clause 16.5.3 it agrees to seek the ICB's views on any proposal to pay or settle that Claim prior to finalising such payment or settlement; and

16.5.2 the Delegation shall be treated as being revoked to the extent that and for so long as NHS England has assumed responsibility for exercising those of the Delegated Functions that are necessary for the purposes of having conduct of the Claim; and

16.5.3 NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or make an adjustment to the Delegated Funds pursuant to clause 9.5.3 for the purposes of meeting any Claim Losses associated with that Claim.

Claim Losses

16.6 The ICB and NHS England shall notify each other within a reasonable time period of becoming aware of any Claim Losses.

16.7 The ICB acknowledges that NHS England will pay to the ICB the funds that are attributable to the Delegated Functions. Accordingly, the ICB acknowledges that it must pay any Claim Losses out of either the Delegated Funds or its Annual Allocation. NHS England may, in respect of any Claim Losses, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or pursuant to clause 9.5.3 make such adjustments to the Delegated Funds to take into account the amount of any Claim Losses (other than any Claim Losses in respect of which NHS England has retained any funds, provisions or other resources to discharge such Claim Losses). For the avoidance of doubt, in circumstances where NHS England suffers any Claim Losses, then NHS England shall be entitled to recoup such Claim Losses pursuant to clause 9.5.3. If and to the extent that NHS England has retained any funds, provisions or other resources to discharge such Claim Losses, then NHS England may either use such funds to discharge the Claim Loss or make an upward adjustment to the amounts paid to the ICB pursuant to clause 9.5.3.

17. DATA PROTECTION, FREEDOM OF INFORMATION AND TRANSPARENCY

17.1 The Parties must ensure that all Personal Data processed by or on behalf of them in the course of carrying out the Delegated Functions and Reserved Functions is processed in accordance with the relevant Party's obligations under Data Protection

Legislation and Data Guidance and the Parties must assist each other as necessary to enable each other to comply with these obligations.

17.2 The ICB must respond to any information governance breach in accordance with IG Guidance for Serious Incidents. If the ICB is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach then as soon as reasonably practical and in any event on or before the first such notification is made the ICB must fully inform NHS England of the information governance breach. This clause does not require the ICB to provide NHS England with information which identifies any individual affected by the information governance breach where doing so would breach Data Protection Legislation.

17.3 Whether or not a Party is a Data Controller or Data Processor will be determined in accordance with Data Protection Legislation and any Data Guidance from a Regulatory or Supervisory Body. The Parties acknowledge that a Party may act as both a Data Controller and a Data Processor.

17.4 Each Party acknowledges that the other is a public authority for the purposes of the Freedom of Information Act 2000 (**"FOIA"**) and the Environmental Information Regulations 2004 (**"EIR"**).

17.5 Each Party may be statutorily required to disclose further information about the Agreement and the Relevant Information in response to a specific request under FOIA or EIR, in which case:

17.5.1 each Party shall provide the other with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR;

17.5.2 each Party shall consult the other regarding the possible application of exemptions in relation to the information requested; and

17.5.3 subject only to clause 16 *(Claims and Litigation)*, each Party acknowledges that the final decision as to the form or content of the response to any request is a matter for the Party to whom the request is addressed.

17.6 NHS England may, from time to time, issue a FOIA or EIR protocol or update a protocol previously issued relating to the dealing with and responding to FOIA or EIR requests in relation to the Delegated Functions. The ICB shall comply with such FOIA or EIR protocols.

17.7 Schedule 4 (*Further Information Governance and Sharing* Provisions) makes further provision about information sharing and information governance.

18. IT INTER-OPERABILITY

18.1 NHS England and the ICB will work together to ensure that all relevant IT systems operated by NHS England and the ICB in respect of the Delegated Functions and the Reserved Functions are inter-operable and that data may be transferred between systems securely, easily and efficiently.

18.2 The Parties will use their respective reasonable endeavours to help develop initiatives to further this aim.

19. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

19.1 The ICB must and must ensure that, in delivering the Delegated Functions, all Staff comply with Law, with Managing Conflicts of Interest in the NHS and other Guidance, and with Good Practice, in relation to gifts, hospitality and other inducements and actual or potential conflicts of interest.

19.2 Without prejudice to the general obligations set out in clause 19.1, the ICB must maintain a register of interests in respect of all persons making decisions concerning the Delegated Functions. This register must be publicly available. For the purposes of this clause, the ICB may rely on an existing register of interests rather than creating a further register.

20. PROHIBITED ACTS AND COUNTER-FRAUD

20.1 The ICB must not commit any Prohibited Act.

20.2 If the ICB or its Staff commits any Prohibited Act in relation to this Agreement with or without the knowledge of NHS England, NHS England will be entitled:

20.2.1 to revoke the Delegation; and

20.2.2 to recover from the ICB the amount or value of any gift, consideration or commission concerned; and

20.2.3 to recover from the ICB any loss or expense sustained in consequence of the carrying out of the Prohibited Act.

20.3 The ICB must put in place and maintain appropriate arrangements, including without limitation Staff training, to address counter-fraud issues, having regard to any relevant Guidance (including from the NHS Counter Fraud Authority).

20.4 If requested by NHS England or the NHS Counter Fraud Authority, the ICB must allow a person duly authorised to act on behalf of the NHS Counter Fraud Authority or on behalf of NHS England to review, in line with the appropriate standards and counter-fraud arrangements put in place by the ICB.

20.5 The ICB must implement any reasonable modifications to its counter-fraud arrangements required by a person referred to in clause 20.4 in order to meet the appropriate standards within whatever time periods as that person may reasonably require.

20.6 The ICB must, on becoming aware of:

20.6.1 any suspected or actual bribery, corruption or fraud involving public funds; or

20.6.2 any suspected or actual security incident or security breach involving Staff or involving NHS resources;

20.6.3 promptly report the matter to NHS England and to the NHS Counter Fraud Authority.

20.7 On the request of NHS England or NHS Counter Fraud Authority, the ICB must allow the NHS Counter Fraud Authority or any person appointed by NHS England, as soon as it is reasonably practicable and in any event not later than 5 Operational Days following the date of the request, access to:

20.7.1 all property, premises, information (including records and data) owned or controlled by the ICB; and

20.7.2 all Staff who may have information to provide;

20.7.3 relevant to the detection and investigation of cases of bribery, fraud or corruption, or security incidents or security breaches directly or indirectly in connection with this Agreement.

21. CONFIDENTIAL INFORMATION OF THE PARTIES

21.1 Except as this Agreement otherwise provides, Confidential Information is owned by the disclosing Party and the receiving Party has no right to use it.

21.2 Subject to clauses 21.3 to 21.5, the receiving Party agrees:

21.2.1 to use the disclosing Party's Confidential Information only in connection with the receiving Party's performance under this Agreement;

21.2.2 not to disclose the disclosing Party's Confidential Information to any third party or to use it to the detriment of the disclosing Party; and

21.2.3 to maintain the confidentiality of the disclosing Party's Confidential Information.

21.3 The receiving Party may disclose the disclosing Party's Confidential Information:

21.3.1 in connection with any Dispute Resolution;

21.3.2 in connection with any litigation between the Parties;

21.3.3 to comply with the Law;

21.3.4 to any appropriate Regulatory or Supervisory Body;

21.3.5 to its Staff, who in respect of that Confidential Information will be under a duty no less onerous than the Receiving Party's duty under clause 21.2;

21.3.6 to NHS Bodies for the purposes of carrying out their functions;

21.3.7 as permitted under or as may be required to give effect to clause 20 (*NHS Counter-Fraud*); and

21.3.8 as permitted under any other express arrangement or other provision of this Agreement.

21.4 The obligations in clauses 21.1 and 21.2 will not apply to any Confidential Information which:

21.4.1 is in or comes into the public domain other than by breach of this Agreement;

21.4.2 the receiving Party can show by its records was in its possession before it received it from the disclosing Party; or

21.4.3 the receiving Party can prove it obtained or was able to obtain from a source other than the disclosing Party without breaching any obligation of confidence.

21.5 This clause 21 does not prevent NHS England from making use of or disclosing any Confidential Information disclosed by the ICB where necessary for the purposes of exercising its functions in relation to the ICB.

21.6 The Parties acknowledge that damages would not be an adequate remedy for any breach of this clause 21 by the receiving Party, and in addition to any right to damages, the disclosing Party will be entitled to the remedies of injunction, specific performance and other equitable relief for any threatened or actual breach of this clause 21.

21.7 This clause 21 will survive the termination of this Agreement for any reason for a period of 5 years.

21.8 This clause 21 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

22. INTELLECTUAL PROPERTY

22.1 The ICB grants to NHS England a fully paid-up, non-exclusive, perpetual licence to use the ICB Deliverables for the purposes of the exercise of its statutory and contractual functions.

22.2 NHS England grants the ICB a fully paid-up, non-exclusive licence to use the NHS England Deliverables for the purpose of performing this Agreement and the Delegated Functions.

22.3 The ICB must co-operate with NHS England to enable it to understand and adopt Best Practice (including the dissemination of Best Practice to other commissioners or providers of NHS services), and must supply such materials and information in relation to Best Practice as NHS England may reasonably request, and (to the extent that any IPR attaches to Best Practice), grants NHS England a fully paid-up, non-exclusive, perpetual licence for NHS England to use Best Practice IPR for the commissioning and provision of NHS services and to share any Best Practice IPR with other commissioners of NHS services (and other providers of NHS services) to enable those parties to adopt such Best Practice.

23. NOTICES

23.1 Any notices given under this Agreement must be sent by e-mail to the other Party's address set out in the Particulars.

23.2 Notices by e-mail will be effective when sent in legible form, but only if, following transmission, the sender does not receive a non-delivery message.

24. DISPUTES

24.1 This clause does not affect NHS England's right to exercise its functions for the purposes of assessing and addressing the performance of the ICB.

24.2 If a Dispute arises out of or in connection with this Agreement then the Parties must follow the procedure set out in this clause:

24.2.1 either Party must give to the other written notice of the Dispute, setting out its nature and full particulars ("**Dispute Notice**"), together with relevant supporting documents. On service of the Dispute Notice, the Agreement Representatives must attempt in good faith to resolve the Dispute;

24.2.2 if the Agreement Representatives are, for any reason, unable to resolve the Dispute within twenty (20) days of service of the Dispute Notice, the Dispute must be referred to the Chief Executive Officer (or equivalent person) of the ICB and a director of or other person nominated by NHS England (and who has authority from NHS England to settle the Dispute) who must attempt in good faith to resolve it; and

24.2.3 if the people referred to in clause 24.2.2 are for any reason unable to resolve the Dispute within twenty (20) days of it being referred to them, the Parties may attempt to settle it by mediation in accordance with the CEDR model mediation procedure. Unless otherwise agreed between the Parties, the mediator must be nominated by CEDR Solve. To initiate the mediation, a Party must serve notice in writing ('Alternative Dispute Resolution' (**ADR**) **notice**) to the other Party to the Dispute, requesting a mediation. A copy of the ADR notice should be sent to CEDR Solve. The mediation will start not later than ten (10) days after the date of the ADR notice.

24.3 If the Dispute is not resolved within thirty (30) days after service of the ADR notice, or either Party fails to participate or to continue to participate in the mediation before the

expiration of the period of thirty (30) days, or the mediation terminates before the expiration of the period of thirty (30) days, the Dispute must be referred to the Secretary of State, who shall resolve the matter and whose decision shall be binding upon the Parties.

25. VARIATIONS

25.1 The Parties acknowledge that the scope of the Delegated Functions may be reviewed and amended from time to time including by revoking this Agreement and making alternative arrangements.

25.2 NHS England may notify the ICB of a Variation Proposal in respect of this Agreement.

25.3 The Variation Proposal will set out the variation proposed and the date on which NHS England requires the variation to take effect.

25.4 The ICB must respond to a Variation Proposal within thirty (30) Operational Days following the date that it is issued by serving notice on NHS England confirming either:

25.4.1 that it accepts the Variation Proposal; or

25.4.2 that it refuses to accept the Variation Proposal, and sets out reasonable grounds for that refusal.

25.5 If the ICB accepts the Variation Proposal, the ICB agrees (without delay) to take all necessary steps (including executing a variation agreement) in order to give effect to any variation by the date on which the proposed variation will take effect as set out in the Variation Proposal.

25.6 If the ICB refuses to accept the Variation Proposal or to take such steps as are required to give effect to the variation, NHS England may terminate this Agreement in respect of some or all of the Delegated Functions.

25.7 The provisions of this clause 25 are without prejudice to the ability of NHS England to issue Contractual Notices which have the effect of varying this Agreement.

26. TERMINATION

26.1 The ICB may:

26.1.1 notify NHS England that it requires NHS England to revoke the Delegation; and

26.1.2 terminate this Agreement;

with effect from the end of 31 March in any calendar year, provided that:

26.1.3 on or before 30 September of the previous calendar year, the ICB sends written notice to NHS England of its requirement that NHS England revoke the Delegation and intention to terminate this Agreement; and

26.1.4 the ICB meets with NHS England within ten (10) Operational Days of NHS England receiving the notice set out at clause 26.1.3 above to discuss arrangements for termination and transition of the Delegated Functions to a successor commissioner,

in which case NHS England shall revoke the Delegation and this Agreement shall terminate with effect from the end of 31 March in the next calendar year.

26.2 NHS England may revoke the Delegation in whole or in part with effect from 23.59 hours on 31 March in any year, provided that it gives notice to the ICB of its intention to

terminate the Delegation on or before 30 September in the year prior to the year in which the Delegation will terminate, and in which case clause 26.4 will apply.

26.3 The Delegation may be revoked in whole or in part, and this Agreement may be terminated by NHS England at any time, including in (but not limited to) the following circumstances:

26.3.1 the ICB acts outside of the scope of its delegated authority;

26.3.2 the ICB fails to perform any material obligation of the ICB owed to NHS England under this Agreement;

26.3.3 the ICB persistently commits non-material breaches of this Agreement;

26.3.4 NHS England is satisfied that its intervention powers under section 14Z61 of the NHS Act apply;

26.3.5 to give effect to legislative changes, including conferral of any of the Delegated or Reserved Functions on the ICB;

26.3.6 failure to agree to a variation in accordance with clause 25 *(Variations)*;

26.3.7 NHS England and the ICB agree in writing that the Delegation shall be revoked and this Agreement shall terminate on such date as is agreed; and/or

26.3.8 the ICB merges with another ICB or other body.

26.4 This Agreement will terminate upon revocation or termination of the full Delegation (including revocation and termination in accordance with this clause 26 *(Termination)*) except that the provisions referred to at clause 28 (*Provisions Surviving Termination*) will continue in full force and effect.

26.5 Without prejudice to clause 13.3 and to avoid doubt, NHS England may waive any right to terminate this Agreement under this clause 26.5 *(Termination)*. Any such waiver is only effective if given in writing and shall not be deemed a waiver of any subsequent right or remedy.

26.6 As an alternative to termination of the Agreement in respect of all the Delegated Functions, NHS England may alternatively terminate the Agreement in respect of specified Delegated Functions (or aspects of such Delegated Functions) only, in which case this Agreement shall otherwise remain in effect.

27. CONSEQUENCE OF TERMINATION

27.1 Termination of this Agreement, or termination of the ICB's exercise of any of the Delegated Functions, will not affect any rights or liabilities of the Parties that have accrued before the date of that termination or which later accrue.

27.2 Subject to clause 27.4, on or pending termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, NHS England, the ICB and if appropriate any successor delegate will:

27.2.1 agree a plan for the transition of the Delegated Functions from the ICB to the successor delegate, including details of the transition, the Parties' responsibilities in relation to the transition, the Parties' arrangements in respect of those staff engaged in the Delegated Functions and the date on which the successor delegate will take responsibility for the Delegated Functions;

27.2.2 implement and comply with their respective obligations under the plan for transition agreed in accordance with clause 27.2.1 above; and

27.2.3 act with a view to minimising any inconvenience or disruption to the commissioning of healthcare in the Area.

27.3 For a reasonable period before and after termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, the ICB must:

27.3.1 co-operate with NHS England and any successor delegate in order to ensure continuity and a smooth transfer of the Delegated Functions; and

27.3.2 at the reasonable request of NHS England:

(a) promptly provide all reasonable assistance and information to the extent necessary to effect an orderly assumption of the Delegated Functions by a successor delegate;

(b) deliver to NHS England all materials and documents used by the ICB in the exercise of any of the Delegated Functions; and

27.3.3 use all reasonable efforts to obtain the consent of third parties to the assignment, novation or termination of existing contracts between the ICB and any third party which relate to or are associated with the Delegated Functions.

27.4 Where any or all of the Delegated Functions or Reserved Functions are to be directly conferred on the ICB, the Parties will co-operate with a view to ensuring continuity and a smooth transfer to the ICB.

28. PROVISIONS SURVIVING TERMINATION

28.1 Any rights, duties or obligations of any of the Parties which are expressed to survive, including those referred to in clause 28.2, or which otherwise by necessary implication survive the termination for any reason of this Agreement, together with all indemnities, will continue after termination, subject to any limitations of time expressed in this Agreement.

28.2 The surviving provisions include the following clauses together with such other provisions as are required to interpret and give effect to them:

28.2.1 Clause 9 (*Finance*);

28.2.2 Clause 12 (*Staffing and Workforce*);

28.2.3 Clause 15 *(Liability and Indemnity*);

28.2.4 Clause 16 (*Claims and Litigation*);

28.2.5 Clause 17 (*Data Protection, Freedom of Information and Transparency*);

28.2.6 Clause 24 (*Disputes*);

28.2.7 Clause 26 (*Termination*);

28.2.8 Schedule 4 (*Further Information Governance and Sharing Provisions*).

29. COSTS

29.1 Each Party is responsible for paying its own costs and expenses incurred in connection with the negotiation, preparation and execution of this Agreement.

30. **SEVERABILITY**

30.1 If any provision or part of any provision of this Agreement is declared invalid or otherwise unenforceable, that provision or part of the provision as applicable will be severed from this Agreement. This will not affect the validity and/or enforceability of the remaining part of that provision or of other provisions.

31. **GENERAL**

31.1 Nothing in this Agreement will create a partnership or joint venture or relationship of principal and agent between NHS England and the ICB.

31.2 A delay or failure to exercise any right or remedy in whole or in part shall not waive that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy.

31.3 This Agreement does not give rise to any rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this Agreement.

SCHEDULE 1

Definitions and Interpretation

1. The headings in this Agreement will not affect its interpretation.

2. Reference to any statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance, includes a reference to that statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance as from time to time updated, amended, extended, supplemented, re-enacted or replaced in whole or in part.

3. Reference to a statutory provision includes any subordinate legislation made from time to time under that provision.

4. References to clauses and schedules are to the clauses and schedules of this Agreement, unless expressly stated otherwise.

5. References to any body, organisation or office include reference to its applicable successor from time to time.

6. Any references to this Agreement or any other documents or resources includes reference to this Agreement or those other documents or resources as varied, amended, supplemented, extended, restated and/or replaced from time to time and any reference to a website address for a resource includes reference to any replacement website address for that resource.

7. Use of the singular includes the plural and vice versa.

8. Use of the masculine includes the feminine and all other genders.

9. Use of the term “including” or “includes” will be interpreted as being without limitation.

10. The following words and phrases have the following meanings:

Additional Pharmaceutical Services	Services provided in accordance with a direction under section 127 of the NHS Act (also referred to as advanced services and enhanced services in the Pharmaceutical Regulations);
Agreement	means this agreement between NHS England and the ICB comprising the Particulars, the Terms and Conditions, the Schedules and the Mandated Guidance;
Agreement Representatives	means the ICB Representative and the NHS England Representative as set out in the Particulars;
Annual Allocation	means the funds allocated to the ICB annually under section 223G of the NHS Act
APMS Contract	means an agreement or contract for the provision of primary medical services made under section 83(2) of the NHS Act (including any arrangements which are made in reliance on a combination of that section and other powers to arrange for primary medical services);
Area	means the area described in the Particulars;

Assigned Staff	means those NHS England staff as agreed between NHS England and the ICB from time to time;
Best Practice	means any methodologies, pathway designs and processes relating to this Agreement or the Delegated Functions developed by the ICB or its Staff for the purposes of delivering the Delegated Functions and which are capable of wider use in the delivery of healthcare services for the purposes of the NHS, but not including inventions that are capable of patent protection and for which patent protection is being sought or has been obtained, registered designs, or copyright in software;
Caldicott Principles	means the patient confidentiality principles set out in the report of the Caldicott Committee (December 1997 as amended by the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*) and now included in the NHS Confidentiality Code of Practice, as may be amended from time to time;
Capital	shall have the meaning set out in the Capital Investment Guidance or such other replacement Mandated Guidance as issued by NHS England from time to time;
Capital Expenditure Functions	means those functions of NHS England in relation to the use and expenditure of Capital funds (but excluding the Premises Costs Directions Functions);
Capital Investment Guidance	means any Mandated Guidance issued by NHS England from time to time in relation to the development, assurance and approvals process for proposals in relation to: • the expenditure of Capital, or investment in property, infrastructure or information and technology; and • the revenue consequences for commissioners or third parties making such investment;
CEDR	means the Centre for Effective Dispute Resolution;
Claims	means, for or in relation to the Delegated Functions (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or the Secretary of State, any governmental, regulatory or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by, any governmental, regulatory or similar body or agency;
Claim Losses	means all Losses arising in relation to any Claim;
Combined Authority	means a body of that name established under the provisions of the Local Democracy, Economic Development and Construction Act 2009;
Community Dental Services	means specialised dental services commissioned for patients who are unable to access treatment from Primary Dental

	Services due to a disability or medical condition, being a form of Prescribed Dental Service;
Community Pharmacy Contractual Framework	means the Community Pharmacy Contractual Framework as published by the Department of Health and Social Care from time to time;
Complaints Regulations	means the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009/309;
Confidential Information	means any information or data in whatever form disclosed, which by its nature is confidential or which the disclosing Party acting reasonably states in writing to the receiving Party is to be regarded as confidential, or which the disclosing Party acting reasonably has marked 'confidential' (including, financial information, strategy documents, tenders, employee confidential information, development or workforce plans and information, and information relating to services) but which is not information which is disclosed in response to a FOIA request, or information which is published as a result of NHS England or government policy in relation to transparency;
Contracts	Means any Prescribed Dental Services Contract, Primary Care Contract or Arrangement or other contract or arrangement in respect of the commissioning of any other Delegated Services;
Contractual Notice	means a contractual notice issued by NHS England to the ICB, or some or all ICBs (as the case may be), from time to time and relating to the allocation of contracts for the purposes of the Delegated Functions and/or the manner in which the Delegated Functions should be exercised by the ICB;
CQC	means the Care Quality Commission;
Data Controller	shall have the same meaning as set out in the UK GDPR;
Data Guidance	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency and the Information Commissioner;
Data Processor	shall have the same meaning as set out in the UK GDPR;
Data Protection Legislation	means the UK GDPR, the Data Protection Act 2018 and all applicable Law concerning privacy, confidentiality or the processing of personal data including but not limited to the Human Rights Act 1998, the Health and Social Care (Safety

	and Quality) Act 2015, the common law duty of confidentiality and the Privacy and Electronic Communications (EC Directive) Regulations 2003;
Data Sharing Agreement	means a data sharing agreement which should be in substantially the same form as the Data Sharing Agreement template shared by NHS England in respect of this Agreement;
Data Subject	shall have the same meaning as set out in the UK GDPR;
Delegated Functions	means the statutory functions delegated by NHS England to the ICB under the Delegation and as set out in detail in this Agreement;
Delegated Funds	means the funds defined in Clause 9.2;
Delegated Services	Means the services commissioned in exercise of the Delegated Functions;
Delegation	means the delegation of the Delegated Functions from NHS England to the ICB as described at clause 6.1;
Dental Care Services	means: (i) Primary Dental Services; and (ii) the Prescribed Dental Services;
Dental Services Contract	means: (i) a GDS Contract; (ii) a PDS Agreement (except for any Community Dental Services PDS Agreement, which constitutes a Prescribed Dental Services Contract); and (iii) any other contract for the provision of health services made pursuant to NHS England's functions under Part 5 of the NHS Act; in each case as amended or replaced from time to time and including all ancillary or related agreements directly relating to the subject matter of such agreements, contracts or arrangements;
Dental Services Provider	means a natural or legal person who holds a Dental Services Contract;
Direct Commissioning Guidance Webpage	means the webpage maintained by NHS England at https://www.england.nhs.uk/commissioning/how-commissioning-is-changing/;
Dispute	a dispute, conflict or other disagreement between the Parties arising out of or in connection with this Agreement;
Effective Date of Delegation	means the Effective Date of Delegation as set out in the Particulars;

EIR	means the Environmental Information Regulations 2004
Enhanced Services	means the nationally defined enhanced services, as set out in such directions made by the Secretary of State pursuant to his powers contained in sections 98A, 114A, 125A and 168A of the NHS Act as are in force from time to time, or which may be prescribed by NHS England under its Reserved Functions, and any other enhanced services schemes locally developed by the ICB in the exercise of its Delegated Functions (and excluding, for the avoidance of doubt, any enhanced services arranged or provided pursuant to the Section 7A Functions);
Escalation Rights	means the escalation rights as defined in clause 14 *(Escalation Rights)*;
Financial Year	shall bear the same meaning as in section 275 of the NHS Act;
FOIA	the Freedom of Information Act 2000;
Further Arrangements	means arrangements for the exercise of Delegated Functions as defined at clause 11.2;
GDS Contract	means a General Dental Services contract made under section 100 of the NHS Act;
GMS Contract	means a General Medical Services contract made under section 84(1) of the NHS Act;
Good Practice	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;
Guidance	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the ICB has a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified to the ICB by any relevant Regulatory or Supervisory Body but excluding Mandated Guidance;
HSCA	means the Health and Social Care Act 2012;
ICB	means an Integrated Care Board established pursuant to section 14Z25 of the NHS Act and named in the Particulars;
ICB Deliverables	all documents, products and materials developed by the ICB or its Staff in relation to this Agreement and the Delegated Functions in any form and required to be submitted to NHS England under this Agreement, including data, reports, policies, plans and specifications;

IG Guidance for Serious Incidents	IG Guidance for Serious Incidents NHS Digital's Checklist Guidance for Information Governance Serious Incidents Requiring Investigation June 2013, available at: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-informationgovernance/data-security-and-protection-toolkit
Indemnity Arrangement	means either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);
Information Law	the UK GDPR, the Data Protection Act 2018, regulations and guidance made under section 13S and section 251 of the NHS Act; guidance made or given under sections 263 and 265 of the HSCA; the Freedom of Information Act 2000; the common law duty of confidentiality; the Human Rights Act 1998 and all other applicable laws and regulations relating to processing of Personal Data and privacy;
IPR	means inventions, copyright, patents, database right, trademarks, designs and confidential know-how and any similar rights anywhere in the world whether registered or not, including applications and the right to apply for any such rights;
Law	means any applicable law, statute, rule, bye-law, regulation, direction, order, regulatory policy, guidance or code, rule of court or directives or requirements of any regulatory body, delegated or subordinate legislation or notice of any regulatory body (including any Regulatory or Supervisory Body);
Local Authority	means a county council in England, a Combined Authority, a district council in England, a London borough council, the Common Council of the City of London or the Council of the Isles of Scilly;
Local Incentive Schemes	means an incentive scheme developed by the ICB in the exercise of its Delegated Functions to extend the range or quality of essential and additional services provided under a Primary Medical Services Contract and support national frameworks in order to meet differing local population needs;
Local Pharmaceutical Services Contract	means • a contract entered into pursuant to section 134 of the NHS Act; or • a contract entered into pursuant to Paragraph 1 of Schedule 12 to the NHS Act;
Local Terms	means the terms set out in Schedule 7 *(Local Terms)* and/or such other Schedule or part thereof as designated as Local Terms;
Losses	means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional

	services) proceedings, demands and charges whether arising under statute, contract or common law;
Managing Conflicts of Interest in the NHS	the NHS publication by that name available at: https://www.england.nhs.uk/about/board-meetings/committees/coi/
Mandated Guidance	means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of the Delegated Functions and issued by NHS England to the ICB as Mandated Guidance from time to time, in accordance with clause 7.2 which at the Effective Date of Delegation shall include the Mandated Guidance set out in the Schedules**;**
National Moderation Panel	Means the NHS England panel in respect of the relevant Delegated Function that will have the delegated authority to approve the ICB arrangements in respect of a Delegated Function;
Need to Know	has the meaning set out in paragraph 6.2 of Schedule 4 (*Further Information Governance and Sharing Provisions)*;
NHS Act	means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022 or other legislation from time to time);
NHS Business Services Authority	means the Special Health Authority established under the NHS Business Services Authority (Establishment and Constitution Order) 2005 SI 2005/2414;
NHS Counter Fraud Authority	means the Special Health Authority established by and in accordance with the NHS Counter Fraud Authority (Establishment, Constitution, and Staff and Other Transfer Provisions) Order 2017/958;
NHS England	means the body established by section 1H of the NHS Act;
NHS England Deliverables	means all documents, products and materials NHS England in which NHS England holds IPRs which are relevant to this Agreement, the Delegated Functions or the Reserved Functions in any form and made available by NHS England to the ICB under this Agreement, including data, reports, policies, plans and specifications;
NHS England Functions	means all functions of NHS England as set out in Legislation excluding any functions that have been expressly delegated;
Non-Personal Data	means data which is not Personal Data;
Out of Hours Contract	means a primary medical services contract for the provision of primary medical services solely during the out of hours period (6.30pm Monday to Thursday until 8am the next day, 6.30pm Friday to 8am Monday, Christmas Day, Good Friday and bank holidays);
Operational Days	a day other than a Saturday, Sunday, Christmas Day, Good Friday or a bank holiday in England;

Particulars	means the Particulars of this Agreement as set out in clause 1 *(Particulars)*;
Party/Parties	means a party or both parties to this Agreement;
PDS Agreement	means a Personal Dental Services Agreement made under section 107 of the NHS Act;
Performers Lists	The lists of healthcare professionals maintained by NHS England pursuant to the National Health Service (Performers Lists) (England) Regulations 2013;
Personal Data	shall have the same meaning as set out in the UK GDPR and shall include references to Special Category Personal Data where appropriate;
Pharmaceutical List	means a list of persons who undertake to provide pharmaceutical services pursuant to regulation 10 of the Pharmaceutical Regulations;
Pharmaceutical Regulations	means the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013/349;
Pharmaceutical Services	means:- (i) services provided pursuant to arrangements under section 126 of the NHS Act; and (ii) Additional Pharmaceutical Services
Pharmaceutical Services Arrangement	means an arrangement for the provision of Pharmaceutical Services, including inclusion in a Pharmaceutical List;
Pharmaceutical Services Provider	means a natural or legal person who is party to a Pharmaceutical Services Arrangement or Local Pharmaceutical Services Contract;
PMS Agreement	means an agreement made in accordance with section 92 of the NHS Act;
Population	means the individuals for whom the ICB is responsible for commissioning health services;
Premises Agreements	means tenancies, leases and other arrangements in relation to the occupation of land for the delivery of services under the Primary Medical Services Contracts;
Premises Costs Directions	means the National Health Service (General Medical Services Premises Costs) Directions 2013, as amended;
Premises Costs Directions Functions	means NHS England's functions in relation to the Premises Costs Directions;
Prescribed Dental Services	means the dental services prescribed by such regulations made pursuant to section 3B(1)(a) of the NHS Act as are in force from time to time (including, for the avoidance of doubt,

services commonly known as secondary care dental services and Community Dental Services);

Prescribed Dental Services Contract means any contract for the provision of Prescribed Dental Services;

Primary Care Contract or Arrangement (PCCA) means:

(i) a Primary Medical Services Contract;

(ii) a Dental Services Contract;

(iii) a Primary Ophthalmic Services Contract;

(iv) a Local Pharmaceutical Services Contract; and

(v) a Pharmaceutical Services Arrangement.

Primary Care Functions means:-

(i) the statutory functions conferred on NHS England under Parts 4, 5, 6 and 7 of the NHS Act and secondary legislation made under those Parts; and

(ii) the other statutory functions conferred on NHS England by either primary legislation, secondary legislation or by arrangement with another person in so far as they are applicable to the discharge of those functions set out at (i) above;

Primary Care Provider means a natural or legal person who holds a Primary Care Contract, or is a Pharmaceutical Services Provider;

Primary Care Provider Personnel means all persons (whether clinical or non-clinical) employed or engaged by a Primary Care Provider or by any Sub-Contractor (including volunteers, agency, locums, casual or seconded personnel) in the provision of Services or any activity related to or connected with the provision of the Services;

Primary Care Services means the services in respect of which NHS England has a duty or power to make arrangements pursuant to the Primary Care Functions;

Primary Dental Services means primary dental care services provided under arrangements made pursuant to Part 5 of the NHS Act, and in accordance with a Dental Services Contract;

Primary Medical Services means primary medical services provided under arrangements made pursuant to Part 4 of the NHS Act, and in accordance with a Primary Medical Services Contract;

Primary Medical Services Contract means:

(i) a PMS Agreement;

(ii) a GMS Contract;

(iii) an APMS Contract; and

(iv) any other contract for the provision of health services made pursuant to NHS England's functions under Part 4 of the NHS Act;

in each case as amended or replaced from time to time and including all ancillary or related agreements directly relating to the subject matter of such agreements, contracts or arrangements but excluding any Premises Agreements and excluding any Out of Hours Contracts[2];

Primary Medical Services Provider means a natural or legal person who holds a Primary Medical Services Contract;

Primary Ophthalmic Services Contract means:

(i) a General Ophthalmic Services Contract; and

(ii) any other contract for the provision of health services made pursuant to NHS England's functions under Part 6 of the NHS Act;

in each case as amended or replaced from time to time and including all ancillary or related agreements directly relating to the subject matter of such agreements, contracts or arrangements;

Primary Ophthalmic Services Provider means a natural or legal person who holds a Primary Ophthalmic Services Contract;

Principles of Best Practice means the Mandated Guidance in relation to property and investment which is to be published either before or after the date of this Agreement;

Prohibited Act the ICB:

(i) offering, giving, or agreeing to give NHS England (or any of their officers, employees or agents) any gift or consideration of any kind as an inducement or reward for doing or not doing or for having done or not having done any act in relation to the obtaining of performance of this Agreement, the Reserved Functions, the Delegation or any other arrangement with the ICB, or for showing or not showing favour or disfavour to any person in relation to this Agreement or any other arrangement with the ICB; and

(ii) in connection with this Agreement, paying or agreeing to pay any commission, other than a payment, particulars of which (including the terms and conditions of the agreement for its payment) have been disclosed in writing to NHS England; or

(iii) committing an offence under the Bribery Act 2010;

QOF means the quality and outcomes framework;

[2] Arrangements for Out of Hours Contracts are dealt with under separate Directions outside of this Agreement and do not form part of any Delegated Functions.

Regulatory or Supervisory Body	means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: (i) CQC; (ii) NHS England; (iii) the Department of Health and Social Care; (iv) the National Institute for Health and Care Excellence; (v) Healthwatch England and Local Healthwatch; (vi) the General Medical Council; (vii) the General Dental Council; (viii) the General Optical Council; (ix) the General Pharmaceutical Council; (x) the Healthcare Safety Investigation Branch; and (xi) the Information Commissioner;
Relevant Information	means the Personal Data and Non-Personal Data processed under the Delegation and this Agreement, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*);
Reserved Functions	means statutory functions of NHS England that it has not delegated to the ICB including but not limited to those set out in the Schedules to this Agreement;
Secretary of State	means the Secretary of State for Health and Social Care from time to time;
Section 7A Functions	means those functions of NHS England exercised pursuant to section 7A of the NHS Act and relating to Primary Care Services;
Section 7A Funds	shall have the meaning in Schedule 10 Part 2;
Special Category Personal Data	shall have the same meaning as in UK GDPR;
Specified Purpose	means the purpose for which the Relevant Information is shared and processed, being to facilitate the exercise of the ICB's Delegated Functions and NHS England's Reserved Functions as specified in paragraph 2.1 of Schedule 4 *(Further Information Governance and Sharing Provisions)* to this Agreement;

Staff or Staffing	means the Parties' employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of either Party (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel;
Staffing Model	means the employment model for the exercise of the Delegated Functions including those as defined in Appendix 2 of the NHS England and NHS Improvement operating models: HR Framework for developing Integrated Care as may be amended or replaced from time to time;
Statement of Financial Entitlements Directions	means the General Medical Services Statement of Financial Entitlements Directions 2021, as amended or updated from time to time;
Sub-Delegate	shall have the meaning in clause 11.2;
Transfer Regulations	means the Transfer of Undertakings (Protection of Employment) Regulations 2006, as amended;
Triple Aim	means the duty to have regard to the wider effects of decisions, which is placed on each of the Parties under section 13NA (as regards NHS England) and section 14Z43 (as regards the ICB) of the NHS Act;
UK GDPR	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018;
Variation Proposal	means a written proposal for a variation to the Agreement, which complies with the requirements of clause 25.3.

SCHEDULE 2

Delegated Functions

Schedule 2A: Primary Medical Services

Part 1: General Obligations

1. Introduction

1.1 This Part 1 of Schedule 2A *(Primary Medical Services)* sets out further provision regarding the carrying out of those Delegated Functions relating to Primary Medical Services, being in summary:

1.1.1 decisions in relation to the commissioning and management of Primary Medical Services;

1.1.2 planning Primary Medical Services in the Area, including carrying out needs assessments;

1.1.3 undertaking reviews of Primary Medical Services in respect of the Area;

1.1.4 management of the Delegated Funds in the Area;

1.1.5 co-ordinating a common approach to the commissioning and delivery of Primary Medical Services with other health and social care bodies in respect of the Area where appropriate; and

1.1.6 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

2. General Obligations

2.1 The ICB is responsible for planning the commissioning of primary medical services.

2.2 The role of the ICB includes:

2.2.1 carrying out needs assessments, and regular reviews of such assessments, to determine the needs of the population in the Area; and

2.2.2 identifying and implementing changes to meet any unmet needs which may be met through the delivery of Primary Medical Services.

2.3 In respect of integrated working, the ICB must:

2.3.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Authorities, Healthwatch, acute and community providers, the Local Medical Committee, and other stakeholders;

2.3.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Primary Medical Services generally; and

2.3.3 work with NHS England to coordinate the exercise of their respective performance management functions.

2.4 In relation to the Delegated Functions, the ICB agrees to perform the following general obligations:

2.4.1 to manage the Primary Medical Services Contracts and perform all of NHS England's obligations under each of the Primary Medical Services Contracts

in accordance with the terms of the Primary Medical Services Contracts as if it were named in the contract in place of NHS England;

2.4.2 actively manage the performance of the Primary Medical Services Provider in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches, serve notices or provide discretionary support;

2.4.3 ensure that it obtains value for money on behalf of NHS England, and avoids making any double payments under any Primary Medical Services Contracts;

2.4.4 notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the ICB of its obligations to perform any of NHS England's obligations under the Primary Medical Services Contracts;

2.4.5 undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;

2.4.6 keep a record of all of the Primary Medical Services Contracts that the ICB manages setting out the following details in relation to each Primary Medical Services Contract:

2.4.6.1 name of the Primary Medical Services Provider;

2.4.6.2 the name by which the Primary Medical Services Provider is known (if different to the name recorded under paragraph 2.4.6.1);

2.4.6.3 location of provision of services; and

2.4.6.4 amounts payable under the Primary Medical Services Contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.5 Without prejudice to clause 9 (*Finance*) of the Agreement or paragraph 2.4 above, the ICB must actively manage each of the relevant Primary Medical Services Contracts including by:

2.5.1 reviewing the performance of the relevant Primary Medical Services Contract, including in respect of quality standards, incentives and the QOF, observance of service specifications, and monitoring of activity and finance;

2.5.2 assessing quality and outcomes (including clinical effectiveness, patient experience, patient safety and addressing inequalities);

2.5.3 managing variations to the relevant Primary Medical Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.5.4 agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);

2.5.5 agreeing local prices, managing agreements or proposals for local variations and local modifications;

2.5.6 conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes; and

2.5.7 complying with and implementing any relevant Mandated Guidance issued from time to time.

2.6 This paragraph is without prejudice to clause 10 (*Information, Planning and Reporting*) or any other provision in this Agreement. The ICB must provide NHS England with:

2.6.1 such information relating to individual Primary Medical Services Providers in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the commissioning or performance of Primary Medical Services Providers;

2.6.2 such data/data sets as required by NHS England to ensure population of any national dashboards;

2.6.3 any other data/data sets as required by NHS England; and

2.6.4 the ICB shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

2.7 It should be noted that while the ICB is also required to exercise functions in respect of dispensing doctors, arrangements in respect of these functions are described in Schedule 2D (Pharmaceutical Services).

Part 2: Specific Obligations

1. Introduction

This Part 2 of Schedule 2A (Delegated Functions – Primary Medical Services) sets out further provision regarding the carrying out of each of the Delegated Functions.

2. Primary Medical Services Contract Management

The ICB must comply with any future national Mandated Guidance on equitable funding as may apply from time to time.

3. Enhanced Services

3.1 The ICB must manage the design (where applicable) and commissioning of any Enhanced Services, including re-commissioning these services annually where appropriate.

3.2 The ICB may consider any local enhanced services entered into with Primary Medical Services Providers in its Area using NHS Standard Contracts. Where these would continue to be beneficial to the Area, the ICB may manage the ongoing design and commissioning (including re-commissioning) of these services via a Local Incentives Scheme.

3.3 The ICB must ensure that it complies with any Mandated Guidance in relation to the design and commissioning of Enhanced Services.

3.4 When commissioning newly designed Enhanced Services the ICB must:

3.4.1 consider the needs of the local population in the Area;

3.4.2 develop the necessary specifications and templates for the Enhanced Services, as required to meet the needs of the local population in the Area;

3.4.3 when developing the necessary specifications and templates for the Enhanced Services, ensure that value for money will be obtained;

3.4.4 consult with Local Medical Committees and other stakeholders and comply with the duty of public involvement and consultation under section 14Z45 of the NHS Act;

3.4.5 liaise with system providers and representative bodies to ensure that the system in relation to the Directed Enhanced Services, NHS England Enhanced Services and Local Enhanced Services will be functional and secure;

3.4.6 support Data Controllers in providing 'fair processing' information as required by the UK GDPR; and

3.4.7 support Primary Medical Services Providers in entering into data processing agreements with data processors in the terms required by the UK GDPR.

4. Design of Local Incentive Schemes

4.1 The ICB may design and offer Local Incentive Schemes for Primary Medical Services Providers, sensitive to the differing needs of their particular communities. This includes in addition to or as an alternative to the national contractual frameworks (including as an alternative to QOF or Enhanced Services), provided that such schemes are voluntary, and the ICB continues to offer the national schemes.

4.2 There is no formal approvals process that the ICB must follow to develop a Local Incentive Scheme, although when designing and implementing any proposed new Local Incentive Scheme the ICB must:

4.2.1 consider the needs of the local population in the Area;

4.2.2 develop the specifications and templates for the Local Incentive Scheme;

4.2.3 consult with Local Medical Committees and other stakeholders and comply with the duty of public involvement and consultation under section 14Z45 of the NHS Act;

4.2.4 liaise with system providers and representative bodies to ensure that the system in relation to the Local Incentive Schemes will be functional and secure;

4.2.5 support Data Controllers in providing privacy information as required by the UK GDPR; and

4.2.6 support Primary Medical Services Providers in entering into data processing agreements with data processors in terms required by the UK GDPR.

4.3 The ICB must be able to:

4.3.1 demonstrate improved outcomes, reduced inequalities and value for money;

4.3.2 support ongoing national reporting requirements (where applicable); and

4.3.3 must reflect the changes agreed as part of the national PMS reviews (https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/05/implement-pms-fund-changes.pdf).

4.4 The ongoing assurance of any new Local Incentive Schemes will form part of the ICB's assurance process under any applicable assurance framework.

4.5 Any new Local Incentive Scheme must be implemented without prejudice to the right of Primary Medical Services Providers operating under a GMS Contract to obtain their entitlements which are negotiated and set nationally.

4.6 NHS England will continue to set national standing rules, to be reviewed annually, and the ICB must comply with these rules which shall for the purposes of this Agreement be Mandated Guidance.

5. Making Decisions on Discretionary Payments or Support

5.1 The ICB must manage and make decisions in relation to any discretionary payments or discretionary support to be made to Primary Medical Services Providers in a consistent, open and transparent way.

5.2 The ICB must exercise its discretion to determine the level of payment or type of support to Primary Medical Services Providers, in accordance with any relevant Mandated Guidance.

6. Making Decisions about Commissioning Urgent Care for Out of Area Registered Patients

6.1 The ICB must manage the design and commissioning of urgent care services (including home visits as required) for its patients registered out of area (including re-commissioning these services annually where appropriate).

6.2 The ICB must ensure that it complies with any Mandated Guidance in relation to the design and commissioning of these services.

6.3 For the purposes of paragraph 6.1, urgent care means the provision of primary medical services on an urgent basis.

7. Transparency and freedom of information

7.1 The ICB must:

7.1.1 Respond to requests for information from members of the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

7.1.2 Provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

8. Planning the Provider Landscape

8.1 The ICB must plan the primary medical services provider landscape in the Area, including considering and taking decisions in relation to:

8.1.1 establishing new Primary Medical Services Providers in the Area;

8.1.2 managing Primary Medical Services Providers providing inadequate standards of patient care;

8.1.3 the procurement or award of new Primary Medical Services Contracts (in accordance with any procurement protocol or Guidance issued by NHS England from time to time);

8.1.4 closure of practices and branch surgeries;

8.1.5 dispersing the patient lists of Primary Medical Services Providers; and

8.1.6 agreeing variations to the boundaries of Primary Medical Services Providers.

8.2 In relation to any new Primary Medical Services Contract to be entered into, the ICB must, without prejudice to any obligation in paragraph 14 (*Procurement and New Contracts*) below, and paragraph 2.5 of Part 1 of this Schedule 2A:

8.2.1 consider and use the form of Primary Medical Services Contract that will ensure compliance with NHS England's obligations under Law taking into account the persons to whom such Primary Medical Services Contracts may be awarded;

8.2.2 provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law; and

8.2.3 for the avoidance of doubt, Schedule 5 (Financial Provisions and Decision Making Limits) deals with the sign off requirements for Primary Medical Services Contracts.

9. Primary Care Networks

9.1 In managing the design and commissioning of the Network Contract Directed Enhanced Services, including re-commissioning these services annually where appropriate, the ICB must plan and manage the Primary Care Networks in the Area, complying with published specifications and Mandated Guidance, including to:

9.1.1 maintain or establish identified Network Areas to support the local population in the Area;

9.1.2 review any waived PCN list size requirements wherever possible and appropriate to best support the local population in the Area;

9.1.3 ensure that each PCN has at all times an accountable Clinical Director;

9.1.4 align each PCN with an ICB that would best support delivery of services to the local population in the Area; and

9.1.5 collaborate and work with other ICBs as appropriate to agree which ICB will be the lead ICB for the PCN.

10. Approving Primary Medical Services Provider Mergers and Closures

10.1 The ICB is responsible for approving Primary Medical Services Provider mergers and Primary Medical Services Provider closures in the Area.

10.2 The ICB must undertake all necessary consultation when taking any decision in relation to Primary Medical Services Provider mergers or Primary Medical Services Provider closures in the Area, including those set out under section 14Z45 of the NHS Act (duty for public involvement and consultation). The consultation undertaken must be appropriate and proportionate in the circumstances and should include consulting with the Local Medical Committee.

10.3 Prior to making any decision in accordance with this paragraph 10 (*Approving Primary Medical Services Provider Mergers and Closures*), the ICB must be able to clearly demonstrate the grounds for such a decision and must have fully considered any impact on the Primary Medical Services Provider's registered population and that of surrounding practices. The ICB must be able to clearly demonstrate that it has considered other options and has entered into dialogue with the Primary Medical Services Provider as to how any closure or merger will be managed.

10.4 In making any decisions pursuant to this paragraph 10 (*Approving Primary Medical Services Provider Mergers and Closures*), the ICB shall act in accordance with relevant Mandated Guidance and also take account of its obligations as set out in paragraph 14 *(Procurement and New Contracts)*, below, where applicable.

11. Making Decisions in relation to Management of Poorly Performing Primary Medical Services Providers

11.1 The ICB must make decisions in relation to the management of poorly performing Primary Medical Services Provider including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the Performers List).

11.2 In accordance with paragraph 11.1 above, the ICB must:

11.2.1 ensure regular and effective collaboration with the CQC to ensure that information on general practice is shared and discussed in an appropriate and timely manner;

11.2.2 ensure that any risks identified are managed and escalated where necessary;

11.2.3 respond to CQC assessments of Primary Medical Services Providers where improvement is required;

11.2.4 where a Primary Medical Services Provider is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and

11.2.5 take appropriate contractual action, including (without limitation) in response to CQC findings.

12. Premises Costs Directions Functions

12.1 The ICB must comply with the Premises Costs Directions and will be responsible for making decisions in relation to the Premises Costs Directions Functions.

12.2 In particular, but without limiting paragraph 12.1, the ICB shall make decisions concerning:

12.2.1 applications for new payments under the Premises Costs Directions (whether such payments are to be made by way of grants or in respect of recurring premises costs); and

12.2.2 revisions to existing payments being made under the Premises Costs Directions.

12.3 The ICB must comply with any decision-making limits set out in Schedule 5 (*Financial Provisions and Decision Making Limits*) when taking decisions in relation to the Premises Costs Directions Functions.

12.4 The ICB will comply with any Guidance issued by the Secretary of State or NHS England in relation to the Premises Costs Directions, including the Principles of Best Practice, and any other Mandated Guidance in relation to the Premises Costs Directions.

12.5 The ICB must work to ensure that the premises estate is properly managed and maintained, including by ensuring strategic estates planning is in place, and work cooperatively with other ICBs as appropriate.

12.6 The ICB must ensure it maintains comprehensive records of the primary care estate and any changes to it.

12.7 The ICB must liaise where appropriate with NHS Property Services Limited and Community Health Partnerships Limited in relation to the Premises Costs Directions Functions.

12.8 The ICB must prioritise the following measures in respect of management of the primary care estate in the Area:

12.8.1 working collaboratively with landlords and tenants to maximise the use of existing estate;

12.8.2 effective asset management practices including (without limitation) regularisation of the occupation of the estate, lease events, rent reviews and up-to-date documentation management; and

12.8.3 seeking the resolution of premises disputes in a timely manner.

13. Maintaining the Performers List

On receiving a notice from a practitioner (who is party to a Primary Medical Services Contract) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the Performers List as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.

14. Procurement and New Contracts

14.1 Until any new arrangements for awarding Primary Medical Services Contracts comes into force, the ICB will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

14.2 In discharging its responsibilities set out in this Schedule 2A, the ICB must comply at all times with Law and any relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services).

14.3 On the coming into force of new arrangements for awarding Primary Medical Services Contracts, the ICB will make decisions on awarding new contracts relevant to the exercise of the Delegated Functions.

14.4 When the ICB makes decisions in connection with the awarding of Primary Medical Services Contracts it should ensure that it is able to demonstrate compliance with requirements for the award of Primary Medical Services Contracts, including that the decision was:

14.4.1 made in the best interest of patients, taxpayers and the population;

14.4.2 robust and defensible, with conflicts of interests appropriately managed;

14.4.3 made transparently; and

14.4.4 compliant with the rules of the regime as set out in NHS England guidance.

14.5 Where the ICB wishes to develop and offer a locally designed contract, it must ensure that it has consulted with the relevant Local Medical Committees in relation to the proposal and that it can demonstrate that the scheme will:

14.5.1 improve outcomes for patients;

14.5.2 reduce inequalities in the population; and

14.5.3 provide value for money.

15. Complaints

15.1 The ICB will handle complaints made in respect of Primary Medical Services in accordance with the Complaints Regulations.

16. Commissioning ancillary support services

16.1 The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

16.1.1 collection and disposal of clinical waste;

16.1.2 provision of translation and interpretation services;

16.1.3 occupational health services.

17. Finance

Further requirements in respect of finance will be specified in Mandated Guidance.

18. Workforce

18.1 The arrangements for the provision and maintenance of sufficient and appropriately qualified, trained and experienced Staff in order for the ICB to fulfil its responsibilities for each of the Delegated Functions ("the Staffing Model"), will be communicated formally to the ICB by NHS England following recommendations made by the National Moderation Panel.

18.2 The ICB is not permitted to vary the Staffing Model agreed with NHS England as part of its application for delegation of the said functions however a variation can be applied for by the ICB and considered by the National Moderation Panel at any time.

Schedule 2B: Dental Care Services

The provisions of this Schedule 2B form part of this Agreement only where indicated in the Particulars.

Part 1A: General Obligations – Primary Dental Services

1. Introduction

1.1 This Part 1A of Schedule 2B *(Dental Care Services)* sets out general provisions regarding the carrying out of those Delegated Functions relating to Primary Dental Services, being in summary:

1.1.1 decisions in relation to the commissioning and management of Primary Dental Services;

1.1.2 planning Primary Dental Services in the Area, including carrying out needs assessments;

1.1.3 undertaking reviews of Primary Dental Services in the Area;

1.1.4 management of the Delegated Funds in the Area;

1.1.5 co-ordinating a common approach to the commissioning and delivery of Primary Dental Services with other health and social care bodies in respect of the Area where appropriate; and

1.1.6 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

2. General Obligations

2.1 The ICB is responsible for planning the commissioning of Primary Dental Services.

2.2 When planning and commissioning Primary Dental Services, the ICB must comply with Mandated Guidance issued by NHS England.

2.3 In respect of integrated working, the ICB must:

2.3.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Dental Professional Networks, Local Authorities, Healthwatch, acute and community providers, the Local Dental Committee, and other stakeholders;

2.3.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Primary Dental Services generally; and

2.3.3 work with NHS England to coordinate the exercise of their respective performance management functions.

2.4 In relation to the Delegated Functions, the ICB agrees to perform the following general obligations with regard to Dental Services Contracts:

2.4.1 to manage the Dental Services Contracts and perform all of NHS England's obligations under each of the Dental Services Contracts in accordance with the terms of the Dental Services Contracts as if it were named in the contract in place of NHS England;

2.4.2 working with other organisations, including the NHS Business Services Authority and the NHS England specialised commissioning team as appropriate, actively manage the performance of the Dental Services Provider in order to secure the needs of people who use the services,

improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches, serve notices or provide discretionary support;

2.4.3 ensure that it obtains value for money on behalf of NHS England, including by avoiding making any double payments under any Dental Services Contracts and reducing the number of contracts which are under-delivering so that funds can be reallocated to meet local oral health needs;

2.4.4 notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the ICB of its obligations to perform any of NHS England's obligations under the Dental Services Contracts;

2.4.5 undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;

2.4.6 keep a record of all of the Dental Services Contracts that the ICB manages on behalf of NHS England setting out the following details in relation to each Dental Services Contract:

2.4.6.1 name of Dental Services Provider;

2.4.6.2 any practice or trading name by which the Dental Services Provider is known (if different to the name recorded under paragraph 2.4.6.1);

2.4.6.3 location of provision of services; and

2.4.6.4 amounts payable under the contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.5 Without prejudice to clause 9 *(Finance)* or paragraph 2.4 above, the ICB must actively manage each of the relevant Dental Services Contracts including by:

2.5.1 reviewing and monitoring spending on services provided pursuant to Dental Services Contracts in the Area;

2.5.2 reviewing and monitoring spending on Primary Dental Services commissioned in the Area;

2.5.3 creating purchase orders, coding invoices and making appropriate amendments within the Compass contractor payments system;

2.5.4 managing the relevant Dental Services Contract, including in respect of quality standards, incentives, observance of service specifications, and monitoring of activity and finance;

2.5.5 assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);

2.5.6 managing variations to the relevant Dental Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.5.7 agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);

2.5.8 undertaking annual contract activity negotiations, including agreeing local prices, managing agreements or proposals for local variations and local modifications;

2.5.9 conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes;

2.5.10 allocating sufficient resources for undertaking contract mediation; and

2.5.11 complying with and implementing any relevant Mandated Guidance issued from time to time.

2.6 This paragraph is without prejudice to clause 10 *(Information, Planning and Reporting)* or any other provision in this Agreement. The ICB must provide NHS England with:

2.6.1 such information relating to individual providers of Primary Dental Services in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the commissioning or performances of providers of Primary Dental Services;

2.6.2 such data/data sets as required by NHS England to ensure population of any national dashboards;

2.6.3 any other data/data sets as required by NHS England; and

2.6.4 the ICB shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

Part 1B: Specific Obligations – Primary Dental Services only

1. Introduction

1.1 This Part 1B of Schedule 2B *(Dental Care Services)* sets out further provision regarding the carrying out of each of the Delegated Functions in relation to Primary Dental Services.

2. Dental Services Contract Management

2.1 The ICB must:

2.1.1 comply with all current and future relevant national Mandated Guidance regarding contract reviews;

2.1.2 monitor contract performance and primary care dental spending, with a view in particular to achieving a reduction in the number of contract holders who are under-delivering, and the reallocation of unused resources to meet the oral health needs of the Area; and

2.1.3 in cooperation with the NHS Business Services Authority, monitor contract performance with a view in particular to addressing patient safety concerns and promoting patient safety.

2.2 The ICB must undertake the annual reconciliation of monies claimed by providers against the services provided under any contract for the provision of Dental Care Services made pursuant to NHS England's functions under Part 5 of the NHS Act procuring such ancillary support services as are required for the performance of this function.

3. Transparency and freedom of information

3.1 The ICB must:

3.1.1 respond to requests for information from members of the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

3.1.2 provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

4. Planning the Provider Landscape

4.1 The ICB must plan the provider landscape in the Area, including considering and taking decisions in relation to:

4.1.1 establishing new Dental Services Providers in the Area;

4.1.2 managing Dental Services Providers providing inadequate standards of patient care;

4.1.3 the procurement or award of new Dental Services Contracts (in accordance with any procurement protocol or Guidance issued by NHS England from time to time); and

4.1.4 closure of practices.

4.2 In relation to any new Dental Services Contract to be entered into, the ICB must, without prejudice to any obligation in paragraph 9 (*Procurement and New Contracts*), below:

4.2.1 consider and use the form of Dental Services Contract that will ensure compliance with NHS England's obligations under Law taking into account the persons to whom such Dental Services Contracts may be awarded;

4.2.2 provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law; and

4.2.3 for the avoidance of doubt, Schedule 5 (*Financial Provisions and Decision Making Limits*) deals with the sign off requirements for Dental Services Contracts.

5. Finance

5.1 Further requirements in respect of finance will be specified in Mandated Guidance.

6. Staffing and Workforce

6.1 Subject to the terms of this Agreement, the Delegated Functions will be carried out by NHS England Staff in accordance with decisions concerning the Delegated Functions made by the ICB unless the Staff carrying out the Delegated Functions have transferred to the ICB (and/or the ICB has engaged or employed Staff for that purpose).

6.2 The arrangements for the provision and maintenance of sufficient and appropriately qualified, trained and experienced Staff in order for the ICB to fulfil its responsibilities for each of the Delegated Functions ("the Staffing Model"), will be communicated formally to the ICB by NHS England following recommendations made by the National Moderation Panel. Further requirements in respect of workforce will be specified in Mandated Guidance.

6.3 The ICB is not permitted to vary the Staffing Model agreed with NHS England as part of its application for delegation of the said functions however a variation can be applied for by the ICB and considered by the National Moderation Panel at any time.

7. Integrating dentistry into communities at Primary Care Network level

7.1 The ICB must exercise the Delegated Functions with a view to achieving greater integration of dentists into the Integrated Care System at the Primary Care Network level.

8. Making Decisions in relation to Management of Poorly Performing Dental Services Providers

8.1 The ICB must make decisions in relation to the management of poorly performing Dental Services Provider including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the Performers List).

8.2 In accordance with paragraph 8.1 above, the ICB must:

8.2.1 ensure regular and effective collaboration with the CQC to ensure that information is shared and discussed in an appropriate and timely manner;

8.2.2 ensure that any risks identified are managed and escalated where necessary;

8.2.3 respond to CQC assessments of Dental Services Providers where improvement is required;

8.2.4 where a Dental Services Provider is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and

8.2.5 take appropriate contractual action including (without limitation) in response to CQC findings.

9. Maintaining the Performers List

On receiving a notice from a practitioner (who is party to a Dental Services Contract) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the Performers List as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.

10. Procurement and New Contracts

10.1 Until any new arrangements for awarding Dental Services Contracts come into force, the ICB will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

10.2 In discharging its responsibilities set out in this Schedule 2B, the ICB must comply at all times with Law and all relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services).

10.3 On the coming into force of new arrangements for awarding Dental Services Contracts, the ICB will make decisions on awarding new contracts relevant to the exercise of the Delegated Functions.

10.4 When the ICB makes decisions in connection with the awarding of Dental Services Contracts it should ensure that it is able to demonstrate compliance with requirements for the award of Dental Services Contracts, including that the decision was:

10.4.1 made in the best interest of patients, taxpayers and the population;

10.4.2 robust and defensible, with conflicts of interests appropriately managed;

10.4.3 made transparently, and

10.4.4 compliant with the rules of the regime as set out in NHS England guidance.

11. Complaints

11.1 The ICB will handle all complaints made in respect of Primary Dental Services in accordance with the Complaints Regulations.

12. Commissioning Ancillary Support Services

12.1 The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

12.1.1 provision of translation and interpretation services; and

12.1.2 occupational health services.

Part 2A: General Obligations – Prescribed Dental Services

1. Introduction

1.1 This Part 2A of Schedule 2B *(Dental Care Services)* sets out general provisions regarding the carrying out of those Delegated Functions relating to Prescribed Dental Services. Prescribed Dental Services constitute Community Dental Services and Secondary Care Dental Services. These include:

1.1.1 decisions in relation to the commissioning and management of Prescribed Dental Services;

1.1.2 planning Prescribed Dental Services in the Area, including carrying out needs assessments;

1.1.3 undertaking reviews of Prescribed Dental Services in the Area;

1.1.4 management of the Delegated Funds in respect of Prescribed Dental Services in the Area;

1.1.5 co-ordinating a common approach to the commissioning and delivery of Prescribed Dental Services with other health and social care bodies where appropriate; and

1.1.6 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

1.2 For the purposes of this Schedule 2B, "Secondary Care Dental Services" refers to Prescribed Dental Services which are not Community Dental Services.

2. General Obligations

2.1 The ICB is responsible for commissioning Prescribed Dental Services for its Population which for the purpose of this Part 2A of Schedule 2B *(Dental Care Services)*, shall refer to a group of people for whom the ICB has core responsibility, as established under the rules published by NHS England under section 14Z31 of the Act.

2.2 In respect of integrated working, the ICB must take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Dental Professional Networks, Local Authorities, Healthwatch, acute and community providers, the Local Dental Committee, managed clinical networks and other stakeholders.

2.3 When planning and commissioning Prescribed Dental Services, the ICB must comply with Mandated Guidance issued by NHS England.

2.4 The provisions of Paragraph 2.4, 2.5 and 2.6 of Part 1A of this Schedule 2B shall apply in respect of Prescribed Dental Services as if "Dental Services Contract" includes all contracts for Prescribed Dental Services and "Primary Dental Services" include Prescribed Dental Services.

2.5 In awarding any new contract for Prescribed Dental Services, the ICB must:

2.5.1 comply with Law and all relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services);

2.5.2 use the current NHS Standard Contract published by NHS England from time to time; or an appropriate contract for the provision of Dental Care Services made pursuant to NHS England's functions under Part 5 of the NHS Act; and

2.5.3 where the NHS Standard Contract is used, pay for the Services in accordance with the NHS Payment Scheme (as defined in the Health and Social Care Act 2012).

Part 2B: Specific Obligations – Prescribed Dental Services

1. Introduction

1.1 This Part 2B of Schedule 2B *(Prescribed Dental Care Services)* sets out further provision regarding the carrying out of each of the Delegated Functions in relation to Prescribed Dental Services.

2. Community Dental Services Commissioning Obligations

2.1 Community Dental Services may currently be contracted for by way of either an NHS Standard Contract or a PDS Agreement, as appropriate to the particular service. Accordingly:

2.1.1 where Community Dental Services are commissioned on PDS Agreement terms (or it is appropriate to commission a new agreement for Community Dental Services on a PDS Agreement or other agreement made pursuant to NHS England's functions under Part 5 of the NHS Act), those contracts must be managed in accordance with the relevant provisions of Part 1A and Part 1B of this Schedule 2B as if they were Primary Dental Services for the purposes of that Part. The provisions of this Part 2A of Schedule 2B also apply; and

2.1.2 where Community Dental Services are commissioned on NHS Standard Contract terms, the provisions of this Part 2A of Schedule 2B apply in full.

3. Secondary Care Dental Services Commissioning Obligations

3.1 For the first financial year following delegation of Secondary Care Dental Services to the ICB (the "Initial Year of Delegation"), the Secondary Care Dental Services shall be commissioned through wider NHS Standard Contracts made between NHS England and the relevant providers that a) cover the whole population of England; and b) typically also cover other services. Accordingly, unless otherwise stated within a Contractual Notice, for the Initial Year of Delegation ONLY the following shall apply:

3.1.1 The commissioning responsibility for the Secondary Care Dental Service elements of the relevant NHS Standard Contracts is delegated to the ICB to the extent that they relate to its Population;

3.1.2 NHS England is, and will remain, the "co-ordinating commissioner" (as defined in the NHS Standard Contract) for those contracts, meaning that NHS England retains core contract management responsibility;

3.1.3 Delegation of commissioning responsibility for the Secondary Care Dental service elements of the relevant NHS Standard Contracts is permitted by clause GC12 of those contracts. NHS England has confirmed these delegation arrangements by letter to each affected provider so that they are aware of the ICB's role as Secondary Care Dental Services commissioner.

3.1.4 whilst the ICB is commissioner of the Secondary Care Dental Service elements of the contract that relate to its Population, it does not have any direct contract management role and must work with NHS England as co-ordinating commissioner, raising any contractual issues with NHS England for consideration and any appropriate action;

3.1.5 The ICB shall ensure that contractual payments are made to providers for the provision of Secondary Care Dental Services in respect of the ICB's Population, as required by the terms of those contracts. This may represent only a proportion of the overall payment due to the provider for Secondary Care Dental Services delivered more widely under that contract.

3.2 For all subsequent financial years following the Initial Year of Delegation the ICB will be responsible for ensuring that appropriate contractual arrangements are in place to ensure continuity of Secondary Care Dental Services for its Population.

4. Prescribed Dental Services Contract Management

4.1 Subject to Paragraph 4.2 of this Part 2B of Schedule 2B, the ICB must:

4.1.1 comply with all current and future relevant national Mandated Guidance regarding contract reviews;

4.1.2 monitor contract performance and prescribed care dental spending, with a view in particular to ensuring the delivery of agreed contract activity, and the reallocation of unused resources to meet the oral health needs of the Area;

4.1.3 monitor contract performance with a view in particular to addressing patient safety concerns and promoting patient safety; and

4.1.4 ensure appropriate oversight of the Prescribed Dental Services, including, where appropriate, procuring such ancillary support services as are required for the performance of this function.

4.2 For the Initial Year of Delegation in respect of Secondary Care Dental Services the requirements set out in paragraph 4.1 of this Part 2B of Schedule 2B do not apply and the terms of the relevant Contractual Notice shall apply.

5. Transparency and freedom of information

5.1 The ICB must:

5.1.1 respond to requests for information from members of the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

5.1.2 provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

6. Planning the Provider Landscape

6.1 The ICB must plan the provider landscape in the Area, including considering and taking decisions in relation to:

6.1.1 establishing new providers of Prescribed Dental Services in the Area;

6.1.2 managing providers of Prescribed Dental Services providing inadequate standards of patient care; and

6.1.3 the procurement or award of new contracts for Prescribed Dental Services (in accordance with any procurement protocol or Guidance issued by NHS England from time to time).

6.2 In relation to any new contracts for Prescribed Dental Services to be entered into, the ICB must, without prejudice to any obligation in paragraph 11 (*Procurement and New Contracts*):

6.2.1 consider and use the form of contract that will ensure compliance with NHS England's obligations under Law taking into account the persons to whom such contracts may be awarded;

6.2.2 provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law.

7. **Staffing and Workforce**

7.1 The provisions of paragraph 6 of Part 1B of this Schedule 2B shall apply.

8. Finance

8.1 The ICB must ensure the financial delivery of the Prescribed Dental Services in accordance with any Mandated Guidance provided by NHS England.

9. Integrating dentistry into communities at Primary Care Network level

9.1 The ICB must exercise the Delegated Functions with a view to achieving greater integration of dentists into the Integrated Care System at the Primary Care Network level.

10. Making Decisions in relation to Management of Poorly Performing Dental Services Providers

10.1 The ICB must make decisions in relation to the management of poorly performing providers of Prescribed Dental Services and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards.

10.2 In accordance with paragraph 9.1 above, the ICB must:

10.2.1 ensure regular and effective collaboration with the CQC to ensure that information is shared and discussed in an appropriate and timely manner;

10.2.2 ensure that any risks identified are managed and escalated where necessary;

10.2.3 respond to CQC assessments of providers of Prescribed Dental Services where improvement is required;

10.2.4 where a providers of Prescribed Dental Services is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and

10.2.5 take appropriate contractual action in response to CQC findings.

11. Maintaining the Performers List

On receiving a notice from a practitioner (who is party to a contract for Prescribed Dental Services) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the Performers List as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.

12. Procurement and New Contracts

12.1 Until any new arrangements for awarding contracts for Prescribed Dental Services come into force, the ICB will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

12.2 In discharging its responsibilities set out in this Schedule 2B, the ICB must comply at all times with Law and all relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services).

12.3 On the coming into force of new arrangements for awarding contracts for Prescribed Dental Services, the ICB will make decisions on awarding new contracts relevant to the exercise of the Delegated Functions.

12.4 When the ICB makes decisions in connection with the awarding of contracts for Prescribed Dental Services it should ensure that it is able to demonstrate compliance with requirements for the award of contracts for Prescribed Dental Services, including that the decision was:

12.4.1 made in the best interest of patients, taxpayers and the population;

12.4.2 robust and defensible, with conflicts of interests appropriately managed;

12.4.3 made transparently, and

12.4.4 compliant with the rules of the regime as set out in NHS England guidance.

13. Commissioning Ancillary Support Services

13.1 The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

13.1.1 provision of translation and interpretation services; and

13.1.2 occupational health services.

14. Complaints

14.1 The ICB shall be responsible for handling complaints made in respect of Prescribed Dental Services.

Schedule 2C: Primary Ophthalmic Services

The provisions of this Schedule 2C form part of this Agreement only where indicated in the Particulars.

Part 1: General Obligations

1. Introduction

1.1 This Part 1 of Schedule 2C *(Primary Ophthalmic Services)* sets out general provisions regarding the carrying out of the Delegated Functions, being, in summary:

1.1.1 decisions in relation to the management of Primary Ophthalmic Services;

1.1.2 undertaking reviews of Primary Ophthalmic Services in the Area;

1.1.3 management of the Delegated Funds in the Area;

1.1.4 co-ordinating a common approach to the commissioning of Primary Ophthalmic Services with other commissioners in the Area where appropriate; and

1.1.5 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

2. General Obligations

2.1 The ICB is responsible for managing the provision of Primary Ophthalmic Services.

2.2 When carrying out Delegated Functions in respect of Primary Ophthalmic Services, the ICB must comply with all Mandated Guidance issued by NHS England.

2.3 The role of the ICB includes identifying and seeking to address any unmet needs which may be met through the delivery of Primary Ophthalmic Services.

2.4 In respect of integrated working, the ICB must:

2.4.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Eye Health Networks, Local Authorities, Healthwatch, acute and community providers, Local Optical Committees, and other stakeholders;

2.4.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Primary Ophthalmic Services generally; and

2.4.3 work with NHS England to coordinate the exercise of their respective performance management functions.

2.5 In relation to the Delegated Functions, the ICB agrees to perform the following general obligations:

2.5.1 to manage the Primary Ophthalmic Services Contracts on behalf of NHS England and perform all of NHS England's obligations under each of the Primary Ophthalmic Services Contracts in accordance with the terms of the Primary Care Contracts as if it were named in the contract in place of NHS England;

2.5.2 working with other organisations, including the NHS Business Services Authority and NHS England as appropriate, actively manage the performance of the Primary Ophthalmic Services Provider in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by taking

timely action to enforce contractual breaches, serve notices or provide discretionary support;

2.5.3 ensure that it obtains value for money on behalf of NHS England and avoids making any double payments under any Primary Ophthalmic Services Contracts;

2.5.4 notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the ICB of its obligations to perform any of NHS England's obligations under the Primary Ophthalmic Services Contracts;

2.5.5 undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;

2.5.6 keep a record of all of the Primary Ophthalmic Services Contracts that the ICB manages on behalf of NHS England setting out the following details in relation to each Primary Ophthalmic Services Contract:

2.5.6.1 name of the Primary Ophthalmic Services Provider;

2.5.6.2 any practice or trading name by which the Primary Ophthalmic Services Provider is known (if different to the name recorded under paragraph 2.5.6.1);

2.5.6.3 location of provision of services; and

2.5.6.4 amounts payable under the Primary Ophthalmic Services Contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.6 Without prejudice to clause 9 *(Finance)* or paragraph 2.5 above, the ICB must actively manage each of the relevant Primary Ophthalmic Services Contracts including by:

2.6.1 managing the relevant Primary Ophthalmic Services Contract, including in respect of quality standards, incentives, observance of service specifications, and monitoring of activity and finance;

2.6.2 assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);

2.6.3 managing variations to the relevant Primary Ophthalmic Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.6.4 agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);

2.6.5 conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes; and

2.6.6 complying with and implementing any relevant Mandated Guidance issued from time to time.

2.7 This paragraph is without prejudice to clause 10 (*Information, Planning and Reporting*) or any other provision in this Agreement. The ICB must provide NHS England with:

2.7.1 such information relating to individual providers of Primary Ophthalmic Services in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the

commissioning or performances of providers of Primary Ophthalmic Services;

2.7.2 such data/data sets as required by NHS England to ensure population of any national dashboards;

2.7.3 any other data/data sets as required by NHS England; and

2.7.4 the ICB shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

Part 2: Specific Obligations

1. Introduction

1.1 This Part 2 of Schedule 2C *(Primary Ophthalmic Services)* sets out further provision regarding the carrying out of each of the Delegated Functions.

2. Primary Ophthalmic Services Contract Management

2.1 The ICB must:

2.1.1 comply with all current and future relevant national Mandated Guidance regarding General Ophthalmic Contract reviews and any other contract reviews;

2.1.2 take on the responsibility for existing services provided pursuant to a Primary Ophthalmic Services Contract, and for commissioning new services;

2.1.3 assume the responsibility for the award of new Primary Ophthalmic Services Contracts; and

2.1.4 monitor contract performance with a view to achieving assurance and improvement in the delivery of services in the context of the ICB;

in each case acknowledging that the NHS Business Services Authority provides end-to-end support services in relation to these functions, as referred to in Schedule 6 (*Mandated Assistance and Support*). The ICB accordingly agrees to co-operate with the NHS Business Services Authority in the delivery of these functions.

3. Transparency and freedom of information

3.1 The ICB must:

3.1.1 Respond to requests for information from members and the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

3.1.2 Provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

4. Maintaining the Performers List

4.1 On receiving a notice from a practitioner (who is party to a Primary Ophthalmic Services Contract) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the performers list as soon as possible after receiving the notice using the Primary Care Support

services provided by NHS England, insofar as that amendment relates to a change in contractor details.

5. Finance

5.1 Further requirements in respect of finance will be specified in Mandated Guidance.

6. Workforce

6.1 The arrangements for the provision and maintenance of sufficient and appropriately qualified, trained and experienced Staff in order for the ICB to fulfil its responsibilities for each of the Delegated Functions ("the Staffing Model"), will be communicated formally to the ICB by NHS England following recommendations made by the National Moderation Panel. Further requirements in respect of workforce will be specified in Mandated Guidance.

6.2 The ICB is not permitted to vary the Staffing Model agreed with NHS England as part of its application for delegation of the said functions however a variation can be applied for by the ICB and considered by the National Moderation Panel at any time.

7. Integrating optometry into communities at Primary Care Network level

7.1 The ICB must exercise the Delegated Functions with a view to achieving greater integration of optometrists into the Integrated Care System at the Primary Care Network level.

8. Complaints

8.1 The ICB will handle complaints made in respect of primary ophthalmic services in accordance with the Complaints Regulations.

9. Commissioning ancillary support services

9.1 The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

9.1.1 provision of translation and interpretation services; and

9.1.2 occupational health services.

Schedule 2D: Delegated Functions – Pharmaceutical Services

The provisions of this Schedule 2D form part of this Agreement only where indicated in the Particulars.

1. In this Schedule, the following additional definitions shall apply:

Advanced Services	has the meaning given to that term by the Pharmaceutical Regulations;
Conditions of Inclusion	means those conditions set out at Part 9 of the Pharmaceutical Regulations;
Delegated Pharmaceutical Functions	the functions set out at paragraph 2 of this Schedule;
Designated Commissioner	has the meaning given to that term at paragraph 2.3 of this Schedule;
Dispensing Doctor	has the meaning given to that term by the Pharmaceutical Regulations;
Dispensing Doctor Decisions	means decisions made under Part 8 of the Pharmaceutical Regulations;
Dispensing Doctor Lists	has the meaning given to that term by the Pharmaceutical Regulations;
Drug Tariff	has the meaning given to that term by the Pharmaceutical Regulations;
Electronic Prescription Service	has the meaning given to that term by the Pharmaceutical Regulations;
Enhanced Services	has the meaning given to that term by the Pharmaceutical Regulations;
Essential Services	is to be construed in accordance with paragraph 3 of Schedule 4 to the Pharmaceutical Regulations;
Fitness to Practise Functions	has the meaning given to that term at paragraph 2.1.10 of this Schedule;
Locally Commissioned Services	means services which are not Essential Services, Advanced Services, Enhanced Services or services commissioned under an LPS Scheme;
LPS Chemist	has the meaning given to that term by the Pharmaceutical Regulations;
LPS Scheme	has the meaning given to that term by Paragraph 1(2) of Schedule 12 to the NHS Act;
NHS Chemist	has the meaning given to that term by the Pharmaceutical Regulations;
Pharmaceutical Lists	has the meaning given to that term at paragraph 2.1.1. of this Schedule and any reference to a Pharmaceutical List should be construed accordingly;

Pharmaceutical Regulations	means the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and reference to a Regulation refers to a provision of the Pharmaceutical Regulations, unless otherwise stated;
Rurality Decisions	means decisions made under Part 7 of the Pharmaceutical Regulations;
Terms of Service	means the terms upon which, by virtue of the Pharmaceutical Regulations, a person undertakes to provide Pharmaceutical Services;

Delegated Pharmaceutical Functions

2. Except in so far as they fall within the scope of the Reserved Functions, and subject to paragraphs 2.2, 2.3, 4 and 5, the ICB agrees to perform the following functions of NHS England in respect of the Area (the "Delegated Pharmaceutical Functions"), in all cases in accordance with relevant Law, Mandated Guidance and other Guidance:

2.1 preparing, maintaining and submitting for publication by NHS England lists of persons, other than medical practitioners or dental practitioners, who have undertaken to provide pharmaceutical services from premises situated within the Area[3], specifically:

2.1.1 lists of persons who have undertaken to provide pharmaceutical services in particular by way of the provision of drugs;

2.1.2 lists of persons who have undertaken to provide pharmaceutical services only by way of the provision of appliances; and

2.1.3 lists of persons participating in the Electronic Prescription Service[4]

collectively referred to in this Schedule as the "Pharmaceutical Lists". In doing so, it is sufficient for the lists referred to at paragraphs 2.1.1.1 and 2.1.1.2 to include a marker showing which persons are also participating in the Electronic Prescription Service, rather than preparing a separate list for the purposes of paragraph 2.1.1.3.

2.1.4 managing and determining applications by persons for inclusion in a Pharmaceutical List[5];

2.1.5 managing and determining applications by persons included in a Pharmaceutical List;

2.1.6 responsibilities for financial resources related to the Delegated Pharmaceutical Functions as described in Mandated Guidance issued by NHS England;

2.1.7 overseeing the compliance of those included in the Pharmaceutical Lists with:

2.1.7.1 their Terms of Service and identifying and investigating breaches, including possible breaches, of those terms;

[3] Including (without limitation) updates to those lists following any removal under regulation 115 of the Pharmaceutical Regulations
[4] Regulation 10 of the Pharmaceutical Regulations
[5] Schedule 2 of the Pharmaceutical Regulations

2.1.7.2 relevant Conditions of Inclusion; and

2.1.7.3 requirements of the Community Pharmacy Contractual Framework.

2.1.8 exercising powers in respect of Performance Related Sanctions and Market Exit[6];

2.1.9 exercising all other rights, and complying with all other obligations, of NHS England in respect of the Terms of Service and Conditions of Inclusion of those included in the Pharmaceutical Lists;

2.1.10 communicating to those included in the Pharmaceutical Lists any announcement made by NHS England modifying Terms of Service of any person included in the Pharmaceutical Lists as a consequence of a disease being, or in anticipation of a disease being imminently:

2.1.11 pandemic; and

2.1.12 a serious risk or potentially a serious risk to human health[7];

2.1.13 communicating to those included in the Pharmaceutical Lists any other matters which NHS England may require the ICB to communicate from time to time;

2.1.14 performing functions in respect of the disqualification of practitioners, and related measures concerning a practitioners inclusion in the Pharmaceutical Lists, set out in Chapter 6 of Part 7 to the NHS Act and the provisions of the Pharmaceutical Regulations made under that Chapter ("the Fitness to Practise Functions");

2.1.15 performing functions in respect of enforcement, reviews and appeals relating to the Fitness to Practise Functions[8];

2.1.16 making LPS Schemes[9], subject to the requirements of paragraph 5;

2.1.17 overseeing the compliance of those who are party to Local Pharmaceutical Services Contracts with the terms of those contracts and identifying and investigating breaches, including possible breaches, of the terms of those contracts;

2.1.18 exercising all rights, and complying with all obligations, of NHS England under Local Pharmaceutical Services Contracts;

2.1.19 determining LPS matters[10] in respect of LPS Schemes;

2.1.20 determining Rurality Decisions and other rurality matters[11];

2.1.21 determining Dispensing Doctor Decisions[12];

2.1.22 preparing and maintaining Dispensing Doctor Lists[13];

[6] Part 10 of the Pharmaceutical Regulations
[7] Regulation 11(3) of the Pharmaceutical Regulations
[8] Part 11 of the Pharmaceutical Regulations
[9] Section 134 NHS Act and Part 13 of the Pharmaceutical Regulations.
[10] Part 13 of the Pharmaceutical Regulations
[11] Part 7 of the Pharmaceutical Regulations
[12] Part 8 of the Pharmaceutical Regulations
[13] Regulation 46 of the Pharmaceutical Regulations

2.1.23 making arrangements for the provision of adequate pharmaceutical service delivery across the ICB area;

2.1.24 making arrangements for the delivery of Essential Services, Advanced Services and Enhanced Services;

2.1.25 supporting implementation and delivery of all elements of the Community Pharmacy Contractual Framework;

2.1.26 consulting with patients, the public and other stakeholders to the extent required by the duty of public involvement and consultation under section 14Z45 of the NHS Act;

2.1.27 responding to Appeals to the Secretary of State and First Tier Tribunal in respect of the Delegated Pharmaceutical Functions[14];

2.1.28 responding to Claims in respect of the Delegated Pharmaceutical Functions;

2.1.29 recovering overpayments from NHS Chemists, LPS Chemists, Dispensing Doctors and Primary Medical Services Providers[15];

2.1.30 bringing any legal proceedings in respect of the Delegated Pharmaceutical Functions;

2.1.31 making any notifications to, and consulting with, third parties in respect of the Delegated Pharmaceutical Functions;

2.1.32 recognising one or more Local Pharmaceutical Committees which it considers are representative of Pharmaceutical Services Providers in the ICB's Area and liaising with and consulting such Local Pharmaceutical Committees as required by the Pharmaceutical Regulations;

2.1.33 commissioning the provision of NHS Smartcards to Pharmaceutical Services Providers and their staff by registration authorities;

2.1.34 making any payments due to NHS Chemists suspended from a Pharmaceutical List in accordance with the determination made by the Secretary of State in respect of such payments; and

2.1.35 undertaking any investigations relating (among other things) to whistleblowing claims (relating to a superintendent pharmacist, a director or the operation of a pharmacy contractor), infection control and patient complaints.

2.2 Where the Area comprises the areas of two or more Health and Wellbeing Boards in their entirety:

2.2.1 the Delegated Pharmaceutical Functions shall be exercised so as to maintain separately in respect of each Health and Wellbeing Board area:

2.2.1.1 Pharmaceutical Lists in respect of premises in that Health and Wellbeing Board area;

2.2.1.2 a list of LPS Chemists providing local pharmaceutical services at or from premises in that Health and Wellbeing Board area[16]; and

[14] Schedule 3 of the Pharmaceutical Regulations
[15] Regulation 94 of the Pharmaceutical Regulations
[16] Regulation 114 of the Pharmaceutical Regulations

2.2.1.3 a Dispensing Doctor List (together the "Relevant Lists"); and

2.2.1.4 the ICB shall comply with such Contractual Notices as NHS England may issue from time to time concerning the arrangements for the exercise of the Delegated Pharmaceutical Functions across two or more Health and Wellbeing Board areas.

2.3 Where the Area comprises part of the area of a Health and Wellbeing Board (the "Relevant Health and Wellbeing Board"):

2.3.1 NHS England shall by Contractual Notice designate:

2.3.1.1 the ICB;

2.3.1.2 another ICB whose area comprises in part the area of the Relevant Health and Wellbeing Board; or

2.3.1.3 NHS England;

as the body responsible for maintaining the Relevant Lists (as defined in paragraph 2.2.1 of this Schedule 2D) in respect of the Relevant Health and Wellbeing Board ("the Designated Commissioner");

2.3.2 the ICB shall exercise the Delegated Pharmaceutical Functions in respect of that part of the Relevant Health and Wellbeing Board's area that falls within the Area but in doing so shall liaise with any Designated Commissioner for the purposes of maintaining the accuracy of the Relevant Lists (as defined in paragraph 2.2.1 of this Schedule 2D) in respect of the Relevant Health and Wellbeing Board; and

2.3.3 the ICB shall comply with all Contractual Notices issued by NHS England for the purposes of determining responsibilities in the circumstances described in this paragraph 2.3.

Prescribed Support

3. Notwithstanding the inclusion of the following within the Delegated Functions, the ICB shall discharge the functions set out at:

3.1 Paragraph 2.1.1 (maintaining Pharmaceutical Lists)

3.2 Paragraph 2.1.2 (managing applications for inclusion)

3.3 Paragraph 2.1.3 (managing applications from those included in a list)

3.4 Paragraph 2.1.5 (overseeing compliance with Terms of Service and Conditions of Inclusion)

3.5 Paragraph 2.1.10 (Fitness to Practise)

3.6 Paragraph 2.1.18 (maintaining and publishing Dispensing Doctors Lists)

3.7 Paragraph 2.1.25 (recovery of overpayments)

with the assistance and support of the NHS Business Services Authority, Primary Care Support England or such other person as NHS England shall designate by Contractual Notice for these purposes from time to time and in accordance with the allocation of operational responsibilities described by NHS England in Mandated Guidance.

LPS Schemes

4. The ICB shall not without the prior written consent of NHS England make any new LPS Schemes.

Barred Persons

5. The ICB must ensure that persons barred from involvement in specific elements of the Delegated Functions are excluded from such involvement in accordance with the Pharmaceutical Regulations.

Other Services

6. The provisions of this schedule are without prejudice to the ability of the ICB to make arrangements for the provision of Locally Commissioned Services for the purposes of the NHS in accordance with its own commissioning functions and using its own financial resources.

Payments

7. In exercising the Delegated Pharmaceutical Functions, the ICB must ensure that:

    7.1 all payments to which the Drug Tariff applies are made solely in accordance with the Drug Tariff; and

    7.2 any other payments for services (including without limitation those relating to LPS Schemes and Enhanced Services) are made in accordance with recognised contractual mechanisms intended to apply to those services.

Flu vaccinations

8. The Parties acknowledge and agree that:

    8.1 responsibility for arranging any national scheme for flu vaccinations remains with NHS England as part of its Section 7A Functions; and

    8.2 where any such national scheme is arranged by NHS England, the ICB is required to commission flu vaccines as Advanced Services. For the purposes of this Agreement, this forms part of the ICB's responsibilities under this Agreement.

Integration

9. In respect of integrated working, the ICB must:

    9.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Authorities, Healthwatch, acute and community providers, professional representative groups, contractor representative groups and other stakeholders;

    9.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Pharmaceutical Services generally; and

    9.3 work with NHS England to coordinate the exercise of their respective performance management functions.

Integrating pharmacy into communities at Primary Care Network level

10. The ICB must exercise the Delegated Functions with a view to achieving greater integration of community pharmacy into the Integrated Care System at the Primary Care Network level including participation in network governance arrangements.

Complaints

11. The ICB will handle complaints made in respect of Pharmaceutical Services and Local Pharmaceutical Services in accordance with the Complaints Regulations.

Commissioning ancillary support services

12. The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

12.1 collection and disposal of clinical waste; and

12.2 provision of translation and interpretation services; and

12.3 occupational health services.

Finance

13. Further requirements in respect of finance will be specified in Mandated Guidance.

Workforce

14. Further requirements in respect of workforce will be specified in Mandated Guidance.

SCHEDULE 3

Reserved Functions

1. Introduction

1.1 In accordance with clause 8.4 of this Agreement, all functions of NHS England other than those defined as Delegated Functions are Reserved Functions.

1.2 This Schedule 3 (*Reserved Functions*) sets out further provision regarding the carrying out of the Reserved Functions.

1.3 The ICB will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions.

2. Management of the national performers list

2.1 Subject to Paragraph 2.2, NHS England will continue to perform its functions under the National Health Service (Performers Lists) (England) Regulations 2013.

2.2 The ICB will carry out administrative tasks in respect of the Performers Lists as described at:

2.2.1 Paragraph 9 of Part 2, Schedule 2A;

2.2.2 Paragraph 9 of Part 2, Schedule 2B; and

2.2.3 Paragraph 6 of Part 2, Schedule 2C.

2.3 NHS England's functions in relation to the management of the national performers list include:

2.3.1 considering applications and decision-making in relation to inclusion on the national performers list, inclusion with conditions and refusals;

2.3.2 identifying, managing and supporting primary care performers where concerns arise; and

2.3.3 managing suspension, imposition of conditions and removal from the national performers list.

2.4 NHS England may hold local Performance Advisory Group ("PAG") meetings to consider all complaints or concerns that are reported to NHS England in relation to a named performer and NHS England will determine whether an initial investigation is to be carried out.

2.5 NHS England may notify the ICB of all relevant PAG meetings at least seven (7) days in advance of such meetings. NHS England may require a representative of the ICB to attend such meetings to discuss any performer concerns and/or quality issues that may impact on individual performer cases.

2.6 The ICB must develop a mechanism to ensure that all complaints regarding any named performer are escalated to the Local NHS England Team for review. The ICB will comply with any Mandated Guidance issued by NHS England in relation to the escalation of complaints about a named performer.

3. Management of the revalidation and appraisal process

3.1 NHS England will continue to perform its functions under the Medical Profession (Responsible Officers) Regulations 2010 (as amended by the Medical Profession (Responsible Officers) (Amendment) Regulations 2013).

3.2 All functions in relation to GP appraisal and revalidation will remain the responsibility of NHS England, including:

3.2.1 the funding of GP appraisers;

3.2.2 quality assurance of the GP appraisal process; and

3.2.3 the responsible officer network.

3.3 Funding to support the GP appraisal is incorporated within the global sum payment to Primary Medical Services Provider.

3.4 The ICB must not remove or restrict the payments made to Primary Medical Services Provider in respect of GP appraisal.

3.5 Appraisal arrangements in respect of all other primary care practitioner groups shall also be Reserved Functions.

4. Administration of payments and related performers list management activities

4.1 NHS England reserves its functions in relation to the administration of payments to individual performers and related performers list management activities under the National Health Service (Performers Lists) (England) Regulations 2013 and other relevant legislation.

4.2 NHS England may continue to pay practitioners who are suspended from the national performers list in accordance with relevant determinations made by the Secretary of State.

4.3 For the avoidance of doubt, the ICB is responsible for any ad hoc or discretionary payments to Primary Medical Services Providers (including those under section 96 of the NHS Act) in accordance with Schedule 2A (*Delegated Functions*) Part 2 paragraphs 5.1 and 5.1 of this Agreement, including where such payments may be considered a consequence of actions taken under the National Health Service (Performers Lists) (England) Regulations 2013.

5. Section 7A and Capital Expenditure Functions

5.1 NHS England retains the Section 7A Functions and will be responsible for taking decisions in relation to the Section 7A Functions.

5.2 In accordance with Schedule 10 Part 2, the ICB will provide certain management and/or administrative services to NHS England in relation to the Section 7A Functions.

5.3 NHS England retains the Capital Expenditure Functions and will be responsible for taking decisions in relation to the Capital Expenditure Functions.

5.4 In accordance with Schedule 10 Part 1, the ICB will provide certain management and/or administrative services to NHS England in relation to the Capital Expenditure Functions.

6. Such other ancillary activities that are necessary in order to exercise the Reserved Functions

6.1 NHS England will continue to comply with its obligations under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

6.2 The ICB must assist NHS England's controlled drug accountable officer ("CDAO") to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

6.3 The ICB must nominate a relevant senior individual within the ICB (the "ICB CD Lead") to liaise with and assist NHS England to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

6.4 The ICB CD Lead must, in relation to the Delegated Functions:

6.4.1 on request provide NHS England's CDAO with all reasonable assistance in any investigation involving the Delegated Functions;

6.4.2 report all complaints involving controlled drugs to NHS England's CDAO;

6.4.3 report all incidents or other concerns involving the safe use and management of controlled drugs to NHS England's CDAO;

6.4.4 analyse the controlled drug prescribing data available; and

6.4.5 on request supply (or ensure organisations from whom the ICB commissions services involving the regular use of controlled drugs supply) periodic self–declaration and/or self-assessments to NHS England's CDAO.

7. Reserved Functions – Primary Medical Services

7.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Medical Services Functions"):

7.1.1 determining the outcomes expected from Primary Medical Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes and the Department of Health and Social Care mandate;

7.1.2 designing and delivering national transformation programmes in support of national priorities;

7.1.3 the negotiation and agreement of matters concerning General Medical Services contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary medical services nationally;

7.1.4 the development of national standard Primary Medical Service contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Medical Services providers;

7.1.5 the provision of commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

7.1.6 the provision of nationally contracted services delivering digital, logistical and support services for Primary Medical Services in England (including but not limited to):

7.1.6.1 Payments;

7.1.6.2 Pensions;

7.1.6.3 Patient Registration;

7.1.6.4 Medical Records;

7.1.6.5 Performer List;

7.1.6.6 Supplies;

7.1.6.7 Call and Recall for Cervical screening (CSAS); and

7.1.6.8 Pharmacy Market Management.

7.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

8. Reserved Functions – Primary Dental Services

8.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Dental Services Functions"):

8.1.1 determining the outcomes expected from Primary Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

8.1.2 the negotiation and agreement of matters concerning Dental Services Contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

8.1.3 the development of national standard Dental Service Contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Dental Services providers;

8.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties; and

8.1.5 the provision of nationally contracted services delivering digital, logistical and support services for Primary Dental Services in England (including but not limited to):

8.1.5.1 Payments;

8.1.5.2 Pensions;

8.1.5.3 Performer List; and

8.1.5.4 Market Management.

8.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

9. Reserved Functions – Primary Ophthalmic Services

9.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Ophthalmic Functions"):

9.1.1 the Primary Ophthalmic Services Contracts policy and associated documentation;

9.1.2 the negotiation and agreement of matters concerning Primary Ophthalmic Services with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of Ophthalmic Services nationally; and

9.1.3 the provision of nationally contracted services delivering digital, logistical and support services for Primary Ophthalmic Services in England (including but not limited to):

9.1.3.1 Payments;

9.1.3.2 Performers List;

9.1.3.3 Market Management/Entry; and

9.1.3.4 Contract management, assurance and post-payment verification.

9.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

10. Reserved Functions – Pharmaceutical Services and Local Pharmaceutical Services

10.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Pharmaceutical Functions"):

10.1.1 publication of Pharmaceutical Lists;

10.1.2 functions of NHS England as a determining authority in relation to pharmaceutical remuneration under Part 12 of the Pharmaceutical Regulations;

10.1.3 functions in respect of lists of performers of pharmaceutical services and assistants, noting that as at the date of this Agreement regulations for the purposes of these functions have not been made[17];

10.1.4 the negotiation and agreement of matters concerning NHS pharmaceutical services with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of Pharmaceutical Services nationally;

10.1.5 the provision of commissioning and contracting policy and guidance to support ICBs to meet their delegated duties; and

10.1.6 administration of the pharmacist pre-registration training grant scheme.

11. Reserved Functions – Primary Dental Services

11.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Dental Services Functions"):

11.1.1 determining the outcomes expected from Primary Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

11.1.2 the negotiation and agreement of matters concerning Dental Services Contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

11.1.3 the development of national standard Dental Service Contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Dental Services providers;

11.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

[17] Part 7, Chapter 4A of the NHS Act (not currently in force)

11.1.5 the provision of nationally contracted services delivering digital, logistical and support services for Primary Dental Services in England (including but not limited to):

11.1.5.1 Payments

11.1.5.2 Pensions

11.1.5.3 Performer List

11.1.5.4 Market Management.

11.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

12. Reserved Functions - Prescribed Dental Services

12.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Prescribed Dental Services Functions"):

12.1.1 determining the outcomes expected from Prescribed Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

12.1.2 in respect of any Prescribed Dental Services contracted pursuant to NHS England's functions under Part 5 of the NHS Act the negotiation and agreement of matters concerning those contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

12.1.3 in respect of any Prescribed Dental Services contracted pursuant to NHS England's functions under Part 5 of the NHS Act, the development of standard contracts and national contract variations and guidance;

12.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

12.1.5 in respect of any Prescribed Dental Services contracted pursuant to NHS England's functions under Part 5 of the NHS Act, the provision of nationally contracted services delivering digital, logistical and support services in England (including but not limited to):

12.1.5.1 Payments

12.1.5.2 Pensions

12.1.5.3 Performer List

12.1.5.4 Market Management.

12.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

SCHEDULE 4

Further Information Governance and Sharing Provisions

1. Introduction

1.1 The purpose of this Schedule 4 *(Further Information Governance and Sharing Provisions* is to set out the scope for the secure and confidential sharing of information between the Parties on a **Need To Know** basis, in order to enable the Parties to exercise their functions in pursuance of this Agreement.

1.2 References in this Schedule 4 *(Further Information Governance and Sharing Provisions)* to the **Need to Know** basis or requirement (as the context requires) should be taken to mean that the Data Controllers' personnel will only have access to Personal Data or Special Category Personal Data if it is lawful for such personnel to have access to such data for the Specified Purpose in paragraph 2.1 and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Special Category Personal Data specified.

1.3 This Schedule and the Data Sharing Agreements entered into under this Schedule are designed to:

1.3.1 provide information about the reasons why Relevant Information may need to be shared and how this will be managed and controlled by the Parties;

1.3.2 describe the purposes for which the Parties have agreed to share Relevant Information;

1.3.3 set out the lawful basis for the sharing of information between the Parties, and the principles that underpin the exchange of Relevant Information;

1.3.4 describe roles and structures to support the exchange of Relevant Information between the Parties;

1.3.5 apply to the sharing of Relevant Information relating to Delegated Functions in respect of

1.3.5.1 Primary Care Providers and Primary Care Provider Personnel; and

1.3.5.2 Dental Services Providers and their personnel;

1.3.5.3 All other providers of Delegated Functions.

1.3.6 apply to the sharing of Relevant Information whatever the medium in which it is held and however it is transmitted;

1.3.7 ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and how this sharing will be managed;

1.3.8 apply to the activities of the Parties' personnel; and

1.3.9 describe how complaints relating to Personal Data sharing between the Parties will be investigated and resolved, and how the information sharing will be monitored and reviewed.

2. Purpose

2.1 The Specified Purpose of the data sharing is to facilitate the exercise of the ICB's Delegated Functions and NHS England's Reserved Functions as described in this Agreement.

2.2 ICBs must ensure that they have in place appropriate Data Sharing Agreements to enable data to be received by it from NHS Digital (or the successor to the relevant statutory functions of NHS Digital) and any other third party organisations from which the ICB must obtain data for the purpose of exercising the Delegated Functions. Specific and detailed purposes must be set out the Data sharing Agreement that complies with all relevant Legislation and Guidance.

3. Benefits of information sharing

3.1 The benefits of sharing information are the achievement of the Specified Purpose set out above, with benefits for service users and other stakeholders in terms of the improved delivery of the NHS services to which this Agreement relates.

4. Lawful basis for Sharing

4.1 Each Party shall comply with all relevant Information Law requirements and good practice in relation to the processing of Relevant Information shared further to this Agreement.

4.2 The ICB shall ensure that there is a Data Protection Impact Assessment ("DPIA") that covers all Delegated Functions. The ICB shall identify the lawful basis for sharing Relevant Information for each purpose and data flow, and where appropriate, enter into a Data Sharing Agreement.

5. Relevant Information to be shared

5.1 The Relevant Information to be shared shall be set out in a Data Sharing Agreement.

6. Restrictions on use of the Shared Information

6.1 Each Party shall only process the Relevant Information as is necessary to achieve the Specified Purpose, and, in particular, shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.

6.2 Access to, and processing of, the Relevant Information provided by a Party must be the minimum necessary to achieve the Specified Purpose. Information and Special Category Personal Data will be handled at all times on a restricted basis, in compliance with Information Law requirements, and the parties' personnel should only have access to Personal Data on a justifiable **Need to Know** basis.

6.3 Neither the provisions of this Schedule 4 *(Further Information Governance and Sharing Provisions)* nor any Data Sharing Agreements entered into in accordance with this Schedule should be taken to permit unrestricted access to data held by any Party. It lays the parameters for the safe and secure sharing and processing of information on a justifiable **Need to Know** basis.

6.4 Neither Party shall subcontract any processing of the Relevant Information without the prior written consent of the other Party. Where a Party subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor which imposes the same obligations as are imposed on the Data Controllers under this Agreement.

6.5 Neither Party shall cause or allow Data to be transferred to any territory outside the United Kingdom without the prior written permission of the responsible Data Controller.

6.6 Any particular restrictions on use of certain Relevant Information are included in the Personal Data Agreement annexed to this Schedule.

7. Ensuring fairness to the Data Subject

7.1 In addition to having a lawful basis for sharing information, the UK GDPR generally requires that the sharing must be fair and transparent. In order to achieve fairness and transparency to the Data Subjects, the Parties will take the following measures:

7.1.1 amendment of internal guidance to improve awareness and understanding among personnel;

7.1.2 amendment of respective privacy notices and policies to reflect the processing of data carried out further to this Agreement, including covering the requirements of articles 13 and 14 UK GDPR and providing these (or making them available to) Data Subjects;

7.1.3 ensuring that information and communications relating to the processing of data is easily accessible and easy to understand, and that clear and plain language be used; and

7.1.4 giving consideration to carrying out activities to promote public understanding of how data is processed where appropriate.

7.2 Each Party shall procure that its notification to the Information Commissioner's Office and record of processing maintained for the purposes of Article 30 UK GDPR reflects the flows of information under this Agreement.

7.3 Each Party shall reasonably cooperate with the other in undertaking any Data Protection Impact Assessment associated with the processing of data further to this Agreement, and in doing so engage with their respective Data Protection Officers in the performance by them of their duties pursuant to Article 39 UK GDPR.

7.4 Further provision in relation to specific data flows should be included in Data Protection Agreements.

8. Governance: personnel

8.1 Each Party must take reasonable steps to ensure the suitability, reliability, training and competence, of any personnel who have access to the Personal Data (and Special Category Personal Data) including reasonable background checks and evidence of completeness should be available on request by each Party.

8.2 The Parties agree to treat all Relevant Information as confidential and imparted in confidence and must safeguard it accordingly. Where any of the Parties' personnel are not healthcare professionals (for the purposes of the Data Protection Act 2018) the employing Parties must procure that personnel operate under a duty of confidentiality which is equivalent to that which would arise if that person were a healthcare professional.

8.3 Each Party shall ensure that all personnel required to access the Personal Data (including Special Category Personal Data) are informed of the confidential nature of the Personal Data and each Party shall include appropriate confidentiality clauses in employment/service contracts of all personnel that have any access whatsoever to the Relevant Information, including details of sanctions for acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure provisions of Information Law requirements, or causes damage to or loss of the Relevant Information.

8.4 Each Party shall provide evidence (further to any reasonable request) that all personnel that have any access to the Relevant Information whatsoever are adequately and appropriately trained to comply with their responsibilities under Information Law and this Agreement.

8.5 Each Party shall ensure that:

8.5.1 only those personnel involved in delivery of the Agreement use or have access to the Relevant Information; and

8.5.2 that such access is granted on a strict **Need to Know** basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited. Evidence of audit should be made freely available on request by the originating Data Controller.; and

8.5.3 specific limitations on the personnel who may have access to the Information are set out in the relevant Data Sharing Agreement

9. Governance: Protection of Personal Data

9.1 At all times, the Parties shall have regard to the requirements of Information Law and the rights of Data Subjects.

9.2 Wherever possible (in descending order of preference), only anonymised information, or strongly or weakly pseudonymised information will be shared and processed by Parties, without the need to share easily identifiable Personal Data. The Parties shall cooperate in exploring alternative strategies to avoid the use of Personal Data in order to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data/Special Category Personal Data.

9.3 Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a **Need to Know** basis. If either Party:

9.3.1 becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or

9.3.2 becomes aware of any security vulnerability or breach,

in respect of the Relevant Information it shall promptly (and within 48 hours) notify the other Party. The Parties shall fully cooperate with one another to remedy the issue as soon as reasonably practicable, and in making information about the incident available to the Information Commissioner and Data Subjects where required by Information Law.

9.4 In processing any Relevant Information further to this Agreement, each Party shall:

9.4.1 process the Personal Data (including Special Category Personal Data) only in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only in accordance with written instructions from the originating Data Controller in respect of its Relevant Information;

9.4.2 process the Personal Data (including Special Category Personal Data) only to the extent as is necessary for the provision of the Specified Purpose or as is required by law or any regulatory body;

9.4.3 process the Personal Data (including Special Category Personal Data) only in accordance with Information Law requirements and shall not perform its obligations under this Agreement in such a way as to cause any other Data

Controller to breach any of their applicable obligations under Information Law; and

9.4.4 process the Personal Data in accordance with the requirements of Information Law and in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) UK GDPR.

9.5 Each Party shall act generally in accordance with Information Law requirements, and in particular shall implement, maintain and keep under review appropriate technical and organisational measures to ensure and to be able to demonstrate that the processing of Personal Data is undertaken in accordance with Information Law, and in particular to protect the Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:

9.5.1 Take account of the nature, scope, context and purposes of processing as well as the risks of varying likelihood and severity for the rights and freedoms of Data Subjects; and

9.5.2 Be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data (and Special Category Personal Data) and having regard to the nature of the Personal Data (and Special Category Personal Data) which is to be protected.

9.6 In particular, each Party shall:

9.6.1 ensure that only personnel authorised under this Agreement have access to the Personal Data (and Special Category Personal Data);

9.6.2 ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display or distribution, of the Relevant Information;

9.6.3 obtain prior written consent from the originating Party in order to transfer the Relevant Information to any third party;

9.6.4 permit the other Party or their representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors or assigns) and comply with all reasonable requests or directions to enable each Party to verify and/or procure that the other is in full compliance with its obligations under this Agreement; and

9.6.5 if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.

9.7 Each Party shall adhere to the specific requirements as to information security set out in the Data Sharing Agreements.

9.8 Each Party shall use best endeavours to achieve and adhere to the requirements of the NHS Digital Data Security and Protection Toolkit.

9.9 The Parties' Single Points of Contact set out in paragraph 14 *(Governance: Single Points of Contact)* below will be the persons who, in the first instance, will have oversight of third party security measures.

10. Governance: Transmission of Information between the Parties

10.1 This paragraph supplements paragraph 9 *(Governance: Protection of Personal Data)* of this Schedule.

10.2 Transfer of Personal Data between the Parties shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net / gcsx) email.

10.3 Wherever possible, Personal Data should be transmitted (and held) in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, so as to ensure that the correct patient record/data is identified.

10.4 Any other special measures relating to security of transfer should be included in a Data Sharing Agreement.

10.5 Each Party shall keep an audit log of Relevant Information transmitted and received in the course of this Agreement.

10.6 The Parties' Single Point of Contact notified pursuant to paragraph 14 *(Governance: Single Points of Contact)* will be the persons who, in the first instance, will have oversight of the transmission of information between the Parties.

11. Governance: Quality of Information

11.1 The Parties will take steps to ensure the quality of the Relevant Information and to comply with the principles set out in Article 5 UK GDPR.

11.2 Special measures relating to ensuring quality are set out in the Personal Data Agreement annexed to this Schedule.

12. Governance: Retention and Disposal of Shared Information

12.1 The non-originating Party shall securely destroy or return the Relevant Information once the need to use it has passed or, if later, upon the termination of this Agreement, howsoever determined. Where Relevant Information is held electronically the Relevant Information will be deleted and formal notice of the deletion sent to the Party that shared the Relevant Information. Once paper information is no longer required, paper records will be securely destroyed or securely returned to the Party they came from.

12.2 Each Party shall provide an explanation of the processes used to securely destroy or return the information, or verify such destruction or return, if requested by the other Party and shall comply with any request of the Data Controllers to dispose of data in accordance with specified standards or criteria.

12.3 If either Party is required by any law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy under this paragraph 12 *(Governance: Retention and Disposal of Shared Information)*, it shall notify the other Party in writing of that retention, giving details of the documents or materials that it must retain.

12.4 Retention of any data shall comply with the requirements of Article 5(1)(e) GDPR and with all good practice including the Records Management NHS Code of Practice, as updated or amended from time to time.

12.5 Any special retention periods should be set out in the Data Sharing Agreements.

12.6 Each Party shall ensure that Relevant Information held in paper form is held in secure files, and, when it is no-longer needed, destroyed using a cross cut shredder or

subcontracted to a confidential waste company that complies with European Standard EN15713.

12.7 Each Party shall ensure that, when no longer required, electronic storage media used to hold or process Personal Data are destroyed or overwritten to current policy requirements.

12.8 Electronic records will be considered for deletion once the relevant retention period has ended.

12.9 In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Party shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

13. Governance: Complaints and Access to Personal Data

13.1 Each Party shall assist the other in responding to any request made under Information Law made by persons who wish to access copies of information held about them ("**Subject Access Requests**"), as well as any other purported exercise of a Data Subject's rights under Information Law or complaint to or investigation undertaken by the Information Commissioner.

13.2 Complaints about information sharing shall be routed through each Party's own complaints procedure but reported to the Single Points of Contact set out in paragraph 14 *(Governance: Single Points of Contact)* below.

13.3 The Parties shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Agreement or any data processing carried out further to it.

13.4 Basic details of the Agreement shall be included in the appropriate log under each Party's Publication Scheme.

14. Governance: Single Points of Contact

14.1 The Parties each shall appoint a Single Point of Contact to whom all queries relating to the particular information sharing should be directed in the first instance.

15. Monitoring and review

1. The Parties shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Information Law and best practice. Specific monitoring requirements must be set out in the relevant Data Sharing Agreement.

SCHEDULE 5

Financial Provisions and Decision Making Limits

Part 1 - Financial Limits and Approvals for Primary Care

1. The ICB shall ensure that any decisions in respect of the Delegated Functions and which exceed the financial limits set out below are only taken:

   1.1 by the following persons and/or individuals set out in column 2 of Table 1 below; and

   1.2 following the approval of NHS England (if any) as set out in column 3 of the Table 1 below.

2. NHS England may, from time to time, update Table 1 by sending a notice to the ICB of amendments to Table 1.

Table 1 – Financial Limits		
Decision	**Person/Individual**	**NHS England Approval**
General		
Taking any step or action in relation to the settlement of a Claim, where the value of the settlement exceeds £100,000	ICB Chief Executive Officer or Chief Finance Officer or Chair	NHS England Head of Legal Services and Local NHS England Team Director or Director of Finance
Any matter in relation to the Delegated Functions which is novel, contentious or repercussive	ICB Chief Executive Officer or Chief Finance Officer or Chair	Local NHS England Team Director or Director of Finance or NHS England Region Director or Director of Finance or NHS England Chief Executive or Chief Financial Officer
Revenue Contracts		
The entering into of any Primary Care Contract or Arrangement which has or is capable of having a term which exceeds five (5) years	ICB Chief Executive Officer or Chief Finance Officer or Chair	Local NHS England Team Director or Director of Finance
Capital Note: As at the date of this Agreement, the ICB will not have delegated or directed responsibility for decisions in relation to Capital expenditure (and these decisions are retained by NHS England) but the ICB may be required to carry out certain administrative services in relation to Capital expenditure under paragraph 13 *(Financial Provisions and Liability).*		

SCHEDULE 6

Mandated Assistance and Support

1. Primary Dental Services

1.1 NHS Business Services Authority has existing agreements with NHS England to support its delivery of the following services:

1.1.1 Contract management – end-to-end administration of contract variations and other regional team/ICB support activities;

1.1.2 Performance management - provide mid and end of year administration process to support regional teams and ICBs and undertake risk based assurance reviews - PPV can also be instigated by the ICS or Counter Fraud;

1.1.3 Clinical assurance reviews – provide clinical assurance of quality of dental services delivered, working in collaboration with regional teams/ICBs to identify and seek to address any concerns;

1.1.4 Provide data reports to teams defining quantity and service delivery at a contractor level.

2. Primary Ophthalmic Services

2.1 NHS Business Services Authority have existing agreements with NHS England to support its delivery of the following services:

2.1.1 Contract management. End-to-end administration of new contract applications, contract variations and contract terminations.

2.1.2 Contract assurance. Administration of the annual contractor assurance declaration and additional in-depth assurance declaration where appropriate. Provision of assurance reports at ICS and contractor level, supporting further assurance decisions.

2.1.3 GOS complaints. Administration of the annual GOS complaints survey.

2.1.4 Post-Payment Verification (PPV). End-to-end process for identifying and verifying GOS claims as part of the national PPV framework. This includes obtaining and reviewing claims and carrying out a financial recovery where appropriate. PPV can also be instigated by the ICS or Counter Fraud.

2.1.5 GOS 4 pre-authorisation of repair or replacement glasses.

3. Pharmaceutical Services and Local Pharmaceutical Services

3.1 NHS Business Services Authority has existing agreements with NHS England to support ICBs to discharge their assurance responsibilities by the delivery of the following services to ICBs:

3.1.1 Performance management – direct support to commissioners and community pharmacy contractors to implement corrective and preventative intervention;

3.1.2 Contract assurance – administration of the annual contractor assurance declaration and additional in-depth assurance declaration where

appropriate, provision of assurance reports at ICS and contractor level supporting further assurance decisions by the ICB;

3.1.3 Post-Payment Verification (PPV) – end-to-end process for identifying and verifying claims as part of the national PPV framework to support ICBs to play their part in ensuring compliance with contractual requirements and delivery of quality and value for money. This includes obtaining and reviewing claims, investigation of outliers and other potential inappropriate claims, along with referrals and investigatory reports to the ICB to consider and decide overpayment recoveries, and carrying out the financial recovery where appropriate. PPV can also be instigated by the ICS or Counter Fraud.

4. Support Services directed by DHSC

4.1 NHS Business Services Authority is directed by DHSC to undertake specific activities as well as having existing agreements with NHS England to support its delivery of primary care services. These include (without limitation):

4.1.1 The administration of national payment platforms for primary care services to dentists, pharmacy contractors, appliance contractors, oxygen contractors and special school eye care providers;

4.1.2 The calculation of payment for covid-19 and flu vaccinations to PCNs and GP practices as well as payments to Dispensing Doctors and prescribing only doctors for personal administration claims and sharing this information accurately and in a timely manner;

4.1.3 Clinical advisory support;

4.1.4 Administration functions;

4.1.5 Assurance services - performance and contract management of primary care providers;

4.1.6 The provision of information to primary care organisations for all contractor groups via standardised reporting (eg. ePACT2, eDEN and eOPS);

4.1.7 Working with NHS England and ICB Counter Fraud Teams to reduce loss across the system.

SCHEDULE 7

Local Terms

Primary Care staffing (including finance)	The employment of the Pharmacy and Optometry team is expected to transfer to Norfolk and Suffolk ICB in summer 2026 as part of the hosting of the Office of Pan ICB Commissioning (OPIC) as agreed between the East of England ICBs
Fitness and PSRC	Administration of the fitness function (assessing the fitness of corporate bodies, sole traders, and partnerships for inclusion on the pharmacy list) is expected to transfer to Norfolk and Suffolk ICB in summer 2026 as part of the agreed hosting arrangements. The Pharmaceutical Services Regulations Committee (PSRC) function is expected to transfer to Norfolk and Suffolk ICB in summer 2026 as part of the agreed hosting arrangements.

SCHEDULE 8

Deployment of NHS England Staff to the ICB

Note: This schedule relates to the Deployment of Staff who are employed by NHS England only.

Deployment of NHS England Staff

1. NHS England may deploy Staff to the ICB for the purposes of carrying out the Delegated Functions.

2. The Parties have agreed that arrangements for the provision of NHS England Staff and the associated employment model envisaged by section 5.9 of the HR Framework **https://www.england.nhs.uk/wp-content/uploads/2021/06/B1427-Human-resources-framework-for-developing-integrated-care-boards-version-2-March-2022.pdf**) will be determined by the National Moderation Panel convened for this purpose and endorsed by NHS England's Executive Group.

3. The Parties agree and acknowledge that the Staffing Models will be developed in conjunction with the ICB and are subject to the decision of the National Moderation Panel and cannot be varied without the express agreement of NHS England.

4. A proposal for a variation to any Staffing Model must be made by means of a formal submission to the National Moderation Panel which will determine the proposal, following which the proposal if approved, will be endorsed by NHS England's Executive Group.

5. Subject to any variation made in accordance with paragraphs 3 and 4 above, a Staffing Model determined in accordance with paragraph 2 will apply for the duration of this Agreement.

Availability of NHS England Staff

6. In addition to any Staff deployed in any communicated Staffing Model arrangement, NHS England may deploy additional Staff to the ICB to perform administrative and management support services together with such other services specified in SCHEDULE 7 (Local Terms) (the "Services") so as to facilitate the ICB in undertaking the Delegated Functions pursuant to the terms of this Agreement.

7. NHS England will take all reasonable steps to ensure that the NHS England Staff deployed for the purposes of carrying out the Delegated Functions shall:

    a. faithfully and diligently perform duties and exercise such powers as may from time to time be reasonably assigned to or vested in them; and

    b. perform all duties assigned to them pursuant to this Schedule 8.

8. The ICB shall notify NHS England if the ICB becomes aware of any act or omission by any NHS England Staff which may have a material adverse impact on the provision of the Services or constitute a material breach of the terms and conditions of employment of the NHS England Staff.

9. NHS England shall use all reasonable efforts to make its Staff available for the purposes of this Schedule 8 whilst the NHS England Staff are absent:

    a. by reason of industrial action;

    b. as a result of the suspension or exclusion of employment or secondment of any Staff by NHS England;

c. in accordance with the NHS England Staff's respective terms and conditions of employment and policies, including, but not limited to, by reason of training, holidays, sickness, injury, trade union duties, paternity leave or maternity or where absence is permitted or required by Law;

d. if making the NHS England Staff available would breach or contravene any Law;

e. as a result of the cessation of employment of any individual NHS England Staff; and/or

f. at such other times as may be agreed between NHS England and the ICB.

Employment of the NHS England Deployed Staff

10. NHS England shall employ their Staff and shall be responsible for the employment of their Staff at all times on whatever terms and conditions as NHS England and their Staff may agree from time to time.

11. NHS England shall pay their Staff their salaries and benefits and make any deductions for income tax liability and national insurance or similar contributions it is required to make from the Staff's salaries and other payments.

12. NHS England shall not, and shall procure that the NHS England Staff shall not, hold themselves out as employees of the ICB.

Management of NHS England staff

13. NHS England where appropriate, shall in consultation with the ICB, make arrangements to ensure the day-to-day control of the activities of their Staff is shared with the ICB and deal with any relevant management issues concerning their Staff including, without limitation, performance appraisal, discipline and leave requests.

14. The ICB agrees to provide all such assistance and co-operation that NHS England may reasonably request from time to time to resolve grievances raised by NHS England Staff and to deal with any disciplinary allegations made against NHS England Staff arising out of or in connection with the provision of the Services which shall include, without limitation, supplying NHS England with all information and the provision of access to all documentation and NHS England Staff as NHS England requires for the purposes of considering and dealing with such issues and participating promptly in any action which may be necessary.

Conduct of Claims

15. If the ICB becomes aware of any matter that may give rise to a claim by or against a member of NHS England Staff, notice of that fact shall be given as soon as possible to NHS England. NHS England and the ICB shall co-operate in relation to the investigation and resolution of any such claims or potential claims.

16. No admission of liability shall be made by or on behalf of the ICB and any such claim shall not be compromised, disposed of or settled without the consent of NHS England.

Confidential Information and Property

17. For the avoidance of doubt, this paragraph 17 (Confidential Information and Property) is without prejudice to any other provision of this Agreement in relation to confidential information.

18. It is acknowledged that to enable the NHS England Staff to provide the Services, the Parties may share Confidential Information.

19. The Parties agree to adopt all such procedures as the other party may reasonably require and to keep confidential all Confidential Information.

Intellectual Property

20. All IPR made, written, designed, discovered or originated by Staff (People Resources) deployed by NHS England, shall be the property of NHS England to the fullest extent permitted by Law and NHS England shall be the absolute beneficial owner of the copyright in any such IPR.

SCHEDULE 9

Mandated Guidance

Primary Medical Care

- Primary Medical Care Policy and Guidance Manual.
- The 'Principles of Best Practice' and any other guidance relating to *the Premises Cost Directions 2013.*
- Guidance relating to the Minimum Practice Income Guarantee.
- Guidance relating to Primary Medical Care discretionary payments.
- Guidance for Commissioners: Interpreting and Translation Services in Primary Care.
- Framework for Patient and Public Participation in Primary Care Commissioning.
- NHS England National Primary Care Occupational Health Service Specification.
- Guidance relating to list cleansing in relation to Primary Medical Care providers.
- Guidance relating to mergers and closures of GP practices and/or Primary Medical Care providers.
- Guidance relating to Primary Medical Care and POD contract reviews.
- Guidance relating to the escalation of complaints from a named 'performer'.
    - Including: *Framework for Managing Performer Concerns.*

Pharmaceutical Services and Local Pharmaceutical Services

- Pharmacy Manual.
- NHS England National Primary Care Occupational Health Service Specification.
- The NHS Pharmacy Regulations Guidance 2020[1].
- Guidance for ICSs and STPs on transformation and improvement opportunities to benefit patients through integrated pharmacy and medicines optimisation.

Primary Ophthalmic Services

- Policy Book for Eye Health.
- NHS England National Primary Care Occupational Health Service Specification.

Primary and Prescribed Dental Services

- Policy Book for Primary Dental Services.
- Securing Excellence in Commissioning NHS Dental Services.
- Securing Excellence in Commissioning NHS Dental Services: Key facts.
- Securing Excellence in Commissioning NHS Dental Services: FAQs.
- Quick Guide: Best use of unscheduled dental care services.
- How to update NHS Choices for Dental Practices.
- Flowchart for managing patients with a dental problem/pain.
- Guidance on NHS 111 Directory of Services for dental providers.
- Definitions – Unscheduled Dental Care.
- Introductory Guide for Commissioning Dental Specialties.
- Guide for Commissioning Dental Specialties: Orthodontics.
- Guide for Commissioning Dental Specialties: Oral Surgery and Oral Medicine.
- Guide for Commissioning Dental Specialties: Special Care Dentistry.
- Guide for Commissioning Service Standards: Conscious Sedation in a Primary Care Setting.
- Commissioning Standard for Dental Specialties: Paediatric Dentistry.
- Commissioning Standard for Urgent Dental Care.
- Commissioning Standard for Restorative Dentistry.

[1] https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-manual/nhs-pharmacy-regulations-guidance-2020/

- Commissioning Standard for Dental Care for People with Diabetes.
- Accreditation of Performers and Providers of Level 2 Complexity Care.
- NHS England National Primary Care Occupational Health Service Specification.
- Dental Access Controls.

Finance

- Guidance on NHS System Capital Envelopes.
- Finance and Payments Guidance for Community Pharmacy, Dental and Primary Care Ophthalmology Services Delegated to ICBs from 2022.
- Managing Public Money (HM Treasury).
- Guidance relating to Personal Service Medical Reviews.
    - Including: *Implementing Personal Medical Services Reviews.*
- Dental Commissioning and Financial Management Guidance.

Workforce

- Guidance on the Employment Commitment.

Other Guidance

- National Guidance on System Quality Groups.
- Managing Conflicts of Interest in the NHS.
- Arrangements for Delegation and Joint Exercise of Statutory Functions.
- Guidance relating to procurement and provider selection.
- IG Guidance relating to serious incidents.
- All other applicable IG and Data Protection Guidance.
- Any applicable Freedom of Information protocols.
- Any applicable guidance on Counter Fraud, including from The NHS Counter Fraud Authority.
- Any applicable guidance relating to the use of data and data sets for reporting.
- Any applicable guidance relating to the commissioning and management of clinical waste in primary care e.g.
    - Including: Management and disposal of healthcare waste.

SCHEDULE 10

Administrative and Management Services

1. The ICB shall provide the following administrative and management services to NHS England:

    1.1 the administrative and management services in relation to the Capital Expenditure Functions and the Capital Expenditure Funds as more particularly set out in this Part 1 of this Schedule 10 (*Administrative and Management Services*); and

    1.2 the administrative and management services in relation to the Section 7A Functions and Section 7A Funds as more particularly set out in Part 2 of this Schedule 10.

    1.3 the administrative and management services in relation to other Reserved Functions as more particularly set out in Part 3 of this Schedule 10 (*Administrative and Management Services*).

Part 1: Administrative and/or Management Services and Funds in relation to the Capital Expenditure Functions

1. The Parties acknowledge that the Capital Expenditure Functions are a Reserved Function.

2. The Parties further acknowledge that:

    2.1 accordingly, the Delegated Funds do not include any funds in respect of amounts payable in relation to the Capital Expenditure Functions (**"Capital Expenditure Funds"**); and

    2.2 NHS England remains responsible and accountable for the discharge of the Capital Expenditure Functions and nothing in Part 1 of this Schedule 10 (*Administrative and Management Services*) shall be construed as a divestment or delegation of NHS England's Capital Expenditure Functions.

3. Without prejudice to paragraph 3 above, the ICB will comply with any Mandated Guidance issued in relation to the Capital Expenditure Functions and shall (on request from NHS England) provide the following administrative services to NHS England in respect of the Capital Expenditure Funds:

    3.1 the administration and payment of sums that NHS England has approved as payable in relation to the Capital Expenditure Functions;

    3.2 if requested by NHS England and taking into account (i) any other support or services provided to NHS England by NHS Property Services Limited or otherwise and (ii) any Mandated Guidance issued in respect of the Capital Expenditure Functions, the provision of advice and/or recommendations to NHS England in respect of expenditure to be made under the Capital Expenditure Functions; and

    3.3 such other support or administrative assistance to NHS England that NHS England may reasonably request in order to facilitate the discharge by NHS England of its responsibilities under or in respect of the Capital Expenditure Functions.

4. NHS England may, at the same time as it allocates the Delegated Funds to the ICB under Clause 9.11, transfer to the ICB such amounts as are necessary to enable the discharge of the ICB's obligations under this Part 1 of Schedule 10 (*Administrative and Management Services*) in respect of the Capital Expenditure Functions.

Part 2 - Administrative and/or Management Services and Funds in relation to Section 7A Functions

1. The Parties acknowledge that the Section 7A Functions are part of the Reserved Functions.

2. The Parties further acknowledge that:

   2.1 accordingly, the Delegated Funds do not include any funds in respect of amounts payable in relation to the Section 7A Functions (whether such arrangements are included in or under Primary Care Contracts or Arrangements or not) (**"Section 7A Funds"**); and

   2.2 NHS England remains responsible and accountable for the discharge of the Section 7A Functions and nothing in this Schedule 10 Part 2 shall be construed as a divestment or delegation of the Section 7A Functions.

3. The ICB will provide the following services to NHS England in respect of the Section 7A Funds:

4. the administration and payment of sums that NHS England has approved as payable under or in respect of arrangements for the Section 7A Functions; and

5. such other support or administrative assistance to NHS England that NHS England may reasonably request in order to facilitate the discharge by NHS England of its responsibilities under or in respect of the Section 7A Funds.

6. NHS England shall, at the same time as it allocates the Delegated Funds to the ICB under Clause 9.11, allocate to the ICB such amounts as are necessary to enable the discharge of the ICB's obligations under this Schedule 10 Part 2 in respect of the Section 7A Funds.

Part 3: Administrative and/or Management Services and Funds in relation to other Reserved Functions

1. NHS England may ask the ICB to provide certain management and/or administrative services to NHS England (from a date to be notified by NHS England to the ICB) in relation to the carrying out of any of the Reserved Functions.

2. If NHS England makes such a request to the ICB, then the ICB will, but only if the ICB agrees to provide such services, from the date requested by NHS England, comply with:

3. provisions equivalent to those set out above in relation to the Capital Expenditure Functions (Part 1 of this Schedule 10) and the Section 7A Functions (Part 2 of this Schedule 10) including in relation to the administration of any funds for such functions but only to the extent that such provisions are relevant to the management or administrative services to be provided; and

4. such other provisions in respect of the carrying out of such management and administrative services as agreed between NHS England and the ICB.

Dated 1 April 2026

(1) **NHS ENGLAND**

- and -

(2) **NHS ESSEX INTEGRATED CARE BOARD**

Delegation Agreement between NHS England and NHS Essex ICB in relation to Specialised Commissioning Functions

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DELEGATION AGREEMENT FOR SPECIFIED FUNCTIONS

1. PARTICULARS

1.1 This Agreement records the particulars of the agreement made between NHS England and the Integrated Care Board (ICB) named below.

Integrated Care Board	NHS Essex
Area	Local Government Areas: Borough of Basildon, District of Braintree, Borough of Brentwood, Borough of Castle Point, City of Chelmsford, City of Colchester, District of Epping Forest, District of Harlow, District of Maldon, District of Rochford, City of Southend-on-Sea, District of Tendring, Borough of Thurrock, District of Uttlesford
Date of Agreement	1st April 2026
ICB Representative	Dr Matthew Sweeting Executive Medical Director
ICB Email Address for Notices	matthew.sweeting@nhs.net
NHS England Representative	Jane Halpin
NHS England Email Address for Notices	england.directcommissioningeast@nhs.net

1.2 This Agreement comprises:

1.2.1 the Particulars (Clause 1),

1.2.2 the Terms and Conditions (Clauses 2 to 32),

1.2.3 the Schedules, and

1.2.4 the Mandated Guidance

Signed by **NHS England**



Clare Panniker
Regional Director - NHS England – East of England
For and on behalf of NHS England

Signed by **NHS Essex Integrated Care Board**

Tom Abell
Chief Executive
For and on behalf of NHS Essex Integrated Care Board

TERMS AND CONDITIONS

2. INTERPRETATION

2.1 This Agreement is to be interpreted in accordance with Schedule 1 (Definitions and Interpretation).

2.2 If there is any conflict or inconsistency between the provisions of this Agreement, that conflict or inconsistency must be resolved according to the following order of priority:

2.2.1 the Developmental Arrangements,

2.2.2 the Particulars and Terms and Conditions (Clauses 1 to 32),

2.2.3 Mandated Guidance,

2.2.4 all Schedules excluding Developmental Arrangements and Local Terms, and

2.2.5 Local Terms.

2.3 This Agreement constitutes the entire agreement and understanding between the Parties relating to the Delegation and supersedes all previous agreements, promises and understandings between them, whether written or oral, relating to its subject matter.

2.4 Where it is indicated that a provision in this Agreement is not used, that provision is not relevant and has no application in this Agreement.

2.5 Where a particular clause is included in this Agreement but is not relevant to the ICB because that clause relates to matters which do not apply the ICB (for example, if the clause only relates to functions that are not Delegated Functions in respect of the ICB), that clause is not relevant and has no application to this Agreement.

3. BACKGROUND

3.1 NHS England has statutory functions (duties and powers) conferred on it by legislation to make arrangements for the provision of prescribed services known as Specialised Services. These services support people with a range of rare and complex conditions. They are currently set out in the Prescribed Specialised Services Manual. The legislative basis for identifying these Specialised Services is Regulation 11 and Schedule 4 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996.

3.2 The ICBs have statutory functions to make arrangements for the provision of services for the purposes of the NHS in their Areas, apart from those commissioned by NHS England.

3.3 Pursuant to section 65Z5 of the NHS Act, NHS England is able to delegate responsibility for carrying out its Commissioning Functions to an ICB. NHS England will remain accountable to Parliament for ensuring that statutory requirements to commission all Specialised Services, and duties set out in the mandate, are being met.

3.4 By this Agreement, NHS England delegates the functions of commissioning certain Specialised Services (the “Delegated Functions”) to the ICB under section 65Z5 of the NHS Act.

3.5 This Agreement also sets out the elements of commissioning those Specialised Services for which NHS England will continue to have responsibility (the “Reserved Functions”).

3.6 Arrangements made under section 65Z5 may be made on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the ICB.

3.7 This Agreement sets out the terms that apply to the exercise of the Delegated Functions by the ICB. It also sets out each Party's responsibilities and the measures required to ensure the effective and efficient exercise of the Delegated Functions and Reserved Functions.

4. TERM

4.1 This Agreement has effect from the Date of Agreement set out in the Particulars and will remain in force unless terminated in accordance with Clause 27 (Termination) below.

5. PRINCIPLES

5.1 In complying with the terms of this Agreement, NHS England and the ICB must:

5.1.1 at all times have regard to the Triple Aim,

5.1.2 at all times act in good faith and with integrity towards each other,

5.1.3 consider how they can meet their legal duties to involve patients and the public in shaping the provision of services, including by working with local communities, under-represented groups and those with protected characteristics for the purposes of the Equality Act 2010,

5.1.4 consider how in performing their obligations they can address health inequalities,

5.1.5 at all times exercise functions effectively, efficiently and economically,

5.1.6 act in a timely manner,

5.1.7 share information and Best Practice, and work collaboratively to identify solutions and enhance the evidence base for the commissioning and provision of health services, eliminate duplication of effort, mitigate risk and reduce cost, and

5.1.8 have regard to the needs and views of the other Party and as far as is lawful and reasonably practicable, take such needs and views into account.

6. DELEGATION

6.1 In accordance with its statutory powers under section 65Z5 of the NHS Act, NHS England hereby delegates the exercise of the Delegated Functions to the ICB to empower it to commission a range of services for its Population, as further described in this Agreement ("Delegation").

6.2 The Delegated Functions are the functions described as being delegated to the ICB as have been identified and included within Schedule 3 to this Agreement but excluding the Reserved Functions set out within Schedule 4.

6.3 The Delegation in respect of each Delegated Function has effect from the Effective Date of Delegation.

6.4 Decisions of the ICB in respect of the Delegated Functions and made in accordance with the terms of this Agreement shall be binding on NHS England and the ICB.

6.5 To the extent that this Agreement applies:

6.5.1 The ICB must ensure that its officers or employees do not make statutory or financial decisions that allocate NHS England resources.

6.5.2 NHS England must ensure that its officers or employees do not make statutory or financial decisions that allocate ICB resources, except as provided for in this Agreement.

6.6 Unless expressly provided for in this Agreement, the ICB is not authorised to take any step or make any decision in respect of Reserved Functions. Any such purported decision of the ICB is invalid and not binding on NHS England unless ratified in writing by NHS England in accordance with the NHS England Scheme of Delegation and Standing Financial Instructions.

6.7 NHS England may, acting reasonably and solely to the extent that the decision relates to the Delegated Functions, substitute its own decision for any decision which the ICB purports to make where NHS England reasonably considers that the impact of the ICB decision could cause the ICB to be acting unlawfully, in breach of this Agreement including Mandated Guidance, or in breach of any Contract. The ICB must provide any information, assistance and support as NHS England requires to enable it to determine whether to make any such decision.

6.8 The terms of Clauses 6.5, 6.6 and 6.7 are without prejudice to the ability of NHS England to enforce the terms of this Agreement or otherwise take action in respect of any failure by the ICB to comply with this Agreement.

7. EXERCISE OF DELEGATED FUNCTIONS

7.1 The ICB must establish effective, safe, efficient and economic arrangements for the discharge of the Delegated Functions.

7.2 The ICB agrees that it will exercise the Delegated Functions in accordance with:

7.2.1 the terms of this Agreement,

7.2.2 Mandated Guidance,

7.2.3 any Contractual Notices,

7.2.4 the Local Terms,

7.2.5 any Developmental Arrangements,

7.2.6 all applicable Law and Guidance,

7.2.7 the ICB's constitution,

7.2.8 the requirements of any assurance arrangements made by NHS England, and

7.2.9 Good Practice.

7.3 The ICB must perform the Delegated Functions in such a manner:

7.3.1 so as to ensure NHS England's compliance with NHS England's statutory duties in respect of the Reserved Functions and to enable NHS England to fulfil its Reserved Functions, and

7.3.2 having regard to NHS England's accountability to the Secretary of State and Parliament in respect of both the Delegated Functions and Reserved Functions, and

7.3.3 so as to ensure that the ICB complies with its statutory duties and requirements including those duties set out in Section 14Z32 to Section 14Z44 of the NHS Act and the NICE Regulations.

7.4 In exercising the Delegated Functions, the ICB must comply with all Mandated Guidance as set out in this Agreement or as otherwise may be issued by NHS England from time to time including, but not limited to, ensuring compliance with National Standards and following National Specifications.

7.5 Where Developmental Arrangements conflict with any other term of this Agreement, the Developmental Arrangements shall take precedence until such time as NHS England agrees to the removal or amendment of the relevant Developmental Arrangements in accordance with Clause 26 (Variations).

7.6 The ICB must develop an operational scheme(s) of delegation defining those individuals or groups of individuals, including committees, who may discharge aspects of the Delegated Functions. For the purposes of this clause, the ICB may include the operational scheme(s) of delegation within its general organisational scheme of delegation.

7.7 NHS England may by Contractual Notice allocate Contracts to the ICB such that they are included as part of the Delegation. The Delegated Functions must be exercised both in respect of the relevant Contract and any related matters concerning any Specialised Service Provider that is a party to a Contract. NHS England may add or remove Contracts where this is associated with an extension or reduction of the scope of the Delegated Functions.

7.8 Subsequent to the Effective Date of Delegation and for the duration of this Agreement, unless otherwise agreed any new Contract entered into in respect of the Delegated Functions shall be managed by the ICB in accordance with the provisions of this Agreement.

7.9 Subject to the provisions of this Agreement, the ICB may determine the arrangements for the exercise of the Delegated Functions.

8. REQUIREMENT FOR ICB COLLABORATION ARRANGEMENT

8.1 Subject to the provisions of Clause 12 (Further Arrangements), the ICB must establish appropriate ICB Collaboration Arrangements with other ICBs in order to ensure that the commissioning of the Delegated Services can take place across an appropriate geographical footprint for the nature of each particular Delegated Service with consideration of population size, provider landscape and patient flow. Such ICB arrangements in respect of the Delegated Functions must be approved in advance by NHS England.

8.2 The ICB must establish, as part of or separate to the arrangements set out in Clause 8.1, an agreement that sets out the arrangements in respect of the Commissioning Team as required by Clause 13.

8.3 The ICB must participate in discussions, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view with the other ICBs within the ICB Collaboration Arrangement. The members of the ICB Collaboration Arrangement shall have a collective responsibility for the operation of the ICB Collaboration Arrangement.

8.4 The ICB shall ensure that any ICB Collaboration Arrangement is documented, and such documentation must include (but is not limited to) the following:

8.4.1 membership which is limited solely to ICBs unless otherwise approved by NHS England,

8.4.2 clear governance arrangements including reporting lines to the ICBs' Boards,

8.4.3 provisions for independent scrutiny of decision making,

8.4.4 the Delegated Functions or elements thereof which are the subject of the arrangements,

8.4.5 the Delegated Services which are subject to the arrangements,

8.4.6 financial arrangements and any pooled fund arrangements,

8.4.7 data sharing arrangements including evidence of a Data Protection Impact Assessment,

8.4.8 terms of reference for decision making, and

8.4.9 limits on onward delegation.

8.5 The ICB must not terminate an ICB Collaboration Arrangement in respect of the Delegated Functions without the prior written approval of NHS England.

9. PERFORMANCE OF THE RESERVED FUNCTIONS AND COMMISSIONING SUPPORT ARRANGEMENTS

9.1 NHS England will remain responsible for the performance of the Reserved Functions.

9.2 For the avoidance of doubt, the Parties acknowledge that the Delegation may be amended, and additional functions may be delegated to the ICB, in which event consequential changes to this Agreement shall be agreed with the ICB pursuant to Clause 26 (Variations) of this Agreement.

9.3 Where it considers appropriate NHS England will work collaboratively with the ICB when exercising the Reserved Functions.

9.4 If there is any conflict or inconsistency between functions that are named as Delegated Functions and functions that are named as Reserved Functions, then such functions shall be interpreted as Reserved Functions unless and until NHS England confirms otherwise. If an ICB identifies such a conflict or inconsistency, it will inform NHS England as soon as is reasonably practicable.

9.5 The Parties acknowledge that they may agree for the ICB to provide Administrative and Management Services to NHS England in relation to certain Reserved Functions and Retained Services in order to assist in the efficient and effective exercise of such functions. Any such Commissioning Team Arrangements shall be set out in writing.

9.6 Notwithstanding any arrangement for or provision of Administrative and Management Services in respect of the Retained Services and Reserved Functions, NHS England shall retain statutory responsibility for, and be accountable for, the commissioning of the Retained Services.

9.7 The Parties acknowledge that they may agree for NHS England to provide Administrative and Management Services to ICBs in relation to certain Delegated Functions and Delegated Services in order to assist in the efficient and effective exercise of such Delegated Functions. Any such Administrative and Management Services shall be set out in writing.

9.8 Notwithstanding any arrangement for or provision of Administrative and Management Services in respect of the Delegated Services, the ICB shall retain delegated responsibility for the commissioning of the Delegated Services.

9.9 Any arrangement made between the ICB and NHS England under Clauses 9.5 or 9.7 must be made in accordance with: Clause 6.5, Clause 10.14 and Paragraph 4.2 of Schedule 4.

10. **FINANCE**

10.1 Without prejudice to any other provision in this Agreement, the ICB must comply with the Finance Guidance and any such financial processes as required by NHS England for the management, reporting and accounting of funds used for the purposes of the Delegated Functions.

10.2 The ICB acknowledges that it will receive funds from NHS England in respect of the Delegated Functions (the "Delegated Funds") and that these are in addition to the funds allocated to it within its Annual Allocation.

10.3 Subject to Clause 10.4 and any provisions in the Schedules or Mandated Guidance, the ICB may use:

10.3.1 its Annual Allocation and the Delegated Funds in the exercise of the Delegated Functions, and

10.3.2 the Delegated Funds and its Annual Allocation in the exercise of the ICB's Functions other than the Delegated Functions.

10.4 The ICB's expenditure on the Delegated Functions must be sufficient to:

10.4.1 ensure that NHS England is able to fulfil its functions, including without limitation the Reserved Functions, effectively and efficiently,

10.4.2 meet all liabilities arising under or in connection with all Contracts in so far as they relate to the exercise of the Delegated Functions,

10.4.3 appropriately commission the Delegated Services in accordance with Mandatory Guidance, National Specifications, National Standards and Guidance, and

10.4.4 meet national commitments from time to time on expenditure on specific Delegated Functions.

10.5 NHS England may increase or reduce the Delegated Funds in any Financial Year, by sending a notice to the ICB of such increase or decrease:

10.5.1 in order to take into account any monthly adjustments or corrections to the Delegated Funds that NHS England considers appropriate, including without limitation, adjustments following any changes to the Delegated Functions, changes in allocations, changes in Contracts, to implement Mandated Guidance or otherwise,

10.5.2 in order to comply with a change in the amount allocated to NHS England by the Secretary of State pursuant to section 223B of the NHS Act,

10.5.3 to take into account any Losses of NHS England for which the ICB is required to indemnify NHS England under Clause 17 (Claims and Litigation),

10.5.4 to take into account any adjustments that NHS England considers appropriate (including without limitation in order to make corrections or otherwise to reflect notional budgets) to reflect funds transferred (or that should have been transferred) to the ICB in respect of the Delegated Functions or funds transferred (or that should have been transferred) to the ICB in respect of Administrative and Management Services, and

10.5.5 in order to ensure compliance by NHS England with its obligations under the NHS Act (including, Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State in respect of NHS England under the NHS Act.

10.6 NHS England acknowledges that the intention of Clause 10.5 is to reflect genuine corrections and adjustments to the Delegated Funds and may not be used to change the allocation of the Delegated Funds unless there are significant or exceptional circumstances that would require such corrections or adjustments.

10.7 The ICB acknowledges that it must comply with its statutory financial duties, including those under Part 11 of the NHS Act to the extent that these sections apply in relation to the receipt of the Delegated Funds.

10.8 NHS England may in respect of the Delegated Funds:

10.8.1 notify the ICB regarding the required payment of sums by the ICB to NHS England in respect of charges referable to the valuation or disposal of assets and such conditions as to records, certificates or otherwise,

10.8.2 by notice, require the ICB to take such action or step in respect of the Delegated Funds, in order to ensure compliance by NHS England of its duties or functions under the NHS (including Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State under the NHS Act.

10.9 The Schedules to this Agreement may identify further financial provisions in respect of the exercise of the Delegated Functions.

10.10 NHS England may issue Mandated Guidance in respect of the financial arrangements in respect of the Delegated Functions.

10.11 NHS England will pay the Delegated Funds to the ICB using the revenue transfer process as used for the Annual Allocation or such other process as notified to the ICB from time to time.

10.12 Without prejudice to any other obligation upon the ICB, for the purposes of the Delegated Functions the ICB agrees that it must use its resources in accordance with:

10.12.1 the terms and conditions of this Agreement including any Mandated Guidance issued by NHS England from time to time in relation to the use of resources for the purposes of the Delegated Functions (including in relation to the form or contents of any accounts),

10.12.2 any NHS payment scheme published by NHS England,

10.12.3 the business rules as set out in NHS England's planning guidance or such other documents issued by NHS England from time to time,

10.12.4 any Capital Investment Guidance,

10.12.5 the HM Treasury Guidance *Managing Public Money* (dated September 2022) as replaced or updated from time to time, and

10.12.6 any other Guidance published by NHS England with respect to the financial management of Delegated Functions.

10.13 Without prejudice to any other obligation upon the ICB, the ICB agrees that it must provide:

10.13.1 all information, assistance and support to NHS England in relation to the audit and/or investigation (whether internal or external and whether under Law or otherwise) in relation to the use of or payment of resources for the purposes of the Delegated Functions and the discharge of those functions,

10.13.2 such reports in relation to the expenditure on the Delegated Functions as set out in Mandated Guidance, the Schedules to this Agreement or as otherwise required by NHS England.

Ledger access and use of financial data

10.14 NHS England and the ICB agree that they shall not access a financial ledger or other finance system that is operated by another organisation, or use data directly obtained from such a financial ledger or other finance system.

10.15 Clause 10.14 applies unless that access or use has been approved in advance by the organisation that operates that financial ledger or other finance system, or as is otherwise expressly provided for in this Agreement.

Pooled Funds

10.16 Subject to the provisions of this Agreement, the ICB may, for the purposes of exercising the Delegated Functions under this Agreement, establish and maintain a pooled fund(s) in respect of any part of the Delegated Funds with:

10.16.1 NHS England in accordance with sections 13V or 65Z6 of the NHS Act,

10.16.2 one or more ICBs in accordance with section 65Z6 of the NHS Act as part of a Further Arrangement, or

10.16.3 NHS England and one or more ICBs in accordance with section 13V of the NHS Act, and

10.16.4 NHS England and one or more ICBs in accordance with section 65Z6 of the NHS Act.

10.17 Where the ICB has decided to enter into arrangements under Clause 10.16 the agreement must be in writing and must specify:

10.17.1 the agreed aims and outcomes of the arrangements,

10.17.2 the payments to be made by each partner and how those payments may be varied,

10.17.3 the specific Delegated Functions which are the subject of the arrangements,

10.17.4 the Delegated Services which are subject to the arrangements,

10.17.5 the duration of the arrangements and provision for the review or variation or termination of the arrangements,

10.17.6 the arrangements in place for governance of the pooled fund, and

10.17.7 the arrangements in place for assuring, oversight and monitoring of the ICB's exercise of the functions referred to in 10.17.3.

10.18 At the date of this Agreement, details of the pooled funds (including any terms as to the governance and payments out of such pooled fund) of NHS England and the ICB are set out in the Local Terms.

11. INFORMATION, PLANNING AND REPORTING

11.1 The ICB must provide to NHS England:

11.1.1 such information or explanations in relation to the exercise of the Delegated Functions as required by NHS England from time to time, and

11.1.2 all such information (and in such form), that may be relevant to NHS England in relation to the exercise by NHS England of its other duties or functions including, without limitation, the Reserved Functions.

11.2 The provisions of this Clause 11 are without prejudice to the ability of NHS England to exercise its other powers and duties in obtaining information from and assessing the performance of the ICB.

Forward Plan and Annual Report

11.3 Before the start of each Financial Year, the ICB must describe in its joint forward plan prepared in accordance with section 14Z52 of the NHS Act how it intends to exercise the Delegated Functions.

11.4 The ICB must report on its exercise of the Delegated Functions in its annual report prepared in accordance with section 14Z58 of the NHS Act.

Risk Register

11.5 The ICB must maintain a risk register in respect of its exercise of the Delegated Functions and periodically review its content. The risk register must follow such format as may be notified by NHS England to the ICB from time to time.

12. FURTHER ARRANGEMENTS

12.1 In addition to any ICB Collaboration Arrangement agreed in accordance with Clause 8 (ICB Collaboration Arrangements) the ICB must give due consideration to whether any of the Delegated Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act ("Further Arrangements").

12.2 The ICB may only make Further Arrangements with another person (a "Sub-Delegate") with the prior written approval of NHS England.

12.3 The approval of any Further Arrangements may:

12.3.1 include approval of the terms of the proposed Further Arrangements, and

12.3.2 require conditions to be met by the ICB and the Sub-Delegate in respect of that arrangement.

12.4 All Further Arrangements must be made in writing.

12.5 The ICB must not terminate Further Arrangements without the prior written approval of NHS England.

12.6 If the ICB enters into a Further Arrangement it must ensure that the Sub-Delegate does not make onward arrangements for the exercise of any or all of the Delegated Functions without the prior written approval of NHS England.

12.7 The terms of this Clause 12 do not prevent the ICB from making arrangements for assistance and support in the exercise of the Delegated Functions with any person, where such arrangements reserve the consideration and making of any decision in respect of a Delegated Function to the ICB.

12.8 Where Further Arrangements are made, and unless NHS England has otherwise given specific prior written agreement, any obligations or duties on the part of the ICB under this Agreement that are relevant to those Further Arrangements shall also require the ICB to ensure that all Sub-Delegates comply with such obligations or duties and support the ICB in doing so.

13. STAFFING, WORKFORCE AND COMMISSIONING TEAMS

13.1 Where there is an arrangement for NHS England to provide Administrative and Management Services to the ICB, the ICB shall provide full co-operation with NHS England and enter into any necessary arrangements with NHS England and, where appropriate, other ICBs in respect of the Specialised Services Staff.

13.2 The ICB shall, if and where required by NHS England, enter into appropriate arrangements with NHS England in respect of the transfer of Specialised Services Staff.

13.3 The ICB shall, where appropriate, enter into an agreement with other ICBs, in order to establish arrangements in respect of the Commissioning Team. Where appropriate, this agreement may be included as part of the ICB Collaboration Arrangement entered into in accordance with Clause 8.

14. BREACH

14.1 If the ICB does not comply with the terms of this Agreement, then NHS England may:

14.1.1 exercise its rights under this Agreement, and

14.1.2 take such steps as it considers appropriate in the exercise of its other functions concerning the ICB.

14.2 Without prejudice to Clause 14.1, if the ICB does not comply with the terms of this Agreement (including if the ICB exceeds its delegated authority under the Delegation), NHS England may (at its sole discretion):

14.2.1 waive its rights in relation to such non-compliance in accordance with Clause 14.3,

14.2.2 ratify any decision in accordance with Clause 6.6,

14.2.3 substitute a decision in accordance with Clause 6.7,

14.2.4 amend Developmental Arrangements or impose new Developmental Arrangements,

14.2.5 revoke the whole or part of the Delegation and terminate this Agreement in accordance with Clause 27 (Termination) below,

14.2.6 exercise the Escalation Rights in accordance with Clause 15 (Escalation Rights), and/or

14.2.7 exercise its rights under common law.

14.3 NHS England may waive any non-compliance by the ICB with the terms of this Agreement provided that the ICB provides a written report to NHS England as required by Clause 14.4 and, after considering the ICB's written report, NHS England is satisfied that the waiver is justified.

14.4 If:

14.4.1 the ICB does not comply with this Agreement,

14.4.2 the ICB considers that it may not be able to comply with this Agreement,

14.4.3 NHS England notifies the ICB that it considers the ICB has not complied with this Agreement, or

14.4.4 NHS England notifies the ICB that it considers that the ICB may not be able to comply with this Agreement,

then the ICB must provide a written report to NHS England within ten (10) Operational Days of the non-compliance (or the date on which the ICB identifies that it may not be able to comply with this Agreement) setting out:

14.4.5 details of and reasons for the non-compliance (or likely non-compliance) with the Agreement and/or the Delegation, and

14.4.6 a plan for how the ICB proposes to remedy the non-compliance.

15. ESCALATION RIGHTS

15.1 If the ICB does not comply with this Agreement, NHS England may exercise the following Escalation Rights:

15.1.1 NHS England may require a suitably senior representative of the ICB to attend a review meeting within ten (10) Operational Days of NHS England becoming aware of the non-compliance, and

15.1.2 NHS England may require the ICB to prepare an action plan and report within twenty (20) Operational Days of the review meeting (to include details of the non-compliance and a plan for how the ICB proposes to remedy the non-compliance).

15.2 If NHS England does not comply with this Agreement, the ICB may require a suitably senior representative of NHS England to attend a review meeting within ten (10) Operational Days of the ICB making NHS England aware of the non-compliance.

15.3 Nothing in Clause 15 (Escalation Rights) will affect NHS England's right to substitute a decision in accordance with Clause 6.8, revoke the Delegation or terminate this Agreement in accordance with Clause 27 (Termination) below.

16. LIABILITY AND INDEMNITY

16.1 NHS England is liable in respect of any Losses arising in respect of NHS England's negligence, fraud, recklessness or deliberate breach in respect of the Delegated Functions and occurring after the Effective Date of Delegation and, if the ICB suffers any Losses in respect of such actions by NHS England, NHS England shall make such adjustments to the Annual Allocation (or other amounts payable to the ICB) in order to reflect any Losses suffered by the ICB (except to the extent that the ICB is liable for such Losses pursuant to Clause 16.3).

16.2 For the avoidance of doubt, NHS England remains liable for a Claim relating to facts, events or circumstances concerning the Delegated Functions before the Effective Date of Delegation.

16.3 The ICB is liable to (and shall pay) NHS England for any Losses suffered by NHS England that result from or arise out of the ICB's negligence, fraud, recklessness or breach of the Delegation (including any actions that are taken that exceed the authority conferred by the Delegation) or this Agreement. In respect of such Losses, NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB or make such adjustments to the Delegated Funds pursuant to Clause 10.5. The ICB shall not be liable to the extent that the Losses arose prior to the Effective Date of Delegation.

16.4 Each Party acknowledges and agrees that any rights acquired, or liabilities (including liabilities in tort) incurred, in respect of the exercise by the ICB of any Delegated

Function are enforceable by or against the ICB only, in accordance with section 65Z5(6) of the NHS Act.

16.5 Each Party will at all times take all reasonable steps to minimise and mitigate any Losses or other matters for which one Party is entitled to be indemnified by or to bring a claim against the other under this Agreement.

17. CLAIMS AND LITIGATION

17.1 Nothing in this Clause 17 (Claims and Litigation) shall be interpreted as affecting the reservation to NHS England of the Reserved Functions.

17.2 Except in the circumstances set out in Clause 17.5 and subject always to compliance with this Clause 17 (Claims and Litigation), the ICB shall be responsible for and shall retain the conduct of any Claim.

17.3 The ICB must:

17.3.1 comply with any policy issued by NHS England from time to time in relation to the conduct of or avoidance of Claims and the pro-active management of Claims,

17.3.2 if it receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim, immediately notify NHS England and send to NHS England all copies of such correspondence,

17.3.3 co-operate fully with NHS England in relation to such Claim and the conduct of such Claim,

17.3.4 provide, at its own cost, to NHS England all documentation and other correspondence that NHS England requires for the purposes of considering and/or resisting such Claim, and

17.3.5 at the request of NHS England, take such actions or step or provide such assistance as may in NHS England's discretion be necessary or desirable having regard to the nature of the Claim and the existence of any time limit in relation to avoiding, disputing, defending, resisting, appealing, seeking a review or compromising such Claim or to comply with the requirements of the provider of an Indemnity Arrangement in relation to such Claim.

17.4 Subject to Clauses 17.3 and 17.5 the ICB is entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit.

NHS England Stepping into Claims

17.5 NHS England may, at any time following discussion with the ICB, send a notice to the ICB stating that NHS England will take over the conduct of the Claim and the ICB must immediately take all steps necessary to transfer the conduct of such Claim to NHS England unless and until NHS England transfers conduct back to the ICB. In such cases:

17.5.1 NHS England shall be entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit, provided that if NHS England wishes to invoke Clause 17.5.3 it agrees to seek the ICB's views on any proposal to pay or settle that Claim prior to finalising such payment or settlement, and

17.5.2 the Delegation shall be treated as being revoked to the extent that and for so long as NHS England has assumed responsibility for exercising those of

the Delegated Functions that are necessary for the purposes of having conduct of the Claim, and

17.5.3 NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or make an adjustment to the Delegated Funds pursuant to Clause 10.5.3 for the purposes of meeting any Claim Losses associated with that Claim.

Claim Losses

17.6 The ICB and NHS England shall notify each other as soon as reasonably practicable of becoming aware of any Claim Losses.

17.7 The ICB acknowledges that NHS England will pay to the ICB the funds that are attributable to the Delegated Functions. Accordingly, the ICB acknowledges that it must pay any Claim Losses out of either the Delegated Funds or its Annual Allocation. NHS England may, in respect of any Claim Losses, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or pursuant to Clause 10.5.3 make such adjustments to the Delegated Funds to take into account the amount of any Claim Losses (other than any Claim Losses in respect of which NHS England has retained any funds, provisions or other resources to discharge such Claim Losses). For the avoidance of doubt, in circumstances where NHS England suffers any Claim Losses, then NHS England shall be entitled to recoup such Claim Losses pursuant to Clause 10.5.3. If and to the extent that NHS England has retained any funds, provisions or other resources to discharge such Claim Losses, then NHS England may either use such funds to discharge the Claim Loss or make an upward adjustment to the amounts paid to the ICB pursuant to Clause 10.5.3.

18. DATA PROTECTION, FREEDOM OF INFORMATION AND TRANSPARENCY

18.1 The Parties must ensure that all Personal Data processed by or on behalf of them while carrying out the Delegated Functions and Reserved Functions is processed in accordance with the relevant Party's obligations under Data Protection Legislation and Data Guidance and the Parties must assist each other as necessary to enable each other to comply with these obligations.

18.2 The ICB must respond to any information governance breach in accordance with Information Governance Guidance for Serious Incidents. If the ICB is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach then, as soon as reasonably practical and in any event on or before the first such notification is made, the ICB must fully inform NHS England of the information governance breach. This clause does not require the ICB to provide NHS England with information which identifies any individual affected by the information governance breach, where doing so would breach Data Protection Legislation.

18.3 Whether or not a Party is a Data Controller or Data Processor will be determined in accordance with Data Protection Legislation and any Data Guidance from a Regulatory or Supervisory Body. The Parties acknowledge that a Party may act as both a Data Controller and a Data Processor.

18.4 NHS England may, from time to time, issue a data sharing protocol or update a protocol previously issued relating to the data sharing in relation to the Delegated Functions and/or Reserved Functions. The ICB shall comply with such data sharing protocols.

18.5 Each Party acknowledges that the other is a public authority for the purposes of the Freedom of Information Act 2000 ("FOIA") and the Environmental Information Regulations 2004 ("EIR").

18.6 Each Party may be required by statute to disclose further information about the Agreement and the Relevant Information in response to a specific request under FOIA or EIR, in which case:

18.6.1 each Party shall provide the other with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR,

18.6.2 each Party shall consult the other regarding the possible application of exemptions in relation to the information requested, and

18.6.3 subject only to Clause 17 (Claims and Litigation), each Party acknowledges that the final decision as to the form or content of the response to any request is a matter for the Party to whom the request is addressed.

18.7 NHS England may, from time to time, issue a FOIA or EIR protocol or update a protocol previously issued relating to the handling and responding to of FOIA or EIR requests in relation to the Delegated Functions. The ICB shall comply with such FOIA or EIR protocols.

18.8 Schedule 6 (Further Information Governance*,* Sharing *and Processing* Provisions) makes further provision about information sharing, information governance and the Data Sharing Agreement.

19. IT INTER-OPERABILITY

19.1 The Parties will work together to ensure that all relevant IT systems they operate in respect of the Delegated Functions and Reserved Functions are inter-operable and that data may be transferred between systems securely, easily and efficiently.

19.2 The Parties will use their respective reasonable endeavours to help develop initiatives to further this aim.

20. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

20.1 The ICB must ensure that, in delivering the Delegated Functions, all Staff comply with Law, with Managing Conflicts of Interest in the NHS and other Guidance, and with Good Practice, in relation to gifts, hospitality and other inducements and actual or potential conflicts of interest.

20.2 Without prejudice to the general obligations set out in Clause 20.1, the ICB must maintain a register of interests in respect of all persons making decisions concerning the Delegated Functions. This register must be publicly available. For the purposes of this clause, the ICB may rely on an existing register of interests rather than creating a further register.

21. PROHIBITED ACTS AND COUNTER-FRAUD

21.1 The ICB must not commit any Prohibited Act.

21.2 If the ICB or its Staff commits any Prohibited Act in relation to this Agreement with or without the knowledge of NHS England, NHS England will be entitled:

21.2.1 to revoke the Delegation,

21.2.2 to recover from the ICB the amount or value of any gift, consideration or commission concerned, and

21.2.3 to recover from the ICB any loss or expense sustained in consequence of the carrying out of the Prohibited Act.

21.3 The ICB must put in place and maintain appropriate arrangements, including without limitation, Staff training, to address counter-fraud issues, having regard to any relevant Guidance, including from the NHS Counter Fraud Authority.

21.4 If requested by NHS England or the NHS Counter Fraud Authority, the ICB must allow a person duly authorised to act on behalf of the NHS Counter Fraud Authority or on behalf of NHS England to review, in line with the appropriate standards, any counter-fraud arrangements put in place by the ICB.

21.5 The ICB must implement any reasonable modifications to its counter-fraud arrangements required by a person referred to in Clause 21.4 in order to meet the appropriate standards within whatever time periods as that person may reasonably require.

21.6 The ICB must, on becoming aware of:

21.6.1 any suspected or actual bribery, corruption or fraud involving public funds, or

21.6.2 any suspected or actual security incident or security breach involving Staff or involving NHS resources,

promptly report the matter to NHS England and to the NHS Counter Fraud Authority.

21.7 On the request of NHS England or NHS Counter Fraud Authority, the ICB must allow the NHS Counter Fraud Authority or any person appointed by NHS England, as soon as it is reasonably practicable and in any event not later than five (5) Operational Days following the date of the request, access to:

21.7.1 all property, premises, information (including records and data) owned or controlled by the ICB, and

21.7.2 all Staff who may have information to provide.

relevant to the detection and investigation of cases of bribery, fraud or corruption, or security incidents or security breaches directly or indirectly in connection with this Agreement.

22. CONFIDENTIAL INFORMATION OF THE PARTIES

22.1 Except as this Agreement otherwise provides, Confidential Information is owned by the disclosing Party and the receiving Party has no right to use it.

22.2 Subject to Clauses 22.3 to 22.5, the receiving Party agrees:

22.2.1 to use the disclosing Party's Confidential Information only in connection with the receiving Party's performance under this Agreement,

22.2.2 not to disclose the disclosing Party's Confidential Information to any third party or to use it to the detriment of the disclosing Party, and

22.2.3 to maintain the confidentiality of the disclosing Party's Confidential Information.

22.3 The receiving Party may disclose the disclosing Party's Confidential Information:

22.3.1 in connection with any dispute resolution procedure under Clause 25,

22.3.2 in connection with any litigation between the Parties,

22.3.3 to comply with the Law,

22.3.4 to any appropriate Regulatory or Supervisory Body,

22.3.5 to its Staff, who in respect of that Confidential Information will be under a duty no less onerous than the receiving Party's duty under Clause 22.2,

22.3.6 to NHS bodies for the purposes of carrying out their functions,

22.3.7 as permitted under or as may be required to give effect to Clause 21 (Prohibited Acts and Counter-Fraud), and

22.3.8 as permitted under any other express arrangement or other provision of this Agreement.

22.4 The obligations in Clauses 22.1 and 22.2 will not apply to any Confidential Information which:

22.4.1 is in, or comes into, the public domain other than by breach of this Agreement,

22.4.2 the receiving Party can show by its records was in its possession before it received it from the disclosing Party, or

22.4.3 the receiving Party can prove it obtained or was able to obtain from a source other than the disclosing Party without breaching any obligation of confidence.

22.5 This Clause 22 does not prevent NHS England making use of or disclosing any Confidential Information disclosed by the ICB where necessary for the purposes of exercising its functions in relation to the ICB.

22.6 The Parties acknowledge that damages would not be an adequate remedy for any breach of this Clause 22 by the receiving Party, and in addition to any right to damages the disclosing Party will be entitled to the remedies of injunction, specific performance and other equitable relief for any threatened or actual breach of this Clause 22.

22.7 This Clause 22 will survive the termination of this Agreement for any reason for a period of five (5) years.

22.8 This Clause 22 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

23. INTELLECTUAL PROPERTY

23.1 The ICB grants to NHS England a fully paid-up, non-exclusive, perpetual licence to use the ICB Deliverables for the purposes of the exercise of its statutory and contractual functions.

23.2 NHS England grants the ICB a fully paid-up, non-exclusive licence to use the NHS England Deliverables for the purpose of performing this Agreement and the Delegated Functions.

23.3 The ICB must co-operate with NHS England to enable it to understand and adopt Best Practice (including the dissemination of Best Practice to other commissioners or providers of NHS services), and must supply such materials and information in relation to Best Practice as NHS England may reasonably request, and (to the extent that any Intellectual Property Rights ("IPR") attaches to Best Practice) grants NHS England a fully paid-up, non-exclusive, perpetual licence for NHS England to use Best Practice IPR for the commissioning and provision of NHS services and to share any Best Practice IPR with other commissioners of NHS services (and other providers of NHS services) to enable those parties to adopt such Best Practice.

24. **NOTICES**

24.1 Any notices given under this Agreement must be sent by e-mail to the other Party's address set out in the Particulars or as otherwise notified by one Party to another as the appropriate address for this Clause 24.1.

24.2 Notices by e-mail will be effective when sent in legible form, but only if, following transmission, the sender does not receive a non-delivery message.

25. **DISPUTES**

25.1 This clause does not affect NHS England's right to exercise its functions for the purposes of assessing and addressing the performance of the ICB.

25.2 If a Dispute arises out of, or in connection with, this Agreement then the Parties must follow the procedure set out in this clause:

25.2.1 either Party must give to the other written notice of the Dispute, setting out its nature and full particulars ("Dispute Notice"), together with relevant supporting documents. On service of the Dispute Notice, the Agreement Representatives must attempt in good faith to resolve the Dispute,

25.2.2 if the Agreement Representatives are, for any reason, unable to resolve the Dispute within twenty (20) Operational Days of service of the Dispute Notice, the Dispute must be referred to the Chief Executive Officer (or equivalent person) of the ICB and a director of or other person nominated by NHS England (and who has authority from NHS England to settle the Dispute) who must attempt in good faith to resolve it, and

25.2.3 if the people referred to in Clause 25.2.2 are for any reason unable to resolve the Dispute within twenty (20) Operational Days of it being referred to them, the Parties may attempt to settle it by mediation in accordance with the CEDR model mediation procedure. Unless otherwise agreed between the Parties, the mediator must be nominated by CEDR. To initiate the mediation, a Party must serve notice in writing ('Alternative Dispute Resolution' ("ADR) notice") to the other Party to the Dispute, requesting a mediation. A copy of the ADR notice should be sent to CEDR. The mediation will start no later than ten (10) Operational Days after the date of the ADR notice.

25.3 If the Dispute is not resolved within thirty (30) Operational Days after service of the ADR notice, or either Party fails to participate or to continue to participate in the mediation before the expiration of the period of thirty (30) Operational Dys, or the mediation terminates before the expiration of the period of thirty (30) Operational Days, the Dispute must be referred to the NHS England Board, who shall resolve the matter and whose decision shall be binding upon the Parties.

26. **VARIATIONS**

26.1 The Parties acknowledge that the scope of the Delegated Functions may be reviewed and amended from time to time including by revoking this Agreement and making alternative arrangements.

26.2 NHS England may vary this Agreement without the ICB's consent where:

26.2.1 it is reasonably satisfied that the variation is necessary in order to comply with legislation, NHS England's statutory duties, or any requirements or direction given by the Secretary of State,

26.2.2 where variation is as a result of amendment to or additional Mandated Guidance,

26.2.3 it is satisfied that any Developmental Arrangements are no longer required,

26.2.4 it reasonably considers that Developmental Arrangements are required under Clause 14 (Breach), or

26.2.5 it is satisfied that such amendment or Developmental Arrangement is required in order to ensure the effective commissioning of the Delegated Services or other Specialised Services.

26.3 Where NHS England wishes to vary the Agreement in accordance with Clause 26.2 it must notice in writing to the ICB of the wording of the proposed variation and the date on which that variation is to take effect which must, unless it is not reasonably practicable, be a date which falls at least thirty (30) Operational Days after the date on which the notice under that clause is given to the ICB.

26.4 For the avoidance of doubt, NHS England may issue or update Mandated Guidance at any point during the term of the Agreement.

26.5 Either Party ("the Proposing Party") may notify the other Party (the "Receiving Party") of a Variation Proposal in respect of this Agreement including, but not limited to the following:

26.5.1 a request by the ICB to add, vary or remove any Developmental Arrangement, or

26.5.2 a request by NHS England to include additional Specialised Services or NHS England Functions within the Delegation, and

the Proposing Party will identify whether the proposed variation may have the impact of changing the scope of the Delegated Functions or Reserved Functions so that NHS England can establish the requisite level of approval required.

26.6 The Variation Proposal will set out the variation proposed and the date on which the Proposing Party requests the variation to take effect.

26.7 When a Variation Proposal is issued in accordance with 26.6, the Receiving Party must respond within thirty (30) Operational Days following the date that it is issued by serving notice confirming either:

26.7.1 that it accepts the Variation Proposal, or

26.7.2 that it refuses to accept the Variation Proposal and setting out reasonable grounds for that refusal.

26.8 If the Receiving Party accepts the Variation Proposal issued in accordance with Clause 26.5, the Receiving Party agrees to take all necessary steps (including executing a variation agreement) in order to give effect to any variation by the date on which the proposed variation will take effect as set out in the Variation Proposal.

26.9 If the Receiving Party refuses to accept a Variation Proposal submitted in accordance with 26.5 to 26.7, or to take such steps as are required to give effect to the variation, then the provisions of Clause 15 (Escalation Rights) shall apply.

26.10 When varying the Agreement in accordance with Clause 26, the Parties must consider the impact of the proposed variation on any ICB Collaboration Arrangements and any Further Arrangements.

27. TERMINATION

27.1 The ICB may:

27.1.1 notify NHS England that it requires NHS England to revoke the Delegation, and

27.1.2 terminate this Agreement,

with effect from the end of 31 March in any calendar year, provided that:

27.1.3 on or before 30 September of the previous calendar year, the ICB sends written notice to NHS England of its requirement that NHS England revoke the Delegation and its intention to terminate this Agreement, and

27.1.4 the ICB meets with NHS England within ten (10) Operational Days of NHS England receiving the notice set out at Clause 27.1.3 above to discuss arrangements for termination and transition of the Delegated Functions to a successor commissioner in accordance with Clause 28.2, and

27.1.5 the ICB confirms satisfactory arrangements for terminating any ICB Collaboration Arrangements or Further Agreements in whole or part as required including agreed succession arrangements for Commissioning Teams,

in which case NHS England shall revoke the Delegation and this Agreement shall terminate with effect from the end of 31 March in the next calendar year.

27.2 NHS England may revoke the Delegation in whole or in part with effect from 23.59 hours on 31 March in any year, provided that it gives notice to the ICB of its intention to terminate the Delegation on or before 30 September in the year prior to the year in which the Delegation will terminate, and in which case Clause 27.4 will apply.

27.3 The Delegation may be revoked in whole or in part, and this Agreement may be terminated by NHS England at any time, including in (but not limited to) the following circumstances:

27.3.1 the ICB acts outside of the scope of its delegated authority,

27.3.2 the ICB fails to perform any material obligation of the ICB owed to NHS England under this Agreement,

27.3.3 the ICB persistently commits non-material breaches of this Agreement,

27.3.4 NHS England is satisfied that its intervention powers under section 14Z61 of the NHS Act apply,

27.3.5 to give effect to legislative changes, including conferral of any of the Delegated or Reserved Functions on the ICB,

27.3.6 failure to agree to a variation in accordance with Clause 26 (Variations),

27.3.7 NHS England and the ICB agree in writing that the Delegation shall be revoked and this Agreement shall terminate on such date as is agreed, and/or

27.3.8 the ICB merges with another ICB or other body.

27.4 This Agreement will terminate upon revocation or termination of the full Delegation (including revocation and termination in accordance with this Clause 27 (Termination)) except that the provisions referred to in Clause 29 (Provisions Surviving Termination) will continue in full force and effect.

27.5 Without prejudice to Clause 14.3 and to avoid doubt, NHS England may waive any right to terminate this Agreement under this Clause 27 (Termination). Any such waiver is only

effective if given in writing and shall not be deemed a waiver of any subsequent right or remedy.

27.6 As an alternative to termination of the Agreement in respect of all the Delegated Functions, NHS England may terminate the Agreement in respect of specified Delegated Functions (or aspects of such Delegated Functions) only, in which case this Agreement shall otherwise remain in effect.

28. CONSEQUENCE OF TERMINATION

28.1 Termination of this Agreement, or termination of the ICB's exercise of any of the Delegated Functions, will not affect any rights or liabilities of the Parties that have accrued before the date of that termination or which later accrue in respect of the term of this Agreement. For the avoidance of doubt, the ICB shall be responsible for any Claims or other costs or liabilities incurred in the exercise of the Delegated Functions during the period of this Agreement unless expressly agreed otherwise by NHS England.

28.2 Subject to Clause 28.4, on or pending termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, NHS England, the ICB and, if appropriate, any successor delegate will:

28.2.1 agree a plan for the transition of the Delegated Functions from the ICB to the successor delegate, including details of the transition, the Parties' responsibilities in relation to the transition, the Parties' arrangements in respect of the Staff engaged in the Delegated Functions and the date on which the successor delegate will take responsibility for the Delegated Functions,

28.2.2 implement and comply with their respective obligations under the plan for transition agreed in accordance with Clause 28.2.1, and

28.2.3 act with a view to minimising any inconvenience or disruption to the commissioning of healthcare in the Area.

28.3 For a reasonable period before and after termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, the ICB must:

28.3.1 co-operate with NHS England and any successor delegate to ensure continuity and a smooth transfer of the Delegated Functions, and

28.3.2 at the reasonable request of NHS England:

28.3.2.1 promptly provide all reasonable assistance and information to the extent necessary for an efficient assumption of the Delegated Functions by a successor delegate,

28.3.2.2 deliver to NHS England all materials and documents used by the ICB in the exercise of any of the Delegated Functions, and

28.3.2.3 use all reasonable efforts to obtain the consent of third parties to the assignment, novation or termination of existing contracts between the ICB and any third party which relate to or are associated with the Delegated Functions.

28.4 Where any or all of the Delegated Functions or Reserved Functions are to be directly conferred on the ICB, the Parties will co-operate with a view to ensuring continuity and a smooth transfer to the ICB.

29. **PROVISIONS SURVIVING TERMINATION**

29.1 Any rights, duties or obligations of any of the Parties which are expressed to survive, including those referred to in Clause 29.2, or which otherwise by necessary implication survive the termination for any reason of this Agreement, together with all indemnities, will continue after termination, subject to any limitations of time expressed in this Agreement.

29.2 The surviving provisions include the following clauses together with such other provisions as are required to interpret and give effect to them:

29.2.1 Clause 10 (Finance),

29.2.2 Clause 13 (Staffing, Workforce and Commissioning Teams),

29.2.3 Clause 16 (Liability and Indemnity),

29.2.4 Clause 17 (Claims and Litigation),

29.2.5 Clause 18 (Data Protection, Freedom of Information and Transparency),

29.2.6 Clause 25 (Disputes),

29.2.7 Clause 27 (Termination),

29.2.8 Schedule 6 (Further Information Governance*,* Sharing *and Processing* Provisions).

30. **COSTS**

30.1 Each Party is responsible for paying its own costs and expenses incurred in connection with the negotiation, preparation and execution of this Agreement.

31. **SEVERABILITY**

31.1 If any provision or part of any provision of this Agreement is declared invalid or otherwise unenforceable, that provision or part of the provision as applicable will be severed from this Agreement. This will not affect the validity and/or enforceability of the remaining part of that provision or of other provisions.

32. **GENERAL**

32.1 Nothing in this Agreement will create a partnership or joint venture or relationship of principal and agent between NHS England and the ICB.

32.2 A delay or failure to exercise any right or remedy in whole or in part shall not waive that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy.

32.3 This Agreement does not give rise to any rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this Agreement.

SCHEDULE 1 DEFINITIONS AND INTERPRETATION

1. The headings in this Agreement will not affect its interpretation.

2. Reference to any statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance, includes a reference to that statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance as from time to time updated, amended, extended, supplemented, re-enacted or replaced in whole or in part.

3. Reference to a statutory provision includes any subordinate legislation made from time to time under that provision.

4. References to clauses and schedules are to the clauses and schedules of this Agreement, unless expressly stated otherwise.

5. References to any body, organisation or office include reference to its applicable successor from time to time.

6. Any references to this Agreement or any other documents or resources includes reference to this Agreement or those other documents or resources as varied, amended, supplemented, extended, restated and/or replaced from time to time and any reference to a website address for a resource includes reference to any replacement website address for that resource.

7. Use of the singular includes the plural and vice versa.

8. Use of the masculine includes the feminine and all other genders.

9. Use of the term “including” or “includes” will be interpreted as being without limitation.

10. The following words and phrases have the following meanings:

Administrative and Management Services	means administrative and management support provided in accordance with Clause 9.5 or 9.7,
Agreement	means this agreement between NHS England and the ICB comprising the Particulars, the Terms and Conditions, the Schedules and the Mandated Guidance,
Agreement Representatives	means the ICB Representative and the NHS England Representative as set out in the Particulars or such person identified to the other Party from time to time as the relevant representative,
Annual Allocation	means the funds allocated to the ICB annually under section 223G of the NHS Act,
Area	means the geographical area covered by the ICB,
Assurance Processes	has the definition given in paragraph 3.1 of Schedule 3,
Best Practice	means any methodologies, pathway designs and processes relating to this Agreement or the Delegated Functions developed by the ICB or its Staff for the purposes of delivering the Delegated Functions and which are capable of wider use in the delivery of healthcare services for the purposes of the NHS, but not including inventions that are capable of patent protection and for which patent protection is being sought or has been obtained, registered designs, or copyright in software,

Capital Investment Guidance	means any Mandated Guidance issued by NHS England from time to time in relation to the development, assurance and approvals process for proposals in relation to: - the expenditure of Capital, or investment in property, infrastructure or information and technology, and - the revenue consequences for commissioners or third parties making such investment,
CEDR	means the Centre for Effective Dispute Resolution,
Claims	means, for or in relation to the Delegated Functions (i) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or the Secretary of State, any governmental, regulatory or similar body, or any department, board or agency or (ii) any dispute with, or any investigation, inquiry or enforcement proceedings by, any governmental, regulatory or similar body or agency,
Claim Losses	means all Losses arising in relation to any Claim,
Clinical Commissioning Policies	means a nationally determined clinical policy setting out the commissioning position on a particular clinical treatment issue and defines accessibility (including a not for routine commissioning position) of a medicine, medical device, diagnostic technique, surgical procedure or intervention for patients with a condition requiring a specialised service,
Clinical Reference Groups	means a group consisting of clinicians, commissioners, public health experts, patient and public voice representatives and professional associations, which offers specific knowledge and expertise on the best ways that Specialised Services should be provided,
Collaborative Agreement	Means the 'Collaboration Agreement for the Commissioning of Delegated Specialised Services in the East of England' agreed between all ICBs in the East of England and NHS England, East of England Regional Team,
Collaborative Commissioning Agreement	means an agreement under which NHS Commissioners set out collaboration arrangements in respect of commissioning Specialised Services Contracts,
Commissioning Functions	means the respective statutory functions of the Parties in arranging for the provision of services as part of the health service,
Commissioning Team	means those Specialised Services Staff that support the commissioning of Delegated Services immediately prior to this Agreement and, at the point that Staff transfer from NHS England to an identified ICB, it shall mean those NHS England

	Staff and such other Staff appointed by that ICB to carry out a role in respect of commissioning the Delegated Services,
Commissioning Team Arrangements	means the arrangements through which the services of a Commissioning Team are made available to another NHS body for the purposes of commissioning the Delegated Services,
Complaints Sharing Protocol	has the definition given in paragraph 7.5 of Schedule 3,
Confidential Information	means any information or data in whatever form disclosed, which by its nature is confidential or which the disclosing Party acting reasonably states in writing to the receiving Party is to be regarded as confidential, or which the disclosing Party acting reasonably has marked 'confidential' (including, financial information, strategy documents, tenders, employee confidential information, development or workforce plans and information, and information relating to services) but which is not information which is disclosed in response to an FOIA request, or information which is published as a result of NHS England or government policy in relation to transparency,
Contracts	means any contract or arrangement in respect of the commissioning of any of the Delegated Services,
Contracting Standard Operating Procedure	means the Contracting Standard Operating Procedure produced by NHS England in respect of the Delegated Services,
Contractual Notice	means a contractual notice issued by NHS England to the ICB, from time to time and relating to allocation of contracts for the purposes of the Delegated Functions,
CQC	means the Care Quality Commission,
Data Controller	shall have the same meaning as set out in the UK GDPR,
Data Guidance	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency and the Information Commissioner,
Data Protection Impact Assessment	means an assessment to identify and minimise the data protection risks in relation to any data sharing proposals,
Data Protection Officer	shall have the same meaning as set out in the Data Protection Legislation,
Data Processing Agreement	means a data processing agreement which should be in substantially the same form as a Data Processing Agreement template approved by NHS England,

Data Processor	shall have the same meaning as set out in the UK GDPR,
Data Protection Legislation	means the UK GDPR, the Data Protection Act 2018 and all applicable Law concerning privacy, confidentiality or the processing of personal data including but not limited to the Human Rights Act 1998, the Health and Social Care (Safety and Quality) Act 2015, the common law duty of confidentiality and the Privacy and Electronic Communications (EC Directive) Regulations 2003,
Data Sharing Agreement	means a data sharing agreement which should be in substantially the same form as a Data Sharing Agreement template approved by NHS England,
Data Subject	shall have the same meaning as set out in the UK GDPR,
Delegated Commissioning Group (DCG)	means the advisory forum in respect of Delegated Services set up by NHS England currently known as the Delegated Commissioning Group for Specialised Services,
Delegated Functions	means the statutory functions delegated by NHS England to the ICB under the Delegation and as set out in detail in this Agreement,
Delegated Funds	means the funds defined in Clause 10.2,
Delegated Services	means the services set out in Schedule 2 of this Agreement and which may be updated from time to time by NHS England,
Delegation	means the delegation of the Delegated Functions from NHS England to the ICB as described at Clause 6.1,
Developmental Arrangements	means the arrangements set out in Schedule 9 as amended or replaced,
Dispute	a dispute, conflict or other disagreement between the Parties arising out of or in connection with this Agreement,
Effective Date of Delegation	means for the Specialised Services set out in Schedule 2, the date set out in Schedule 2 as the date delegation will take effect in respect of that particular Specialised Service and for any future delegations means the date agreed by the parties as the date that the delegation will take effect,
EIR	means the Environmental Information Regulations 2004,
Escalation Rights	means the escalation rights as defined in Clause 15 (Escalation Rights),
Finance Guidance	means the guidance, rules and operating procedures produced by NHS England that relate to these delegated arrangements, including but not limited to the following: - Commissioning Change Management Business Rules,

	- Contracting Standard Operating Procedure, - Cashflow Standard Operating Procedure, - Finance and Accounting Standard Operating Procedure, - Service Level Framework Guidance,
Financial Year	shall bear the same meaning as in section 275 of the NHS Act,
FOIA	means the Freedom of Information Act 2000,
Further Arrangements	means arrangements for the exercise of Delegated Functions as defined at Clause 12,
Good Practice	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner,
Guidance	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the ICB has a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified to the ICB by any relevant Regulatory or Supervisory Body but excluding Mandated Guidance,
High Cost Drugs	means medicines not reimbursed though national prices and identified on the NHS England high cost drugs list,
Host ICB	Means the designated host ICB that will employ the Commissioning Team as part of the Commissioning Team Arrangements after 2024/25. They will take the lead ICB role for managing the work of the Commissioning Team employed within NHS England on behalf of the ICBs.
ICB	means an Integrated Care Board established pursuant to section 14Z25 of the NHS Act and named in the Particulars,
ICB Collaboration Arrangement	means an arrangement entered into by the ICB and at least one other ICB under which the parties agree joint working arrangements in respect of the exercise of the Delegated Functions,
ICB Deliverables	all documents, products and materials developed by the ICB or its Staff in relation to this Agreement and the Delegated Functions in any form and required to be submitted to NHS England under this Agreement, including data, reports, policies, plans and specifications,
ICB Functions	the Commissioning Functions of the ICB,

Information Governance Guidance for Serious Incidents	means the checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation (2015) as may be amended or replaced,
Indemnity Arrangement	means either: (i) a policy of insurance, (ii) an arrangement made for the purposes of indemnifying a person or organisation, or (iii) a combination of (i) and (ii),
IPR	means intellectual property rights and includes inventions, copyright, patents, database right, trademarks, designs and confidential know-how and any similar rights anywhere in the world whether registered or not, including applications and the right to apply for any such rights,
Law	means any applicable law, statute, rule, bye-law, regulation, direction, order, regulatory policy, guidance or code, rule of court or directives or requirements of any regulatory body, delegated or subordinate legislation or notice of any regulatory body (including any Regulatory or Supervisory Body),
Local Terms	means the terms set out in Schedule 8 (Local Terms) and/or such other Schedule or part thereof as designated as Local Terms,
Losses	means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services) proceedings, demands and charges whether arising under statute, contract or common law,
Managing Conflicts of Interest in the NHS	the NHS publication by that name available at: https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/ ,
Mandated Guidance	means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of the Delegated Functions and issued by NHS England to the ICB as Mandated Guidance from time to time, in accordance with Clause 7.34 which at the Effective Date of Delegation shall include the Mandated Guidance set out in Schedule 7,
National Commissioning Group (NCG)	means the advisory forum in respect of the Retained Services currently known as the National Commissioning Group for Specialised, Health and Justice and Armed Forces Services,
National Standards	means the service standards for each Specialised Service, as set by NHS England and included in Clinical Commissioning Policies or National Specifications,
National Specifications	the service specifications published by NHS England in respect of Specialised Services,

Need to Know	has the meaning set out in paragraph 1.2 of Schedule 6 (*Further Information Governance, Sharing and Processing Provisions*),
NICE Regulations	means the National Institute for Health and Care Excellence (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013 as amended or replaced,
NHS Act	means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022 and other legislation from time to time),
NHS Counter Fraud Authority	means the Special Health Authority established by and in accordance with the NHS Counter Fraud Authority (Establishment, Constitution, and Staff and Other Transfer Provisions) Order 2017/958,
NHS Digital Data Security and Protection Toolkit	means the toolkit published by NHS Digital and available on the NHS Digital website at: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/data-security-and-protection-toolkit ,
NHS England	means the body established by section 1H of the NHS Act,
NHS England Deliverables	means all documents, products and materials NHS England in which NHS England holds IPRs which are relevant to this Agreement, the Delegated Functions or the Reserved Functions in any form and made available by NHS England to the ICB under this Agreement, including data, reports, policies, plans and specifications,
NHS England Functions	means all functions of NHS England as set out in legislation excluding any functions that have been expressly delegated,
Non-Personal Data	means data which is not Personal Data,
Operational Days	a day other than a Saturday, Sunday, Christmas Day, Good Friday or a bank holiday in England,
Oversight Framework	means the NHS Oversight Framework, as may be amended or replaced from time to time, and any relevant associated Guidance published by NHS England,
Party/Parties	means a party or both parties to this Agreement,
Patient Safety Incident Response Framework	means the framework published by NHS England and made available on the NHS England website at: https://www.england.nhs.uk/patient-safety/incident-response-framework/ ,
Personal Data	shall have the same meaning as set out in the UK GDPR and shall include references to Special Category Personal Data where appropriate,
Population	means, in relation to any particular delegated service, the group of people for which the ICB would have the duty to arrange for

	the provision of that service under section 3 of the NHS Act (hospital and other services), if it was not a service which NHS England had a duty to arrange under its Specialised Commissioning Functions; For guidance on the persons for whom an ICB is responsible for arranging services see *Who Pays? Determining which NHS commissioner is responsible for commissioning healthcare services and making payments to providers,*
Prescribed Specialised Services Manual	means the document which may be amended or replaced from time to time which is currently known as the prescribed specialised services manual which describes how NHS England and ICBs commission specialised services and sets out the identification rules which describe how NHS England and ICBs identify Specialised Services activity within data flows,
Provider Collaborative	means a group of Specialised Service Providers who have agreed to work together to improve the care pathway for one or more Specialised Services,
Provider Collaborative Guidance	means the guidance published by NHS England in respect of Provider Collaboratives,
Prohibited Act	means the ICB: (i) offering, giving, or agreeing to give NHS England (or an of their officers, employees or agents) any gift or consideration of any kind as an inducement or reward for doing or not doing or for having done or not having done any act in relation to the obtaining of performance of this Agreement, the Reserved Functions, the Delegation or any other arrangement with the ICB, or for showing or not showing favour or disfavour to any person in relation to this Agreement or any other arrangement with the ICB, and (ii) in connection with this Agreement, paying or agreeing to pay any commission, other than a payment, particulars of which (including the terms and conditions of the agreement for its payment) have been disclosed in writing to NHS England, or (iii) committing an offence under the Bribery Act 2010,
Regional Quality Group	means a group set up to act as a strategic forum at which regional partners from across health and social care can share, identify and mitigate wider regional quality risks and concerns as well as share learning so that quality improvement and best practice can be replicated,
Regulatory or Supervisory Body	means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: (i) CQC,

	(ii) NHS England, (iii) the Department of Health and Social Care, (iv) the National Institute for Health and Care Excellence, (v) Healthwatch England and Local Healthwatch, (vi) the General Medical Council, (vii) the General Dental Council, (viii) the General Optical Council, (ix) the General Pharmaceutical Council, (x) the Healthcare Safety Investigation Branch, and (xi) the Information Commissioner,
Relevant Clinical Networks	means those clinical networks identified by NHS England as required to support the commissioning of Specialised Services for the Population,
Relevant Information	means the Personal Data and Non-Personal Data processed under the Delegation and this Agreement, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*),
Reserved Functions	means statutory functions of NHS England that it has not delegated to the ICB including but not limited to those set out in the Schedules to this Agreement,
Retained Services	means those Specialised Services for which NHS England shall retain commissioning responsibility, as set out in Schedule 5,
Secretary of State	means the Secretary of State for Health and Social Care,
Shared Care Arrangements	means arrangements put in place to support patients receiving elements of their care closer to home, whilst still ensuring that they have access to the expertise of a specialised centre and that care is delivered in line with the expectation of the relevant National Specification,
Single Point of Contact	means the member of Staff appointed by each relevant Party in accordance with Paragraph 9.6 of Schedule 6,
Special Category Personal Data	shall have the same meaning as in UK GDPR,
Specialised Commissioning Budget	means the budget identified by NHS England for the purpose of exercising the Delegated Functions,
Specialised Commissioning Functions	means the statutory functions conferred on NHS England under Section 3B of the NHS Act and Regulation 11 and Schedule 4 of the National Health Service Commissioning Board and

	Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996 (as amended or replaced),
Specialised Services	means the services commissioned in exercise of the Specialised Commissioning Functions,
Specialised Services Contract	means a contract for the provision of Specialised Services entered into in the exercise of the Specialised Commissioning Functions,
Specialised Services Provider	means a provider party to a Specialised Services Contract,
Specialised Services Staff	means the Staff or roles identified as carrying out the Delegated Functions immediately prior to the date of this Agreement,
Specified Purpose	means the purpose for which the Relevant Information is shared and processed, being to facilitate the exercise of the ICB's Delegated Functions and NHS England's Reserved Functions as specified in paragraph 2.1. of Schedule 6 (Further Information Governance*,* Sharing *and Processing* Provisions) to this Agreement,
Staff or Staffing	means the Parties' employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of either Party (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel,
Sub-Delegate	shall have the meaning in Clause 12.2,
System Quality Group	means a group set up to identify and manage concerns across the local system. The system quality group shall act as a strategic forum at which partners from across the local health and social care footprint can share issues and risk information to inform response and management, identify and mitigate quality risks and concerns as well as share learning and best practice,
Triple Aim	means the duty to have regard to wider effect of decisions, which is placed on each of the Parties under section 13NA (as regards NHS England) and section 14Z43 (as regards the ICB) of the NHS Act,
UK GDPR	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018,
Variation Proposal	means a written proposal for a variation to the Agreement, which complies with the requirements of Clause 26.5.

SCHEDULE 2 DELEGATED SERVICES

NHS England delegates to the ICB the statutory function for commissioning the Specialised Services set out in this Schedule 2 (Delegated Services) subject to the reservations set out in Schedule 4 (Retained Functions) and the provisions of any Developmental Arrangements set out in Schedule 9.

The list of Delegated Services set out in Schedule 2 of this Agreement contains two categories of service: the first is drawn from the Prescribed Specialised Services (PSS) Manual and aligns to Schedule 4 of the 2012 Standing Rules Regulations; the second is the sub-service line codes that NHS England has introduced over time to assist in the commissioning of Specialised Services. From time-to-time, NHS England will amend the list of sub-service line codes, either to repurpose, remove or add a code.

This is done to support in the management of finances, activity or for other administrative reasons; or to support transformational work that may be ongoing in the service area that requires a sub-service line code to track and manage funding and activity. The intention is that any changes will be supportive of ICBs' commissioning responsibilities, and that there will be a small number of changes in the Delegated Services sub-service line codes in any one year.

All future changes to sub-service line codes relating to Delegated Services will be developed with ICBs. ICBs will be engaged and have the opportunity to provide comment on the proposed change before it is made. Changes to the sub-service line codes will be discussed at and agreed by the Delegated Commissioning Group, hosted by NHS England and attended by ICB representatives. If changes are agreed, the latest lists will be made available on the NHS England website here [NHS England » NHS England service codes by year] and a more detailed version on the Future NHS site here [Service Portfolio Analysis - Integrating specialised services within Integrated Care Systems - FutureNHS Collaboration Platform].

The PSS Manual Lines in Schedule 2 of the Agreement, which derive from the 2012 Standing Rules Regulations, will not be altered unless there is a decision of the NHS England Board, which will necessitate wider engagement with ICBs and stakeholders.

The following Specialised Services will be delegated to the ICB on 1 April 2025:

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
2	Adult congenital heart disease services	13X	Adult congenital heart disease services (non-surgical)
		13Y	Adult congenital heart disease services (surgical)
3	Adult specialist pain management services	31Z	Adult specialist pain management services
4	Adult specialist respiratory services	29M	Interstitial lung disease (adults)
		29S	Severe asthma (adults)
		29L	Lung volume reduction (adults)
		29V	Complex home ventilation (adults)
5	Adult specialist rheumatology services	26Z	Adult specialist rheumatology services
6	Adult secure mental health services	22S(a)	Secure and specialised mental health services (adult) (medium and low) – excluding LD/ASD/WEMS/ABI/DEAF
		22S(c)	Secure and specialised mental health services (adult) (Medium and low) – ASD MHLDA PC
		22S(d)	Secure and specialised mental health services (adult) (Medium and low) – LD MHLDA PC
7	Adult Specialist Cardiac Services	13A	Complex device therapy

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
		13B	Cardiac electrophysiology & ablation
		13C	Inherited cardiac conditions
		13E	Cardiac surgery (inpatient)
		13F	PPCI for ST- elevation myocardial infarction
		13H	Cardiac magnetic resonance imaging
		13T	Complex interventional cardiology
		13Z	Cardiac surgery (outpatient)
8	Adult specialist eating disorder services	22E	Adult specialist eating disorder services MHLDA PC
9	Adult specialist endocrinology services	27E	Adrenal Cancer (adults)
		27Z	Adult specialist endocrinology services
11	Adult specialist neurosciences services	08O	Neurology (adults)
		08P	Neurophysiology (adults)
		08R	Neuroradiology (adults)
		08S	Neurosurgery (adults)
		08T	Mechanical Thrombectomy
		58A	Neurosurgery LVHC national: surgical removal of clival chordoma and chondrosarcoma
		58B	Neurosurgery LVHC national: EC-IC bypass (complex/high flow)
		58C	Neurosurgery LVHC national: transoral excision of dens
		58D	Neurosurgery LVHC regional: anterior skull based tumours
		58E	Neurosurgery LVHC regional: lateral skull based tumours
		58F	Neurosurgery LVHC regional: surgical removal of brainstem lesions
		58G	Neurosurgery LVHC regional: deep brain stimulation
		58H	Neurosurgery LVHC regional: pineal tumour surgeries - resection
		58I	Neurosurgery LVHC regional: removal of arteriovenous malformations of the nervous system
		58J	Neurosurgery LVHC regional: epilepsy
		58K	Neurosurgery LVHC regional: insula glioma's/complex low grade glioma's
		58L	Neurosurgery LVHC local: anterior lumbar fusion
	Adult specialist neurosciences services (continued)	58M	Neurosurgery LVHC local: removal of intramedullary spinal tumours
		58N	Neurosurgery LVHC local: intraventricular tumours resection
		58O	Neurosurgery LVHC local: surgical repair of aneurysms (surgical clipping)
		58P	Neurosurgery LVHC local: thoracic discectomy
		58Q	Neurosurgery LVHC local: microvascular decompression for trigeminal neuralgia
		58R	Neurosurgery LVHC local: awake surgery for removal of brain tumours
		58S	Neurosurgery LVHC local: removal of pituitary tumours including for Cushing's and acromegaly
12	Adult specialist ophthalmology services	37C	Artificial Eye Service
		37Z	Adult specialist ophthalmology services
13	Adult specialist orthopaedic services	34A	Orthopaedic surgery (adults)
		34R	Orthopaedic revision (adults)
15	Adult specialist renal services	11B	Renal dialysis
		11C	Access for renal dialysis
		11T	Renal Transplantation
16	Adult specialist services for people living with HIV	14A	Adult specialised services for people living with HIV

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
17	Adult specialist vascular services	30Z	Adult specialist vascular services
18	Adult thoracic surgery services	29B	Complex thoracic surgery (adults)
		29Z	Adult thoracic surgery services: outpatients
29	Haematopoietic stem cell transplantation services (adults and children)	02Z	Haematopoietic stem cell transplantation services (adults and children)
		ECP	Extracorporeal photopheresis service (adults and children)
30	Bone conduction hearing implant services (adults and children)	32B	Bone anchored hearing aids service
		32D	Middle ear implantable hearing aids service
32	Children and young people's inpatient mental health service	23K	Tier 4 CAMHS (general adolescent including eating disorders) MHLDA PC
		23L	Tier 4 CAMHS (low secure) MHLDA PC
		23O	Tier 4 CAMHS (PICU) MHLDA PC
		23U	Tier 4 CAMHS (LD) MHLDA PC
		23V	Tier 4 CAMHS (ASD) MHLDA PC
35	Cleft lip and palate services (adults and children)	15Z	Cleft lip and palate services (adults and children)
36	Cochlear implantation services (adults and children)	32A	Cochlear implantation services (adults and children)
40	Complex spinal surgery services (adults and children)	06Z	Complex spinal surgery services (adults and children)
		08Z	Complex neuro-spinal surgery services (adults and children)
45	Cystic fibrosis services (adults and children)	10Z	Cystic fibrosis services (adults and children)
54	Fetal medicine services (adults and adolescents)	04C	Fetal medicine services (adults and adolescents)
58	Specialist adult gynaecological surgery and urinary surgery services for females	04A	Severe Endometriosis
		04D	Complex urinary incontinence and genital prolapse
58A	Specialist adult urological surgery services for men	41P	Penile implants
		41S	Surgical sperm removal
		41U	Urethral reconstruction
59	Specialist allergy services (adults and children)	17Z	Specialist allergy services (adults and children)
61	Specialist dermatology services (adults and children)	24Z	Specialist dermatology services (adults and children)
62	Specialist metabolic disorder services (adults and children)	36Z	Specialist metabolic disorder services (adults and children)
63	Specialist pain management services for children	23Y	Specialist pain management services for children
64	Specialist palliative care services for children and young adults	E23	Specialist palliative care services for children and young adults
65	Specialist services for adults with infectious diseases	18A	Specialist services for adults with infectious diseases
		18E	Specialist Bone and Joint Infection (adults)
72	Major trauma services (adults and children)	34T	Major trauma services (adults and children)
78	Neuropsychiatry services (adults and children)	08Y	Neuropsychiatry services (adults and children)
83	Paediatric cardiac services	23B	Paediatric cardiac services

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
94	Radiotherapy services (adults and children)	01R	Radiotherapy services (Adults)
		51R	Radiotherapy services (Children)
		01S	Stereotactic Radiosurgery / radiotherapy
98	Specialist secure forensic mental health services for young people	24C	FCAMHS MHLDA PC
103A	Specialist adult haematology services	03C	Castleman disease
105	Specialist cancer services (adults)	01C	Chemotherapy
		01J	Anal cancer (adults)
		01K	Malignant mesothelioma (adults)
		01M	Head and neck cancer (adults)
		01N	Kidney, bladder and prostate cancer (adults)
		01Q	Rare brain and CNS cancer (adults)
		01U	Oesophageal and gastric cancer (adults)
		01V	Biliary tract cancer (adults)
		01W	Liver cancer (adults)
		01X	Penile cancer (adults)
		01Y	Cancer Outpatients (adults)
		01Z	Testicular cancer (adults)
		04F	Gynaecological cancer (adults)
		19V	Pancreatic cancer (adults)
		19C	Biliary tract cancer surgery (adults)
		19M	Liver cancer surgery (adults)
		19Q	Pancreatic cancer surgery (adults)
		24Y	Skin cancer (adults)
		29E	Management of central airway obstruction (adults)
		51A	Interventional oncology (adults)
		51B	Brachytherapy (adults)
		51C	Molecular oncology (adults)
		61M	Head and neck cancer surgery (adults)
		61Q	Ophthalmic cancer surgery (adults)
		61U	Oesophageal and gastric cancer surgery (adults)
		61Z	Testicular cancer surgery (adults)
		33C	Transanal endoscopic microsurgery (adults)
		33D	Distal sacrectomy for advanced and recurrent rectal cancer (adults)
106	Specialist cancer services for children and young adults	01T	Teenage and young adult cancer
		23A	Children's cancer
106A	Specialist colorectal surgery services (adults)	33A	Complex surgery for faecal incontinence (adults)
		33B	Complex inflammatory bowel disease (adults)
107	Specialist dentistry services for children	23P	Specialist dentistry services for children
108	Specialist ear, nose and throat services for children	23D	Specialist ear, nose and throat services for children
109	Specialist endocrinology services for children	23E	Specialist endocrinology and diabetes services for children
110	Specialist gastroenterology, hepatology and nutritional support services for children	23F	Specialist gastroenterology, hepatology and nutritional support services for children
112	Specialist gynaecology services for children	73X	Specialist paediatric surgery services - gynaecology
113	Specialist haematology services for children	23H	Specialist haematology services for children
114	Specialist haemoglobinopathy services	38S	Sickle cell anaemia (adults and children)

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
	(adults and children)		
		38T	Thalassemia (adults and children)
115	Specialist immunology services for adults with deficient immune systems	16X	Specialist immunology services for adults with deficient immune systems
115A	Specialist immunology services for children with deficient immune systems	16Y	Specialist immunology services for children with deficient immune systems
115B	Specialist maternity care for adults diagnosed with abnormally invasive placenta	04G	Specialist maternity care for women diagnosed with abnormally invasive placenta
118	Neonatal critical care services	NIC	Specialist neonatal care services
119	Specialist neuroscience services for children	23M	Specialist neuroscience services for children
		07Y	Paediatric neurorehabilitation
		08J	Selective dorsal rhizotomy
120	Specialist ophthalmology services for children	23N	Specialist ophthalmology services for children
121	Specialist orthopaedic services for children	23Q	Specialist orthopaedic services for children
122	Paediatric critical care services	PIC	Specialist paediatric intensive care services
124	Specialist perinatal mental health services (adults and adolescents)	22P	Specialist perinatal mental health services (adults and adolescents) MHLDA PC
125	Specialist plastic surgery services for children	23R	Specialist plastic surgery services for children
126	Specialist rehabilitation services for patients with highly complex needs (adults and children)	07Z	Specialist rehabilitation services for patients with highly complex needs (adults and children)
127	Specialist renal services for children	23S	Specialist renal services for children
128	Specialist respiratory services for children	23T	Specialist respiratory services for children
129	Specialist rheumatology services for children	23W	Specialist rheumatology services for children
130	Specialist services for children with infectious diseases	18C	Specialist services for children with infectious diseases
131	Specialist services for complex liver, biliary and pancreatic diseases in adults	19L	Specialist services for complex liver diseases in adults
		19P	Specialist services for complex pancreatic diseases in adults
		19Z	Specialist services for complex liver, biliary and pancreatic diseases in adults
		19B	Specialist services for complex biliary diseases in adults
132	Specialist services for haemophilia and other related bleeding disorders (adults and children)	03X	Specialist services for haemophilia and other related bleeding disorders (Adults)
		03Y	Specialist services for haemophilia and other related bleeding disorders (Children)
134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	05C	Specialist augmentative and alternative communication aids (adults and children)
		05E	Specialist environmental controls (adults and children)
		05P	Prosthetics (adults and children)
135	Specialist paediatric surgery services	23X	Specialist paediatric surgery services - general surgery
136	Specialist paediatric urology services	23Z	Specialist paediatric urology services
139A	Specialist morbid obesity services for children	35Z	Specialist morbid obesity services for children

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
139AA	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital	04P	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital
ACC	Adult Critical Care	ACC	Adult critical care

SCHEDULE 3 DELEGATED FUNCTIONS

1 Introduction

1.1 Subject to the reservations set out in Schedule 4 (Reserved Functions) and the provisions of any Developmental Arrangements, NHS England delegates to the ICB the statutory function for commissioning the Delegated Services. This Schedule 3 sets out the key powers and duties that the ICB will be required to carry out in exercise of the Delegated Functions being, in summary:

1.1.1 decisions in relation to the commissioning and management of Delegated Services,

1.1.2 planning Delegated Services for the Population, including carrying out needs assessments,

1.1.3 undertaking reviews of Delegated Services in respect of the Population,

1.1.4 supporting the management of the Specialised Commissioning Budget,

1.1.5 co-ordinating a common approach to the commissioning and delivery of Delegated Services with other health and social care bodies in respect of the Population where appropriate, and

1.1.6 such other ancillary activities that are necessary to exercise the Specialised Commissioning Functions.

1.2 When exercising the Delegated Functions, ICBs are not acting on behalf of NHS England but acquire rights and incur any liabilities in exercising the functions.

2 General Obligations

2.1 The ICB is responsible for planning the commissioning of the Delegated Services in accordance with this Agreement. This includes ensuring at all times that the Delegated Services are commissioned in accordance with the National Standards.

2.2 The ICB shall put in place arrangements for collaborative working with other ICBs in accordance with Clause 8 (Requirement for ICB Collaboration Arrangement).

2.3 The Developmental Arrangements set out in Schedule 9 shall apply.

Specific Obligations

3 Assurance and Oversight

3.1 The ICB must at all times operate in accordance with:

3.1.1 the Oversight Framework published by NHS England,

3.1.2 any national oversight and/or assurance guidance in respect of Specialised Services and/or joint working arrangements, and

3.1.3 any other relevant NHS oversight and assurance guidance,

collectively known as the “Assurance Processes”.

3.2 The ICB must:

3.2.1 develop and operate in accordance with mutually agreed ways of working in line with the Assurance Processes,

3.2.2 oversee the provision of Delegated Services and the outcomes being delivered for its Population in accordance with the Assurance Processes,

3.2.3 assure that Specialised Service Providers are meeting, or have an improvement plan in place to meet, National Standards,

3.2.4 provide any information and comply with specific actions in relation to the Delegated Services, as required by NHS England, including metrics and detailed reporting.

4 Attendance at governance meetings

4.1 The ICB must ensure that there is appropriate representation at forums established through the ICB Collaboration Arrangement.

4.2 The ICB must ensure that an individual(s) has been nominated to represent the ICB at the Delegated Commissioning Group (DCG) and regularly attends that group. This could be a single representative on behalf of the members of an ICB Collaboration Arrangement. Where that representative is not an employee of the ICB, the ICB must have in place appropriate arrangements to enable the representative to feedback to the ICB.

4.3 The ICB should also ensure that they have a nominated representative with appropriate subject matter expertise to attend National Standards development forums as requested by NHS England. This could be a single representative on behalf of the members of an ICB Collaboration Arrangement. Where that representative is not an employee of the ICB, the ICB must have in place appropriate arrangements to enable the representative to feedback to the ICB.

5 Clinical Leadership and Clinical Reference Groups

5.1 The ICB shall support the development of clinical leadership and expertise at a local level in respect of Specialised Services.

5.2 The ICB shall support local and national groups including Relevant Clinical Networks and Clinical Reference Groups that are involved in developing Clinical Commissioning Policies, National Specifications, National Standards and knowledge around Specialised Services.

6 Clinical Networks

6.1 The ICB shall participate in the planning, governance and oversight of the Relevant Clinical Networks, including involvement in agreeing the annual plan for each Relevant Clinical Network. The ICB shall seek to align the network priorities with system priorities and to ensure that the annual plan for the Relevant Clinical Network reflects local needs and priorities.

6.2 The ICB will be involved in the development and agreement of a single annual plan for the Relevant Clinical Network.

6.3 The ICB shall monitor the implementation of the annual plan and receive an annual report from the Relevant Clinical Network that considers delivery against the annual plan.

6.4 The ICB shall actively support and participate in dialogue with Relevant Clinical Networks and shall ensure that there is a clear and effective mechanism in place for giving and receiving information with the Relevant Clinical Networks including network reports.

6.5 The ICB shall support NHS England in the management of Relevant Clinical Networks.

6.6 The ICB shall actively engage and promote Specialised Service Provider engagement in appropriate Relevant Clinical Networks.

6.7 Where a Relevant Clinical Network identifies any concern, the ICB shall seek to consider and review that concern as soon as is reasonably practicable and take such action, if any, as it deems appropriate.

6.8 The ICB shall ensure that network reports are considered where relevant as part of exercising the Delegated Functions.

7 Complaints

7.1 This part (*Complaints*) applies from the Effective Date of Delegation or the date on which the Commissioning Team is transferred to the relevant Host ICB (whichever is the later) ("the Applicable Date").

7.2 The ICB will be responsible for all complaints in respect of the Delegated Services that are received from the Applicable Date, regardless of whether the circumstances to which the complaint relates occurred prior to the Applicable Date.

7.3 For the avoidance of doubt, NHS England will retain responsibility for all complaints in respect of the Delegated Services that were received prior to the Applicable Date.

7.4 At all times the ICB shall operate in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and shall co-operate with other ICBs to ensure that complaints are managed effectively.

7.5 Where NHS England has provided the ICB with a protocol for sharing complaints in respect of any or all Specialised Services then those provisions shall apply and are deemed to be part of this Agreement (the "Complaints Sharing Protocol").

7.6 The ICB shall:

7.6.1 work with local organisations, including other ICBs that are party to the ICB Collaboration Arrangement or Commissioning Team, to ensure that arrangements are in place for the management of complaints in respect of the Delegated Services.

7.6.2 consider, in the context of the ICB Collaboration Arrangement for the commissioning of the Delegated Services and employment arrangements for the Commissioning Team, whether it is best placed to manage the complaint, or whether it should be transferred to another ICB that is better placed to affect change.

7.6.3 provide the relevant individuals at NHS England with appropriate access to complaints data held by the ICB that is necessary to carry out the complaints function as set out in the Complaints Sharing Protocol.

7.6.4 Provide such information relating to key performance indicators ("KPIs") as is requested by NHS England.

7.6.5 co-operate with NHS England in respect of the review of complaints related to the Delegated Services and shall, on request, share any learning identified in carrying out the complaints function.

7.6.6 take part in any peer review process put in place in respect of the complaints function.

8 Commissioning and optimisation of High Cost Drugs

8.1 The ICB must support the effective and efficient commissioning of High Cost Drugs for Delegated Services.

8.2 The ICB must support NHS England in its responsibility for the financial management and reimbursement of High Cost Drugs for Specialised Services. The ICB and NHS England must agree the support to be provided. The support must be set out in writing and may include staffing, processes, reporting, prescribing analysis and oversight arrangements, but is not limited to these matters.

8.3 The ICB must ensure equitable access to High Cost Drugs used within the Delegated Services that may be impacted by health inequalities and develop a strategy for delivering equitable access.

8.4 The ICB must develop and implement Shared Care Arrangements across the Area of the ICB.

8.5 The ICB must provide clinical and commissioning leadership in the commissioning and management of High Cost Drugs.

8.6 The ICB must ensure:

8.6.1 safe and effective use of High Cost Drugs in line with national Clinical Commissioning Policies, NICE technology appraisal or highly specialised technologies guidance,

8.6.2 effective introduction of new medicines,

8.6.3 compliance with all NHS England commercial processes and frameworks for High Cost Drugs,

8.6.4 Specialised Services Providers adhere to all NHS England commercial processes and frameworks for High Cost Drugs,

8.6.5 appropriate use of Shared Care Arrangements, ensuring that they are safe and well monitored, and

8.6.6 consistency of prescribing and unwarranted prescribing variation are addressed.

8.7 The ICB must engage in the development, implementation and monitoring of initiatives that enable use of better value medicines. Such schemes include those at a local, regional or national level.

8.8 Where the relevant pharmacy teams have transferred to the ICB or Host ICB, the ICB must provide:

8.8.1 support to prescribing networks and forums, including but not limited to, Immunoglobulin Assessment panels, prescribing networks and medicines optimisation networks,

8.8.2 expert medicines advice and input into the Individual Funding Request process for Delegated Services,

8.8.3 advice and input to national procurement and other commercial processes relating to medicines and High Cost Drugs (for example, arrangements for Homecare),

8.8.4 advice and input to NHS England policy development relating to medicines and High Cost Drugs.

9 Contracting

9.1 The ICB shall be responsible for ensuring appropriate arrangements are in place for the commissioning of the Delegated Services which for the avoidance of doubt includes:

9.1.1 co-ordinating or collaborating in the award of appropriate Specialised Service Contracts,

9.1.2 drafting of the contract schedules so that it reflects Mandatory Guidance, National Specifications and any specific instructions from NHS England, and

9.1.3 management of Specialised Services Contracts.

9.2 The ICB must comply with the Contracting Standard Operating Procedure issued by NHS England.

9.3 In relation to the contracting for NHS England Retained Services where the ICB has agreed to act as the co-ordinating commissioner, to implement NHS England's instructions in relation to those Retained Services and, where appropriate, put in place a Collaborative Commissioning Agreement with NHS England as a party.

10 Data Management and Analytics

10.1 The ICB shall:

10.1.1 lead on standardised collection, processing, and sharing of data for Delegated Services in line with broader NHS England, Department of Health and Social Care and government data strategies,

10.1.2 lead on the provision of data and analytical services to support commissioning of Delegated Services,

10.1.3 ensure collaborative working across partners on agreed programmes of work focusing on provision of pathway analytics,

10.1.4 share expertise and existing reporting tools with partner ICBs in the ICB Collaboration Arrangement,

10.1.5 ensure interpretation of data is made available to NHS England and other ICBs within the ICB Collaboration Arrangement,

10.1.6 ensure data and analytics teams within ICBs and NHS England work collaboratively on jointly agreed programmes of work focusing on provision of pathway analytics,

10.2 The ICB must ensure that the data reporting and analytical frameworks, as set out in Mandated Guidance or as otherwise required by NHS England, are in place to support the commissioning of the Delegated Services.

11 Finance

11.1 The provisions of Clause 10 (Finance) of this Agreement set out the financial requirements in respect of the Delegated Functions.

12 Freedom of Information and Parliamentary Requests

12.1 The ICB shall lead on the handling, management and response to all Freedom of Information and parliamentary correspondence relating to Delegated Services.

13 **Incident Response and Management**

13.1 The ICB shall:

13.1.1 lead on local incident management for Delegated Services as appropriate to the stated incident level,

13.1.2 support national and regional incident management relating to Specialised Services, and

13.1.3 ensure surge events and actions relating to Specialised Services are included in ICB escalation plans.

13.2 In the event that an incident is identified that has an impact on the Delegated Services (such as potential failure of a Specialised Services Provider), the ICB shall fully support the implementation of any requirements set by NHS England around the management of such incident and shall provide full co-operation to NHS England to enable a co-ordinated national approach to incident management. NHS England retains the right to take decisions at a national level where it determines this is necessary for the proper management and resolution of any such incident and the ICB shall be bound by any such decision.

14 **Individual Funding Requests**

14.1 The ICB shall provide any support required by NHS England in respect of determining an Individual Funding Request and shall implement the decision of the Individual Funding Request panel.

15 **Innovation and New Treatments**

15.1 The ICB shall support local implementation of innovative treatments for Delegated Services.

16 **Mental Health, Learning Disability and Autism Specialised Services**

16.1 The ICB will oversee the lead provider contract(s) relating to mental health, learning disability and autism (MHLDA) Provider Collaboratives that are transferred to the ICB on 1 April 2025 by NHS England. This includes complying with all terms and conditions of the contract(s), including in respect of notice periods and extensions.

16.2 If the ICB proposes to terminate a MHLDA lead provider contract before the end of its term, it must seek written approval from NHS England in advance.

16.3 In the performance of its commissioning responsibilities for MHLDA Specialised Services, the ICB shall:

16.3.1 Have regard to any commissioning guidance relating to MHLDA Specialised Services issued by NHS England,

16.3.2 Comply with the requirements of the Mental Health Investment Standard and related guidance issued by NHS England,

16.3.3 Generally have regard to the need to commission MHLDA Specialised Services for the ICB's Population in such a manner as to ensure safe, efficient and effective services, across appropriate geographies, and which may require partnership working across other ICB or other organisational boundaries, and

16.3.4 Ensure that its case management function will work collaboratively across Delegated Services and Retained Services to support the oversight and

progression of individual patient care, including the movement across elements of the care pathway.

17 **Provider Selection and Procurement**

17.1 The ICB shall:

17.1.1 run appropriate local provider selection and procurement processes for Delegated Services,

17.1.2 align all procurement processes with any changes to national procurement policy (for example new legislation) for Delegated Services,

17.1.3 support NHS England with national procurements where required with subject matter expertise on provider engagement and provider landscape, and

17.1.4 monitor and provide advice, guidance and expertise to NHS England on the overall provider market and provider landscape.

17.2 In discharging these responsibilities, the ICB must comply at all times with Law and any relevant Guidance including but not limited to Mandated Guidance, any applicable procurement law and Guidance on the selection of, and award of contracts to, providers of healthcare services.

17.3 When the ICB makes decisions in connection with the awarding of Specialised Services Contracts, it should ensure that it can demonstrate compliance with requirements for the award of such Contracts, including that the decision was:

17.3.1 made in the best interest of patients, taxpayers and the Population,

17.3.2 robust and defensible, with conflicts of interests appropriately managed,

17.3.3 made transparently, and

17.3.4 compliant with relevant Guidance and legislation.

18 Quality

18.1 The ICB must ensure that appropriate arrangements for quality oversight are in place. This must include:

18.1.1 clearly defined roles and responsibilities for ensuring governance and oversight of Delegated Services,

18.1.2 defined roles and responsibilities for ensuring robust communication and appropriate feedback, particularly where Delegated Services are commissioned through an arrangement with one or more other ICBs,

18.1.3 working with providers and partner organisations to address any issues relating to Delegated Services and escalate appropriately if such issues cannot be resolved,

18.1.4 developing and standardising processes that align with regional systems to ensure oversight of the quality of Delegated Services, and participating in local System Quality Groups and Regional Quality Groups, or their equivalent,

18.1.5 ensuring processes are robust and concerns are identified, mitigated and escalated as necessary,

18.1.6 ensuring providers are held to account for delivery of safe, patient-focused and quality care for Delegated Services, including mechanisms for monitoring patient complaints, concerns and feedback, and

18.1.7 the implementation of the Patient Safety Incident Response Framework for the management of incidents and serious events, appropriate reporting of any incidents, undertaking any appropriate patient safety incident investigation and obtaining support as required.

18.2 The ICB must establish a plan to ensure that the quality of the Delegated Services is measured consistently, using nationally and locally agreed metrics triangulated with professional insight and soft intelligence.

18.3 The ICB must ensure that the oversight of the quality of the Delegated Services is integrated with wider quality governance in the local system and aligns with the NHS England National Quality Board's recommended quality escalation processes.

18.4 The ICB must ensure that there is a System Quality Group (or equivalent) to identify and manage concerns across the local system.

18.5 The ICB must ensure that there is appropriate representation at any Regional Quality Groups or their equivalent.

18.6 The ICB must have in place all appropriate arrangements in respect of child and adult safeguarding and comply with all relevant Guidance.

19 Service Planning and Strategic Priorities

19.1 The ICB is responsible for setting local commissioning strategy, policy and priorities and planning for and carrying out needs assessments for the Delegated Services.

19.2 In planning, commissioning and managing the Delegated Services, the ICB must have processes in place to assess and monitor equitable patient access, in accordance with the access criteria set out in Clinical Commissioning Policies and National Specifications, taking action to address any apparent anomalies.

19.3 The ICB must ensure that it works with Specialised Service Providers and Provider Collaboratives to translate local strategic priorities into operational outputs for Delegated Services.

19.4 The ICB shall provide input into any consideration by NHS England as to whether the commissioning responsibility in respect of any of the Retained Services should be delegated.

20 National Standards, National Specifications and Clinical Commissioning Policies

20.1 The ICB shall provide input into national decisions on National Standards and national transformation regarding Delegated Services through attendance at governance meetings.

20.2 The ICB shall facilitate engagement with local communities on National Specification development.

20.3 The ICB must comply with the National Specifications and relevant Clinical Commissioning Policies and ensure that all clinical Specialised Services Contracts accurately reflect Clinical Commissioning Policies and include the relevant National Specification, where one exists in relation to the relevant Delegated Service.

20.4 The ICB must co-operate with any NHS England activities relating to the assessment of compliance against National Standards, including through the Assurance Processes.

20.5 The ICB must have appropriate mechanisms in place to ensure National Standards and National Specifications are being adhered to.

20.6 Where the ICB has identified that a Specialised Services Provider may not be complying with the National Standards set out in the relevant National Specification, the ICB shall consider the action to take to address this in line with the Assurance Processes.

21 Transformation

21.1 The ICB shall:

21.1.1 prioritise pathways and services for transformation according to the needs of its Population and opportunities for improvement in ICB commissioned services and for Delegated Services,

21.1.2 lead ICB and ICB Collaboration Arrangement driven transformation programmes across pathways for Delegated Services,

21.1.3 lead the delivery locally of transformation in areas of national priority (such as Cancer, Mental Health and Learning Disability and Autism), including supporting delivery of commitments in the NHS Long Term Plan,

21.1.4 support NHS England with agreed transformational programmes for Retained Services,

21.1.5 support NHS England with agreed transformational programmes and identify future transformation programmes for consideration and prioritisation for Delegated Services where national co-ordination and enablement may support transformation,

21.1.6 work collaboratively with NHS England on the co-production and co-design of transformation and improvement interventions and solutions in those areas prioritised, and

21.1.7 ensure Relevant Clinical Networks and other clinical networks use levers to facilitate and embed transformation at a local level for Delegated Services.

SCHEDULE 4 RESERVED FUNCTIONS

Introduction

1 Reserved Functions in Relation to the Delegated Services

1.1 In accordance with Clause 6.2 of this Agreement, all functions of NHS England other than those defined as Delegated Functions, are Reserved Functions.

1.2 This Schedule sets out further provision regarding the carrying out of the Reserved Functions as they relate to the Delegated Functions.

1.3 The ICB will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions.

1.4 The following functions and related activities shall continue to be exercised by NHS England.

2 Retained Services

2.1 NHS England shall commission the Retained Services set out in Schedule 5.

3 Reserved Specialised Service Functions

3.1 NHS England shall carry out the functions set out in this Schedule 4 in respect of the Delegated Services.

Reserved Functions

4 Assurance and Oversight

4.1 NHS England shall:

4.1.1 have oversight of what ICBs are delivering (inclusive of Delegated Services) for their Populations and all patients,

4.1.2 design and implement appropriate assurance of ICBs' exercise of Delegated Functions including the Assurance Processes,

4.1.3 help the ICB to coordinate and escalate improvement and resolution interventions where challenges are identified (as appropriate),

4.1.4 ensure that the NHS England Board is assured that Delegated Functions are being discharged appropriately,

4.1.5 ensure specialised commissioning considerations are appropriately included in NHS England frameworks that guide oversight and assurance of service delivery, and

4.1.6 host a Delegated Commissioning Group ("DCG") that will undertake an assurance role in line with the Assurance Processes. This assurance role shall include assessing and monitoring the overall coherence, stability and sustainability of the commissioning model of Specialised Services at a national level, including identification, review and management of appropriate cross-ICB risks.

4.2 Where an officer or employee of NHS England is performing its Reserved Functions in respect of assurance and oversight, NHS England must ensure that those officers or employees do not hold responsibility for, or undertake any, decision making in respect of the ICB's Delegated Functions.

5 Attendance at governance meetings

5.1 NHS England shall ensure that there is appropriate representation in respect of Reserved Functions and Retained Services at local governance forums (for example, the Regional Leadership Team) and at the National Commissioning Group ("NCG").

5.2 NHS England shall:

5.2.1 ensure that there is appropriate representation by NHS England subject matter expert(s) at National Standards development forums,

5.2.2 ensure there is appropriate attendance by NHS England representatives at nationally led clinical governance meetings, and

5.2.3 co-ordinate, and support key national governance groups.

6 Clinical Leadership and Clinical Reference Groups

6.1 NHS England shall be responsible for the following:

6.1.1 developing local leadership and support for the ICB relating to Specialised Services,

6.1.2 providing clinical leadership, advice and guidance to the ICB in relation to the Delegated Services,

6.1.3 providing point-of-contact and ongoing engagement with key external bodies, such as interest groups, charities, NICE, DHSC, and Royal Colleges, and enabling access to clinical trials for new treatments and medicines.

6.2 NHS England will host Clinical Reference Groups, which will lead on the development and publication of the following for Specialised Services:

6.2.1 Clinical Commissioning Policies,

6.2.2 National Specifications, including National Standards for each of the Specialised Services.

7 Clinical Networks

7.1 Unless otherwise agreed between the Parties, NHS England shall put in place contractual arrangements and funding mechanisms for the commissioning of the Relevant Clinical Networks.

7.2 NHS England shall ensure development of multi-ICB, and multi-region (where necessary) governance and oversight arrangements for Relevant Clinical Networks that give line of sight between all clinical networks and all ICBs whose Population they serve.

7.3 NHS England shall be responsible for:

7.3.1 developing national policy for the Relevant Clinical Networks,

7.3.2 developing and approving the specifications for the Relevant Clinical Networks,

7.3.3 maintaining links with other NHS England national leads for clinical networks not focused on Specialised Services,

7.3.4 convening or supporting national networks of the Relevant Clinical Networks,

7.3.5 agreeing the annual plan for each Relevant Clinical Network with the involvement of the ICB and Relevant Clinical Network, ensuring these reflect national and regional priorities,

7.3.6 managing Relevant Clinical Networks jointly with the ICB, and

7.3.7 agreeing and commissioning the hosting arrangements of the Relevant Clinical Networks.

8 Complaints

8.1 NHS England shall manage all complaints in respect of the Delegated Services that are received prior to the Effective Date of Delegation or the date on which the Commissioning Team is transferred to the Host ICB (whichever is the later).

8.2 NHS England shall provide the relevant individuals at the ICB with appropriate access to complaints data held by NHS England that is necessary to carry out the complaints function as set out in the Complaints Sharing Protocol.

8.3 NHS England shall manage all complaints in respect of the Retained Services.

8.4 NHS England shall set out what information the ICB is required to provide when reporting on the key performance indicators. NHS England should notify the ICB in advance and provide sufficient time to allow compliance.

9 Commissioning and optimisation of High Cost Drugs

9.1 Unless otherwise agreed with the ICB, NHS England shall manage a central process for reimbursement of High Costs Drugs for Specialised Services. This may include making reimbursements directly to Specialised Services Providers.

9.2 In respect of pharmacy and optimisation of High Cost Drugs, NHS England shall:

9.2.1 where appropriate, ensure that only validated drugs spend is reimbursed, there is timely drugs data and drugs data quality meets the standards set nationally,

9.2.2 support the ICB on strategy for access to medicines used within Delegated Services, minimising barriers to health inequalities,

9.2.3 provide support, as reasonably required, to the ICB to assist it in the commissioning of High Cost Drugs for Delegated Services including shared care agreements,

9.2.4 seek to address consistency of prescribing in line with national commissioning policies, introduction of new medicines, and addressing unwarranted prescribing variation,

9.2.5 develop medicines commissioning policies and criteria for access to medicines within Specialised Services,

9.2.6 develop support tools, including prior approval criteria, and frameworks to support the delivery of cost-effective and high quality commissioning of High Cost Drugs,

9.2.7 co-ordinate the development, implementation and monitoring of initiatives that enable the use of better value medicines,

9.2.8 where appropriate, co-ordinate national procurement or other commercial processes to secure medicines or High Cost Drugs for Specialised Services.

10 Contracting

10.1 NHS England shall retain the following obligations in relation to contracting for Delegated Services:

10.1.1 ensure Specialised Services are included in national NHS England contracting and payment strategy (for example, Aligned Payment Incentives),

10.1.2 provide advice for ICBs on schedules to support the Delegated Services,

10.1.3 set, publish or make otherwise available the Contracting Standard Operating Procedure and Mandated Guidance detailing contracting strategy and policy for Specialised Services, and

10.1.4 provide and distribute contracting support tools and templates to the ICB.

10.2 In respect of the Retained Services, NHS England shall:

10.2.1 where appropriate, ensure a Collaborative Commissioning Agreement is in place between NHS England and the ICB(s), and

10.2.2 where appropriate, construct model template schedules for Retained Services and issue to ICBs.

11 Data Management and Analytics

11.1 NHS England shall:

11.1.1 support the ICB by collaborating with the wider data and analytics network (nationally) to support development and local deployment or utilisation of support tools,

11.1.2 support the ICB to address data quality and coverage needs, accuracy of reporting Specialised Services activity and spend on a Population basis to support commissioning of Specialised Services,

11.1.3 ensure inclusion of Specialised Services data strategy in broader NHS England, DHSC and government data strategies,

11.1.4 lead on defining relevant contractual content of the information schedule (Schedule 6) of the NHS Standard Contract for Clinical Services,

11.1.5 work collaboratively with the ICB to drive continual improvement of the quality and coverage of data used to support commissioning of Specialised Services,

11.1.6 provide a national analytical service to support oversight and assurance of Specialised Services, and support (where required) the national Specialised Commissioning team, Programmes of Care and Clinical Reference Groups, and

11.1.7 provide access to data and analytic subject matter expertise to support the ICB when considering local service planning, needs assessment and transformation.

12 Finance

12.1 The provisions of Clause 10 shall apply in respect of the financial arrangements in respect of the Delegated Functions.

12.2 NHS England shall:

12.2.1 hold the budgets for prescribed specialised services top-up payments for specialist centres,

12.2.2 administer the top-up payments schemes, and

12.2.3 make top-up payments to the Specialised Services Providers.

12.3 For the avoidance of doubt, the functions set out in 12.2 include top-up payments for the Delegated Services and Retained Services.

13 Freedom of Information and Parliamentary Requests

13.1 NHS England shall:

13.1.1 lead on handling, managing and responding to all national FOIA and parliamentary correspondence relating to Retained Services, and

13.1.2 co-ordinate a response when a single national response is required in respect of Delegated Services.

14 Incident Response and Management

14.1 NHS England shall:

14.1.1 provide guidance and support to the ICB in the event of a complex incident,

14.1.2 lead on national incident management for Specialised Services as appropriate to stated incident level and where nationally commissioned services are impacted,

14.1.3 lead on monitoring, planning and support for service and operational resilience at a national level and provide support to the ICB, and

14.1.4 respond to specific service interruptions where appropriate, for example, supplier and workforce challenges and provide support to the ICB in any response to interruptions.

15 Individual Funding Requests

15.1 NHS England shall be responsible for:

15.1.1 leading on Individual Funding Requests (IFR) policy, IFR governance and managing the IFR process for Delegated Services and Retained Services,

15.1.2 taking decisions in respect of IFRs at IFR Panels for both Delegated Services and Retained Services, and

15.1.3 providing expertise for IFR decisions, including but not limited to pharmacy, public health, nursing and medical and quality.

16 Innovation and New Treatments

16.1 NHS England shall support the local implementation of innovative treatments for Delegated Services.

16.2 NHS England shall ensure services are in place for innovative treatments such as advanced medicinal therapy products recommended by NICE technology appraisals within statutory requirements.

16.3 NHS England shall provide national leadership for innovative treatments with significant service impacts including liaison with NICE.

17 Mental Health, Learning Disability and Autism Specialised Services

17.1 NHS England shall issue commissioning guidance for MHLDA Specialised Services in relation to the Delegated Services and Retained Services.

17.2 NHS England shall prepare and issue National Specifications and Clinical Commissioning Policies for MHLDA Specialised Services.

17.3 NHS England will monitor the ICB's compliance with the Mental Health Investment Standard in respect of MHLDA Delegated Services.

17.4 NHS England shall ensure that its case management function will work collaboratively across Delegated Services and Retained Services to support the oversight and progression of individual patient care, including the movement across elements of the care pathway.

18 Provider Selection and Procurement

18.1 In relation to procurement, NHS England shall be responsible for:

18.1.1 setting standards and agreeing frameworks and processes for provider selections and procurements for Specialised Services,

18.1.2 monitoring and providing advice, guidance and expertise on the overall provider market in relation to Specialised Services, and

18.1.3 where appropriate, running provider selection and procurement processes for Specialised Services.

19 Quality

19.1 In respect of quality, NHS England shall:

19.1.1 work with the ICB to ensure oversight of Specialised Services through quality surveillance and risk management and escalate as required,

19.1.2 work with the ICB to seek to ensure that quality and safety issues and risks are managed effectively and escalated to the National Specialised Commissioning Quality and Governance Group (QGG), or other appropriate forums, as necessary,

19.1.3 work with the ICB to seek to ensure that the quality governance and processes for Delegated Services are aligned and integrated with broader clinical quality governance and processes in accordance with National Quality Board Guidance,

19.1.4 facilitate improvement when quality issues impact nationally and regionally, through programme support, and mobilising intensive support when required on specific quality issues,

19.1.5 provide guidance on quality and clinical governance matters and benchmark available data,

19.1.6 support the ICB to identify key themes and trends and utilise data and intelligence to respond and monitor as necessary,

19.1.7 report on quality to both NCG and DCG as well as QGG and Executive Quality Group as required,

19.1.8 facilitate and support the national quality governance infrastructure (for example, the QGG), and

19.1.9 identify and act upon issues and concerns that cross multiple ICBs, coordinating response and management as necessary.

20 National Standards, National Specifications and Clinical Commissioning Policies

20.1 NHS England shall carry out:

20.1.1 development, engagement and approval of National Standards for Specialised Services (including National Specifications, Clinical Commissioning Policies, quality and data standards),

20.1.2 production of national commissioning products and tools to support commissioning of Specialised Services,

20.1.3 maintenance and publication of the Prescribed Specialised Services Manual and engagement with the DHSC on policy matters, and

20.1.4 determination of content for national clinical registries.

21 Transformation

21.1 NHS England shall be responsible for:

21.1.1 co-ordinating and enabling ICB-led specialised service transformation programmes for Delegated Services where necessary,

21.1.2 supporting the ICB to implement national policy and guidance across its Populations for Retained Services,

21.1.3 supporting the ICB with agreed transformational programmes where national transformation support has been agreed for Delegated Services,

21.1.4 providing leadership for transformation programmes and projects that have been identified as priorities for national coordination and support, or are national priorities for the NHS, including supporting delivery of commitments in the NHS Long Term Plan,

21.1.5 co-production and co-design of transformation programmes with the ICB and wider stakeholders, and

21.1.6 providing access to subject matter expertise including Clinical Reference Groups, national clinical directors, Programme of Care leads for the ICB where it needs support, including in relation to local priority transformation.

SCHEDULE 5 RETAINED SERVICES

NHS England shall retain the function of commissioning the Specialised Services that are not Delegated Services and as more particularly set out by NHS England and made available from time to time.

SCHEDULE 6 FURTHER INFORMATION GOVERNANCE, SHARING AND PROCESSING PROVISIONS

PART 1

1 Introduction

1.1 This Schedule sets out the scope for the secure and confidential sharing of information between the Parties on a Need To Know basis, or where a Party acts as a Data Processor on behalf of the other Party in order to enable the Parties to exercise their functions in pursuance of this Agreement.

1.2 References in this Schedule (Further Information Governance and Sharing Provisions) to the Need to Know basis or requirement (as the context requires) should be taken to mean that each Party's Staff will only have access to Personal Data or Special Category Personal Data if it is lawful for such Staff to have access to such data for the Specified Purpose in paragraph 2.1 and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Special Category Personal Data specified.

1.3 This Schedule (including the details at Part 2 and 3 of this Schedule) and any Data Sharing Agreement and/or Data Processing Agreements entered into under this Schedule are designed to:

1.3.1 provide information about the reasons why Relevant Information may need to be shared and/or processed on behalf of another Party and how this will be managed and controlled by the Parties,

1.3.2 describe the purposes for which the Parties have agreed to share and/or the basis on which a Party is instructed to act as a Data Processor in relation to the Relevant Information,

1.3.3 set out the lawful basis for the processing of Relevant Information and sharing of information between the Parties, and the principles that underpin the exchange of Relevant Information,

1.3.4 describe roles and structures to support the exchange of Relevant Information between the Parties,

1.3.5 apply to the sharing and processing of Relevant Information relating to Specialised Services Providers and their Staff,

1.3.6 apply to the sharing and processing of Relevant Information whatever the medium in which it is held and however it is transmitted,

1.3.7 ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and processed and how this sharing and processing will be managed,

1.3.8 apply to the activities of the Parties' Staff, and

1.3.9 describe how complaints relating to Personal Data sharing between the Parties and wider processing will be investigated and resolved, and how the information sharing and processing will be monitored and reviewed.

2 Purpose

2.1 The Specified Purpose of the data sharing and associated processing is to facilitate the exercise of the Delegated Functions and NHS England's Reserved Functions.

2.2 Each Party must ensure that they have in place appropriate data sharing or data processing arrangements to enable data to be received from any third party organisations from which the Parties must obtain data in order to achieve the Specified Purpose.

2.3 Where necessary specific and detailed purposes must be set out in a Data Sharing Agreement or Data Processing Agreement that complies with all relevant legislation and Guidance.

3 Benefits of information sharing

3.1 The benefits of sharing information are the achievement of the Specified Purpose, with benefits for service users and other stakeholders in terms of the improved delivery of the Delegated Services.

4 Lawful basis for sharing

4.1 The Parties shall comply with all relevant Data Protection Legislation requirements and Good Practice in relation to the processing of Relevant Information shared further to this Agreement.

4.2 The Parties shall ensure that there is a Data Protection Impact Assessment ("DPIA") that covers processing undertaken in pursuance of the Specified Purpose. The DPIA shall identify the lawful basis for sharing Relevant Information for each purpose and data flow.

4.3 Further details regarding the Relevant Information to be shared shall be set out in a Data Sharing Agreement and/or Data Processing Agreement.

5 Restrictions on use of the Shared Information

5.1 Each Party shall only process the Relevant Information as is necessary to achieve the Specified Purpose and, in particular, shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.

5.2 Access to, and processing of, the Relevant Information provided by a Party must be the minimum necessary to achieve the Specified Purpose. Information and Special Category Personal Data will be handled at all times on a restricted basis, in compliance with Data Protection Legislation requirements, and the Parties' Staff should only have access to Personal Data on a justifiable Need to Know basis.

5.3 Neither the provisions of this Schedule nor any associated Data Sharing Agreement and/or Data Processing Agreement should be taken to permit unrestricted access to data held by any of the Parties.

5.4 Neither Party shall subcontract any processing of the Relevant Information without the prior consent of the other Party. Where a Party subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor, which imposes the same obligations as are imposed on that Party under this Agreement, and shall remain liable for the performance of the subcontractor's obligations.

5.5 The Parties shall not cause or allow Relevant Information to be transferred to any territory outside the United Kingdom without the prior written permission of the responsible Data Controller.

5.6 Any particular restrictions on use of certain Relevant Information should be included in a Data Sharing Agreement and/or Data Processing Agreement.

6 Ensuring fairness to the Data Subject

6.1 In addition to having a lawful basis for sharing information, the UK GDPR generally requires that the sharing must be fair and transparent. In order to achieve fairness and transparency to the Data Subjects, the Parties will take the following measures as reasonably required:

6.1.1 amendment of internal guidance to improve awareness and understanding among Staff,

6.1.2 amendment of respective privacy notices and policies to reflect the processing of data carried out further to this Agreement, including covering the requirements of articles 13 and 14 UK GDPR and providing these (or making them available to) Data Subjects,

6.1.3 ensuring that information and communications relating to the processing of data is clear and easily accessible, and

6.1.4 giving consideration to carrying out activities to promote public understanding of how data is processed where appropriate.

6.2 Each Party shall procure that its notification to the Information Commissioner's Office, and record of processing maintained for the purposes of Article 30 UK GDPR, reflects the flows of information under this Agreement.

6.3 The Parties shall reasonably co-operate in undertaking any DPIA associated with the processing of data further to this Agreement, and in doing so engage with their respective Data Protection Officers in the performance by them of their duties pursuant to Article 39 UK GDPR.

6.4 Further provision in relation to specific data flows may be included in a Data Sharing Agreement and/or Data Processing Agreement between the Parties.

7 Governance: Staff

7.1 The Parties must take reasonable steps to ensure the suitability, reliability, training and competence, of any Staff who have access to Personal Data, and Special Category Personal Data, including ensuring reasonable background checks and evidence of completeness are available on request.

7.2 The Parties agree to treat all Relevant Information as confidential and imparted in confidence and must safeguard it accordingly. Where any of the Parties' Staff are not healthcare professionals (for the purposes of the Data Protection Act 2018), the employing Parties must procure that Staff operate under a duty of confidentiality which is equivalent to that which would arise if that person were a healthcare professional.

7.3 The Parties shall ensure that all Staff required to access Personal Data (including Special Category Personal Data) are informed of the confidential nature of the Personal Data. The Parties shall include appropriate confidentiality clauses in employment/service contracts of all Staff that have any access whatsoever to the Relevant Information, including details of sanctions for acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure provisions of Data Protection Legislation requirements, or cause damage to or loss of the Relevant Information.

7.4 Each Party shall provide evidence (further to any reasonable request) that all Staff that have any access to the Relevant Information whatsoever are adequately and appropriately trained to comply with their responsibilities under Data Protection Legislation and this Agreement.

7.5 The Parties shall ensure that:

7.5.1 only those Staff involved in delivery of the Agreement use or have access to the Relevant Information,

7.5.2 that such access is granted on a strict Need to Know basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited. Evidence of audit should be made freely available on request by the originating Data Controller, and

7.5.3 specific limitations on the Staff who may have access to the Relevant Information are set out in any Data Sharing Agreement and/or Data Processing Agreement entered into in accordance with this Schedule.

8 Governance: Protection of Personal Data

8.1 At all times, the Parties shall have regard to the requirements of Data Protection Legislation and the rights of Data Subjects.

8.2 Wherever possible (in descending order of preference), only anonymised information, or, strongly or weakly pseudonymised information will be shared and processed by the Parties. The Parties shall co-operate in exploring alternative strategies to avoid the use of Personal Data in order to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data or Special Category Personal Data.

8.3 Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need to Know basis.

8.4 If any Party becomes aware of:

8.4.1 any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable, or

8.4.2 any security vulnerability or breach in respect of the Relevant Information,

it shall promptly, within 48 hours, notify the other Parties. The Parties shall fully co-operate with one another to remedy the issue as soon as reasonably practicable, and in making information about the incident available to the Information Commissioner and Data Subjects where required by Data Protection Legislation.

8.5 In processing any Relevant Information further to this Agreement, the Parties shall process the Personal Data and Special Category Personal Data only:

8.5.1 in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only in accordance with written instructions from the originating Data Controller in respect of its Relevant Information including any instructions set out in a Data Processing Agreement entered into under this Schedule, unless required by law (in which case, the processor shall inform the relevant Data Controller of that legal requirement before processing, unless that law prohibits such information on important grounds of public interest),

8.5.2 to the extent as is necessary for the provision of the Specified Purpose or as is required by law or any regulatory body, and

8.5.3 in accordance with Data Protection Legislation requirements, in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) UK GDPR, and not in such a way as to cause any other Data Controller to breach any of their applicable obligations under Data Protection Legislation.

8.6 The Parties shall act generally in accordance with Data Protection Legislation requirements. This includes implementing, maintaining and keeping under review appropriate technical and organisational measures to ensure and demonstrate that the processing of Personal Data is undertaken in accordance with Data Protection Legislation, and in particular to protect Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing, and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:

8.6.1 take account of the nature, scope, context and purposes of processing as well as the risks, of varying likelihood and severity for the rights and freedoms of Data Subjects, and

8.6.2 be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data and Special Category Personal Data, and having the nature of the Personal Data and Special Category Personal Data which is to be protected.

8.7 In particular, each Party shall:

8.7.1 ensure that only Staff as provided under this Schedule have access to the Personal Data and Special Category Personal Data,

8.7.2 ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display or distribution, of the Relevant Information,

8.7.3 obtain prior written consent from the originating Party in order to transfer the Relevant Information to any third party,

8.7.4 permit any other party or their representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors or assigns) and comply with all reasonable requests or directions to enable each Party to verify and/or procure that the other is in full compliance with its obligations under this Agreement, and

8.7.5 if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.

8.8 The Parties shall adhere to the specific requirements as to information security set out in any Data Sharing Agreement and/or Data Processing Agreement entered into in accordance with this Schedule.

8.9 The Parties shall use best endeavours to achieve and adhere to the requirements of the NHS Digital Data Security and Protection Toolkit.

8.10 The Parties' Single Points of Contact set out in paragraph 13 will be the persons who, in the first instance, will have oversight of third party security measures.

9 Governance: Transmission of Information between the Parties

9.1 This paragraph supplements paragraph 8 of this Schedule.

9.2 Transfer of Personal Data between the Parties shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net or gcsx) e-mail.

9.3 Wherever possible, Personal Data should be transmitted and held in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, so as to ensure that the correct patient record and/or data is identified.

9.4 Any other special measures relating to security of transfer should be specified in a Data Sharing Agreement and/or Data Processing Agreement entered into in accordance with this Schedule.

9.5 Each Party shall keep an audit log of Relevant Information transmitted and received in the course of this Agreement.

9.6 The Parties' Single Point of Contact notified pursuant to paragraph 13 will be the persons who, in the first instance, will have oversight of the transmission of information between the Parties.

10 Governance: Quality of Information

10.1 The Parties will take steps to ensure the quality of the Relevant Information and to comply with the principles set out in Article 5 UK GDPR.

11 Governance: Retention and Disposal of Shared Information

11.1 A non-originating Party shall securely destroy or return the Relevant Information once the need to use it has passed or, if later, upon the termination of this Agreement, howsoever determined. Where Relevant Information is held electronically, the Relevant Information will be deleted and formal notice of the deletion sent to the Party that shared the Relevant Information. Once paper information is no longer required, paper records will be securely destroyed or securely returned to the Party they came from.

11.2 Each Party shall provide an explanation of the processes used to securely destroy or return the information, or verify such destruction or return, upon request and shall comply with any request of the Data Controllers to dispose of data in accordance with specified standards or criteria.

11.3 If a Party is required by any law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy in accordance with this Schedule, it shall notify the other Parties in writing of that retention, giving details of the documents or materials that it must retain.

11.4 Retention of any data shall comply with the requirements of Article 5(1)(e) GDPR and with all Good Practice including the Records Management NHS Code of Practice, as updated or amended from time to time.

11.5 The Parties shall set out any special retention periods in a Data Sharing Agreement where appropriate.

11.6 The Parties shall ensure that Relevant Information held in paper form is held in secure files, and, when it is no-longer needed, destroyed using a cross cut shredder or subcontracted to a confidential waste company that complies with European Standard EN15713.

11.7 Each Party shall ensure that, when no longer required, electronic storage media used to hold or process Personal Data are destroyed or overwritten to current policy requirements.

11.8 Electronic records will be considered for deletion once the relevant retention period has ended.

11.9 In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Party shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

12 Governance: Complaints and Access to Personal Data

12.1 The Parties shall assist each other in responding to any requests made under Data Protection Legislation made by persons who wish to access copies of information held about them ("Subject Access Requests"), as well as any other exercise of a Data Subject's rights under Data Protection Legislation or complaint to or investigation undertaken by the Information Commissioner.

12.2 Complaints about processing shall be reported to the Single Points of Contact and the ICB. Complaints about information sharing shall be routed through each Parties' own complaints procedure unless otherwise provided for in the Agreement or determined by

the ICB. Where the complaint relates to processing undertaken by a Party acting as a Data Processor on behalf of the other Party, complaints shall be routed through the relevant Data Controller's own complaints procedure unless otherwise provided for in the Agreement.

12.3 The Parties shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Schedule or any data processing carried out further to it.

12.4 Basic details of the Agreement shall be included in the appropriate log under each Party's publication scheme.

13 Governance: Single Points of Contact

13.1 The Parties each shall appoint a Single Point of Contact to whom all queries relating to the particular information sharing should be directed in the first instance.

14 Monitoring and review

14.1 The Parties shall monitor and review on an ongoing basis the sharing and wider processing of Relevant Information to ensure compliance with Data Protection Legislation and Best Practice. Specific monitoring requirements must be set out in the relevant Data Sharing Agreement and/or Data Processing Agreement.

SCHEDULE 6: Further Information Governance~~,~~ Sharing and Processing Provisions

PART 2

Data Sharing Agreement

Description	**Details**
Subject matter of the processing	Due to the complexities of Specialised Services and the distinctions between Delegated Functions and Reserved Functions, both the ICB Commissioning Teams (employed by the Host ICB) delivering Delegated Functions and the NHS England teams delivering Reserved Functions will need access to Relevant Information, which contains Personal Data. As set out in Schedule 6, Part 1, Paragraph 2.1, the Specified Purpose for sharing data is: *'…to facilitate the exercise of the Delegated Functions and NHS England's Reserved Functions.'* In order to achieve this purpose in the most effective, efficient and cost effective manner, the data will be hosted by NHS England in a collaborative working space which ICBs will have access to. NHS England will be responsible for ensuring that Commissioning Team staff have sufficient and appropriate access to Relevant Information to enable those staff to fulfil their commissioning functions in respect of the Delegated Services, including those described in Schedule 3 (Delegated Functions) to this agreement. In addition, NHS England may process the data for the following purposes: • development, oversight, and the quality improvement of Specialised Commissioning Functions; • undertaking work to evaluate the effectiveness of innovation and changes in delivery models and advising other bodies and organisations about these functions; • arranging the provision of services to support commissioning activities, to enable reporting and evaluations; • undertaking analysis, audits, and inspections to assess and assure the quality of Specialised Commissioning Functions; • supporting healthcare organisations to interpret population health data and evidence, and to undertake reviews of the likely effectiveness and cost-effectiveness of a range of interventions; • development a of strategies on population health outcomes and to identify gaps or deficiencies in current care and to produce recommendations for improvements, including in relation to specific pathways of care; • using and supporting health organisations to use health economic tools to support decision-making and interpreting data about the surveillance or assessment of a population's health to improve health outcomes and reduce health inequalities; • the development of population health policies and strategies, and their implementation,
Duration of the processing	Unless otherwise specified in this Data Sharing Agreement, the processing shall commence on the Effective Date of Delegation and, as per paragraph

	11.1 of this Schedule, shall continue until the need to use it has passed or, if later, upon the termination of this Agreement.
Nature and purpose of the processing	Personal Data is shared between the Parties in relation to the delivery of the Delegated Functions. Such processing should ensure continued: • Provision of live services and associated reporting; • Quality improvement and assurance of services; • Dissemination of data for health and research purposes.
Type of Personal Data being Processed	There will be data shared between NHS England and ICBs, either directly, via shared SharePoint workspaces (hosted by NHS England) or via the Commissioning Support Unit (CSU) and the Data Services for Commissioners Regional Offices (DSCROs) in respect of both the delegated and retained services. This will be as needed in order to successfully deliver the specialised commissioning functions covered in this Agreement.
Categories of Data Subject	Where required, this data will be anonymised or pseudonymised. There will be at times the need to share identifiable and special category data. This will be mapped out in the associated DPIA and data flow mapping documents.

SCHEDULE 6: Further Information Governance~~,~~ Sharing and Processing Provisions

PART 3

Data Processing Agreement

Description	Details
Identity of the Controller and Processor	The ICB is the Data Controller and NHS England is the Data Processor.
Subject matter of the processing	Both the ICB Commissioning Teams (employed by the Host ICB) delivering Delegated Functions and the NHS England teams delivering Reserved Functions will need access to Relevant Information. In order to achieve this purpose in the most effective, efficient and cost effective manner, the data will be hosted by NHS England in a collaborative working space which ICBs will have access to. Consequently, NHS England will act as a Data Processor on behalf of the ICB in relation to the Relevant Information required to commission the Delegated Services and fulfil the Delegated Functions.
Duration of the processing	Unless otherwise specified in this Data Processing Agreement the processing shall commence on the Effective Date of Delegation and, as per paragraph 11.1 of this Schedule, shall continue until the need to use it has passed or, if later, upon the termination of this Agreement.
Plan for return and destruction of the data once the processing is complete	As set out in paragraph 11.1 of this Schedule
Nature and purpose of the processing	This Data Processing Agreement considers processing of any data by NHS England on behalf of the ICB Commissioning Teams in relation to the delivery of the Delegated Functions. Such processing should ensure continued: • Provision of live services and associated reporting; • Quality improvement and assurance of services; • Dissemination of data for health and research purposes.
Type of Personal Data being Processed	There will be data shared between NHS England and ICBs, either directly, via shared SharePoint workspaces (hosted by NHS England) or via the Commissioning Support Unit (CSU) and the Data Services for Commissioners Regional Offices (DSCROs) in respect of both the delegated and retained services. This will be as needed in order to successfully deliver the specialised commissioning functions covered in this Agreement.
Categories of Data Subject	Where required, this data will be anonymised or pseudonymised. There will be at times the need to share identifiable and special category data. This will be mapped out in the associated DPIA and data flow mapping documents.

SCHEDULE 7 MANDATED GUIDANCE

Generally applicable Mandated Guidance

- National Guidance on System Quality Groups.
- Managing Conflicts of Interest in the NHS.
- Arrangements for Delegation and Joint Exercise of Statutory Functions.
- Guidance relating to procurement and provider selection.
- Information Governance Guidance relating to serious incidents.
- All other applicable IG and Data Protection Guidance.
- Any applicable Freedom of Information protocols.
- Any applicable Guidance on Counter Fraud, including from The NHS Counter Fraud Authority.
- Any applicable Guidance relating to the use of data and data sets for reporting.
- Guidance relating to the processes for making and handling individual funding requests, including:
    - Commissioning policy: Individual funding requests,
    - Standard operating procedures: Individual funding requests.

Workforce

- Guidance on the Employment Commitment.

Finance

- Guidance on NHS System Capital Envelopes.
- Managing Public Money (HM Treasury).

Specialised Services Mandated Guidance

- Commissioning Change Management Business Rules.
- Cashflow Standard Operating Procedure.
- Finance and Accounting Standard Operating Procedure.
- Provider Collaborative Guidance.
- Clinical Commissioning Policies.
- National Specifications.
- National Standards.
- The Prescribed Specialised Services Manual

SCHEDULE 8 LOCAL TERMS

The ICB, along with the other two ICBs in the East of England region and NHS England, has signed a Collaboration Agreement that sets out the detail needed to ensure that delegated specialised commissioned services are delivered safely and effectively.

This Schedule 8 (Local Terms) makes reference to appropriate clauses or schedules within the Collaboration Agreement, where necessary.

General

Where there is a Dispute as to the content of this Schedule, the Parties should follow the Disputes procedure set out at Clause 25.

Following signature of the Agreement, this Schedule can be amended by the Parties using the Variations procedure at Clause 26.

NHS England can amend this Schedule without the ICB's consent by using the variation procedure set out in Clause 26.2 but the expectation is that variations should be by consent.

Part 1 – the service to be planned or commissioned at an ICB level

In the first instance, all delegated services will be commissioned collectively by all three ICBs. Any changes to this arrangement will be reflected in the Collaboration Agreement, Schedule 3 (Individual Schemes).

Part 2 – the services to be planned or commissioned by an ICB Collaboration Arrangement

In the first instance, all delegated services will be commissioned collectively by all three ICBs. Any changes to this arrangement will be reflected in the Collaboration Agreement, Schedule 3 (Individual Schemes).

Part 3 – Funding arrangements

Funding arrangements are set out in the Collaboration Agreement, Schedule 4 (Financial Arrangements).

Part 4 – Workforce and Commissioning Team Arrangements

Workforce and commissioning team arrangements are set out in the Collaboration Agreement, Schedule 5 (Commissioning Team Arrangements).

Part 5 – ICB Collaboration Arrangements

These are detailed in the Collaboration Agreement signed by the three ICBs in the East of England region and NHS England.

Part 6 – Pooled Funds and Non-Pooled Funds

The ICBs have determined that they will not seek to create Pooled or Non-Pooled Funds. Financial arrangements are set out in the Collaboration Agreement, Schedule 4 (Financial Arrangements).

Part 7 – Provider Collaboratives

The arrangements for the mental health, learning disability and autism (MHLDA) Provider Collaboratives are set out in Clause 16 of Schedule 3.

Part 8 – Further Governance Arrangements

The Partners have established a Joint Commissioning Consortium to oversee and take decisions in relation to the Delegated Services. The Joint Commissioning Consortium will also oversee and advise NHS England on its retained commissioning activity. Terms of reference for the Consortium have been agreed as a separate document.

The Joint Commissioning Consortium is not a formal committee of the Board and its members will be Authorised Officers from each of the ICBs and NHS England. The ICB shall ensure that their Authorised Officer and any substitutes have appropriate delegated authority, in accordance with the ICB's Scheme of Reservation and Delegation, to represent the interests of the ICB on the Consortium and any other sub-groups established by the Consortium.

Further details are set out in the Collaboration Agreement, Schedule 2 (Governance Arrangements).

SCHEDULE 9 DEVELOPMENTAL ARRANGEMENTS

These Development Arrangements take precedence over the terms of this Agreement including other Schedules, and the Agreement shall be read as varied by these Developmental Arrangements. Save as varied by these Developmental Arrangements the Agreement remains in full force and effect.

The Developmental Arrangements

The following Developmental Arrangements apply to this Agreement:

1. With reference to the NHS Oversight Framework and the ICB's assessed status within the NHS Oversight Framework, the ICB and NHS England agree that:
    a. Any decision that impacts on the overall spend of the specialised service allocation (the Delegated Funds) must have NHS England (regional) approval before the commissioning change is made or any change process is begun.

2. This Developmental Arrangement:
    a. applies if the ICB is assessed as within segments 3 and 4 (NOF3 or NOF4) of the NHS Oversight Framework at the time of signing the agreement or, an equivalent score at the time the annual ICB capability assessment is undertaken.
    b. should not act as barrier to innovation and change but does reflect NHS England's continued accountability for Delegated Services, its role in oversight and assurance and the need to work together to support those systems facing the greatest challenges.

3. NHS England may issue further Guidance on this Developmental Arrangement to ensure it aligns with any amended Oversight Framework.

SCHEDULE 10: ADMINISTRATIVE AND MANAGEMENT SERVICES

Administrative and management services are set out in the Collaboration Agreement, Schedule 6 (Commissioning Team Arrangements).

8. Duty to Engage

8.1. Communications and Engagement Strategy [to follow]

9. Use of the ICB Seal

9.1. Guidance for use of the ICB Seal [to follow]

10. Selection Process for Non-ICB Committee Members

10.1. Selection Process for non-ICB Committee Members [to follow]