Integrated Care Board Meeting Agenda (Open Session)

Friday 01 July 2022 09:30 – 12:00

Room GF04, Sir John Robinson House
Sir John Robinson Way, Arnold, NG5 6DA

"We will enable each and every citizen to enjoy their best possible health and wellbeing."

Principles:

- We will work with, and put the needs of, our **citizens** at the heart of the ICS.
- We will be **ambitious** for the health and wellbeing of our local population.
- We will work to the principle of **system** by default, moving from operational silos to a system wide perspective.

Core values:

- We will be **open** and **honest** with each other.
- We will be **respectful** in working together
- We will be **accountable**, doing what we say we will do and following through on agreed actions.

	Item	Presenter	Type	Time
Introductory Items				
1.	Welcome, introductions and apologies	Kathy McLean	Verbal	09:30
2.	Confirmation of quoracy	Kathy McLean	Verbal	
3.	Declaration and management of interests	Kathy McLean	Paper	
ICB Establishment and Governance Arrangements				
4.	Establishment of NHS Nottingham and Nottinghamshire Integrated Care Board	Kathy McLean	Paper	09:40
5.	Establishment of the Nottingham and Nottinghamshire Integrated Care Partnership	Amanda Sullivan	Paper	
Leadership, Strategy and Planning				
6.	Chair's Report	Kathy McLean	Paper	10:30
7.	Chief Executive's Report	Amanda Sullivan	Paper	
8.	Business Deliverables for 2022/23	Stuart Poynor	Paper	
9.	Delegation of Functions from NHS England to ICBs	Lucy Dadge	Paper	
10.	Emergency Preparedness, Resilience and Response (EPRR) Incident Response Plan	Lucy Dadge	Paper	
Closing Items				
11.	Questions from the public relating to items on the agenda	Kathy McLean	Verbal	11:50
12.	Any other business	Kathy McLean	Verbal	

Date and time of next Board meeting held in public: 8 September 2022 at 9:00 (Sir John Robinson House)

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	01/07/2022
Paper Title:	Declaration and management of interests
Paper Reference:	ICB 22 003
Report Author:	Lucy Branson, Associate Director of Governance
Report Sponsor:	Dr Kathy McLean, ICB Chair
Presenter:	Dr Kathy McLean, ICB Chair
Recommendation(s):	The Board is asked to **RECEIVE** this item.

Summary:

As custodians of tax-payers money, Integrated Care Boards (ICBs) are required to implement and demonstrate robust arrangements for the identification and management of conflicts of interest. These arrangements should support good judgement about how any interests should be approached and managed; safeguarding the organisation from any perception of inappropriateness in its decision-making and assuring the public that money is being spent free from undue influence. The ICB's arrangements for the management of conflicts of interests are set out in the organisation's Standards of Business Conduct Policy.

Details of the declared interests for members of the Board are attached. An assessment of these interests has been performed against the meeting agenda; this has confirmed that there are no known conflicts or potential conflicts of interest that require managing at the meeting.

Members are also reminded of their individual responsibility to highlight any interests not already declared should a conflict (or potential conflict) become apparent in discussions during the course of the meeting.

Appendices:

Appendix A: Extract from the ICB's Register of Declared Interests for members of the Board.

Key Strategic Risks:

To be confirmed in line with the development of the Board's Assurance Framework.

Applicable Statutory Duties:	
Duty to promote the NHS Constitution	No
Duty as to effectiveness, efficiency and economy	Yes
Duty as to improvement in quality of services	No
Duties as to reducing inequalities	No
Duty to promote involvement of each patient	No
Duty as to patient choice	No
Duty to obtain appropriate advice	No
Duty to promote innovation	No
Duty in respect of research	No
Duty to promote education and training	No
Duty to promote integration	No

Applicable Statutory Duties:	
Duty to have regard to the wider effect of decisions	No
Duties as to climate change	No
Duties regarding public involvement and consultation	No
Public sector equalities duties	No

Report Previously Received By:
N/A

Are there any conflicts of interest requiring management?
This paper sets out how any declared interests in agenda items for the meeting are required to be managed.

Is this item confidential?
No

Register of Declared Interests

• As required by section 14Z30 of the NHS Act 2006 (as amended), the ICB has made arrangements to manage conflicts and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interests.

• This document is extracted, for the purposes of this meeting, from the ICB's full Register of Declared Interests.

• The register is reviewed in advance of the meeting to ensure the consideration of any known interests in relation to the meeting agenda. Where necessary (for example, where there is a direct financial interest), members may be fully excluded from participating in an item and this will include them not receiving the paper(s) in advance of the meeting.

• Members and attendees are reminded that they can raise an interest at the beginning of, or during discussion of, an item if they realise that they do have a (potential) interest that hasn't already been declared.

Name	Current position(s) held in the CCG	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Financial Interest	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interest	Loyalty Interest	Date the interest became relevant to the ICB	Date To:	Action taken to mitigate risk
ADAMOU, Marios	Non-Executive Director	South West Yorkshire Partnership NHS Foundation Trust	Employed as a Consultant Psychiatrist	✓					01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
ADAMOU, Marios	Non-Executive Director	Marios Adamou LTD - providng eductional and advisory services	Director	✓					01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
ADAMOU, Marios	Non-Executive Director	University of Huddersfield	Visiting Professor			✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
ADAMOU, Marios	Non-Executive Director	National Institute for Health and Care Research	Member of Health Technology Assessment Prioritisation Committee			✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
BREWIN, Dr John	NHS Trust and NHS Foundation Trust Partner Member	Nottinghamshire Healthcare NHS Foundation Trust	Chief Executive	✓					01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
BRIGGS, David	Medical Director	British Medical Associaton	Member				✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
BROOKS, Melanie	Local Authority Partner Member	Nottinghamshire County Council	Corporate Director for Adult Social Care and Health	✓					01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration	Mid Nottinghamshire and Greater Nottingham Lift Co (public sector)	Director	✓					01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration	Valley Road Surgery	Registered Patient			✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration	Nottingham Schools Trust	Chair and Trustee			✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration	Care Workers Union	Director (not remunerated)			✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration	Cleaners Union	Director (not remunerated)			✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, John Stephen	Non-Executive Director	Nottingham Business Improvement District (BID)	Non-Executive Chair		✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.

Name	Current position(s) held in the CCG	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Financial Interest	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interest	Loyalty Interest	Date the interest became relevant to the ICB	Date To:	Action taken to mitigate risk
JACKSON, John Stephen	Non-Executive Director	Nottingham High School	Governor		✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, John Stephen	Non-Executive Director	Portland College	Governor		✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, John Stephen	Non-Executive Director	Marketing Nottingham	Non-Executive Director		✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, John Stephen	Non-Executive Director	Derbyshire Health United CIC	Non-Executive Director	✓					01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, John Stephen	Non-Executive Director	IBC Ltd (currently inactive)	Joint Owner and Chief Executive Officer	✓					01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
LIM, Dr Kelvin	Primary Care Partner Member	Primary Integrated Community Services	Director	✓					01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
LIM, Dr Kelvin	Primary Care Partner Member	NEMS	Shareholder	✓					01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
LIM, Dr Kelvin	Primary Care Partner Member	Church Walk Medical Services	Shareholder	✓					01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
LIM, Dr Kelvin	Primary Care Partner Member	Eastwood Primary Care Centre	GP Partner	✓					01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MALEY, Caroline	Non-Executive Director	No relevant interests declared	Not applicable						Not applicable	Not applicable	Not applicable
MCLEAN, Kathy	ICB Chair	University Hospitals of Derby and Burton NHS Foundation Trust	Trust Chair	✓					01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	Treetops Hospice	Spouse is a trustee of Treetops Hospice				✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	Kathy McLean Limited - Private limited company to offer health related advice	Director	✓					01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	Barts Health NHS Trust (London)	Non-Executive Director	✓					01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	NHS Employers	Chair of the national negotiation committee for Staff and Associate Specialists on behalf of NHS Employers		✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	Care Quality Commission (CQC)	Occasional Advisor	✓					01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	Public Sector Consultancy	Senior Clinical Advisor	✓					01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	NHS England/Improvement	Lay Advisor	✓					01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	NEMS Healthcare Ltd	Spouse is shareholder				✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.

Name	Current position(s) held in the CCG	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Financial Interest	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interest	Loyalty Interest	Date the interest became relevant to the ICB	Date To:	Action taken to mitigate risk
MCLEAN, Kathy	ICB Chair	NHS Providers Board	Trustee		✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
POYNOR, Stuart	Director of Finance	No relevant interests declared	Not applicable						Not applicable	Not applicable	Not applicable
ROBINSON, Paul	NHS Trust and NHS Foundation Trust Partner Member	Sherwood Forest Hospitals NHS Foundation Trust	Chief Executive	✓					01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
SULLIVAN, Amanda	Chief Executive	Hillview Surgery	Registered Patient			✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
TOWLER, Jon	Non-Executive Director	Sherwood Medical Practice	Registered Patient			✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
TOWLER, Jon	Non-Executive Director	Major Oak Medical Practice, Edwinstowe	Family members are registered patients				✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
TOWLER, Jon	Non-Executive Director	YPO - a publicly owned central purchasing body based in Wakefield, Yorkshire. It is owned and governed by a consortium of county, metropolitan and borough councils in Yorkshire and the North West England. It provides a wide range of resources and services to schools, councils, charities, emergency services, and other public sector organisations.	Independent Director	✓					01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
UNDERWOOD, Catherine	Local Authority Partner Member	Nottingham City Council	Corporate Director of People	✓					01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
WADDINGHAM, Rosa	Director of Nursing	No relevant interests declared	Not applicable						Not applicable	Not applicable	Not applicable

The following individuals will be in attendance at the meeting but are not part of the Board's membership:

BRANSON, Lucy	Associate Director of Governance	St George's Medical Practice	Registered Patient			✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.

NHS Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	01/07/2022
Paper Title:	**Establishment of NHS Nottingham and Nottinghamshire ICB**
Paper Reference:	ICB 22 004
Report Author:	Lucy Branson, Associate Director Governance
Report Sponsor:	Kathy McLean, ICB Chair
Presenter:	Kathy McLean, ICB Chair
Recommendation(s):	The Board is asked to: 1. **RECEIVE** the Constitution and Standing Orders, as approved by NHS England. 2. **RECEIVE** the Primary Medical Services Delegation Agreement from NHS England to the ICB. 3. **APPROVE** the Governance Handbook, including the Standing Financial Instructions and Scheme of Reservation and Delegation. 4. **APPROVE** the appointment of Committee Chairs set out in paragraph 13c) of the paper. 5. **APPROVE** the appointment of the Board level roles set out in paragraph 17a) and 17b) of the paper. 6. **ADOPT** the organisational policies listed at Appendix F. 7. **ENDORSE** the use of emergency powers by the Chair and Chief Executive to make an urgent decision to appoint the ICB's external auditor.

Summary:

The Integrated Care Boards (Establishment) Order 2022 made by NHS England will take effect and bring the ICB into being on 1 July 2022. The establishment order also brings into effect the ICB's Constitution (and Standing Orders).

This paper summarises the action needed to bring into effect the ICB's governance arrangements and presents a number of key documents for this purpose, including the ICB's Governance Handbook that sets out the terms of reference for the Board's committees and sub-committees, the Standing Financial Instructions and the Scheme of Reservation and Delegation. The paper also presents a suite of organisational policies for adoption and deals with further actions required to appoint to a range of Board and committee roles. Several key points for noting in relation to the new statutory arrangements brought into effect by the Health and Care Act 2022 are also highlighted for Board members' attention throughout the paper.

Appendices:

A. NHS Nottingham and Nottinghamshire ICB Constitution and Standing Orders
B. Delegation Agreement in respect of Primary Medical Services between NHS England and NHS Nottingham and Nottinghamshire ICB
C. NHS Nottingham and Nottinghamshire ICB Governance Handbook
D. NHS Nottingham and Nottinghamshire ICB Standing Financial Instructions
E. NHS Nottingham and Nottinghamshire ICB Scheme of Reservation and Delegation
F. Organisational policies to be adopted by NHS Nottingham and Nottinghamshire ICB

Key Strategic Risks:
To be confirmed in line with the development of the Board's Assurance Framework.

Applicable Statutory Duties:	
Duty to promote the NHS Constitution	Yes
Duty as to effectiveness, efficiency and economy	Yes
Duty as to improvement in quality of services	Yes
Duties as to reducing inequalities	Yes
Duty to promote involvement of each patient	Yes
Duty as to patient choice	Yes
Duty to obtain appropriate advice	Yes
Duty to promote innovation	Yes
Duty in respect of research	Yes
Duty to promote education and training	Yes
Duty to promote integration	Yes
Duty to have regard to the wider effect of decisions	Yes
Duties as to climate change	Yes
Duties regarding public involvement and consultation	Yes
Public sector equalities duties	Yes

Report Previously Received By:
Several key areas in the enclosed documentation have been reviewed prior to presentation at this inaugural meeting of the Board; specifically: • The former CCG Governing Bodies were responsible for proposing the ICB's initial Constitution, which was developed collaboratively with system partners and ICB designate leaders. • Proposed committee terms of reference, Standing Financial Instructions and key organisational policies have been reviewed by some designate ICB Board members during the transition period ahead of the ICB's establishment.

Are there any conflicts of interest requiring management?
No

Is this item confidential?
No

Establishment of NHS Nottingham and Nottinghamshire Integrated Care Board

Introduction and context

1. The Health and Care Act 2022 will see Integrated Care Systems (ICSs) being established across England on a statutory basis on 1 July 2022. ICSs are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. Each ICS will include:

    a) An **Integrated Care Board (ICB)** – a statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the ICS area. When ICBs are legally established, clinical commissioning groups (CCGs) will be abolished and most of their statutory functions will be conferred on ICBs.

    b) An **Integrated Care Partnership (ICP)** – a statutory committee jointly formed between the ICB and the upper-tier local authorities that fall within the ICS area. The ICP will bring together a broad alliance of partners concerned with improving the care, health and wellbeing of the population. The ICP is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area.

    c) **Place-based partnerships** to lead the detailed design and delivery of integrated services across their localities and neighbourhoods. The partnerships will involve the NHS, local councils, community and voluntary organisations, local residents, people who use services, their carers and representatives and other community partners with a role in supporting the health and wellbeing of the population.

    d) **Provider collaboratives** will bring providers together to achieve the benefits of working at scale across multiple places and one or more ICSs, to improve quality, efficiency and outcomes and address unwarranted variation and inequalities in access and experience across different providers.

2. The purpose of ICSs is to bring partner organisations together to:

    a) **Improve outcomes** in population health and healthcare.

    b) **Tackle inequalities** in outcomes, experience and access.

    c) Enhance **productivity and value for money**.

    d) Help the NHS support broader **social and economic development**.

3. This paper focusses on the establishment of NHS Nottingham and Nottinghamshire ICB and bringing into effect its governance arrangements. Further papers on the agenda for this meeting will focus on the other core elements of the ICS.

Establishment Order and Constitution

4. NHS Nottingham and Nottinghamshire ICB was established on 1 July 2022 by The Integrated Care Boards (Establishment) Order 2022. The establishment order also brings into effect the ICB's Constitution.

5. The Health and Care Act 2022 requires ICBs to have a Constitution, which must set out the ICB's name, area, its Board membership and associated appointment requirements (including disqualification criteria), along with arrangements for discharging functions, demonstrating accountability, making decisions, managing conflicts of interests, and for public involvement.

6. There is no requirement for the Board to approve the Constitution, though it is important that all Board members ensure they are familiar with its content. The following points are highlighted for members' attention:

    a) The Constitution has been developed through consultation with a wide range of system partners and wider stakeholders, in line with the nationally mandated template.

    b) Any proposed amendments to the Constitution can only be made by applying to NHS England, and amendments cannot be implemented until approval is granted.

    c) The ICB's Standing Orders are appended to the Constitution. These set out the arrangements and procedures to be used at meetings of the Board and its committees, including arrangements for deputies, quorum requirements and decision-making arrangements.

    d) The Board has a statutory duty to keep under review the skills, knowledge and experience of its members to enable to Board to effectively carry out its functions. Arrangements will be established to satisfy this requirement through the Chair on an annual basis.

    e) The Constitution sets out the ICB's formal partner trusts as:

        i) Sherwood Forest Hospitals NHS Foundation Trust.

        ii) Nottingham University Hospitals NHS Trust.

        iii) Nottinghamshire Healthcare NHS Foundation Trust.

        iv) East Midlands Ambulance Services NHS Trust.

        v) Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust.

Formal partner status means that these trusts must agree the ICB's Joint Forward Plan and the Joint Capital Resource Use Plan and will be party to any joint statutory financial duties.

f) The ICB will be subject to an annual assessment of its performance by NHS England and a report containing a summary of the results of this assessment will be published. The performance assessment will assess how well the ICB has discharged its functions during that year, including an assessment of how well it has discharged its general statutory duties.

7. The Constitution and Standing Orders are appended for noting at **Appendix A**.

Delegation Agreement for Primary Medical Services

8. Functions in relation to primary medical services have been previously delegated to CCGs, and as ICBs become legal entities and CCGs are abolished, ICBs will automatically take on these delegated functions from 1 July 2022.

9. The Delegation Agreement for Primary Medical Services is appended for noting at **Appendix B**. This will be signed by the ICB's Chief Executive and returned to NHS England on 1 July 2022.

10. The following points are highlighted for members' attention, which summarise key changes to the delegation being made to ICBs:

a) Liability moves to the ICB – The Health and Care Act 2022 locates liability with the body exercising delegated functions at the point of delegation.

b) Financial flexibility – Funds will be received by the ICB in relation to the delegated functions on an annual basis, which will be in addition to the ICB's Annual Allocation. These delegated funds can be used in the exercise of any ICB functions, rather than being limited to the delegated functions, as long as the obligations within the delegation agreement are met.

c) Onward delegation – This is permitted by the agreement, subject to some parameters. Onward delegation to providers (NHS trusts or foundation trusts) or joint committees including providers is not permitted. Onward delegation to joint committees of ICBs is permitted and does not require NHS England approval. Other delegations or joint committees are permitted subject to approval by NHS England. 'Triple delegation' – the further delegation of a function from a body which has delegated functions from the ICB – is prohibited.

d) Planning and reporting – The ICB is required to include its plans for exercising the delegated functions and a report on its performance against these plans in its Joint forward Plan and Annual Report.

e) Duty to comply with guidance – ICBs need to comply with a list of specified guidance when exercising the delegated functions. This will include guidance such as the Primary Care policy manuals.

f) Responsibility for the management of primary medical services complaints is delegated to the ICB for from 1 July; however, it has been agreed that this responsibility will be operationally transitioned from NHS England over a three-month period. This is to facilitate further work being completed on the workforce and operating model linked to wider primary care delegations.

Governance Handbook

11. The ICB's Constitution is supported by a comprehensive Governance Handbook, which includes a number of key governing documents that are subject to Board approval. These include the terms of reference for all committees and sub-committees, the Standing Financial Instructions and the Scheme of Reservation and Delegation.

12. The Governance Handbook also includes further information in support of the ICB's governance arrangements, including a summary of the Board's role and responsibilities, along with details of Executive Director Portfolios. Guidance for members of the public in relation to the ICB's meetings that are held in public, including how members of the public can ask questions of the Board is also included.

13. The Governance Handbook is appended for review and approval at **Appendix C**. The following points are highlighted for members' attention:

    a) The terms of reference for each of the Board's committees and sub-committees (in line with the structure chart on page 5 of the handbook) are presented for review and approval. These have been designed to ensure that the four core aims of the ICS are embedded across all committees and have taken account of national guidance where available.

    b) These are presented as the initial terms of reference for the committees and sub-committees, and it is anticipated that they will require further review and refinement as the new system arrangements evolve and mature over the coming months.

    c) In line with the ICB's Constitution, the Board is required to appoint the Chairs of its committees, which are proposed as follows:

        i) Jon Towler, Non-Executive Director, is appointed as Chair of the Remuneration Committee and the Strategic Planning and Integration Committee.

ii) Caroline Maley, Non-Executive Director, is appointed as the Chair of the Audit and Risk Committee.

iii) Stephen Jackson, Non-Executive Director, is appointed as Chair of the Finance and Performance Committee.

iv) Marios Adamou, Non-Executive Director, is appointed as Chair of the Quality and People Committee.

d) Chairs of sub-committees will be appointed by the relevant parent committees.

e) In line with statutory requirements, the ICB Chair is required to approve all individuals appointed as members of any committees or sub-committees that exercise the ICB's commissioning functions. This is line with the same responsibility placed on the ICB Chair when appointing Board members in order to confirm that individuals could not be regarded as undermining the independence of the health service because of their involvement with the private healthcare sector or otherwise. This is relevant to the Strategic Planning and Integration Committee and its Primary Care Contracting Sub-Committee. A process to satisfy this requirement will be implemented following approval of the terms of reference.

f) The ICB has flexibility to include members who are not Board members or ICB employees within the membership of any of its committees. This can be seen in the Quality and People Committee and Finance and Performance Committee, which both include Non-Executive Director membership from system partners. The Strategic Planning and Integration Committee also includes membership from Local Authority partners.

g) The Health and Care Act brings in greater delegation and joint working freedoms for ICBs; it allows ICBs to delegate any of their functions to be exercised by, or jointly with, one or more ICB, NHS trust or foundation trust, NHS England, or local authority. These arrangements will be governed by secondary legislation, which is expected to impose a number of restrictions on functions that cannot be delegated, or to make certain delegations subject to conditions. NHS England also has the power to issue statutory guidance on the exercise of these freedoms. As the secondary legislation and statutory guidance is not yet in place, ICBs will not be able to formally delegate function during 2022/23.

h) Work is ongoing to establish an ICS Partners Reference Group to support the work of the Board. This will be the successor forum to the former ICS Partnership Board and will meet to discuss and influence the development of key strategies, plans and system developments.

14. The Standing Financial Instructions (Annex A to the Governance Handbook) set out the arrangements for managing the ICB's financial affairs and are

attached for review and approval at **Appendix D**. These have been developed in line with the national template for ICB SFIs and have been reviewed by Non-Executive Directors whilst appointed in designate capacity ahead of the ICB being established.

15. The Scheme of Reservation and Delegation (Appendix B to the Governance Handbook) sets out the functions and decisions that are reserved to the Board and those that have been delegated to individuals, or to committees and sub-committees, or to another body or bodies, or to be exercised jointly with another body or bodies. This is attached for review and approval at **Appendix E**.

16. The ICB has developed a Functions and Decisions Map, which is a high-level structural chart that sets out where key decisions are taken or where functions are delegated to different parts of the system – it aims to be an easy-to-read version of the ICB's Scheme of Reservation and Delegation, designed to present the ICB's governance arrangements in a simple way. The ICB's Functions and Decisions Map is published in full on the ICB's website at www.notts.icb.nhs.uk.

Appointment to lead roles on the Board

17. The ICB's Constitution and other national guidance stipulate a number of lead roles on the Board, some of which require agreement by the Board. The following proposals are presented in line with relevant Committee chairing responsibilities:

    a) It is proposed that Caroline Maley, Non-Executive Director, be appointed as Conflicts of Interest Guardian (in line with paragraph 6.1.6 of the ICB's Constitution) and Non-Executive Lead for EPRR.

    b) It is proposed that Jon Towler, Non-Executive Director, be appointed as Wellbeing Guardian and Non-Executive Lead for Freedom to Speak Up.

18. In addition to the above, members are asked to note the following appointments made by the Chair and Chief Executive in line with the ICB's Constitution and national policy requirements:

    a) Jon Towler, Non-Executive Director, has been appointed as Vice-Chair (in line with section 3.13 of the ICB's Constitution).

    b) Stuart Poynor, Director of Finance, has been appointed as Deputy Chief Executive (in line with section 3.14 of the ICB's Constitution) and Net Zero Lead.

    c) Dave Briggs, Medical Director, has been appointed as Senior Information Risk Owner (SIRO).

    d) Rosa Waddingham, Director of Nursing, has been appointed as Caldicott Guardian.

e) Lucy Dadge, Director of Integration, has been appointed as Emergency Accountable Officer.

Property and Staff Transfer Schemes

19. At this time NHS England will utilise its powers under the Health and Social Care Act 2022 to transfer the property and staff of NHS Bassetlaw CCG and NHS Nottingham and Nottinghamshire CCG to the ICB.

20. The Property Transfer Scheme covers assets and liabilities and all contracts and the rights to claim under contracts; it also provides the ability for the ICB to rely on actions previously taken by the CCGs (for example, notices given on contracts or procurement processes which have already commenced).

21. The Staff Transfer Scheme covers the transfer of all employees from the CCGs, with the protection of COSOP (Cabinet Office Statement of Practice, which provides TUPE-like protection).

22. The above transfer schemes were underpinned by a robust due diligence exercise that was completed to ensure that the ICB is fully aware of the assets and liabilities it is taking on. No significant issues were highlighted as part of this work and appropriate arrangements have been put in place to ensure the preservation of organisational memory and a safe handover from the assurance committees of the outgoing CCGs.

Organisational Policies

23. Corporate policies are an integral part of the organisation's system of internal control as they help to ensure compliance with relevant legislation and national guidance; as well as conveying other organisational standards, responsibilities and expectations. A key element of the due diligence work undertaken ahead of the ICB's establishment has been to ensure that a complete set of corporate policies is in place by the 1 July 2022. This has involved reviewing, consolidating and updating existing CCG policies to ensure they are 'fit for purpose' for the new statutory arrangements.

24. A complete list of the ICB's organisational policies is provided at **Appendix F**. This includes those policies specifically referenced within the ICB's Constitution, as well as those that the ICB is required to have in place as a statutory body. All policies are available for Board members to review as required within the 'reading room' of the electronic board papers system. Once adopted by the Board, these will be published on the ICB's website.

25. The Board is asked to formally adopt this full suite of policies to bring these into effect for the ICB from 1 July 2022. Future policy approvals will be undertaken by the Board, or appropriate Committee, as outlined within the ICB's Scheme of

Reservation and Delegation. It should be noted that a 'blanket' review date of three years has been applied to all policies at this time; however, an assessment of review dates will be undertaken and presented to a future meeting of the Audit and Risk Committee, in line with its responsibility to oversee the ICB's policy management framework, and consideration will be given at this time to staggering review dates.

26. Members are asked to note that the following policies are assigned for Board ownership and approval:

    a) Standards of Business Conduct Policy, which incorporates the policy and procedures for the identification and management of interest.

    b) Policy for Public Involvement and Engagement.

    c) Risk Management Policy, which incorporates an initial risk appetite statement for the ICB.

    d) Equality, Diversity and Inclusion Policy.

    e) Freedom to Speak Up Policy.

27. Commissioning policies were a key focus of the due diligence work, as these are more likely to present complexities in terms of alignment, due to the potential need to consult on any differences in policy position between the former CCGs. A desktop assessment has confirmed that work to align some commissioning policies was not able to be completed prior to ICB's establishment, and as such, a plan has been developed to confirm the timeline for policy alignment in line with legal advice. Delivery of this will be overseen by the Strategic Planning and Integration Committee. Members are asked to note that for a short period of time a differential policy position will be in place in relation to policies that relate to restricted services and access to fertility treatments in line with the former CCG policies.

Appointment of the ICB's External Auditor

28. The ICB is required to appoint its external auditor in line with the Local Audit and Accountability Act 2014. This requires the establishment of an Auditor Panel (terms of reference as set out within the proposed Governance Handbook) to advise the Board on the selection and appointment of the external auditor in line with legislation.

29. Due to the required timescales for making this appointment, the Board is asked to endorse the use of emergency powers to be exercised by the Chair and Chief Executive for an urgent decision on this ahead of the next scheduled Board meeting in September. A meeting of the Auditor Panel is scheduled for 1 July following its establishment for this purpose and a record of the urgent decision will be reported to the next Board meeting.

Appendix A

NHS Nottingham and Nottinghamshire Integrated Care Board

CONSTITUTION

Version	Effective Date	Changes
1.0	1 July 2022	First version constitution on establishment of the ICB.

Contents

1. Introduction

1.1 Background/ Foreword

1.1.1 NHS England has set out the following as the four core purposes of Integrated Care Systems:

(a) Improve outcomes in population health and healthcare.

(b) Tackle inequalities in outcomes, experience and access.

(c) Enhance productivity and value for money.

(d) Help the NHS support broader social and economic development.

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

(a) Improving the health of children and young people.

(b) Supporting people to stay well and independent.

(c) Acting sooner to help those with preventable conditions.

(d) Supporting those with long-term conditions or mental health issues.

(e) Caring for those with multiple needs as populations age.

(f) Getting the best from collective resources so people get care as quickly as possible.

1.1.3 In Nottingham and Nottinghamshire, the Integrated Care Partnership will form the 'guiding mind' for the Integrated Care System in creating an integrated care strategy that will set out how the assessed needs of its area are to be met by the Integrated Care Board, NHS England and relevant local authorities. The Integrated Care Board will pay due regard to this integrated care strategy when exercising its functions.

1.2 Name

1.2.1 The name of this Integrated Care Board is NHS Nottingham and Nottinghamshire Integrated Care Board (referred to in this constitution as "**the ICB**").

1.3 Area covered by the Integrated Care Board

1.3.1 The area covered by the ICB (referred to in this constitution as "**the ICB Area**") is coterminous with the District of Ashfield, District of Bassetlaw, Borough of Broxtowe, Borough of Gedling, District of Mansfield, District of Newark and Sherwood, City of Nottingham and Borough of Rushcliffe.

1.4 Statutory framework

1.4.1 The ICB is established by order made by NHS England under powers in the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022 ("**the 2006 Act**").

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

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

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

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

(a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act).

(b) Exercising its functions effectively, efficiently, and economically (section 14Z33 of the 2006 Act).

(c) Duties in relation children including safeguarding, promoting welfare etc (including the Children Acts 1989 and 2004, and the Children and Families Act 2014).

(d) Adult safeguarding and carers (the Care Act 2014).

(e) Equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35 of the 2006 Act).

(f) Information law (for instance, data protection laws, such as the UK General Data Protection Regulation, the Data Protection Act 2018, and the Freedom of Information Act 2000).

(g) Provisions of the Civil Contingencies Act 2004.

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

1.4.7 The performance assessment will assess how well the ICB has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under:

(a) Section 14Z34 of the 2006 Act (improvement in quality of services).

(b) Section 14Z35 of the 2006 Act (reducing inequalities).

(c) Section 14Z38 of the 2006 Act (obtaining appropriate advice).

(d) Section 14Z40 of the 2006 Act (promoting research).

(e) Section 14Z43 of the 2006 Act (having regard to the wider effect of decisions).

(f) Section 14Z44 of the 2006 Act (public involvement and consultation).

(g) Sections 223GB to 223N of the 2006 Act (financial duties).

(h) Section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

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

1.5 Status of this constitution

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

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

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

1.6 Variation of this constitution

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

(a) Where the ICB applies to NHS England in accordance with NHS England's published procedure and that application is approved.

(b) Where NHS England varies the constitution of its own initiative (other than on application by the ICB).

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

(a) The Chair or Chief Executive may periodically propose amendments to this constitution.

(b) All proposed amendments shall be considered and endorsed by the Board of the ICB in line with its procedures for making decisions (as set out in the ICB's Standing Orders), prior to an application being made to NHS England to vary the constitution.

(c) Proposed amendments to this constitution will not be implemented until an application to NHS England for variation has been approved.

1.7 Related documents

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

1.7.2 The following are appended to this constitution and form part of it for the purpose of the provisions set out at 1.6 of this constitution and the ICB's legal duty to have a constitution:

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

1.7.3 The following do not form part of this constitution but are required to be published:

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

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

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

(d) **Governance Handbook** – this brings together all the ICB's governance documents, so it is easy for interested people to navigate. It includes (but is not limited to):

  (i) The above documents (a) to (c).

  (ii) Terms of reference for all committees and sub-committees of the Board that exercise ICB functions.

  (iii) Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to one or more other body (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body); or to a joint committee of the ICB and one or more of those organisations in accordance with section 65Z6 of the 2006 Act.

  (iv) Terms of reference of any joint committee of the ICB and one or more other body (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body).

  (v) The up-to-date list of eligible providers of primary medical services as referenced at 3.6.2 of this constitution.

(e) **Key policy documents** – which should also be included in the Governance Handbook or linked to it – including (but not limited to):

  (i) Standards of Business Conduct Policy, which incorporates the ICB's policy and procedures for the identification and management of conflicts of interest.

  (ii) Policy for public involvement and engagement.

2. Composition of the Board of the ICB

2.1 Background

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

2.1.2 Further information about the individuals who fulfil these roles can be found on the ICB's website at www.notts.icb.nhs.uk.

2.1.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB (referred to in this constitution as **"the Board"** and members of the ICB referred to as **"Board Members"**) consists of a Chair, a Chief Executive, and at least three Ordinary Members.

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

2.1.5 NHS England Policy requires the ICB to appoint the following additional Ordinary Members: three executive members, namely a Director of Finance, a Medical Director, and a Director of Nursing; and at least two non-executive members.

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

(a) NHS trusts and NHS foundation trusts who provide services within the ICB Area and are of a prescribed description.

(b) The primary medical services (general practice) providers within the ICB Area and are of a prescribed description.

(c) The local authorities which are responsible for providing social care and whose areas coincide with or include the whole or any part of the ICB Area.

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

2.2 Board membership

2.2.1 The ICB has five Partner Members:

(a) Two from the NHS trusts and NHS foundation trusts who provide services within the ICB Area.

(b) One from the primary medical services (general practice) providers within the ICB Area.

(c) Two from the local authorities that provide social care and whose areas coincide with the ICB Area.

2.2.2 The ICB has also appointed the following further Ordinary Members to the Board (which are in addition to those set out at 2.1.5 and 2.1.6 of this constitution):

(a) Two non-executive members.

(b) One executive member, namely a Director of Integration.

2.2.3 The Board is therefore composed of the following members:

(a) Chair.

(b) Chief Executive.

(c) Two Partner Members – NHS trusts and NHS foundation trusts.

(d) One Partner Member – providers of primary medical services.

(e) Two Partner Members – local authorities.

(f) Four Non-Executive members:

(i) One to be Chair of the Audit and Risk Committee.

(ii) One to be Chair of the Remuneration Committee.

(iii) Two further Non-Executive members.

(g) Director of Finance.

(h) Medical Director.

(i) Director of Nursing.

(j) Director of Integration.

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

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

2.3 Regular participants and observers at meetings of the Board

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

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

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

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

3. Appointments process for the Board

3.1 Eligibility criteria for Board membership

3.1.1 Each member of the ICB must:

(a) Comply with the criteria of the Fit and Proper Person Test.

(b) Be willing to uphold the Seven Principles of Public Life (known as the Nolan Principles).

(c) Fulfil the requirements relating to experience, knowledge, skills, and attributes set out in the relevant role specification.

3.2 Disqualification criteria for Board membership

3.2.1 A Member of Parliament.

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

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

(a) In the United Kingdom of any offence.

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

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

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

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

(a) That it was not in the interests of, or conducive to the good management of, the health service body or of the health service that the person should continue to hold that office.

(b) That the person failed, without reasonable cause, to attend any meeting of that health service body for three successive meetings.

(c) That the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest.

(d) Of misbehaviour, misconduct, or failure to carry out the person's duties.

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

(a) The person's suspension from a register held by the regulatory body, where that suspension has not been terminated.

(b) The person's erasure from such a register, where the person has not been restored to the register.

(c) A decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded.

(d) A decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.

3.2.8 A person who is subject to:

(a) A disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002.

(b) An order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

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

which the person was responsible, to which the person was privy, or which the person by their conduct contributed to or facilitated.

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

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

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

3.3 Chair

3.3.1 The ICB Chair is to be appointed by NHS England, with the approval of the Secretary of State for Health and Social Care.

3.3.2 In addition to the criteria specified at 3.1 of this constitution, this member must fulfil the following additional eligibility criteria:

(a) The Chair will be independent.

3.3.3 Individuals will not be eligible if:

(a) They hold a role in another health or care organisation within the ICB Area.

(b) Any of the disqualification criteria set out at 3.2 of this constitution apply.

(c) They are an employee of the ICB, or a person seconded to the ICB.

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

3.4 Chief Executive

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

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

3.4.3 Further to the criteria specified at 3.1 of this constitution, the Chief Executive must fulfil the following additional eligibility criteria:

(a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

3.4.4 Individuals will not be eligible if:

(a) Any of the disqualification criteria set out at 3.2 of this constitution apply.

(b) Subject to the provisions set out at 3.4.3(a) of this constitution, they hold any other employment or executive role.

3.5 Partner Member – NHS trusts and NHS foundation trusts

3.5.1 These Partner Members are jointly nominated by the NHS trusts and NHS foundation trusts which provide services for the purposes of the health service within the ICB Area and meet the forward plan condition or (if the forward plan condition is not met) the level of services provided condition, as prescribed in regulations:

(a) Sherwood Forest Hospitals NHS Foundation Trust.

(b) Nottingham University Hospitals NHS Trust.

(c) Nottinghamshire Healthcare NHS Foundation Trust.

(d) East Midlands Ambulance Services NHS Trust.

(e) Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust.

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

(a) Be the Chief Executive or relevant Executive Director of one of the NHS trusts or NHS foundation trusts within the ICB Area.

(b) One member must be able to bring an informed view of hospital, urgent and emergency care services.

(c) The other member must have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

3.5.3 Individuals will not be eligible if:

(a) Any of the disqualification criteria set out at 3.2 of this constitution apply.

(b) They are an employee of the ICB, or a person seconded to the ICB.

3.5.4 These members will be appointed by the Chief Executive, subject to the approval of the Chair.

3.5.5 The appointment process will be as follows for each of these Partner Member roles:

(a) **Joint nomination:** When a vacancy arises, each eligible organisation listed at 3.5.1 of this constitution will be invited to nominate an

individual who meets the required criteria for the role (as set out at 3.5.2 and 3.5.3 of this constitution). Eligible organisations may choose to nominate an individual from their own organisation or from another eligible organisation listed at 3.5.1 of this constitution. There is no requirement for every eligible organisation to nominate an individual.

All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, specifying a date for responses to be provided. The list will be adopted on the specified date and taken forward to step (b) below if the eligible organisations have expressly confirmed the list or provided no response.

Should no individuals be nominated, or if a majority of the eligible organisations do not agree the list, then the nomination process will be re-run until sufficient nominations are received and/or agreement is reached.

(b) **Assessment, selection and appointment:** The agreed list of jointly nominated individuals 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 as set out at 3.5.2 and 3.5.3 of this constitution. If there is more than one suitable nominee, then the panel will select the most suitable for appointment. Should no individual be eligible for appointment following assessment, then the nomination process at 3.5.5(a) of this constitution will be repeated.

(c) **Approval:** The individual identified as most suitable for appointment will then be subject to approval by the Chair before taking up their role on the Board.

3.5.6 Except as provided for at 3.5.8 of this constitution, the normal term of office for these Partner Members will be two years.

3.5.7 There is no limit to the number of terms of office that can be served by an individual, whether consecutively or otherwise; however, no individual will have the right to be automatically reappointed, as the appointment process set out at 3.5.5 of this constitution will be followed at the end of each term of office.

3.5.8 Normal terms of office may be varied at the discretion of the Chair, based on the ICB's requirements at the time of appointment and to facilitate Board continuity.

3.6 Partner Member – providers of primary medical services

3.6.1 This Partner Member is jointly nominated by the providers of primary medical services for the purposes of the health service within the ICB 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 ICB's Governance Handbook. The list will be kept up to date but does not form part of this constitution.

3.6.2 This member must fulfil the eligibility criteria set out at 3.1 of this constitution and the following additional eligibility criteria:

(a) Be a registered medical practitioner, performing primary medical services for one of the providers set out at 3.6.1 of this constitution.

3.6.3 Individuals will not be eligible if:

(a) Any of the disqualification criteria set out at 3.2 of this constitution apply.

(b) They are an employee of the ICB, or a person seconded to the ICB.

3.6.4 This member will be appointed by the Chief Executive, subject to the approval of the Chair.

3.6.5 The appointment process will be as follows:

(a) **Joint nomination:** When a vacancy arises, individuals that meet the required criteria for this role (as set out at 3.6.2 and 3.6.3 of this constitution) may nominate themselves for this role. All self-nominations must be seconded by at least one of the eligible organisations described at 3.6.1. There is no requirement for every eligible organisation to nominate an individual.

All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, specifying a date for responses to be provided. The list will be adopted on the specified date and taken forward to step (b) below if the eligible organisations have expressly confirmed the list or provided no response.

Should no individuals be nominated, or if a majority of the eligible organisations do not agree the list, then the nomination process will be re-run until sufficient nominations are received and/or agreement is reached.

(b) **Assessment, selection and appointment:** The agreed list of jointly nominated individuals 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 as set out at 3.6.2 and 3.6.3 of this constitution. If there is more than one suitable nominee, then the panel will select the most suitable for appointment. Should no

individual be eligible for appointment following assessment, then the nomination process at 3.6.5(a) of this constitution will be repeated.

(c) **Approval:** The individual identified as most suitable for appointment will then be subject to approval by the Chair before taking up their role on the Board.

3.6.6 Except as provided for at 3.6.8 of this constitution, the normal term of office for this Partner Member will be three years.

3.6.7 There is no limit to the number of terms of office that can be served by an individual, whether consecutively or otherwise; however, no individual will have the right to be automatically reappointed, as the appointment process set out at 3.6.5 of this constitution will be followed at the end of each term of office.

3.6.8 Normal terms of office may be varied at the discretion of the Chair, based on the ICB's requirements at the time of appointment and to facilitate Board continuity.

3.7 Partner Members – local authorities

3.7.1 These Partner Members are jointly nominated by the local authorities whose areas coincide with, or include the whole or any part of, the ICB Area. Those local authorities are:

(a) Nottingham City Council.

(b) Nottinghamshire County Council.

3.7.2 This member will fulfil the eligibility criteria set out at 3.1 of this constitution and the following additional eligibility criteria:

(a) Be the Chief Executive or hold a relevant executive level role of one of the bodies listed at 3.7.1 of this constitution or be a member of one of these bodies if deemed most appropriate.

(b) One member must be able to bring a perspective of the social care needs and health and wellbeing characteristics of people and communities living in an urban city area.

(c) The other member must be able to bring a perspective of the social care needs and health and wellbeing characteristics of people and communities living in market towns and rural areas.

3.7.3 Individuals will not be eligible if:

(a) Any of the disqualification criteria set out at 3.2 of this constitution apply.

(b) They are an employee of the ICB, or a person seconded to the ICB.

3.7.4 These members will be appointed by the Chief Executive, subject to the approval of the Chair.

3.7.5 The appointment process will be as follows for each of these Partner Member roles:

(a) **Joint nomination:** When a vacancy arises, each eligible organisation listed at 3.7.1 of this constitution will be invited to nominate an individual who meets the required criteria for the role (as set out at 3.7.2 and 3.7.3 of this constitution). Eligible organisations may choose to nominate an individual from their own organisation or from another eligible organisation listed at 3.7.1 of this constitution. There is no requirement for every eligible organisation to nominate an individual.

The eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, specifying a date for responses to be provided. The list will be adopted on the specified date and taken forward to step (b) below if the eligible organisations have expressly confirmed the list or provided no response.

Should no individuals be nominated, or if the eligible organisations do not agree the list, then the nomination process will be re-run until sufficient nominations are received and/or agreement is reached.

(b) **Assessment, selection and appointment:** The agreed list of jointly nominated individuals 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 as set out at 3.7.2 and 3.7.3 of this constitution. If there is more than one suitable nominee, then the panel will select the most suitable for appointment. Should no individual be eligible for appointment following assessment, then the nomination process at 3.7.5(a) of this constitution will be repeated.

(c) **Approval:** The individual identified as most suitable for appointment will then be subject to approval by the Chair before taking up their role on the Board.

3.7.6 Except as provided for at 3.7.8 of this constitution, the normal term of office for these Partner Members will be three years.

3.7.7 There is no limit to the number of terms of office that can be served by an individual, whether consecutively or otherwise; however, no individual will have the right to be automatically reappointed, as the appointment process set out at 3.7.5 of this constitution will be followed at the end of each term of office.

3.7.8 Normal terms of office may be varied at the discretion of the Chair, based on the ICB's requirements at the time of appointment and to facilitate Board continuity.

3.8 Non-Executive members

3.8.1 The ICB will appoint four Non-Executive members.

3.8.2 These members will be appointed and approved by the Chair.

3.8.3 These members will fulfil the eligibility criteria set out at 3.1 and the following additional eligibility criteria:

(a) One shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit and Risk Committee.

(b) Another should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration Committee.

(c) Have a connection to (such as living or working in) the ICB Area.

3.8.4 Individuals will not be eligible if:

(a) Any of the disqualification criteria set out at 3.2 of this constitution apply.

(b) They hold a position or office in another health or care organisation that provides services within the ICB Area.

(c) They are an employee of the ICB, or a person seconded to the ICB.

3.8.5 Except as provided for at 3.8.7 of this constitution, the normal term of office for an Non-Executive member will be three years and the total time able to be served is nine years in total.

3.8.6 The Chair may approve the re-appointment of an individual to the role of Non-Executive member for further terms of office up to the maximum number of years able to be served, subject to demonstration of continuing competence through a satisfactory annual performance appraisal. No individual will have the right to be automatically re-appointed.

3.8.7 Normal terms of office may be varied at the discretion of the Chair, based on the ICB's requirements at the time of appointment and to facilitate Board continuity.

3.9 Director of Finance

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

(a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

(b) Be a qualified accountant with full professional membership.

3.9.2 Individuals will not be eligible if:

(a) Any of the disqualification criteria set out at 3.2 of this constitution apply.

3.9.3 This member will be appointed by the Chief Executive, subject to the approval of the Chair.

3.10 Medical Director

3.10.1 This member will fulfil the eligibility criteria set out at 3.1 of this constitution and the following additional eligibility criteria:

(a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

(b) Be a registered medical practitioner.

3.10.2 Individuals will not be eligible if:

(a) Any of the disqualification criteria set out at 3.2 of this constitution apply.

3.10.3 This member will be appointed by the Chief Executive, subject to the approval of the Chair.

3.11 Director of Nursing

3.11.1 This member will fulfil the eligibility criteria set out at 3.1 of this constitution and the following additional eligibility criteria:

(a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

(b) Be a registered nurse.

3.11.2 Individuals will not be eligible if:

(a) Any of the disqualification criteria set out at 3.2 of this constitution apply.

3.11.3 This member will be appointed by the Chief Executive, subject to the approval of the Chair.

3.12 Director of Integration

3.12.1 This member will fulfil the eligibility criteria set out at 3.1 of this constitution and the following additional eligibility criteria:

(a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

3.12.2 Individuals will not be eligible if:

(a) Any of the disqualification criteria set out at 3.2 of this constitution apply.

3.12.3 This member will be appointed by the Chief Executive, subject to the approval of the Chair.

3.13 Vice-Chair

3.13.1 Subject to 3.13.2 of this constitution, the Chair will appoint a Non-Executive member as Vice-Chair. Any such appointment will be for a period not exceeding the remainder of the individual's term as a Non-Executive member, as specified on appointment.

3.13.2 Any Non-Executive member appointed as Vice-Chair may resign at any time from the office of Vice-Chair by giving notice in writing to the Chair. In the event of a resignation, the Chair may appoint another Non-Executive member as Vice-Chair in accordance with the provisions set out at 3.13.1 of this constitution.

3.13.3 Where the Chair has ceased to hold office, or where they are unable to perform their duties as Chair owing to illness or any other cause, the Vice-Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be. References to the Chair in this constitution and the ICB's Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation shall, so long as there is no Chair able to perform those duties, be taken to include references to the Vice-Chair.

3.14 Deputy Chief Executive

3.14.1 Subject to paragraph 3.14.2 of this constitution, the Chief Executive will appoint an Executive Director as Deputy Chief Executive subject to approval of the Chair.

3.14.2 Any Executive Director appointed as Deputy Chief Executive may resign at any time from the office of Deputy Chief Executive by giving notice in writing to the Chief Executive and Chair. In the event of a resignation, the

Chief Executive may appoint another Executive Director as Deputy Chief Executive in accordance with the provisions of paragraph 3.14.1 of this constitution.

3.14.3 Where the Chief Executive has ceased to be employed, or where they are unable to perform their duties as Chief Executive owing to illness or any other cause, the Deputy Chief Executive shall act as Chief Executive until a new Chief Executive is appointed or the existing Chief Executive resumes their duties, as the case may be. References to the Chief Executive in this constitution and the ICB's Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation shall, so long as there is no Chief Executive able to perform those duties, be taken to include references to the Deputy Chief Executive.

3.15 Board members: removal from office

3.15.1 Arrangements for the removal from office of Board Members is subject to the relevant terms of appointment and application of the relevant ICB policies and procedures.

3.15.2 With the exception of the Chair, Board Members shall be removed from office if any of the following occurs:

(a) 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) They fail to attend three consecutive Board meetings (except under extenuating circumstances, such as illness).

(c) They fail to uphold the Seven Principles of Public Life (known as the Nolan Principles) or 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; and seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise.

(d) They are subject to disciplinary proceedings by a regulator or professional body.

3.15.3 Board Members may be suspended pending the outcome of an investigation into whether any of the matters set out at 3.15.2 of this constitution apply.

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

3.15.5 The Chair of the ICB may only be removed by NHS England, subject to the approval of the Secretary of State for Health and Social Care.

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

(a) Terminate the appointment of the ICB's Chief Executive.

(b) Direct the Chair of the ICB as to which individual to appoint as a replacement and on what terms.

3.16 Board members: terms of appointment

3.16.1 With the exception of the Chair and Non-Executive members, arrangements for remuneration and any allowances will be agreed by the Remuneration Committee in line with the ICB remuneration policy and any other relevant policies published on the ICB's website and any guidance issued by NHS England or other relevant body. Remuneration for the Chair will be set by NHS England. Remuneration for Non-Executive members will be set by a Non-Executive Director Remuneration Panel. The Non-Executive Director Remuneration Panel will operate under terms of reference agreed by the Board and published in the ICB's Governance Handbook.

3.16.2 With the exception of the Chair and Non-Executive members, other terms of appointment will be determined by the Remuneration Committee.

3.16.3 Terms of appointment of the Chair will be determined by NHS England. Terms of appointment of the Non-Executive members will be determined by the Non-Executive Director Remuneration Panel.

3.17 Specific arrangements for appointment of Ordinary Members made at establishment

3.17.1 Individuals may be identified as "Designate Ordinary Members" prior to the ICB being established.

3.17.2 Relevant nomination procedures for Partner Members in advance of establishment are deemed to be valid so long as they are undertaken in full and in accordance with the requirements set out at 3.5 to 3.7 of this constitution.

3.17.3 Any appointment and assessment processes undertaken in advance of establishment to identify Designate Ordinary Members should follow, as far as possible, the processes set out at 3.5 to 3.12 of this constitution. However, a modified process, agreed by the Chair, will be considered valid.

3.17.4 On the day of establishment, a panel consisting of the Chair, Chief Executive and the ICB's governance lead will appoint the Ordinary Members who are expected to all be individuals who have been identified as designate appointees pre ICB establishment. The Chair will approve these appointments.

3.17.5 For the avoidance of doubt, the arrangements set out at 3.17.1 to 3.17.4 of this constitution are only valid in relation to the appointments of the initial Ordinary Members and all appointments post establishment will be made in accordance with 3.5 to 3.12 of this constitution.

4. Arrangements for exercising functions

4.1 Good governance

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

4.1.2 The ICB has a Standards of Business Conduct Policy, which sets out the standards and public service values that members of the Board and its committees must follow whilst undertaking ICB business. The Standards of Business Conduct Policy is published on the ICB's website.

4.2 General

4.2.1 The ICB will:

(a) Comply with all relevant laws including but not limited to the 2006 Act and the duties prescribed within it and any relevant regulations.

(b) Comply with directions issued by the Secretary of State for Health and Social Care.

(c) Comply with directions issued by NHS England.

(d) Have regard to statutory guidance including that issued by NHS England.

(e) Take account, as appropriate, of other documents, advice and guidance issued by relevant authorities, including that issued by NHS England.

(f) Respond to reports and recommendations made by local Healthwatch organisations within the ICB Area.

4.2.2 The ICB will develop and implement the necessary systems and processes to comply with the requirements set out at 4.2.1(a) to 4.2.1(f) of this constitution, documenting them as necessary in this constitution, its Governance Handbook and other relevant policies and procedures as appropriate.

4.3 Authority to act

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

(a) Any of its Board Members or employees.

(b) A committee or sub-committee of the Board.

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

4.3.3 Where arrangements are made under section 65Z5, section 65Z6, or section 75 of the 2006 Act, the Board must authorise the arrangement, which must be described as appropriate in the SoRD.

4.4 Scheme of Reservation and Delegation

4.4.1 The ICB has agreed a Scheme of Reservation and Delegation (SoRD), which is published in full on the ICB's website at www.notts.icb.nhs.uk.

4.4.2 Only the Board may agree the SoRD and any amendments to the SoRD may only be approved by the Board on the recommendation of the Chair or Chief Executive.

4.4.3 The SoRD sets out:

(a) Those functions that are reserved to the Board.

(b) Those functions that have been delegated to individuals or to committees and sub-committees.

(c) Those functions delegated to, or by, one or more other body, or to be exercised jointly with one or more other body, under sections 65Z5, 65Z6 and 75 of the 2006 Act.

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

4.5 Functions and Decisions Map

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

4.5.2 The Functions and Decisions Map is published on the ICB's website at www.notts.icb.nhs.uk.

4.5.3 The map includes:

(a) Key functions reserved to the Board of the ICB.

(b) Commissioning functions delegated to committees and individuals.

(c) Commissioning functions delegated under sections 65Z5 and 65Z6 of the 2006 Act to be exercised by, or jointly with any one or more body (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body.

(d) Functions delegated to the ICB (for example, from NHS England).

4.6 Committees and sub-committees

4.6.1 The Board may appoint committees and arrange for its functions to be exercised by such committees. Committees may appoint sub-committees and arrange for the functions exercisable by the committee to be exercised by those sub-committees, if empowered to do so by the Board.

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

4.6.3 Each committee and sub-committee established by the ICB operates under terms of reference agreed by the Board, or by the relevant parent committee in the case of sub-committees. All terms of reference are published in the ICB's Governance Handbook.

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

(a) Report regularly to the Board (or parent committee in the case of sub-committees) to provide assurance that they are effectively discharging delegated responsibilities.

(b) Review their effectiveness on at least an annual basis.

4.6.5 Any committee or sub-committee established in accordance with the provisions set out at 4.6 of this constitution may consist of, or include, persons who are not Board Members or employees.

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

4.6.7 All members of committees and sub-committees are required to act in accordance with this constitution, including the ICB's Standing Orders, as well as the ICB's Standing Financial Instructions and any other relevant ICB policies.

4.6.8 The following committees will be maintained:

(a) **Audit and Risk Committee:** This committee is accountable to the Board and provides an independent and objective view of the ICB's compliance with its statutory responsibilities. The Audit and Risk Committee will be chaired by the Non-Executive member listed at paragraph 2.2.3(f)(i) of this constitution. The Chair of the ICB cannot chair or be a member of the Audit and Risk Committee.

(b) **Remuneration Committee:** This committee is accountable to the Board for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB. The Remuneration Committee will be chaired by the Non-Executive member listed at paragraph 2.2.3(f)(ii) of this constitution. The Chair of the ICB cannot be chair of the Remuneration Committee but can be a member. The Chair of Audit and Risk Committee cannot chair or be a member of the Remuneration Committee.

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

4.7 Delegations made under section 65Z5 of the 2006 Act

4.7.1 As per 4.3.2 of this constitution, the ICB may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other body as defined by the 2006 Act (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body), subject to regulations.

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

4.7.3 Each delegation made under section 65Z5 of the 2006 Act will be set out in a delegation agreement which defines the terms of the delegation. This may, for joint arrangements, include establishing and maintaining a pooled fund. The power to approve delegation agreements made under this provision will be reserved to the Board.

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

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

5. Procedures for making decisions

5.1 Standing Orders

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

(a) Conducting the business of the ICB.

(b) The procedures to be followed during meetings.

(c) The process to delegate functions.

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

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

5.2 Standing Financial Instructions

5.2.1 The ICB has agreed a set of Standing Financial Instructions (SFIs), which set out the arrangements for managing the ICB's financial affairs (associated delegated limits of financial authority are set out in the Scheme of Reservation and Delegation).

5.2.2 A copy of the SFIs is published on the ICB's website at www.notts.icb.nhs.uk.

6. Arrangements for conflicts of interest management and standards of business conduct

6.1 Conflicts of interests

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

6.1.2 The ICB has an agreed policy and procedures for the identification and management of conflicts of interest; these are incorporated within the ICB's Standards of Business Conduct Policy, which published on the ICB's website at www.notts.icb.nhs.uk.

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

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

6.1.5 Where an individual, including any individual directly involved with the business or decision-making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this constitution and the ICB's policy and procedures for the identification and management of conflicts of interest.

6.1.6 The Board will appoint a Conflicts of Interest Guardian from its non-executive members to further strengthen scrutiny and transparency of ICB's decision-making processes. In collaboration with the ICB's governance lead, their role is to:

(a) Act as a conduit for anyone with concerns relating to conflicts of interest.

(b) Be a safe point of contact for employees or workers of the ICB to raise concerns in relation to conflicts of interest.

(c) Support the rigorous application of the principles and policies for managing conflicts of interest.

(d) Provide independent advice and judgment where there is any doubt about how to apply conflicts of interest policies and principles in individual situations.

(e) Provide advice on minimising the risks of conflicts of interest.

6.2 Principles

6.2.1 In discharging its functions, the ICB will abide by the following principles for managing conflicts of interest to ensure they are handled with integrity and probity, in an open and transparent way:

(a) Conducting business appropriately: decision-making will be geared towards always meeting the statutory duties of the ICB; ensuring that needs assessments, engagement and consultation mechanisms, commissioning strategies and provider selection procedures are robust and based on expert professional advice.

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

(i) Considering potential conflicts of interest when appointing individuals to the Board or other decision-making committees; clearly distinguishing between those individuals who should be involved in formal decision taking, and those whose input informs decisions.

(ii) Ensuring individuals receive proper induction and training so that they understand their obligations to declare their interests.

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

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

(d) Being balanced and proportionate: identifying and managing conflicts, preserving the spirit of collective decision-making wherever possible, and not expecting to eliminate conflicts completely.

(e) Transparency and sound record keeping: clearly documenting the rationale for decision-making so that an audit trail of actions taken is evident and able to withstand scrutiny.

(f) Creating an environment and culture where individuals feel supported and confident in declaring relevant information and raising concerns.

6.3 Declaring and registering interests

6.3.1 The ICB maintains a register of the interests of:

(a) Board Members.

(b) Members of the Board's committees and sub-committees.

(c) Its employees.

6.3.2 In accordance with section 14Z30(2) of the 2006 Act, the register of interests is published on the ICB's website at www.notts.icb.nhs.uk.

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

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

6.3.5 All declarations will be entered in the register as per 6.3.1 of this constitution.

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

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

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

6.4 Standards of business conduct

6.4.1 Board Members, members of the Board's committees and sub-committees and employees will at all times comply with this constitution and be aware of their responsibilities as outlined in it. They should:

(a) Act in good faith and in the interests of the ICB.

(b) Follow the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles).

(c) Comply with the ICB Standards of Business Conduct Policy, and any requirements set out in the policy for managing conflicts of interest.

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

7. Arrangements for ensuring accountability and transparency

7.1.1 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 12(2) of Schedule 1B to the 2006 Act.

7.2 Meetings and publications

7.2.1 The ICB will comply with the Public Bodies (Admission to Meetings) Act 1960, as set out at Standing Order 4.11, including admission to meetings held in public and publication of associated papers and minutes.

7.2.2 Annual accounts will be externally audited and published.

7.2.3 A clear complaints process will be published.

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

7.2.5 Information will be provided to NHS England as required.

7.2.6 This constitution and the ICB's Governance Handbook will be published as well as other key documents, including but not limited to:

(a) All ICB policies, including those relating to conflicts of interest.

(b) Registers of interests.

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

(a) Explain how the ICB proposes to discharge its duties under:

(i) Sections 14Z34 to 14Z45 of the 2006 Act (general duties of integrated care boards).

(ii) Sections 223GB and 223N of the 2006 Act (financial duties).

(b) Set out any steps that the ICB proposes to take to implement the joint local health and wellbeing strategies to which it is required to have regard under Section 116B(1) of the Local Government and Public Involvement in Health Act 2007.

(c) Set out any steps that the ICB proposes to take to address the particular needs of children and young persons under the age of 25.

(d) Set out any steps that the ICB proposes to take to address the particular needs of victims of abuse (including domestic abuse and sexual abuse, whether of children or adults).

7.3 Scrutiny and decision making

7.3.1 Five Non-Executive members will be appointed to the Board (including the Chair) and all Board and committee and sub-committee members will comply with the Nolan Principles of Public Life and meet the criteria described in the Fit and Proper Person Test.

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

7.3.3 The ICB will comply with the requirements of the NHS Provider Selection Regime, including complying with existing procurement rules until the provider selection regime comes into effect.

7.3.4 The ICB will take all reasonable steps to comply with local authority health overview and scrutiny requirements.

7.4 Annual report

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

(a) Explain how the ICB has discharged its duties under sections 14Z34 to 14Z45 and 14Z49 of the 2006 Act (general duties of integrated care boards).

(b) Review the extent to which the ICB has exercised its functions in accordance with its plans published under section 14Z52 (forward plan) and section 14Z56 (capital resource use plan) of the 2006 Act.

(c) Review the extent to which the ICB has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised).

(d) Review any steps the ICB has taken to implement any joint local health and wellbeing strategies to which it is required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.

(e) Include a statement of the amount of expenditure incurred by the ICB during the financial year in relation to mental health and a calculation of the proportion of the expenditure incurred by the ICB during the financial year that relates to mental health. An explanation of the statement and calculation must be provided.

8. Arrangements for determining the terms and conditions of employees

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

8.1.2 The Board has established a Remuneration Committee which is chaired by a Non-Executive member other than the Chair or Audit and Risk Committee Chair.

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

(a) Expert human resources advisors attending meetings to support the Remuneration Committee in discharging its responsibilities.

8.1.4 The Board may appoint independent members or advisers to the Remuneration Committee who are not members of the Board.

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

8.1.6 The duties of the Remuneration Committee include:

(a) Setting the remuneration, allowances and other terms of appointment for members of the Board, except for the Chair and non-executive members.

(b) Setting any allowances for members of committees or sub-committees of the Board, who are not members of the Board.

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

9. Arrangements for public involvement

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

(a) The planning of the commissioning arrangements by the ICB.

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

(c) Decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

9.1.2 In line with section 14Z54 of the 2006 Act, the ICB and its partner NHS trusts and NHS foundation trusts will make appropriate arrangements to consult with the ICB's population when preparing or revising their joint five-year plan. Public consultation will be completed in accordance with the ICB's policy for public involvement and engagement.

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

(a) Putting the voices of people and communities at the centre of decision-making and governance.

(b) Starting engagement early when developing plans, feeding back to people and communities how engagement has influenced activities and decisions.

(c) Understanding the needs, experience and aspirations of people and communities for health and care, using engagement to find out if change is having the desired effect.

(d) Building relationships with excluded groups – especially those affected by inequalities.

(e) Working with Healthwatch and the voluntary, community and social enterprise sector as key partners.

(f) Providing clear and accessible public information about vision, plans and progress to build understanding and trust.

(g) Using community development approaches that empower people and communities, making connections to social action.

(h) Using co-production, insight and engagement to achieve accountable health and care services.

(i) Co-producing and redesigning services and tackling system priorities in partnership with people and communities.

(j) Learning from what works and building on the assets of all health and care partners – networks, relationships, activity in local places.

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

9.1.5 These arrangements include:

(a) The creation, implementation and evaluation of a system-wide strategy for engaging with people and communities, to be reviewed at least every three years.

(b) The establishment of a Citizen Intelligence Advisory Group to ensure the Board is supported in discharging the duties set out in 9.1.1.

(c) Having a Board approved policy for public involvement and engagement, which will require the ICB to:

(i) Be clear about who is being engaged, the possible options, the engagement process, what is being proposed and the scope to influence.

(ii) Ensure that engagement takes place in a suitable timeframe to allow decisions to be genuinely influenced by feedback received.

(iii) Adapt engagement activities and methods to meet the specific needs of different patient groups and communities.

(iv) Keep the burden of engagement to a minimum to retain continued buy-in to the process by people and communities.

(v) Ensure that responses to engagement exercises are carefully analysed with clear feedback provided to participants, which set out the decision made and the influence the results of the engagement exercise had on the final decision.

Appendix 1: Definitions of terms used in this constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022.
ICB Board	Members of the ICB.
ICB Area	The geographical area that the ICB has responsibility for, as defined in part 2 of this constitution.
Committee	A committee created and appointed by the ICB Board.
Sub-Committee	A committee created and appointed by and reporting to a committee.
Integrated Care Partnership	The statutory joint committee for the ICB Area established by the ICB and each responsible upper tier local authority whose area coincides with or falls wholly or partly within the ICB Area.
Ordinary Member	The Board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the Board are referred to as Ordinary Members.
Partner Members	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are and appointed in accordance with the procedures set out in Section 3 of this constitution, having been nominated by the following: • NHS trusts and foundation trusts who provide services within the ICB Area and are of a prescribed description. • The primary medical services (general practice) providers within the ICB Area and are of a prescribed description. • The local authorities which are responsible for providing social care and whose area coincides with or includes the whole or any part of the ICB Area.
Health Service Body	Health service body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.

Appendix 2: Standing Orders

1. Introduction

1.1.1 These Standing Orders have been drawn up to regulate the proceedings of NHS Nottingham and Nottinghamshire Integrated Care Board ("**the ICB**") so that the ICB can fulfil its obligations as set out largely in the National Health Service Act 2006 ("**the 2006 Act**"), as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022. They form part of the ICB's Constitution.

1.1.2 These Standing Orders should be read alongside the ICB's constitution, Standing Financial Instructions and Scheme of Reservation and Delegation, which together describe the ICB's governance framework.

1.1.3 These Standing Orders set out the:

(a) Arrangements for conducting the business of the ICB.

(b) Procedures to be followed during meetings of the Board of the ICB ("**the Board**") and its committees and sub-committees.

2. Amendment and review

2.1.1 These Standing Orders are effective from the date the ICB is established.

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

2.1.3 Amendments to these Standing Orders will be made in line with the procedure set out at section 1.6 of the ICB's constitution.

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

3. Interpretation, application, and compliance

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

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

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

3.1.4 In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from the ICB's governance lead, will provide a settled view which shall be final.

3.1.5 All members of the Board, its committees and sub-committees and all employees have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible. If the Chief Executive is responsible for the non-compliance, then this should instead be reported to the ICB's lead for governance.

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

4. Meetings of the Board

4.1 Calling meetings

4.1.1 Meetings of the Board shall be held at regular intervals at such times and places as the Board may determine. The Board will normally meet no less than six times per year. Terms of reference for committees and sub-committees will specify the required frequency of meetings.

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

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

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

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

(d) A failure to give notice in accordance with the above requirements shall not invalidate a decision otherwise taken in accordance with these Standing Orders.

4.1.3 In accordance with Public Bodies (Admission to Meetings) Act 1960, a public notice of the time and place of meetings open to the public, and how to access the meetings, all be given by posting it at the offices of the ICB and electronically on the ICB's website at least three clear days before the meeting, or if the meeting is convened at shorter notice, then at the time it is convened.

4.2 Chair of a meeting

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

4.2.2 If the Chair is absent or is disqualified from participating by reason of a conflict of interests, then the Vice Chair will preside. If both the Chair and Vice Chair are absent or disqualified from participating, then a Non-Executive member of the Board (other than the Chair of the Audit and Risk Committee) shall be chosen by the members present, or by a majority of them, and shall preside.

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

4.3 Agenda, supporting papers and business to be transacted

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

4.3.2 Except where the emergency provisions apply (as provided for in Standing Order 4.1.2(c)), the agenda and supporting papers will be circulated to all members of the Board at least five calendar days before the meeting.

4.3.3 Agendas and papers for meetings open to the public will be published electronically in advance of the meetings on the ICB's website at www.notts.icb.nhs.uk.

4.4 Petitions

4.4.1 Where a valid petition has been received by the ICB, it shall be included as an item for the agenda of the next meeting of the Board in accordance with the process set out within the ICB's Governance Handbook.

4.5 Nominated deputies

4.5.1 With the permission of the Chair, the Executive Directors and Partner Members of the Board may nominate a deputy to attend a meeting of the Board that they are unable to attend. Deputies may speak, but not vote, on their behalf, and will not count towards the quorum unless Standing Order 4.7.2(c) applies.

4.5.2 Any nomination of a deputy must be made in writing to the Chair in advance of the meeting, confirming that the individual nominated to deputise fulfils the requirements of the role and is not disqualified. Ad-hoc deputy arrangements are not permitted. The decision of the Chair (or in their absence, the person presiding over the meeting) regarding authorisation of nominated deputies is final.

4.5.3 Terms of reference for committees and sub-committees will specify the extent to which nominated deputies are allowed.

4.6 Virtual meetings

4.6.1 The Board may meet virtually using telephone, video and other electronic means when necessary. Where a virtual meeting is convened, the usual process for meetings of the Board will apply, including those relating to the quorum (as set out in Standing Order 4.7) and those relating to meetings being open to the public and representatives of the press (as set out in Standing Order 4.11).

4.6.2 Virtual attendance at in-person meetings will be permitted at the discretion of the Chair.

4.7 Quorum

4.7.1 The quorum for meetings of the Board will be five members, including:

(a) The Chair of the meeting and one further Non-Executive Director.

(b) The Chief Executive or the Director of Finance.

(c) The Medical Director or the Director of Nursing.

(d) One Partner Member.

4.7.2 For the sake of clarity:

(a) No person can act in more than one capacity when determining the quorum.

(b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interests, shall no longer count towards the quorum.

(c) An officer in attendance for an Executive Director in accordance with Standing Order 4.5.1 may only count towards the quorum if they have formal acting up status.

(d) A failure to comply with the above requirements as to quorum shall not invalidate a decision otherwise taken in accordance with these Standing Orders.

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

4.8 Vacancies and defects in appointments

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

4.9 Decision making

4.9.1 The ICB has agreed to use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate. Where helpful, the Board may draw on third party support such as peer review or mediation by NHS England.

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

(a) All members of the Board who are present at the meeting will be eligible to cast one vote each.

(b) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote, but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.

(c) For the sake of clarity, any participants or observers at the meeting (in accordance with section 2.3 of the ICB's constitution) will not have voting rights.

(d) A resolution will be passed if more votes are cast for the resolution than against it.

(e) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.

(f) No resolution will be passed if it is unanimously opposed by all the Executive Directors present or by all the Non-Executive Directors present.

(g) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

4.9.3 Decision-making arrangements for committees and sub-committees will be set out within the appropriate terms of reference.

Emergency powers for urgent decisions

4.9.4 In the case of urgent decisions and extraordinary circumstances, every attempt will be made for the Board to meet virtually. Where this is not possible Standing Orders 4.9.5 and 4.9.6 will apply.

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

4.9.6 The exercise of such powers by the Chair and Chief Executive will be reported to the next formal meeting of the Board for formal ratification and to the Audit and Risk Committee for review of the reasonableness of the decision to use emergency powers.

4.9.7 Decision-making arrangements set out within committee and sub-committee terms of reference will specify the extent to which urgent decisions can be taken in extraordinary circumstances.

4.10 Minutes

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

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

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

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

4.11 Admission of public and representatives of the press

4.11.1 In accordance with the Public Bodies (Admission to Meetings) Act 1960, meetings of the Board, and meetings of committees that are comprised entirely of Board Members or at which all Board Members are present, at which public functions are exercised, will be open to the public. There is no requirement for meetings of the Remuneration Committee or the Audit and Risk Committee to be open to the public.

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

4.11.3 The Chair (or in their absence, the person presiding over the meeting) shall give such directions as they think fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press, such as to ensure that the Board's business can be conducted without interruption or disruption.

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

4.11.5 Matters to be dealt with at a meeting following the exclusion of the public and representatives of the press shall be confidential to the members of the Board.

4.11.6 Members of the Board and any regular participants or employees of the ICB in attendance will not reveal or disclose the contents of papers or minutes marked as 'confidential' or 'private' outside of the Board, without the express permission of the Board. This prohibition will apply equally to the content of any discussion during the Board meeting that may take place on such papers or minutes.

5. Suspension of Standing Orders

5.1.1 In exceptional circumstances, except where it would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or NHS England, any part of these Standing Orders may be suspended at any meeting of the Board by the Chair (or the person presiding over the meeting), provided that a majority of members present, including at least one executive member and one non-executive member, are in favour of suspension.

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

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

6. Execution of documents

6.1 Custody of seal, sealing of documents and register of sealings

6.1.1 The ICB will have a common seal for executing certain documents, as required by legislation.

6.1.2 The seal will be kept by the ICB's lead for governance in a secure place.

6.1.3 The seal swill be affixed in the presence of two officers of the ICB, to include either the Chief Executive or the Director of Finance, and shall be attested by them.

6.1.4 An entry of every sealing will be made and numbered consecutively in a register provided for that purpose.

6.1.5 A report of all sealings will be made to the Board, or a committee nominated by the Board, at least annually.

6.2 Execution of a document by signature

6.2.1 Where any document will be a necessary step in legal proceedings on behalf of the ICB, it will, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any other executive member of the Board.

Appendix B

DATED: 2022

Delegation Agreement in respect of:

(i) Primary Medical Services

between:

NHS England

-and-

NHS Nottingham and Nottinghamshire Integrated Care Board

Table of contents

Clause heading and number — Page number

Delegation Agreement for Primary Care & Dental 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 Nottingham and Nottinghamshire**
Area	**Area of the ICB as defined in its Constitution**
Date of Agreement	**The date stated on the front page of this document**
Effective Date of Delegation	**1 July 2022**
ICB Representative	**Amanda Sullivan**
ICB Email Address for Notices	**Amanda.sullivan7@nhs.net**
NHS England Representative	**Dale Bywater**
NHS England Email Address for Notices	**dale.bywater1@nhs.net**

The following parts of Schedule 2 are included in this Agreement[1]:

Schedule 2A – Primary Medical Services	**Yes**
Schedule 2B – Primary Dental Services and Prescribed Dental Services	**Primary Dental Services: No** **Prescribed Dental Services: No**
Schedule 2C – Primary Ophthalmic Services	**No**
Schedule 2D – Pharmaceutical Services and Local Pharmaceutical Services	**No**

1.2 This Agreement comprises:

1.2.1 the Particulars (clause 1);

1.2.2 the Terms and Conditions (clauses 2 to 31); and

1.2.3 the Schedules.

[1] This table must be completed to indicate which services are included in the Delegation.

Signed by **NHS England**

Dale Bywater

Regional Director for the Midlands

(for and on behalf of NHS England)

Signed by **NHS Nottingham and Nottinghamshire Integrated Care Board**

Amanda Sullivan

Chief Executive Officer

(for and on behalf of NHS Nottingham and Nottinghamshire 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 SCHEDULE 1 to SCHEDULE 6, SCHEDULE 8 and SCHEDULE 9 to this Agreement; and

2.2.3 SCHEDULE 7 (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 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 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 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 the people of the Area, as further described in this Agreement ("**the Delegation**").

6.2 The Delegated Functions are the functions described as being delegated to the ICB in such of the following Schedules as have been marked as included within this Agreement:

6.2.1 Schedule 2A: Primary medical services;

6.2.2 Schedule 2B: Primary dental services and prescribed dental services;

6.2.3 Schedule 2C: Primary ophthalmic services;

6.2.4 Schedule 2D: Pharmaceutical services and local pharmaceutical services.

6.3 The Delegation has effect from the Effective Date of Delegation.

6.4 NHS England may by Contractual Notice allocate Primary Care Contracts or Arrangements and Prescribed Dental Services Contracts in place at the Effective Date of Delegation to the ICB for the purposes of determining the scope of the Delegated Functions. The Delegated Functions must be exercised both in respect of the relevant Primary Care Contract or Arrangement or Prescribed Dental Services Contract and any related matters concerning the Primary Care Provider that is a party to that Primary Care Contract or Arrangement, or provider of Prescribed Dental Services that is party to that Prescribed Dental Services Contract.

6.5 Subsequent to the Effective Date of Delegation and for the duration of this Agreement, any new Primary Care Contract or Arrangement entered into in respect of premises in the Area shall be managed by the ICB in accordance with the provisions of this Agreement as if it had been allocated to the ICB in accordance with clause 6.4.

6.6 NHS England may by Contractual Notice add or remove Primary Care Contracts or Arrangements or Prescribed Dental Services 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 Primary Care Contracts or Arrangements or Prescribed Dental Services 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 The ICB is not authorised by this Agreement to take any step or make any decision in respect of Primary Care Services or Prescribed Dental Services beyond the scope of the Delegated Functions.

6.9 NHS England may, at its discretion, substitute its own decision for any decision which the ICB purports to make that is outside the scope of the Delegated Functions. This will take the form of NHS England considering the issue and decision purportedly made by the ICB and then making its own decision. The ICB must provide any information, assistance and support as NHS England requires to enable it to determine whether to make any such decision. In any event such a decision by NHS England shall not extend to those actions or decisions that are of themselves not capable of being delegated by NHS England to the ICB.

6.10 The terms of clause 6.9 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;

7.1.2 any Contractual Notices, including without limitation any Standing Financial Instructions;

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 or otherwise referred to in 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 sections 65Z5 and 75 of the NHS Act.

7.6 The ICB must develop an operational scheme 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 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 Primary Care Functions and functions in respect of Prescribed Dental Services, other than the Delegated Functions, including but not limited to those set out in SCHEDULE 3 to this Agreement ("the Reserved Functions").

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 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.

8.5 The Parties acknowledge that, as from the date of this Agreement, the ICB shall provide administrative and management services to NHS England in relation to certain Reserved Functions and that such administrative and management services are as follows:

8.5.1 the administrative and management services in relation to the Capital Expenditure Functions and the Capital Expenditure Funds as more particularly set out in clauses 9.14 to 9.17; and

8.5.2 the administrative and management services in relation to the Section 7A Functions and Section 7A Funds as more particularly set out in clauses 9.18 to 9.21.

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 the NHS England central finance team's operational process (as such process is updated from time to time) for the 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, 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 Primary Care Contracts and Arrangements allocated to the ICB in accordance with clauses 6.4 to 6.6;

9.4.3 meet all liabilities arising under or in connection with all Prescribed Dental Services Contracts allocated to the ICB in accordance with clauses 6.4 to 6.6 in so far as they relate to the Delegated Functions; and

9.4.4 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 Primary Care Contracts or Arrangements 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 clauses 9.14 to 9.23 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 SCHEDULE 5 (Financial Provisions and Decision Making Limits) sets out further financial provisions in respect of the exercise of the Delegated Functions and, in particular, Table 1 in SCHEDULE 5 (*Financial Provisions and Decision Making Limits)* sets out certain financial limits and approvals required in relation to the exercise of the Delegated Functions.

9.10 NHS England may issue Mandated Guidance in respect of the use of funds for the purposes of the Delegated Functions.

Payment and Transfer

9.11 NHS England will pay the Delegated Funds to the ICB monthly using the same 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;

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;

9.12.4 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); and

9.12.5 the HM Treasury guidance *Managing Public Money* (dated July 2013 and found at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212123/Managing_Public_Money_AA_v2_-_chapters_annex_web.pdf).

9.13 Without prejudice to any other obligation upon the ICB, the ICB agrees that it must provide 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.

Administrative and/or Management Services and Funds in relation to the Capital Expenditure Functions

9.14 The Parties acknowledge that the Capital Expenditure Functions are a Reserved Function.

9.15 The Parties further acknowledge that:

9.15.1 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

9.15.2 NHS England remains responsible and accountable for the discharge of the Capital Expenditure Functions and nothing in clauses 9.14 to 9.17 shall be construed as a divestment or delegation of NHS England's Capital Expenditure Functions.

9.16 Without prejudice to clause 9.15 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:

9.16.1 the administration and payment of sums that NHS England has approved as payable in relation to the Capital Expenditure Functions;

9.16.2 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

9.16.3 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.

9.17 NHS England may, at the same time as it allocates the Delegated Funds to the ICB under paragraph 9.11, transfer to the ICB such amounts as are necessary to enable the discharge of the ICB's obligations under this clause 9 *(Finance)* in respect of the Capital Expenditure Functions.

Administrative and/or Management Services and Funds in relation to Section 7A Functions

9.18 The Parties acknowledge that the Section 7A Functions are part of the Reserved Functions.

9.19 The Parties further acknowledge that:

9.19.1 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

9.19.2 NHS England remains responsible and accountable for the discharge of the Section 7A Functions and nothing in this clause 9 *(Finance)* shall be construed as a divestment or delegation of the Section 7A Functions.

9.20 The ICB will provide the following services to NHS England in respect of the Section 7A Funds:

9.20.1 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

9.20.2 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.

9.21 NHS England shall, at the same time as it allocates the Delegated Funds to the ICB under paragraph 9.11, allocate to the ICB such amounts as are necessary to enable the discharge of the ICB's obligations under this clause 9 *(Finance)* in respect of the Section 7A Funds.

Administrative and/or Management Services and Funds in relation to other Reserved Functions

9.22 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.

9.23 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:

9.23.1 provisions equivalent to those set out above in relation to the Capital Expenditure Functions (clauses 9.14 to 9.17) and the Section 7A Functions (clauses 9.18 to 9.21) 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

9.23.2 such other provisions in respect of the carrying out of such management and administrative services as agreed between NHS England and the ICB.

Pooled Funds

9.24 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:

9.24.1 NHS England in accordance with sections 13V or 65Z6 of the NHS Act;

9.24.2 one or more ICBs in accordance with section 65Z6 of the NHS Act as part of a Further Arrangement; or

9.24.3 NHS England and one or more ICBs in accordance with section 13V of the NHS Act; and

9.24.4 NHS England and one or more ICBs in accordance with section 65Z6 of the NHS Act.

9.25 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 sections 65Z5 and 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 sections 65Z5 and 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;

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 at SCHEDULE 6 and such other persons as NHS England may require from time to time.

11.9 Where Further Arrangements are made, 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

12.1 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).

12.2 SCHEDULE 8 makes further provision about deployment of NHS England Staff to the ICB for the purposes of carrying out the relevant Delegated Functions.

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 15.3.

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 6.9;

13.2.3 revoke the Delegation and terminate this Agreement in accordance with clause 25.7 *(Termination)* below;

13.2.4 exercise the Escalation Rights in accordance with clause 14 *(Escalation Rights)*; and/or

13.2.5 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 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 date of this Agreement.

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 s65Z5(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. 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 of FOIA or EIR requests in relation to the Delegated Functions. The ICB shall comply with such FOIA or EIR protocols.

17.7 SCHEDULE 4 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, the 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;

promptly report the matter to NHS England and to the NHS Counter Fraud Authority.

20.7 On the request of NHS England or the 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;

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 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 setting 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.

25.8 The Parties acknowledge that this Agreement is likely to require variation to take effect from 1 April 2023 as initial delegation arrangements are developed further. Accordingly, both Parties agree to engage constructively with a view to agreeing any such variation proposal in line with the provisions of this clause 25. In particular, the Parties agree to act reasonably and with the understanding that a single variation proposal will need to be accepted by all ICBs to ensure consistency across all delegation arrangements.

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 at the end of 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, 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 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 *(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);

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 and the Schedules;
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 an FOIA request, or information which is published as a result of NHS England or government policy in relation to transparency;
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 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 Subject	shall have the same meaning as set out in the UK GDPR;
Delegated Functions	means the 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 paragraph 9.2;
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)*;
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 from time to time, in accordance with clause 7.2**;**
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;
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;
Personal Data Agreement	means the agreement governing Information Law issues completed further to SCHEDULE 4 (Further *Information Governance and Sharing Provisions)*;
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;
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	means primary ophthalmic services provided under arrangements made pursuant to Part 6 of the NHS Act, and in accordance with a Primary Ophthalmic 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;

[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.

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 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;
QOF	means the quality and outcomes framework;
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) NICE; (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 the functions which are reserved to NHS England (and are therefore not delegated to the ICB under the Delegation) and as set out in detail in clause 8 and SCHEDULE 3 (Reserved Functions) of 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 clause 9.19.1;
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 as defined in Appendix 2 of the NHS England and NHS Improvement operating models: HR Framework for developing Integrated Care;
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 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 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

3. 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.

4. 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.

5. Enhanced Services

5.1 The ICB must manage the design (where applicable) and commissioning of any Enhanced Services, including re-commissioning these services annually where appropriate.

5.2 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.

5.3 The ICB must ensure that it complies with any Mandated Guidance in relation to the design and commissioning of Enhanced Services.

5.4 When commissioning newly designed Enhanced Services the ICB must:

5.4.1 consider the needs of the local population in the Area;

5.4.2 develop the necessary specifications and templates for the Enhanced Services, as required to meet the needs of the local population in the Area;

5.4.3 when developing the necessary specifications and templates for the Enhanced Services, ensure that value for money will be obtained;

5.4.4 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;

5.4.5 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;

5.4.6 support Data Controllers in providing 'fair processing' information as required by the UK GDPR; and

5.4.7 support Primary Medical Services Providers in entering into data processing agreements with data processors in the terms required by the UK GDPR.

6. Design of Local Incentive Schemes

6.1 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.

6.2 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:

6.2.1 consider the needs of the local population in the Area;

6.2.2 develop the specifications and templates for the Local Incentive Scheme;

6.2.3 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;

6.2.4 liaise with system providers and representative bodies to ensure that the system in relation to the Local Incentive Schemes will be functional and secure;

6.2.5 support Data Controllers in providing privacy information as required by the UK GDPR; and

6.2.6 support Primary Medical Services Providers in entering into data processing agreements with data processors in terms required by the UK GDPR.

6.3 The ICB must be able to:

6.3.1 demonstrate improved outcomes, reduced inequalities and value for money;

6.3.2 support ongoing national reporting requirements (where applicable); and

6.3.3 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) .

6.4 The ongoing assurance of any new Local Incentive Schemes will form part of the ICB's assurance process under any applicable assurance framework.

6.5 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.

6.6 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.

7. Making Decisions on Discretionary Payments or Support

7.1 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.

7.2 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.

8. Making Decisions about Commissioning Urgent Care for Out of Area Registered Patients

8.1 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).

8.2 The ICB must ensure that it complies with any Mandated Guidance in relation to the design and commissioning of these services.

8.3 For the purposes of paragraph 2.15, urgent care means the provision of primary medical services on an urgent basis.

9. Transparency and freedom of information

9.1 The ICB must:

9.1.1 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

9.1.2 Provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

10. Planning the Provider Landscape

10.1 The ICB must plan the primary medical services provider landscape in the Area, including considering and taking decisions in relation to:

10.1.1 establishing new Primary Medical Services Providers in the Area;

10.1.2 managing Primary Medical Services Providers providing inadequate standards of patient care;

10.1.3 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);

10.1.4 closure of practices and branch surgeries;

10.1.5 dispersing the patient lists of Primary Medical Services Providers; and

10.1.6 agreeing variations to the boundaries of Primary Medical Services Providers.

10.2 In relation to any new Primary Medical Services Contract to be entered into, the ICB must, without prejudice to any obligation in paragraph 16 (Procurement and New Contracts) below, and paragraph 2.5 of Part 1 of this Schedule 2A:

10.2.1 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;

10.2.2 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

10.2.3 for the avoidance of doubt, Schedule 5 (Financial Provisions and Decision Making Limits) deals with the sign off requirements for Primary Medical Services Contracts.

11. Primary Care Networks

11.1 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:

11.1.1 maintain or establish identified Network Areas to support the local population in the Area;

11.1.2 review any waived PCN list size requirements wherever possible and appropriate to best support the local population in the Area;

11.1.3 ensure that each PCN has at all times an accountable Clinical Director;

11.1.4 align each PCN with an ICB that would best support delivery of services to the local population in the Area; and

11.1.5 collaborate and work with other ICBs as appropriate to agree which ICB will be the lead ICB for the PCN.

12. Approving Primary Medical Services Provider Mergers and Closures

12.1 The ICB is responsible for approving Primary Medical Services Provider mergers and Primary Medical Services Provider closures in the Area.

12.2 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.

12.3 Prior to making any decision in accordance with this paragraph 12 (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.

12.4 In making any decisions pursuant to this paragraph 12 (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 16 *(Procurement and New Contracts)*, below, where applicable.

13. Making Decisions in relation to Management of Poorly Performing Primary Medical Services Providers

13.1 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).

13.2 In accordance with paragraph 13.1 above, the ICB must:

13.2.1 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;

13.2.2 ensure that any risks identified are managed and escalated where necessary;

13.2.3 respond to CQC assessments of Primary Medical Services Providers where improvement is required;

13.2.4 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

13.2.5 take appropriate contractual action, including (without limitation) in response to CQC findings.

14. Premises Costs Directions Functions

14.1 The ICB must comply with the Premises Costs Directions and will be responsible for making decisions in relation to the Premises Costs Directions Functions.

14.2 In particular, but without limiting paragraph 14.1, the ICB shall make decisions concerning:

14.2.1 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

14.2.2 revisions to existing payments being made under the Premises Costs Directions.

14.3 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.

14.4 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.

14.5 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.

14.6 The ICB must ensure it maintains comprehensive records of the primary care estate and any changes to it.

14.7 The ICB must liaise where appropriate with NHS Property Services Limited and Community Health Partnerships Limited in relation to the Premises Costs Directions Functions.

14.8 The ICB must prioritise the following measures in respect of management of the primary care estate in the Area:

14.8.1 working collaboratively with landlords and tenants to maximise the use of existing estate;

14.8.2 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

14.8.3 seeking the resolution of premises disputes in a timely manner.

15. 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.

16. Procurement and New Contracts

16.1 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.

16.2 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).

16.3 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.

16.4 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:

16.4.1 made in the best interest of patients, taxpayers and the population;

16.4.2 robust and defensible, with conflicts of interests appropriately managed;

16.4.3 made transparently; and

16.4.4 compliant with the rules of the regime as set out in NHS England guidance.

16.5 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:

16.5.1 improve outcomes for patients;

16.5.2 reduce inequalities in the population; and

16.5.3 provide value for money.

17. Complaints

17.1 The ICB will handle complaints made in respect of Primary Medical Services in accordance with the Complaints Regulations.

18. Commissioning ancillary support services

18.1 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:

18.1.1 collection and disposal of clinical waste;

18.1.2 provision of translation and interpretation services;

18.1.3 occupational health services for performers registered on the Performers List.

18.2 The arrangements for the provision of ancillary services to Primary Medical Services Providers are described in Schedule 7 (Local Terms).

19. Finance

Further requirements in respect of finance will be specified in Mandated Guidance.

20. Workforce

20.1 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.

20.2 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: General Obligations – Prescribed Dental Services (applicable only if Prescribed Dental Services are included in the Particulars)

1. Introduction

1.1 This Part 1B of Schedule 2B *(Dental Care Services)* sets out general provisions regarding the carrying out of those Delegated Functions relating to Prescribed Dental Services.

1.2 For the purposes of Paragraph 2.1 of this Part 1B of Schedule 2B *(Dental Care Services)*, the term “Population” refers 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.

1.3 Community Dental Services are a form of Prescribed Dental Services. However, they may be governed by the terms of either an NHS Standard Contract or a PDS Agreement, as appropriate to the particular service. Accordingly:

1.3.1 where Community Dental Services are commissioned on PDS Agreement terms (or it is appropriate to commission any new PDS Agreement for such services), those contracts must be managed in accordance with the relevant provisions of Part 1A of this Schedule 2B as if they were Primary Dental Services for the purposes of that Part only. The provisions of this Part 1B of Schedule 2B also apply, with the exception of paragraphs 2.5.2 and 2.5.3; and

1.3.2 where Community Dental Services are commissioned on NHS Standard Contract terms, the provisions of this Part 1B of Schedule 2B apply in full.

2. General Obligations

2.1 NHS England may, by Contractual Notice, designate the ICB as the body responsible for commissioning Prescribed Dental Services for its Population and allocate Prescribed Dental Contracts to the ICB in accordance with clause 6.4 of this Agreement.

2.2 Each Contractual Notice referred to in paragraph 2.1 above will set out, in relation to each Prescribed Dental Services Contract, which rights, obligations and duties under that Presecribed Dental Services Contract are to be delegated to the ICB and which are to be retained by NHS England.

2.3 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, and other stakeholders.

2.4 When planning and commissioning Prescribed Dental Services, the ICB must comply with Mandated Guidance issued by NHS England.

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 subject to paragraph 1.3.1 of this Part 1B, use the current NHS Standard Contract published by NHS England from time to time; and

2.5.3 subject to paragraph 1.3.1 of this Part 1B, pay for the Services in accordance with the National Tariff or the NHS Payment Scheme (each as defined in the Health and Social Care Act 2012) as applicable from time to time.

Part 2: Specific Obligations – Primary Dental Services only

1. Introduction

1.1 This Part 2 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 a GDS Contract, PDS Agreement and Personal Dental Services Plus Agreement 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 10 (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. 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 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

9.1 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 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.

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 complaints made in respect of Primary Dental Services in accordance with the Complaints Regulations.

12. Commissioning Ancillary Support Services

12.1 The arrangements for the provision of ancillary services to Primary Dental Services Providers are described in Schedule 7 (Local Terms).

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

3. Introduction

3.1 This Part 2 of Schedule 2C *(Primary Ophthalmic Services)* sets out further provision regarding the carrying out of each of the Delegated Functions.

4. Primary Ophthalmic Services Contract Management

4.1 The ICB must:

4.1.1 comply with all current and future relevant national Mandated Guidance regarding General Ophthalmic Contract reviews and any other contract reviews;

4.1.2 take on the responsibility for existing services provided pursuant to a Primary Ophthalmic Services Contract, and for commissioning new services;

4.1.3 assume the responsibility for the award of new Primary Ophthalmic Services Contracts; and

4.1.4 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. The ICB accordingly agrees to co-operate with the NHS Business Services Authority in the delivery of these functions.

5. Transparency and freedom of information

5.1 The ICB must:

5.1.1 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

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. Maintaining the Performers List

6.1 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.

7. Finance

7.1 Further requirements in respect of finance will be specified in Mandated Guidance.

8. Workforce

8.1 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.

8.2 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.

9. Integrating optometry into communities at Primary Care Network level

9.1 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.

10. Complaints

10.1 The ICB will handle complaints made in respect of primary ophthalmic services in accordance with the Complaints Regulations.

11. Commissioning ancillary support services

11.1 The arrangements for the provision of ancillary services to Primary Ophthalmic Services Providers are described in Schedule 7 (Local Terms).

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 give 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:

2.1.1. 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:

2.1.1.1. lists of persons who have undertaken to provide pharmaceutical services in particular by way of the provision of drugs;

2.1.1.2. lists of persons who have undertaken to provide pharmaceutical services only by way of the provision of appliances; and

2.1.1.3. 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.

2.1.2. managing and determining applications by persons for inclusion in a Pharmaceutical List[5];

[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

2.1.3. managing and determining applications by persons included in a Pharmaceutical List;

2.1.4. responsibilities for financial resources related to the Delegated Pharmaceutical Functions as described in Mandated Guidance issued by NHS England;

2.1.5. overseeing the compliance of those included in the Pharmaceutical Lists with:

2.1.5.1. their Terms of Service and identifying and investigating breaches, including possible breaches, of those terms;

2.1.5.2. relevant Conditions of Inclusion; and

2.1.5.3. requirements of the Community Pharmacy Contractual Framework.

2.1.6. exercising powers in respect of Performance Related Sanctions and Market Exit[6];

2.1.7. 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;

2.1.8. 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:

2.1.8.1. pandemic; and

2.1.8.2. a serious risk or potentially a serious risk to human health[7];

2.1.9. communicating to those included in the Pharmaceutical Lists any other matters which NHS England may require the ICB to communicate from time to time;

2.1.10. 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");

2.1.11. performing functions in respect of enforcement, reviews and appeals relating to the Fitness to Practise Functions[8];

2.1.12. making LPS Schemes[9], subject to the requirements of paragraph 5;

2.1.13. 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;

2.1.14. exercising all rights, and complying with all obligations, of NHS England under Local Pharmaceutical Services Contracts;

2.1.15. determining LPS matters[10] in respect of LPS Schemes;

2.1.16. determining Rurality Decisions and other rurality matters[11];

2.1.17. determining Dispensing Doctor Decisions[12];

[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

2.1.18. preparing and maintaining Dispensing Doctor Lists[13];
2.1.19. making arrangements for the provision of adequate pharmaceutical service delivery across the ICB area;
2.1.20. making arrangements for the delivery of Essential Services, Advanced Services and Enhanced Services;
2.1.21. supporting implementation and delivery of all elements of the Community Pharmacy Contractual Framework;
2.1.22. 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;
2.1.23. responding to Appeals to the Secretary of State and First Tier Tribunal in respect of the Delegated Pharmaceutical Functions[14];
2.1.24. responding to Claims in respect of the Delegated Pharmaceutical Functions;
2.1.25. recovering overpayments from NHS Chemists, LPS Chemists, Dispensing Doctors and Primary Medical Services Providers[15];
2.1.26. bringing any legal proceedings in respect of the Delegated Pharmaceutical Functions;
2.1.27. making any notifications to, and consulting with, third parties in respect of the Delegated Pharmaceutical Functions;
2.1.28. recognising one or more Local Pharmaceutical Committees which it considers are representative of Pharmaceutical Services Providers in the ICB's Area and liasing with and consulting such Local Pharmaceutical Committees as required by the Pharmaceutical Regulations;
2.1.29. commissioning the provision of NHS Smartcards to Pharmaceutical Services Providers and their staff by registration authorities;
2.1.30. 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
2.1.31. 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
2.2.1.3. a Dispensing Doctor List (together the "Relevant Lists"); and

[13] Regulation 46 of the Pharmaceutical Regulations
[14] Schedule 3 of the Pharmaceutical Regulations
[15] Regulation 94 of the Pharmaceutical Regulations
[16] Regulation 114 of the Pharmaceutical Regulations

2.2.2. 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 3.3.

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 3.1.1 (maintaining Pharmaceutical Lists)
   3.2. Paragraph 3.1.2 (managing applications for inclusion)
   3.3. Paragraph 3.1.3 (managing applications from those included in a list)
   3.4. Paragraph 3.1.5 (overseeing compliance with Terms of Service and Conditions of Inclusion)
   3.5. Paragraph 3.1.10 (Fitness to Practise)
   3.6. Paragraph 3.1.18 (maintaining and publishing Dispensing Doctors Lists)
   3.7. Paragraph 3.1.25 (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 clause 9.20.

Integration

9. In respect of integrated working, the ICB must:

        9.1.1. 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;

        9.1.2. work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Pharmaceutical Services generally; and

        9.1.3. 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 arrangements for the provision of ancillary services to Pharmaceutical Services Providers are described in Schedule 7 (Local Terms).

13. **Finance**

    13.1. Further requirements in respect of finance will be specified in Mandated Guidance.

14. **Workforce**

    14.1. 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 2 (Delegated Functions) Part 1 paragraphs 7.1 and 7.2 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 In accordance with clause 9.18, 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 clauses 9.20 and 9.21, the ICB will provide certain management and/or administrative services to NHS England in relation to the Section 7A Functions.

5.3 In accordance with clause 9.14, 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 clauses 9.16 and 9.17, 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.

[17] Part 7, Chapter 4A of the NHS Act (not currently in force)

SCHEDULE 4

Further Information Governance and Sharing Provisions

1. Introduction

1.1. The purpose of this Schedule 4 *(Further Information Governance and Sharing Provisions)* and the Personal Data Agreement at the Annex 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 Personal Data Agreement is 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

1.3.5.1. Primary Care Providers and Primary Care Provider Personnel; and

1.3.5.2. Dental Services Providers and their personnel;

1.3.6. 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. Specific and detailed purposes are set out in the Personal Data Agreement annexed to this Schedule.

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 local delivery of Primary Care Services and Primary Dental Services.

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 Parties shall identify the lawful basis for sharing Relevant Information for each purpose and data flow, and document these in the Personal Data Agreement annexed to this Schedule.

5. Relevant Information to be shared

5.1. The Relevant Information to be shared is set out in the Personal Data Agreement annexed to this Schedule.

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 the Personal Data Agreement annexed to 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 is included in the Personal Data Agreement annexed to this Schedule.

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. These access controls are set out in the Personal Data Agreement annexed to this Schedule; and

8.5.3. specific limitations on the personnel who may have access to the Information are set out in the Personal Data Agreement annexed to this Schedule.

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 Personal Data Agreement.

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 are specified in the Personal Data Agreement annexed to this Schedule.

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 are set out in the Personal Data Agreement annexed to this Schedule.

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. Details of the single points of contact shall be set out in the Personal Data Agreement.

15. Monitoring and review

15.1. 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 are set out in the Personal Data Agreement annexed to this Agreement.

Annex

Template Personal Data Agreement

Data flow subject matter: [Description]
Data flow duration: *The duration of the delegation arrangement* **[OR Insert alternative period]**
Nature and purpose of processing: *Described in the Delegation Agreement at Schedule 4 paragraph 2.1 above*

Description of information flow and Single Points of Contact for parties involved

Originating Data Controller	[Insert:]			
Contact details for Single Point of Contact for Originating Data Controller	**Name of point of contact**	**Title**	**Contact (email)**	**Contact (phone)**
Recipient Data Controller	[Insert:]			
Contact details for Single Point of Contact of Recipient Data Controller	**Name of point of contact**	**Title**	**Contact (email)**	**Contact (phone)**

Description of information to be shared

Comprehensive description of Relevant Information to be shared – including the type(s) of personal data to be shared and categories of personal data	[Insert:]
Anonymised / not information about individual persons	**Yes / No**
Strongly pseudonymised	**Yes / No**

Weakly pseudonymised	**Yes / No**
Person -identifiable data	**Yes / No**
Justification for the level of identifiability required	[Insert or N/A:]

Legal basis for disclosure and use

GDPR Article 6 Legitimising Condition/s	[Insert or N/A:]	
GDPR Article 9 Exemption/s	[Insert or N/A:]	
Confidentiality	**Explicit consent**	Yes / No [If yes, how documented?:]
	Implied Consent	Yes / No [If yes, how have you implied consent?:]
	Statutory required/permitted disclosure	[Insert statutory basis:]
	Public interest disclosure	[Insert how the public interest favours use/disclosure of the information:]
	Other legal basis	[Insert:]
s. 13Z3 / 14Z61 NHS Act 2006 justification	**S. 13Z3 condition(s) to permit disclosure**	[Insert:]
	S. 14Z23 condition(s) to permit disclosure	[Insert:]
Other specific legal considerations		

Restrictions on use of information

[Insert:]

Governance arrangements

Specific measures to ensure fairness to the Data Subject, including privacy impact assessments undertaken	[Insert:]
Access controls on use of information	[Insert:]
Specific limitations on Personnel who may access information	[Insert:]
Other specific security requirements (transmission)	[Insert:]
Other specific security requirements (general)	[Insert:]
Specific requirements as to ensuring quality of information	[Insert:]
Specific requirements for retention and destruction of information	[Insert:]
Specific monitoring and review arrangements	[Insert:]

SCHEDULE 5

Financial Provisions and Decision Making Limits

Financial Limits and Approvals

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

2.1 NHS Business Services Authority has existing agreements with NHS England to support its delivery of the following services:

2.1.1 Contract management – end-to-end administration of contract variations and other regional team/ICB support activities;

2.1.2 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;

2.1.3 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;

2.1.4 Provide data reports to teams defining quantity and service delivery at a contractor level.

3. Primary Ophthalmic Services

3.1 NHS Business Services Authority have existing agreements with NHS England to support its delivery of the following services:

3.1.1 Contract management. End-to-end administration of new contract applications, contract variations and contract terminations.

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.

3.1.3 GOS complaints. Administration of the annual GOS complains survey.

3.1.4 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.

3.1.5 GOS 4 pre-authorisation of repair or replacement glasses.

4 **Pharmaceutical Services and Local Pharmaceutical Services**

4.1 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:

4.1.1 Performance management – direct support to commissioners and community pharmacy contractors to implement corrective and preventative intervention;

4.1.2 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;

4.1.3 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.

5 **Support Services directed by DHSC**

5.1 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):

5.1.1 The administration of national payment platforms for primary care services to dentists, pharmacy contractors, appliance contractors, oxygen contractors and special school eye care providers;

5.1.2 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;

5.1.3 Clinical advisory support;

5.1.4 Administration functions;

5.1.5 Assurance services - performance and contract management of primary care providers;

5.1.6 The provision of information to primary care organisations for all contractor groups via standardised reporting (eg. ePACT2, eDEN and eOPS);

5.1.7 Working with NHS England and ICB Counter Fraud Teams to reduce loss across the system.

SCHEDULE 7

Local Terms

None

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

1. 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.

2. 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:

   2.1 faithfully and diligently perform duties and exercise such powers as may from time to time be reasonably assigned to or vested in them; and

   2.2 perform all duties assigned to them pursuant to this Schedule 8.

3. 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.

4. 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:

   4.1 by reason of industrial action;

4.2 as a result of the suspension or exclusion of employment or secondment of any Staff by NHS England;

4.3 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;

4.4 if making the NHS England Staff available would breach or contravene any Law;

4.5 as a result of the cessation of employment of any individual NHS England Staff; and/or

4.6 at such other times as may be agreed between NHS England and the ICB.

Employment of the NHS England Deployed Staff

1. 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.

2. 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.

3. 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

1. 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.

2. 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

1. 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.

2. 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

1. 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.

2. It is acknowledged that to enable the NHS England Staff to provide the Services, the Parties may share Confidential Information.

3. The Parties agree to adopt all such procedures as the other party may reasonably require and to keep confidential all Confidential Information.

Intellectual Property

1. 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.

Primary Ophthalmic Services

- Policy Book for Eye Health.

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.
- Commissioning Standard for Dental Care for People with Diabetes.
- Accreditation of Performers and Providers of Level 2 Complexity Care.

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.*

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

Appendix C

Governance Handbook

Version	Effective Date	Changes
1.0	1 July 2022	First version Governance Handbook on establishment of the ICB.

Contents

1. Introduction

1.1 Establishment of the ICB and its Constitution

1.1.1 NHS Nottingham and Nottinghamshire Integrated Care Board ("the ICB") was established by NHS England on 1 July 2022 by The Integrated Care Boards (Establishment) Order 2022.

1.1.2 The ICB has a **Constitution** that sets out the statutory framework that the ICB operates within and its arrangements for demonstrating accountability and transparency. It also sets out the ICB's Board membership and associated appointment processes, arrangements for exercising the ICB's functions and procedures for making decisions. Provisions for conflicts of interest management and required standards of business conduct are also included.

1.1.3 The ICB also has a set of **Standing Orders**, which form part of the Constitution and set out the:

(a) Arrangements and procedures for meetings of the ICB Board

(b) Processes to appoint committees and sub-committees of the Board.

1.2 Governance Handbook

1.2.1 This Governance Handbook, which sits alongside the ICB's Constitution, brings together the following key documents:

(a) **Terms of Reference** – for all committees and sub-committees of the Board that exercise ICB functions and make decisions.

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

(c) **Scheme of Reservation and Delegation** – which sets out functions that are reserved to the Board, functions that have been delegated to an individual or to committees and sub-committees, and functions delegated to another body or bodies or to be exercised jointly with another body or bodies.

1.2.2 This Governance Handbook also includes further information in support of the ICB's governance arrangements, including:

(a) A summary of the Board's role and responsibilities, along with details of Executive director Portfolios.

(b) An up-to-date list of eligible providers of primary medical services as referenced at 3.6.2 of the ICB's Constitution.

(c) Guidance for members of the public in relation to the ICB's meetings that are held in public, including how members of the public can ask questions of the Board.

(d) The procedure for the consideration of petitions received by the ICB.

1.2.3 The ICB has developed a **Functions and Decisions Map**, which is a high-level structural chart that sets out where key decisions are taken or where functions are delegated to different parts of the system – it aims to be an easy-to-read version of the ICB's Scheme of Reservation and Delegation, designed to present the ICB's governance arrangements in a simple way. The ICB's Functions and Decisions Map is published in full on the ICB's website at www.notts.icb.nhs.uk.

1.2.4 The ICB has a suite of key policy documents, covering different aspects of its corporate and commissioning responsibilities. This includes its **Standards of Business Conduct Policy** (which incorporates the ICB's policy and procedures for the identification and management of conflicts of interest) and its **Policy for Public Involvement and Engagement** are published in full on the ICB's website at www.notts.icb.nhs.uk.

1.3 Review and amendment of the Governance Handbook

1.3.1 To ensure that this Governance Handbook remains up-to-date and relevant, the ICB's lead for governance will ensure that it is reviewed on an ongoing basis and at least annually to ensure it continues to support effective governance and decision-making.

1.3.2 The Board will approve all amendments to the Governance Handbook.

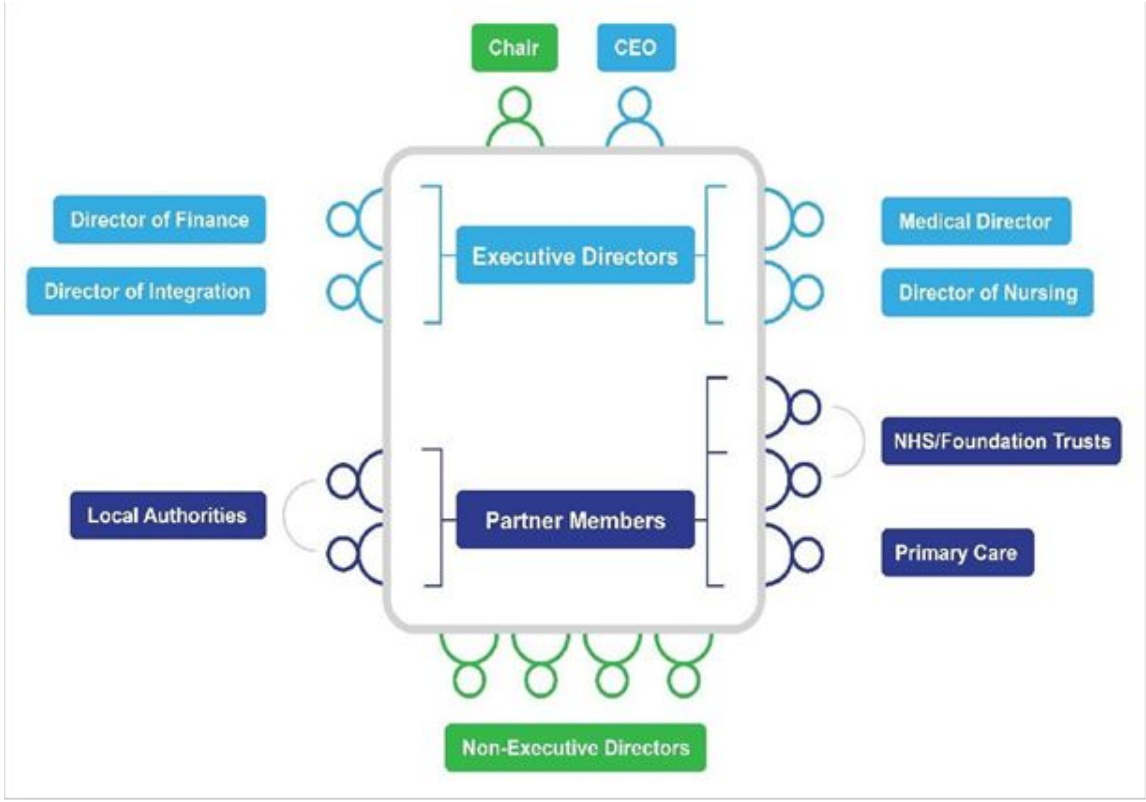
2. The Board – Roles and Responsibilities

The ICB is governed by a unitary Board, which means all Board members are collectively and corporately accountable for organisational performance.

Non-Executive Members – provide an independent view on the running of the organisation, bringing purposeful, constructive scrutiny and challenge to Board and committee discussions.

Executive Members – manage the day-to-day responsibilities of the organisation.

Partner Members – bring knowledge and a perspective from their relevant sectors to the work of the Board; these cover mental health, hospital, urgent and emergency care services, primary and community care, and social care.



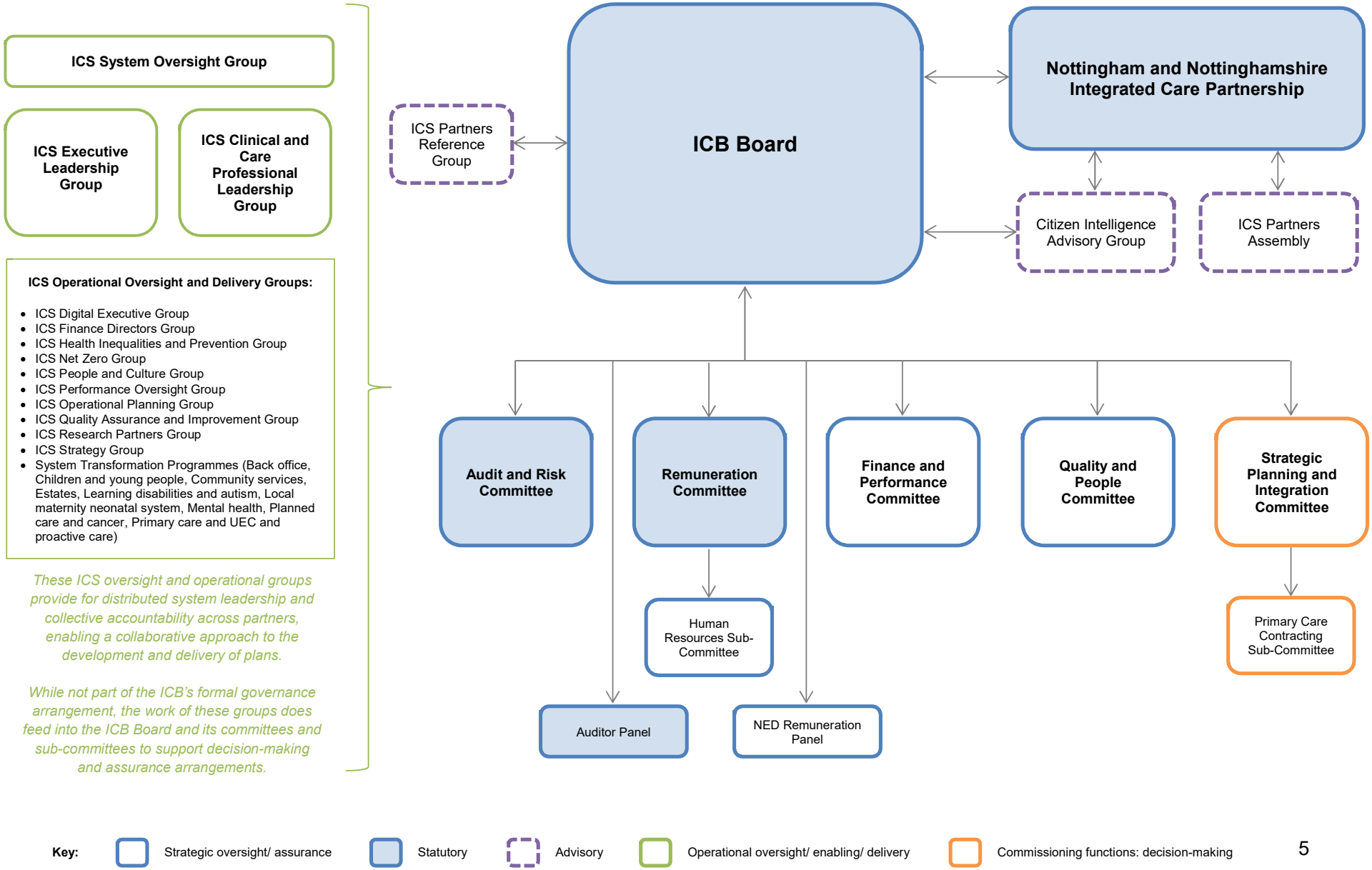
The Board is responsible for:

- Ensuring the ICB plays its role in achieving the four aims of the Integrated Care System:
  - i) Improve outcomes in population health and healthcare
  - ii) Tackle inequalities in outcomes, experience and access
  - iii) Enhance productivity and value for money
  - iv) Help the NHS support broader social and economic development.
- Formulating a plan for the organisation.
- Holding the organisation to account for the delivery of the plan; by being accountable for ensuring the organisation operates effectively and with openness, transparency and candour and by seeking assurance that systems of control are robust and reliable and that statutory duties are being met.
- Shaping a healthy culture for the organisation and the system through its interaction with system partners.

4. Executive Director Portfolios

Executive Director	Portfolio of responsibilities	
Chief Executive	• ICB Accountable Officer	• Communications and engagement
Director of Finance	• Deputy Chief Executive • Financial planning and stewardship and resource allocation (including new payment mechanisms and risk sharing arrangements) • Capital planning • Operational planning • Performance and system oversight arrangements	• PMO • Estates • Social and economic development and environmental sustainability • Audit and counter fraud arrangements
Medical Director	• Health inequalities • Clinical prioritisation and transformation • JSNA • Population health management and system intelligence • Data, digital and technology	• Clinical and care professional leadership and engagement • Research, evidence and evaluation • Innovation • Senior Information Risk Owner (SIRO)
Director of Nursing	• Quality improvement and IPC • Safeguarding • Continuing healthcare and personalisation • Individual funding requests • People and culture (including ICB HR and OD)	• Equality, diversity and inclusion • Medicines management • Corporate governance, risk and assurance • Information governance • Caldicott Guardian
Director of Integration	• Integrated care strategy and strategic planning (ICB five-year plan) • Integration of health, social care and health-related services • System development (primary care networks, place-based partnerships, provider collaborative and joint commissioning with local authorities) • Commissioning hospital and other health services (including NHSE delegated functions) and strategic service change and development of new care models • Children and young people	• Special educational needs and disabilities (SEND) • Outcomes based contracting • Provider selection regime • EPRR and Accountable Emergency Officer (AEO)

4. ICB Board and Committee Structure



5. Audit and Risk Committee – Terms of Reference

1. Purpose	The Audit and Risk Committee ("the Committee") exists to: a) Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the ICB's activities that supports the achievement of the organisation's objectives. b) Provide the Board with an independent and objective view of the ICB's financial systems, financial information and compliance with the laws, regulations and directions governing the ICB in as far as they relate to finance. c) Scrutinise every instance of non-compliance with the ICB's Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions and monitor compliance with the ICB's Standards of Business Conduct Policy. d) Approve the ICB's Annual Report and Accounts. The Committee is also responsible for overseeing the ICB's compliance with the regulatory requirements for information governance, health and safety and emergency preparedness. The Committee will also monitor progress against the ICB's overarching policy work programme.
2. Status	The Committee is established in accordance with the National Health Service Act 2006 (as amended by the Health and Care Act 2022) and the ICB's Constitution. It is a statutory committee of, and accountable to, the Board. The Board has authorised the Committee to: a) Investigate any activity within its terms of reference. b) Seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. c) Obtain outside legal or other independent advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary. d) Create sub-committees or task and finish groups to take forward specific programmes of work as considered necessary by the Committee's membership. The Committee shall determine the membership and terms of reference of any such sub-committees or task and finish group. Any sub-committee or task and finish group established may consist of, or include, persons who are not Board members or ICB employees.
3. Duties	*Integrated governance, risk management and internal control* The Committee will review the establishment and maintenance of an effective system of integrated governance, risk management

	and internal control across the whole of the ICB's activities, which supports the achievement of its objectives. The Committee will: a) Review the adequacy and effectiveness of the ICB's risk management arrangements and all risk and control related disclosure statements (including the annual governance statement) together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances. b) Review the adequacy and effectiveness of the underlying assurance processes that indicate the degree of achievement of the ICB's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements. This will include reviewing the outcome of the annual effectiveness assessment of all committees prior to consideration by the Board. c) Review of all instances of non-compliance with Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation. d) Review the reasonableness of the use of emergency powers for urgent decisions by the Chair of the ICB and Chief Executive on behalf of the Board and all instances where Standing Orders have been suspended. e) Review the reasonableness of the use of emergency powers for urgent decisions on behalf of the Strategic Planning and Integration Committee and Finance and Performance Committee. f) Approve and monitor compliance with standards of business conduct policies and any related reporting and self-certifications. g) Scrutinise compliance with legislative and regulatory requirements relating to information governance and the extent to which associated systems and processes are effective and embedded within the ICB. h) Monitor progress against the ICB's overarching Policy Work Programme. In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from Executives and managers, as appropriate. The Committee will use the Board Assurance Framework to guide its work and that of the audit and assurance functions that report to it. *Internal audit* The Committee will approve arrangements for the provision of internal audit services.

	The Committee will ensure that there is an effective internal audit function established by management that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, ICB Chief Executive, ICB Chair and the Board. This will be achieved by: i) Considering the provision of the internal audit service and the costs involved; ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation. j) Reviewing and approving of the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the ICB (as identified in the Board Assurance Framework). k) Considering the major findings of internal audit work (and management's response) and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources. l) Monitoring the effectiveness of internal audit and completing an annual review. *External audit* 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: m) 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. n) Discussing with the external auditors their local evaluation of audit risks and assessment of the organisation and the impact on the audit fee. o) Reviewing all external audit reports, including the report to those charged with governance and any work undertaken outside of the audit plan, together with the appropriateness of management responses. The Committee will also ensure a cost-efficient external audit service. *Counter fraud* The Committee will approve arrangements for the provision of counter fraud, bribery and corruption services. The Committee will satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption (including cyber security) that meet NHS Counter Fraud Authority's standards and will review the outcomes of work in these areas. This will be achieved by:

	p) Reviewing, approving and monitoring counter fraud work plans; receiving regular updates on counter fraud activity and monitoring the implementation of action plans. q) Ensuring that the counter fraud service submits an Annual Report, outlining key work undertaken during each financial year and progress in achieving the requirements of the Government Functional Standard 13 for counter fraud. The Committee will refer any suspicions of fraud, bribery and corruption to the NHS Counter Fraud Authority. *Financial reporting and stewardship* r) The Committee will monitor the integrity of the financial statements of the ICB and any formal announcements relating to its financial performance. s) The Committee will 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. t) The Committee will scrutinise the outcome of the annual review of the Standing Financial Instructions, recommending any amendments to the Board for approval. u) The Committee will: i) Be notified of any new bank accounts or changes to existing bank accounts, and any arrangements made with the ICB's bankers for accounts to be overdrawn. ii) Approve the use of procurement or other card services by the ICB, including the types of card services that should be allowed, the types of transactions that should be permitted, the individuals who should be issued with a card, and the overall credit and individual transaction limits to be associated with each card. iii) Monitor the actual use of card services against authorised uses. iv) Review all instances where competitive tendering requirements have been waived. v) Review the extent to which debt is being managed effectively. vi) Scrutinise any retrospective approvals to commit revenue expenditure. vii) Review all losses and special payments (including special severance payments). *Annual report and accounts* v) The Committee will review and approve the annual report and accounts, focusing particularly on:

	i) The wording in the annual governance statement and other disclosures. ii) Changes in, and compliance with, accounting policies, practices and estimation techniques. iii) Unadjusted mis-statements in the financial statements. iv) Significant judgements in preparation of the financial statements. v) Significant adjustments resulting from the audit. vi) Letters of representation. vii) Explanations for significant variances. *Information governance* w) The Committee will scrutinise compliance with legislative and regulatory requirements relating to information governance and the extent to which associated systems and processes are effective and embedded within the ICB. This will include oversight of the ICB's performance against the Data Security and Protection Toolkit (DSPT) standards. *Other regulatory and mandatory requirements* The Committee will also ensure the adequacy and effectiveness of the ICB's arrangements in relation to: x) The role of the ICB in respect of emergencies; overseeing the organisation's compliance against the requirements of the Civil Contingencies Act (2004) (CCA), the NHSE Emergency Preparedness, Resilience and Response (EPRR) Framework and any other mandated guidance pertaining to EPRR and business continuity. y) The statutory and mandatory requirements for health, safety, security and fire. z) The development and embedment of robust incident management processes, including ensuring that any 'lessons learnt' are routinely identified and appropriate actions are implemented to avoid reoccurrence. aa) The Committee will also review and approve policies specific to the Committee's remit. bb) Monitor the quality of data that informs the work of the Committee; this includes review of the timeliness, accuracy, validity, reliability, relevance and completeness of data.
4. Membership	The Committee's membership will be comprised of three Non-Executive Directors of the Board. Between them, the members will possess knowledge, skills and experience in accounting, risk management, internal, external audit; and technical or specialist issues pertinent to the ICB's business. *Attendees*

	The following will be routine attendees at the Committee's meetings: a) Director of Finance (or a suitable deputy, as appropriate) b) Associate Director of Governance (or a suitable deputy, as appropriate) c) Internal Audit d) External Audit Other officers may be invited to attend meetings when the Committee is discussing areas of risk or operation that fall within their areas of responsibility. This will include: e) The Chief Executive being invited to attend, at least annually, to discuss with the Committee the process for assurance that supports the annual governance statement. f) The Local Counter Fraud Specialist being invited to attend at least twice per year. The Chair of the ICB will also be invited to attend one meeting each year to gain further assurance regarding the effectiveness of the ICB's governance arrangements.
5. Chair and deputy	The Board will appoint a Non-Executive Director who has qualifications, expertise or experience to enable them to lead on finance and audit matters to be Chair of the Committee. In the event of the Chair being unable to attend all or part of the meeting, a replacement from within the Committee's membership will be nominated to deputise for that meeting.
6. Quorum	The Committee will be quorate with a minimum of two members present. If any Committee member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
7. Decision-making arrangements	Committee members will seek to reach decisions by consensus where possible. If a consensus agreement cannot be reached, then the item will be escalated to the Board for a decision.
8. Meeting arrangements	The Committee will meet no less than six times per year at appropriate times in the reporting and audit cycle. The Head of Internal Audit and representatives from external audit have a right of direct access to the Chair of the Committee and may request a meeting if they consider that one is necessary. The Committee will meet privately with the internal and external auditors at least once during the year.

	Meetings of the Committee, other than those regularly scheduled above, shall be summoned by the secretary to the Committee at the request of the Chair. The Committee may meet virtually using telephone, video and other electronic means. Where a virtual meeting is convened, the usual process for meetings of the Committee will apply, including those relating to the quorum (as set out in section 6 of these terms of reference). Virtual attendance at in-person meetings will be permitted at the discretion of the Chair. There is no requirement for meetings of the Committee to be open to the public. Secretariat support will be provided to the Committee to ensure the day-to-day work of the Committee is proceeding satisfactorily. Agendas and supporting papers will be circulated no later than five calendar days in advance of meetings and will be distributed by the secretary to the Committee. Any items to be placed on the agenda are to be sent to the secretary no later than seven calendar days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added on receipt of permission from the Chair. Agendas will be agreed with the Chair prior to the meeting.
9. Minutes of meetings	Minutes will be taken at all meetings and presented according to the corporate style. The minutes will be ratified by agreement of the Committee at the following meeting. The ratified minutes will be published on the ICB's website, redacted as appropriate.
10. Conflicts of interest management	In advance of any meeting of the Committee, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals. At the beginning of each Committee meeting, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declarations will be formally recorded in the minutes for the meeting. The Chair of the Committee will determine how declared interests should be managed, which is likely to involve one the following actions:

	a) Requiring the conflicted individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Committee's decision-making arrangements. b) Allowing the conflicted individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Committee's decision-making arrangements and where there is a clear benefit to the conflicted individual being included in both. d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.
11. Reporting responsibilities and review of effectiveness	The Committee will provide assurance to the Board that it is effectively discharging its delegated responsibilities, as set out in these terms of reference, by: a) Providing an assurance report to the Board following each of the Committee's meetings; summarising the items discussed, decisions made and any specific areas of concern that warrant immediate Board attention; and b) Providing an annual report to the Board, summarising how the Committee has discharged its duties across the year, key achievements and any identified areas of required committee development. This report will be informed by the Committee's annual review of its effectiveness. Any items of specific concern, or which require Board approval, will be the subject of a separate report.
12. Review of terms of reference	These terms of reference will be formally reviewed on an annual basis but may be amended at any time to adapt to any national guidance as and when issued. An early review of these terms of reference may be required during the ICB's first year of operation, as wider system working arrangements evolve. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Issue Date:	Status:	Version:	Review Date:
1 July 2022	FOR APPROVAL	1.0	30 June 2023

6. Auditor Panel – Terms of Reference

1. Purpose and duties	The Auditor Panel ("the Panel") exists to advise the Board on the selection and appointment of the organisation's external auditor. This includes: a) Agreeing and overseeing a robust process for selecting the external auditors in line with the organisation's normal procurement rules. b) Making a recommendation to the Board as to who should be appointed. c) Ensuring that any conflicts of interest are dealt with effectively. d) Advising the Board on the maintenance of an independent relationship with the appointed external auditor. e) Advising the Board (if asked) on whether or not any proposal from the external auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable. f) Agreeing the ICB's position regarding the purchase of non-audit services from the appointed external auditor g) Advising the Board on any decision about the removal or resignation of the external auditor. The Panel will monitor the quality of data that informs its work; this includes review of the timeliness, accuracy, validity, reliability, relevance and completeness of data.
2. Status	The Panel has been established by the Board in accordance with The Local Audit and Accountability Act 2014 (the Act). The Board has authorised the Panel to: a) Investigate any activity within its terms of reference. b) Seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Panel. c) Obtain outside legal or other independent advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary.
3. Membership	The Panel's membership will be comprised of three Non-Executive Directors of the Board. *Attendees* Senior Managers may be invited to attend meetings of the Panel to support the Panel in discharging its responsibilities.

4. Chair and deputy	The Board will appoint a Non-Executive Director who has qualifications, expertise or experience to enable them to lead on finance and audit matters to be Chair of the Panel. In the event of the Chair being unable to attend all or part of the meeting, a replacement from within the Panel's membership will be nominated to deputise for that meeting.
5. Quorum	The Panel will be quorate with a minimum of two members present. If any Panel member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
6. Decision-making arrangements	Panel members will seek to reach decisions by consensus where possible. If a consensus agreement cannot be reached, then the item will be escalated to the Board for a decision.
7. Meeting arrangements	The Panel shall agree the frequency and timing of meetings needed to allow it to discharge its responsibilities. The Panel may meet virtually using telephone, video and other electronic means. Where a virtual meeting is convened, the usual process for meetings of the Panel will apply, including those relating to the quorum (as set out in section 5 of these terms of reference). Virtual attendance at in-person meetings will be permitted at the discretion of the Chair. There is no requirement for meetings of the Panel to be open to the public. Secretariat support will be provided to the Panel. Agendas and supporting papers will be circulated no later than five calendar days in advance of meetings and will be distributed by the secretary to the Panel. Any items to be placed on the agenda are to be sent to the secretary no later than seven calendar days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added on receipt of permission from the Chair. Agendas will be agreed with the Chair prior to the meeting.
8. Minutes of meetings and reporting responsibilities	Minutes will be taken at all meetings and presented according to the corporate style. The minutes will be ratified by agreement of the Panel (this may be performed virtually due to the timings between meetings). The Panel will report in writing to the Board following each of its meetings in the form of a report from the Chair of the Panel.

9. Conflicts of interest management	In advance of any meeting of the Panel, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals. At the beginning of each meeting, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declarations will be formally recorded in the minutes for the meeting. The Chair of the Panel will determine how declared interests should be managed, which is likely to involve one the following actions: a) Requiring the conflicted individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Panel's decision-making arrangements. b) Allowing the conflicted individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Panel's decision-making arrangements and where there is a clear benefit to the conflicted individual being included in both. d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.
10. Review of terms of reference	These terms of reference will be formally reviewed on an annual basis but may be amended at any time in order to adapt to any national guidance as and when issued. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Issue Date:	Status:	Version:	Review Date:
1 July 2022	FOR APPROVAL	1.0	30 June 2023

7. Remuneration Committee – Terms of Reference

1. Purpose	The main purpose of the Remuneration Committee ("the Committee") is to exercise the ICB's functions as set out in paragraphs 18 to 20 of Schedule 1B to the NHS Act 2006 (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022). The remit of the Committee excludes the remuneration, fees, allowances and other terms of appointment for the Chair of the ICB and for the non-executive members of the Board. These will be set by NHS England and the NED Remuneration Panel respectively.
2. Status	The Committee is established in accordance with the National Health Service Act 2006 (as amended by the Health and Care Act 2022) and the ICB's Constitution. It is a statutory committee of, and accountable to, the Board. The Board has authorised the Committee to: a) Investigate any activity within its terms of reference. b) Seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. c) Obtain outside legal or other independent advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary. d) Create sub-committees or task and finish groups to take forward specific duties or programmes of work as considered necessary by the Committee's membership. The Committee shall determine the membership and terms of reference of any such sub-committees or task and finish group. Any sub-committee or task and finish group established may consist of or include persons who are not Board members or ICB employees.
3. Duties	a) Determine the remuneration, fees, allowances and other terms of appointment for Executive Directors and all other Very Senior Manager (VSM) appointments (substantive and fixed term). Remuneration proposals will be guided by the relevant national pay frameworks, ensuring that Very Senior Managers are fairly rewarded for their individual contribution to the organisation, whilst ensuring proper regard to the organisation's circumstances and performance. b) Determine any allowances to be paid to other Board, committee and sub-committee members who are not employees (excluding Non-Executive Directors).

	c) Determine the remuneration, fees, allowances and other terms of appointment for any individuals engaged on a contract for service. d) Scrutinise and approve all proposed exit payments, ensuring that appropriate ICB policies and national guidance have been followed, and seeking HM Treasury pre-approval if required (which will be required for any proposed special severance payments). e) Oversee compliance with the requirements set out in the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, as necessary. f) Oversee arrangements for human resources management for all staff employed by the ICB. g) Monitor the quality of data that informs the work of the Committee; this includes review of the timeliness, accuracy, validity, reliability, relevance and completeness of data.
4. Membership	The Committee's membership will be comprised of four Non-Executive Directors of the Board, which includes the Chair of the ICB. The Chair of the Audit and Risk Committee cannot be a member of the Committee. *Attendees* Senior Managers may be invited to attend meetings of the Committee to support the Committee in discharging its responsibilities (providing their own remuneration is not being discussed). This will include expert human resources advisors.
5. Chair and deputy	The Board will appoint a Non-Executive Director to be Chair of the Committee. The Chair of the ICB cannot be Chair of the Committee. In the event of the Chair being unable to attend all or part of the meeting, a replacement from within the Committee's membership will be nominated to deputise for that meeting.
6. Quorum	The Committee will be quorate with a minimum of three members present. If any Committee member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
7. Decision-making arrangements	Committee members will seek to reach decisions by consensus where possible. Should this not be possible, then a vote of the

	Committee members will be required, the process for which will be, as follows: a) All members of the Committee who are present at the meeting will be eligible to cast one vote each. In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote. b) A decision will be passed if more votes are cast for it than against it. c) Casting vote – If an equal number of votes are cast for and against a resolution, then the Chair of the Committee will have a casting vote. Should a vote be taken, the outcome of the vote, and any dissenting views, will be recorded in the minutes of the meeting. The Committee will take proper account of National Agreements, for example Agenda for Change and relevant guidance issued by the Government, the Department of Health and Social Care and NHS England in reaching its determinations.
8. Meeting arrangements	The Committee will meet as required, with a minimum of two meetings per year. The Committee may meet virtually using telephone, video and other electronic means. Where a virtual meeting is convened, the usual process for meetings of the Committee will apply, including those relating to the quorum (as set out in section 6 of these terms of reference). Virtual attendance at in-person meetings will be permitted at the discretion of the Chair. There is no requirement for meetings of the Committee to be open to the public. Secretariat support will be provided to the Committee to ensure the day-to-day work of the Committee is proceeding satisfactorily. Agendas and supporting papers will be circulated no later than five calendar days in advance of meetings and will be distributed by the secretary to the Committee. Any items to be placed on the agenda are to be sent to the secretary no later than seven calendar days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added on receipt of permission from the Chair. Agendas will be agreed with the Chair prior to the meeting.
9. Minutes of meetings and reporting responsibilities	Minutes will be taken at all meetings and presented according to the corporate style. The minutes will be ratified by agreement of the Committee (this may be performed virtually due to the timings between meetings). The Committee will report in writing to the Board at least annually in the form of a report from the Chair of the Committee.

10. Conflicts of interest management	In advance of any meeting of the Committee, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals. At the beginning of each Committee meeting, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declarations will be formally recorded in the minutes for the meeting. The Chair of the Committee will determine how declared interests should be managed, which is likely to involve one the following actions: a) Requiring the conflicted individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Committee's decision-making arrangements. b) Allowing the conflicted individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Committee's decision-making arrangements and where there is a clear benefit to the conflicted individual being included in both. d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.
11. Review of terms of reference	These terms of reference will be formally reviewed on an annual basis, but may be amended at any time in order to adapt to any national guidance as and when issued. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Issue Date:	Status:	Version:	Review Date:
1 July 2022	FOR APPROVAL	1.0	30 June 2023

8. Human Resources Sub-Committee Terms of Reference

1. Purpose	The Human Resources Sub-Committee ("the Sub-Committee") exists to ensure that rigorous and transparent employee policies, procedures and systems are in place and kept under review for all staff employed by the ICB.
2. Status	The Sub-Committee is established in accordance with the National Health Service Act 2006 (as amended by the Health and Care Act 2022) and the ICB's Constitution. It is a sub-committee of, and accountable to, the Remuneration Committee. The Remuneration Committee has authorised the Sub-Committee to: a) Investigate any activity within its terms of reference. b) Seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Sub-Committee. c) Obtain outside legal or other independent advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary.
3. Duties	a) Oversee the development and implementation of the ICB's workforce and organisational development plans, including establishment of, and monitoring performance against, a set of key workforce indicators (including turnover, sickness, appraisals) and monitoring workforce demographics and performance against relevant equality standards. b) Ensure that the views and experiences of the ICB's workforce, as highlighted by the annual staff survey, are appropriately responded to. c) Ensure effective arrangements are in place regarding staff engagement and communication with the ICB's workforce, establishing appropriate links with staff groups/networks to ensure feedback is meaningfully considered. d) Approve off-payroll and consultancy appointments in line with the Scheme of Reservation and Delegation. e) Review and approve the organisation's human resources policies. f) Oversee the identification and management of risks relating to the Sub-Committee's remit. g) Monitor the quality of data that informs the work of the Committee; this includes review of the timeliness, accuracy, validity, reliability, relevance and completeness of data.
4. Membership	The Sub-Committee's membership will be comprised of: a) Chief Executive

	b) Director of Finance c) Medical Director d) Director of Nursing e) Director of Integration *Attendees* The Sub-Committee may invite a range of Senior Managers to attend meetings to support the Sub-Committee in discharging its responsibilities. This will include expert human resources advisors.
5. Chair and deputy	The Chief Executive will be Chair of the Sub-Committee. In the event of the Chair being unable to attend all or part of the meeting, a replacement from within the Committee's membership will be nominated to deputise for that meeting.
6. Quorum	The Sub-Committee will be quorate with a minimum of three members present. To ensure that the quorum can be maintained, the managerial members of the Sub-Committee are able nominate a suitable deputy to attend a meeting of the Sub-Committee that they are unable to attend to speak and vote on their behalf. Sub-Committee members are responsible for fully briefing their nominated deputies and for informing the secretariat so that the quorum can be maintained. If any Sub-Committee member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
7. Decision-making arrangements	Committee members will seek to reach decisions by consensus where possible. Should this not be possible, then a vote of the Sub-Committee members will be required, the process for which will be, as follows: a) All members of the Sub-Committee who are present at the meeting will be eligible to cast one vote each. In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote. b) A decision will be passed if more votes are cast for it than against it. c) Casting vote – If an equal number of votes are cast for and against a resolution, then the Chair of the Sub-Committee will have a casting vote. Should a vote be taken, the outcome of the vote, and any dissenting views, will be recorded in the minutes of the meeting.

8. Meeting arrangements	The Sub-Committee will meet on a quarterly basis. The Sub-Committee may meet virtually using telephone, video and other electronic means. Where a virtual meeting is convened, the usual process for meetings of the Sub-Committee will apply, including those relating to the quorum (as set out in section 6 of these terms of reference). Virtual attendance at in-person meetings will be permitted at the discretion of the Chair. There is no requirement for meetings of the Sub-Committee to be open to the public. Secretariat support will be provided to the Sub-Committee to ensure the day-to-day work of the Sub-Committee is proceeding satisfactorily. Agendas and supporting papers will be circulated no later than five calendar days in advance of meetings and will be distributed by the secretary to the Sub-Committee. Any items to be placed on the agenda are to be sent to the secretary no later than seven calendar days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added on receipt of permission from the Chair. Agendas will be agreed with the Chair prior to the meeting.
9. Minutes of meetings	Minutes will be taken at all meetings and presented according to the corporate style. The minutes will be ratified by agreement of the Sub-Committee at the following meeting. The ratified minutes will be published on the ICB's website, redacted as appropriate.
10. Conflicts of interest management	In advance of any meeting of the Sub-Committee, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals. At the beginning of each Sub-Committee meeting, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declarations will be formally recorded in the minutes for the meeting. The Chair of the Sub-Committee will determine how declared interests should be managed, which is likely to involve one the following actions: a) Requiring the conflicted individual to withdraw from the meeting for that part of the discussion if the conflict could be

	seen as detrimental to the Sub-Committee's decision-making arrangements. b) Allowing the conflicted individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Sub-Committee's decision-making arrangements and where there is a clear benefit to the conflicted individual being included in both. d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.
11. Reporting responsibilities and review of committee effectiveness	The Sub-Committee will provide assurance to the Remuneration Committee that it is effectively discharging its delegated responsibilities, as set out in these terms of reference, by: a) Providing bi-annual assurance reports to the Remuneration Committee; summarising the items discussed, decisions made and any specific areas of concern that warrant attention. b) Providing an annual report to the Remuneration Committee, summarising how the Sub-Committee has discharged its duties across the year, key achievements and any identified areas of required development. This report will be informed by the Sub-Committee's annual review of its effectiveness.
12. Review of terms of reference	These terms of reference will be formally reviewed on an annual basis but may be amended at any time in order to adapt to any national guidance as and when issued. Any proposed amendments to the terms of reference will be submitted to the Remuneration Committee for approval.

Issue Date:	Status:	Version:	Review Date:
1 July 2022	FOR APPROVAL	1.0	30 June 2023

9. NED Remuneration Panel – Terms of Reference

1. Purpose and duties	The Non-Executive Director (NED) Remuneration Panel ("the Panel") exists to set the remuneration, fees, allowances and other terms of appointment for the non-executive members of the Board. The remit of the Panel excludes the remuneration, fees, allowances and other terms of appointment for the Chair of the ICB, which will be set by NHS England. The Panel will monitor the quality of data that informs its work; this includes review of the timeliness, accuracy, validity, reliability, relevance and completeness of data.
2. Status	The Panel has been established by the Board in accordance with the ICB's constitution. The Board has authorised the Panel to: a) Investigate any activity within its terms of reference. b) Seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Panel. c) Obtain outside legal or other independent advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary.
3. Membership	The Panel's membership will be comprised of the ICB Chair, a non-remunerated Partner Member of the Board and the ICB's governance lead. *Attendees* Senior Managers may be invited to attend meetings of the Panel to support the Panel in discharging its responsibilities. This will include expert human resources advisors.
4. Chair and deputy	The ICB Chair will be Chair of the Panel. Should the ICB Chair be unable to attend all or part of the meeting, then a further non-remunerated Partner Member will be invited to join the Panel's membership and one of the non-remunerated Partner Members will be nominated to deputise for that meeting.
5. Quorum	The Panel will be quorate with a minimum of two members present. If any member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
6. Decision-making arrangements	Committee members will seek to reach decisions by consensus where possible. Should this not be possible, then a vote of the

	Panel members will be required, the process for which will be, as follows: a) All members of the Panel who are present at the meeting will be eligible to cast one vote each. In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote. b) A decision will be passed if more votes are cast for it than against it. c) Casting vote – If an equal number of votes are cast for and against a resolution, then the Chair of the Panel will have a casting vote. Should a vote be taken, the outcome of the vote, and any dissenting views, will be recorded in the minutes of the meeting. The Panel will take proper account of relevant guidance issued by the Government, the Department of Health and Social Care and NHS England in reaching its determinations.
7. Meeting arrangements	The Panel will meet as required, with a minimum of one meeting per year. The Committee may meet virtually using telephone, video and other electronic means. Where a virtual meeting is convened, the usual process for meetings of the Committee will apply, including those relating to the quorum (as set out in section 5 of these terms of reference). Virtual attendance at in-person meetings will be permitted at the discretion of the Chair. There is no requirement for meetings of the Panel to be open to the public. Secretariat support will be provided to the Panel to ensure its work is proceeding satisfactorily. Agendas and supporting papers will be circulated no later than five calendar days in advance of meetings and will be distributed by the secretary to the Panel. Any items to be placed on the agenda are to be sent to the secretary no later than seven calendar days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added on receipt of permission from the Chair. Agendas will be agreed with the Chair prior to the meeting.
8. Minutes of meetings and reporting responsibilities	Minutes will be taken at all meetings and presented according to the corporate style. The minutes will be ratified by agreement of the Panel (this may be performed virtually due to the timings between meetings). The Panel will report in writing to the Board at least annually in the form of a report from the Chair of the Panel.

9. Conflicts of interest management	In advance of any meeting of the Panel, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals. At the beginning of each meeting, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declarations will be formally recorded in the minutes for the meeting. The Chair of the Panel will determine how declared interests should be managed, which is likely to involve one the following actions: a) Requiring the conflicted individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Committee's decision-making arrangements. b) Allowing the conflicted individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Committee's decision-making arrangements and where there is a clear benefit to the conflicted individual being included in both. d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.
10. Review of terms of reference	These terms of reference will be formally reviewed on an annual basis, but may be amended at any time in order to adapt to any national guidance as and when issued. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Issue Date:	Status:	Version:	Review Date:
1 July 2022	FOR APPROVAL	1.0	30 June 2023

10. Finance and Performance Committee – Terms of Reference

1. Purpose	The Finance and Performance Committee ("the Committee") exists to: a) Scrutinise arrangements for ensuring the delivery of the ICB's statutory financial duties in line with sections 223GB to 223N of the NHS Act 2006 (as amended by the Health and Care Act 2022). b) Oversee the ICB's performance management framework, including scrutiny of actions to: i) Tackle heath inequalities and deliver improved health outcomes; and ii) Address shortfalls in performance against national and local health targets and performance standards. The Committee is also responsible for scrutinising the ICB's arrangements and delivery in relation to operational planning, estates, environmental sustainability (including statutory duties as to climate change) and data and digital, ensuring continuous improvements in performance and outcomes. The Committee also oversights non-healthcare contracts. The remit of the Committee incorporates the relevant requirements set out within the Delegation Agreement between NHS England and the ICB (Primary Medical Services), insofar as they relate to finance, performance and estates.
2. Status	The Committee is established in accordance with the National Health Service Act 2006 (as amended by the Health and Care Act 2022) and the ICB's constitution. It is a committee of, and accountable to, the Board. The Board has authorised the Committee to: a) Investigate any activity within its terms of reference. b) Seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. c) Obtain outside legal or other independent advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary. d) Create sub-committees or task and finish groups to take forward specific duties or programmes of work as considered necessary by the Committee's membership. The Committee shall determine the membership and terms of reference of any such sub-committees or task and finish group. Any sub-committee or task and finish group established may consist of or include persons who are not Board members or ICB employees.

3. Duties	a) Oversee the development of robust joint financial plans with the ICB's partner NHS trusts and NHS foundation trusts and recommend these for approval by the Board; ensuring that plans clearly demonstrate the use of resources to improve outcomes and tackle health inequalities. This will include: i) A plan to meet statutory financial duties, for inclusion within the joint five-year forward plan (the system financial strategy). ii) A joint capital resource use plan. b) Ensure the ICB's annual budgets are prepared within the limits of available funds and recommend these for approval by the Board. c) Review and scrutinise delivery of the joint financial plans and the ICB's in-year budgetary position, ensuring that: i) Required efficiencies are identified and delivered, including opportunities at system level where the scale of partners together and the ability to work across organisations can be leveraged. ii) Robust action plans are developed in response to any material breaches. iii) Monies designated for integration are used for that purpose. iv) The ICB's expenditure in each financial year does not exceed the aggregate of any sums received within that financial year. v) Local capital and revenue resource use for each financial year does not exceed the limits specified by NHS England. vi) Any joint financial objectives set by NHS England for the ICB and its partner NHS trusts and NHS foundation trusts are achieved. d) Oversee arrangements for robust prioritisation of future capital resource use and the development of capital funding bids. e) Oversee a system-based approach to preparing the annual operational plan, ensuring alignment with national priorities and recommending this for approval by the Board. f) Oversee the ICB's performance management framework, including scrutiny of identified improvement plans to address shortfalls in performance against national and local health targets and performance standards. g) Review and scrutinise the ICB's performance against measures put in place to reduce inequalities between persons with respect to their ability to access health services,

	and between patients with respect to the outcomes achieved for them by the provision of health services. h) Examine performance at system, organisation and place levels, focussing in detail on specific issues where performance is showing deterioration, or where there are issues of concern. Any areas of deteriorating performance that could compromise health outcomes or quality of service will be referred to the Quality and People Committee for scrutiny of potential harm and appropriate interventions. i) Scrutinise the extent to which system transformational change programmes are driving improvements in performance. j) Oversee the development of the ICS Digital and Data Strategy in line with the seven success measures within the 'What Good Looks Like' framework and recommend this for approval by the Board; ensuring the strategy is underpinned by a sustainable financial plan and scrutinising delivery against the approved plan. k) Ensure compliance to digital and data sharing standards across the system. l) Oversee the development of the ICS Green Plan in line with national guidance and targets and recommend this for approval by the Board; subsequently scrutinising net zero progress against the approved plan and overseeing an annual update to the plan considering: i) Progress made and the ability to increase or accelerate agreed actions ii) New initiatives generated by staff or partner organisations iii) Advancements in technology and other enablers iv) Likely increase in ambition and breadth of national carbon reduction initiatives and targets. m) Oversee the development of a system-wide estates strategy and recommend this for approval by the Board; subsequently scrutinising its delivery. n) Approve the ICB's estates plan for the GP practices within its area and scrutinise arrangements for ensuring that the GP practice premises estate is properly managed and maintained. o) Make decisions in relation to the Premises Costs Directions Functions (in relation to General Medical Services), in line with any associated guidance issued by the Secretary of State for Health and Care or NHS England. p) Approve ICB headquarters estate and lease arrangements.

	q) Make decisions on resource allocations, procurement approaches and contract awards for non-healthcare services, in line with the Scheme of Reservation and Delegation (this excludes the appointment of the ICB's external auditor, which is completed in line with legislation by an Auditor Panel, convened for this purpose). r) Review and approve policies specific to the Committee's remit. s) Oversee the identification and management of risks relating to the Committee's remit. t) Monitor the quality of data that informs the work of the Committee; this includes review of the timeliness, accuracy, validity, reliability, relevance and completeness of data.
4. Membership	The Committee will have six members, comprised as follows: *Non-Executive Members* a) Two Non-Executive Directors of the ICB Board. b) Two Non-Executive Directors nominated from the NHS trusts, NHS foundation trusts and social enterprise organisations (that are significant providers of NHS services) within the ICB's area. *Managerial Members* c) Director of Finance d) Medical Director *Attendees* The Committee may invite a range of Senior Managers to attend meetings to support the Committee in discharging its responsibilities. The Chair of the ICB will also be invited to attend one meeting each year to gain further assurance regarding the effectiveness of the ICB's governance arrangements.
5. Chair and deputy	The Board will appoint one of the ICB Non-Executive Directors to be Chair of the Committee. In the event of the Chair being unable to attend all or part of the meeting, a replacement from within the Committee's non-executive membership will be nominated to deputise for that meeting.
6. Quorum	The Committee will be quorate with a minimum of three members, to include one Non-Executive Director of the ICB Board and one managerial member. To ensure that the quorum can be maintained, the managerial members of the Committee are able nominate a suitable deputy to attend a meeting of the Committee that they are unable to attend to speak and vote on their behalf. Committee members are

	responsible for fully briefing their nominated deputies and for informing the secretariat so that the quorum can be maintained. If any Committee member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
7. Decision-making arrangements	Committee members will seek to reach decisions by consensus where possible. Should this not be possible, then a vote of the Committee members will be required, the process for which will be, as follows: a) All members of the Committee who are present at the meeting will be eligible to cast one vote each. In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote. b) A decision will be passed if more votes are cast for it than against it. c) Casting vote – If an equal number of votes are cast for and against a resolution, then the Chair of the Committee will have a casting vote. Should a vote be taken, the outcome of the vote, and any dissenting views, will be recorded in the minutes of the meeting. On occasion, the Committee may be required to take urgent decisions. An urgent decision is one where the requirement for the decision to be made arises between the scheduled meetings of the Committee and in relation to which a decision must be made prior to the next scheduled meeting. The powers which are delegated to the Committee, may for an urgent decision be exercised by the Chair of the Committee and the Director of Finance, subject to every effort having been made to consult with as many members of the Committee as possible in the given circumstances. The exercise of such powers by the Chair of the Committee and the Director of Finance will be reported to the next formal meeting of the Committee for formal ratification and to the Audit and Risk Committee for review of the reasonableness of the decision to use emergency powers.
8. Meeting arrangements	Meetings of the Committee will be scheduled on a monthly basis and the Committee will meet no less than ten times per year. Meetings of the Committee, other than those regularly scheduled above, shall be summoned by the secretary to the Committee at the request of the Chair.

	The Committee may meet virtually using telephone, video and other electronic means. Where a virtual meeting is convened, the usual process for meetings of the Committee will apply, including those relating to the quorum (as set out in section 6 of these terms of reference). Virtual attendance at in-person meetings will be permitted at the discretion of the Chair. There is no requirement for meetings of the Committee to be open to the public. Secretariat support will be provided to the Committee to ensure the day-to-day work of the Committee is proceeding satisfactorily. Agendas and supporting papers will be circulated no later than five calendar days in advance of meetings and will be distributed by the secretary to the Committee. Any items to be placed on the agenda are to be sent to the secretary no later than seven calendar days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added on receipt of permission from the Chair. Agendas will be agreed with the Chair prior to the meeting.
9. Minutes of meetings	Minutes will be taken at all meetings and presented according to the corporate style. The minutes will be ratified by agreement of the Committee at the following meeting. The ratified minutes will be published on the ICB's website, redacted as appropriate.
10. Conflicts of interest management	In advance of any meeting of the Committee, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals. At the beginning of each Committee meeting, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declarations will be formally recorded in the minutes for the meeting. The Chair of the Committee will determine how declared interests should be managed, which is likely to involve one the following actions: a) Requiring the conflicted individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Committee's decision-making arrangements.

	b) Allowing the conflicted individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Committee's decision-making arrangements and where there is a clear benefit to the conflicted individual being included in both. d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.
11. Reporting responsibilities and review of committee effectiveness	The Committee will provide assurance to the Board that it is effectively discharging its delegated responsibilities, as set out in these terms of reference, by: a) Providing an assurance report to the Board following each of the Committee's meetings; summarising the items discussed, decisions made and any specific areas of concern that warrant immediate Board attention. b) Providing an annual report to the Board, summarising how the Committee has discharged its duties across the year, key achievements and any identified areas of required committee development. This report will be informed by the Committee's annual review of its effectiveness. Any items of specific concern, or which require Board approval, will be the subject of a separate report.
12. Review of terms of reference	These terms of reference will be formally reviewed on an annual basis but may be amended at any time in order to adapt to any national guidance as and when issued. An early review of these terms of reference may be required during the ICB's first year of operation, as wider system working arrangements evolve. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Issue Date:	Status:	Version:	Review Date:
1 July 2022	FOR APPROVAL	1.0	30 June 2023

11. Quality and People Committee – Terms of Reference

1. Purpose	The Quality and People Committee ("the Committee") exists to ensure that the ICB is: a) Meeting its statutory requirements with regard to continuous quality improvements and enabling a single understanding of and shared commitment to quality care across the system that is safe, effective, equitable, and that provides a personalised experience and improved outcomes. b) Developing robust arrangements with partners to support 'one workforce' by leading system development and implementation of the ICS People Plan. The Committee also scrutinises the robustness of safeguarding, medicines management and research arrangements, compliance with equality legislation (including the Public Sector Equality Duty), and effectiveness of patient and public engagement arrangements. The remit of the Committee incorporates the relevant requirements set out within the Delegation Agreement between NHS England and the ICB (Primary Medical Services), insofar as they relate to quality and people.
2. Status	The Committee is established in accordance with the National Health Service Act 2006 (as amended by the Health and Care Act 2022) and the ICB's constitution. It is a committee of, and accountable to, the Board. The Board has authorised the Committee to: a) Investigate any activity within its terms of reference. b) Seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. c) Obtain outside legal or other independent advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary. d) Create sub-committees or task and finish groups to take forward specific duties or programmes of work as considered necessary by the Committee's membership. The Committee shall determine the membership and terms of reference of any such sub-committees or task and finish group. Any sub-committee or task and finish group established may consist of or include persons who are not Board members or ICB employees.
3. Duties	a) Oversee the development of the ICB's quality strategy and shared quality improvement priorities and plans, ensuring these have collective system ownership and are reflective of

	local quality challenges, focused on reducing inequalities in the quality of care. b) Scrutinise the effectiveness and sustained delivery of the quality strategy, improvement priorities and plans. c) Scrutinise arrangements in place to work with partners to support system quality management, combining quality planning, quality assurance and control, and quality improvement, ensuring system structures operate effectively with timely action being taken to address areas of concern. d) Scrutinise arrangements for ensuring that personalised care becomes 'business as usual' across the health and care system, ensuring delivery of national and local requirements. e) Scrutinise arrangements for safeguarding vulnerable adults and children in line with the ICB's statutory responsibilities. f) Ensure that the ICB's arrangements include effective and transparent mechanisms with regard to co-production, learning and improvement. This will include learning from incidents, never events and complaints. g) Scrutinise arrangements for ensuring the safe and effective management of medicines. h) Scrutinise arrangements for ensuring the promotion of research as an essential function for continual improvement in health, well-being, high quality care and reducing health inequalities. i) Scrutinise arrangements for public involvement and consultation in line with the ICB's statutory responsibilities. This will include: i) Overseeing the development and delivery of the ICB's public involvement and engagement strategy, ensuring the diversity of the population is effectively considered, including those who experience the greatest health inequalities. ii) Reviewing and scrutinising how people's voices and experiences across providers and partners are co-ordinated and heard. j) Scrutinise arrangement for meeting the ICB's equality duties. This will include overseeing the development and implementation of equality improvement plans and the delivery of associated equality objectives. k) Oversee and scrutinise arrangements for the design, implementation and effectiveness of the ICS People Plan, which will include: i) Ensuring partners are aligned across the ICS to develop and support the 'one workforce', including through closer collaboration across the health and care

	sector, and with local government, the voluntary and community sector and volunteers. ii) Scrutinising delivery of local strategic and operational people priorities. iii) Reviewing action being taken to protect the health and wellbeing of people working within the ICS footprint. iv) Monitoring leadership development, talent management and succession planning approaches in order to drive the culture, behaviours and outcomes needed for people working in the system and the local population. v) Overseeing plans to develop – and where required, grow – the 'one workforce' to meet future need, through new ways of working, technology and wider innovation to meet population health needs and to create flexible and rewarding career pathways for those working in the system. vi) Ensuring collaboration across system partners to support local social and economic growth and a vibrant local labour market. l) Review and approve policies specific to the Committee's remit. m) Oversee the identification and management of risks relating to the Committee's remit. n) Monitor the quality of data that informs the work of the Committee; this includes review of the timeliness, accuracy, validity, reliability, relevance and completeness of data.
4. Membership	The Committee will have six members, comprised as follows: *Non-Executive Members* a) Two Non-Executive Directors of the ICB Board. b) Two Non-Executive Directors nominated from the NHS trusts, NHS foundation trusts and social enterprise organisations (that are significant providers of NHS services) within the ICB's area. *Managerial Members* c) Director of Nursing d) Director of Integration *Attendees* The Committee may invite a range of Senior Managers to attend meetings to support the Committee in discharging its responsibilities.

	The Chair of the ICB will also be invited to attend one meeting each year to gain further assurance regarding the effectiveness of the ICB's governance arrangements.
5. Chair and deputy	The Board will appoint one of the ICB Non-Executive Directors to be Chair of the Committee. In the event of the Chair being unable to attend all or part of the meeting, a replacement from within the Committee's non-executive membership will be nominated to deputise for that meeting.
6. Quorum	The Committee will be quorate with a minimum of three members, to include one Non-Executive Director of the ICB Board and one managerial member. To ensure that the quorum can be maintained, the managerial members of the Committee are able nominate a suitable deputy to attend a meeting of the Committee that they are unable to attend to speak and vote on their behalf. Committee members are responsible for fully briefing their nominated deputies and for informing the secretariat so that the quorum can be maintained. If any Committee member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
7. Decision-making arrangements	Committee members will seek to reach decisions by consensus where possible. Should this not be possible, then a vote of the Committee members will be required, the process for which will be, as follows: a) All members of the Committee who are present at the meeting will be eligible to cast one vote each. In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote. b) A decision will be passed if more votes are cast for it than against it. c) Casting vote – If an equal number of votes are cast for and against a resolution, then the Chair of the Committee will have a casting vote. Should a vote be taken, the outcome of the vote, and any dissenting views, will be recorded in the minutes of the meeting.
8. Meeting arrangements	Meetings of the Committee will be scheduled on a monthly basis and the Committee will meet no less than ten times per year. Meetings of the Committee, other than those regularly scheduled above, shall be summoned by the secretary to the Committee at the request of the Chair.

	The Committee may meet virtually using telephone, video and other electronic means. Where a virtual meeting is convened, the usual process for meetings of the Committee will apply, including those relating to the quorum (as set out in section 6 of these terms of reference). Virtual attendance at in-person meetings will be permitted at the discretion of the Chair. There is no requirement for meetings of the Committee to be open to the public. Secretariat support will be provided to the Committee to ensure the day-to-day work of the Committee is proceeding satisfactorily. Agendas and supporting papers will be circulated no later than five calendar days in advance of meetings and will be distributed by the secretary to the Committee. Any items to be placed on the agenda are to be sent to the secretary no later than seven calendar days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added on receipt of permission from the Chair. Agendas will be agreed with the Chair prior to the meeting.
9. Minutes of meetings	Minutes will be taken at all meetings and presented according to the corporate style. The minutes will be ratified by agreement of the Committee at the following meeting. The ratified minutes will be published on the ICB's website, redacted as appropriate.
10. Conflicts of interest management	In advance of any meeting of the Committee, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals. At the beginning of each Committee meeting, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declarations will be formally recorded in the minutes for the meeting. The Chair of the Committee will determine how declared interests should be managed, which is likely to involve one the following actions: a) Requiring the conflicted individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Committee's decision-making arrangements.

	b) Allowing the conflicted individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Committee's decision-making arrangements and where there is a clear benefit to the conflicted individual being included in both. d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.
11. Reporting responsibilities and review of committee effectiveness	The Committee will provide assurance to the Board that it is effectively discharging its delegated responsibilities, as set out in these terms of reference, by: c) Providing an assurance report to the Board following each of the Committee's meetings; summarising the items discussed, decisions made and any specific areas of concern that warrant immediate Board attention. d) Providing an annual report to the Board, summarising how the Committee has discharged its duties across the year, key achievements and any identified areas of required committee development. This report will be informed by the Committee's annual review of its effectiveness. Any items of specific concern, or which require Board approval, will be the subject of a separate report.
12. Review of terms of reference	These terms of reference will be formally reviewed on an annual basis but may be amended at any time in order to adapt to any national guidance as and when issued. An early review of these terms of reference may be required during the ICB's first year of operation, as wider system working arrangements evolve. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Issue Date:	Status:	Version:	Review Date:
1 July 2022	FOR APPROVAL	1.0	30 June 2023

12. Strategic Planning and Integration Committee – Terms of Reference

1. Purpose	The Strategic Planning and Integration Committee ("the Committee") exists to exercise the ICB's duties and powers to commission certain health services, as set out in sections 3 and 3A of the NHS Act 2006 (as amended by the Health and Care Act 2022), other than those explicitly delegated elsewhere. See **schedule 1** attached to these terms of reference for further details of the relevant health services. The remit of the Committee also incorporates the relevant requirements set out within the Delegation Agreement between NHS England and the ICB (Primary Medical Services), insofar as they relate to the planning, design and commissioning of primary medical services. In exercising these functions, the Committee will make strategic commissioning decisions in order to further the four aims of the ICS to: improve outcomes in population health and healthcare; tackle inequalities in outcomes, experience and access; enhance productivity and value for money; and help the NHS support broader social and economic development. When making decisions, the Committee will actively promote system development in line with the principles of subsidiarity and collaboration, and compliance with the general duties of ICBs as set out in sections 14Z32 to 14Z45 of the NHS Act 2006 (as amended), public sector equality duties, social value duties, the rules set out in NHS Provider Selection Regime (or existing procurement rules until the PSR comes into effect). See **schedule 1** attached to these terms of reference for further details of the general duties. The Committee will also oversee: a) Arrangements for developing the ICB's Joint Forward Plan. b) Ongoing system developments, including development of proposals for onward approval by the Board regarding the delegation of functions to be exercised by, or jointly with partners, within a place or at scale, in line with secondary legislation and statutory guidance issued by NHS England. c) Development of applications to NHS England for further delegated functions.
2. Status	The Committee is established in accordance with the National Health Service Act 2006 (as amended) and the ICB's Constitution. It is a committee of, and accountable to, the Board. The Board has authorised the Committee to: a) Investigate any activity within its terms of reference.

	b) Seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. c) Obtain outside legal or other independent advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary. d) Create sub-committees or task and finish groups to take forward specific duties or programmes of work as considered necessary by the Committee's membership. The Committee shall determine the membership and terms of reference of any such sub-committees or task and finish group. Any sub-committee or task and finish group established may consist of or include persons who are not Board members or ICB employees. Individuals appointed as members of any sub-committee or task and finish group that is established to exercise the ICB's commissioning functions will be subject to approval by the ICB Chair (in line with the membership approval requirements set out in section 4 of these terms of reference).
3. Duties	a) Oversee the development of the ICB's Joint Forward Plan, ensuring it is prepared with the ICB's partner NHS trusts and NHS foundation trusts in line with any directions or guidance issued by NHS England, and recommending this for approval by the Board. b) Steer the development of strategic commissioning proposals in order to ensure that integrated services are in place to deliver the ICS Outcomes Framework and the ambitions and shared priorities set out in the Integrated Care Strategy, Joint Local Health and Wellbeing Strategies, and the ICB's Joint Forward Plan. Strategic commissioning proposals will facilitate the transformation of services to tackle complex challenges, including: i) Improving the health of children and young people. ii) Supporting people to stay well and independent. iii) Acting sooner to help those with preventable conditions. iv) Supporting those with long-term conditions or mental health issues. v) Caring for those with multiple needs as populations age. vi) Getting the best from collective resources so people get care as quickly as possible. c) Ensure the ICB's statutory duties and regulatory assurance roles in considering proposals for service change and reconfiguration are effectively discharged.

	d) Make resource allocation decisions (regarding investment and disinvestment business cases in line with the financial limits set out within the Scheme of Reservation and Delegation). When making decisions, the Committee will consider strategic alignment, impact on health inequalities, clinical effectiveness, anticipated health benefit/ health gain, cost effectiveness and affordability. e) Make decisions in relation to the award of healthcare contracts (in line with the financial limits set out within the Scheme of Reservation and Delegation), ensuring compliance with existing procurement rules until the NHS Provider Selection Regime comes into effect. f) Oversee arrangements for the commissioning of primary medical services and for primary medical services contract management, making decisions in relation to: i) The design of any enhanced services and local incentive schemes. ii) Urgent care services for out of area registered patients. iii) Establishing any new primary medical services providers in the area, in line with plans regarding the primary medical services provider landscape. g) Review and scrutinise regular updates regarding ongoing system development, including those relating to primary care networks, place-based partnerships, provider collaboratives, and joint and delegated commissioning arrangements. h) Oversee the development of proposals for ICB functions to be exercised by or jointly with any one or more other body (another ICB, an NHS trust, an NHS foundation trust, NHS England, a local authority, combined authority or any other prescribed body) under sections 65Z5 of the NHS Act 2006 (as amended) and recommend these for approval by the Board. Arrangements may involve the functions in question to be exercised by a joint committee and for the establishment of a pooled fund to fund those functions (under section 65Z6 of the 2006 Act). i) Oversee the development of proposals for the ICB to enter into partnership arrangements with one or more local authority under section 75 of the NHS Act 2006 (as amended) and recommend these for approval by the Board. These partnership arrangements will relate to the exercise of NHS functions and health-related functions, where the partnership arrangement is likely to lead to an improvement in the way these functions are exercised. Partnership arrangements may also include the establishment of a pooled fund made up of contributions from each partner.

	j) Oversee the development of applications to NHS England for further delegated functions relating to primary pharmacy, ophthalmology and dental services and specialised services. k) Review and scrutinise the impact of delegation agreements and partnership arrangements, ensuring they are delivering better outcomes, addressing health inequalities, sustaining joined-up, efficient and effective services and enhancing productivity. l) Oversee evaluation of the return on investment of funded healthcare services in terms of reduced health inequalities and improved health outcomes. m) Review an annual report on the work of the Individual Funding Request Panel. n) Review an annual report on the work of the Mental Health and Learning Disability Specialist Treatment/Funding Panel. This will include review and approval of the Panel's terms of reference on an annual basis. o) Review and approve policies specific to the Committee's remit and in line with the ICB's Scheme of Reservation and Delegation. p) Oversee the identification and management of risks relating to the Committee's remit. q) Monitor the quality of data that informs the work of the Committee; this includes review of the timeliness, accuracy, validity, reliability, relevance and completeness of data.
4. Membership	The Committee will have 11 members, comprised as follows: *Non-Executive Members* a) Three Non-Executive Directors of the ICB Board *Clinical Members* b) Medical Director c) Deputy Director of Nursing d) Independent GP Advisor *Managerial Members* e) Chief Executive f) Director of Integration g) Operational Director of Finance h) Health and social care commissioning representative from Nottingham City Council i) Health and social care commissioning representative from Nottinghamshire County Council All individuals appointed as members of the Committee are required to be approved by the ICB Chair due to the Committee's role in exercising ICB commissioning functions. The ICB Chair will

	not approve an individual to be a member of the Committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the individual's involvement with the private healthcare sector or otherwise. *Attendees* A representative from Healthwatch Nottingham and Nottinghamshire will have a standing invitation to attend meetings of the Committee. The Committee may also invite a range of Senior Managers to attend meetings to support the Committee in discharging its responsibilities. The Chair of the ICB will also be invited to attend one meeting each year to gain further assurance regarding the effectiveness of the ICB's governance arrangements.
5. Chair and deputy	The Board will appoint one of the ICB Non-Executive Directors to be Chair of the Committee. In the event of the Chair being unable to attend all or part of the meeting, a replacement from within the Committee's non-executive membership will be nominated to deputise for that meeting. In such circumstances, care will be taken to ensure that the Audit and Risk Committee Chair's role of Conflicts of Interest Guardian is not compromised.
6. Quorum	The Committee will be quorate with a minimum of five members, to include two non-executive members, one clinical member and one managerial member. To ensure that the quorum can be maintained, the Medical Director and Director of Integration are able nominate a suitable deputy to attend a meeting of the Committee that they are unable to attend to speak and vote on their behalf. In line with the requirement for the ICB Chair to approve all individuals appointed as members of the Committee, all deputies must be nominated and approved by the ICB Chair in advance of the meeting. Committee members are responsible for fully briefing their nominated deputies and for informing the secretariat so that the quorum can be maintained. Ad hoc deputy arrangements are not permitted. If any Committee member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

	For the sake of clarity, no person can act in more than one capacity when determining the quorum.
7. Decision-making arrangements	Committee members will seek to reach decisions by consensus where possible. Should this not be possible, then a vote of the Committee members will be required, the process for which will be, as follows: a) All members of the Committee who are present at the meeting will be eligible to cast one vote each. In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote. b) A decision will be passed if more votes are cast for it than against it. c) Casting vote – If an equal number of votes are cast for and against a resolution, then the Chair of the Committee will have a casting vote. Should a vote be taken, the outcome of the vote, and any dissenting views, will be recorded in the minutes of the meeting. On occasion, the Committee may be required to take urgent decisions. An urgent decision is one where the requirement for the decision to be made arises between the scheduled meetings of the Committee and in relation to which a decision must be made prior to the next scheduled meeting. The powers which are delegated to the Committee, may for an urgent decision be exercised by the Chair of the Committee and the Chief Executive subject to every effort having been made to consult with as many members of the Committee as possible in the given circumstances. The exercise of such powers by the Chair of the Committee and the Chief Executive will be reported to the next formal meeting of the Committee for formal ratification and to the Audit and Risk Committee for review of the reasonableness of the decision to use emergency powers.
8. Meeting arrangements	Meetings of the Committee will be scheduled on a monthly basis and the Committee will meet, as a minimum, on a bi-monthly basis. Meetings of the Committee, other than those regularly scheduled above, shall be summoned by the secretary to the Committee at the request of the Chair. The Committee may meet virtually using telephone, video and other electronic means when necessary. Where a virtual meeting is convened, the usual process for meetings of the Committee will apply, including those relating to the quorum (as set out in section 6 of these terms of reference) and those relating to meetings being open to the public and representatives of the press (as set out in

	section 9 of these terms of reference). Virtual attendance at in-person meetings will be permitted at the discretion of the Chair. Secretariat support will be provided to the Committee to ensure the day-to-day work of the Committee is proceeding satisfactorily. Agendas and supporting papers will be circulated no later than five calendar days in advance of meetings and will be distributed by the secretary to the Committee. Any items to be placed on the agenda are to be sent to the secretary no later than seven calendar days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added on receipt of permission from the Chair. Agendas will be agreed with the Chair prior to the meeting.
9. Admission of public and the press	Meetings of the Committee will normally be open to the public. However, the Committee may, by resolution, exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) wherever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time. In the event the public could be excluded from a meeting of the Committee, the ICB shall consider whether the subject matter of the meeting would in any event be subject to disclosure under the Freedom of Information Act 2000, and if so, whether the public should be excluded in such circumstances. The Committee may resolve (as permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960, as amended from time to time, to exclude the public from a meeting (whether during whole or part of the proceedings) to suppress or prevent disorderly conduct or behaviour. The Chair of the Committee (or person presiding over the meeting) shall give such directions as they think fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Committee's business shall be conducted without interruption and disruption. Matters to be dealt with by the Committee following the exclusion of representatives of the press, and other members of the public shall be confidential to the members of the Committee. Members of the Committee and any individual in attendance or who receives any such minutes or papers in advance of or following a meeting shall not reveal or disclose the contents of papers or minutes that are marked as being confidential outside of the

	Committee without the express permission of the Committee. This will apply equally to the content of any discussion during the Committee meeting which may take place on such papers or minutes.
10. Minutes of meetings	Minutes will be taken at all meetings and presented according to the corporate style. The minutes will be ratified by agreement of the Committee at the following meeting. The ratified minutes will be published on the ICB's website, redacted as appropriate.
11. Conflicts of interest management	In advance of any meeting of the Committee, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals. At the beginning of each Committee meeting, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declarations will be formally recorded in the minutes for the meeting. The Chair of the Committee (or person presiding over the meeting) will determine how declared interests should be managed, which is likely to involve one the following actions: a) Requiring the conflicted individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Committee's decision-making arrangements. b) Allowing the conflicted individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Committee's decision-making arrangements and where there is a clear benefit to the conflicted individual being included in both. d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.
12. Reporting responsibilities and review of committee effectiveness	The Committee will provide assurance to the Board that it is effectively discharging its delegated responsibilities, as set out in these terms of reference, by: a) Providing an assurance report to the Board following each of the Committee's meetings; summarising the items discussed,

	decisions made and any specific areas of concern that warrant immediate Board attention. b) Providing an annual report to the Board, summarising how the Committee has discharged its duties across the year, key achievements and any identified areas of required committee development. This report will be informed by the Committee's annual review of its effectiveness. Any items of specific concern, or which require Board approval, will be the subject of a separate report.
13. Review of terms of reference	These terms of reference will be formally reviewed on an annual basis but may be amended at any time to adapt to any national guidance as and when issued. An early review of these terms of reference may be required during the ICB's first year of operation, as wider system working arrangements evolve. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Issue Date:	Status:	Version:	Review Date:
1 July 2022	FOR APPROVAL	1.0	30 June 2023

Schedule 1

Duties of Integrated Care Boards (ICBs) to commission certain health services

ICBs must arrange for the provision of the following to such extent as it considers necessary to meet the reasonable requirements of the people for whom it has responsibility:

a) Hospital accommodation.

b) Other accommodation for the purpose of any service provided under the NHS Act 2006 (as amended).

c) Medical services other than primary medical services.

d) Dental services other than primary dental services.

e) Ophthalmic services other than primary ophthalmic services.

f) Nursing and ambulance services.

g) Such other services or facilities for the care of pregnant women, women who are breastfeeding and young children as the ICB considers are appropriate as part of the health service.

h) Such other services or facilities for palliative care as the ICB considers are appropriate as part of the health service.

i) Such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as the ICB considers are appropriate as part of the health service.

j) Such other services or facilities as are required for the diagnosis and treatment of illness.

Note: ICBs' duties to arrange for the provision of services or facilities does not apply to the extent that NHS England has a duty to arrange for their provision, or another ICB has a duty to arrange for their provision.

Power of Integrated Care Boards to commission certain services

ICBs may arrange for the provision of such services or facilities as it considers appropriate for the purposes of the health service that relate to securing improvement:

a) In the physical and mental health of the people for whom it has responsibility.

b) In the prevention, diagnosis and treatment of illness in those people.

Note: ICBs may not arrange for the provision of a service or facility if NHS England has a duty to arrange for its provision.

General duties of Integrated Care Boards

a) Duty to promote NHS Constitution (section 14Z32)

b) Duty as to effectiveness, efficiency and economy (section 14Z33)

c) Duty as to improvement in quality of services (section 14Z34)

d) Duties as to reducing inequalities (section 14Z35)

e) Duty to promote involvement of each patient (section 14Z36)

f) Duty as to patient choice (section 14Z37)

g) Duty to obtain appropriate advice (section 14Z38)

h) Duty to promote innovation (section 14Z39)

i) Duty in respect of research (section 14Z40)

j) Duty to promote education and training (section 14Z41)

k) Duty to promote integration (section 14Z42)

l) Duty to have regard to wider effect of decisions (section 14Z43)

m) Duties as to climate change (section 14Z44)

n) Public involvement and consultation by ICBs (section 14Z45)

13. Primary Care Contracting Sub-Committee Terms of Reference

1. Purpose	The Primary Care Contracting Sub-Committee ("the Sub-Committee") exists to exercise requirements set out within the Delegation Agreement between NHS England and the ICB (Primary Medical Services), insofar as they relate to contract management.
2. Status	The Sub-Committee is established in accordance with the National Health Service Act 2006 (as amended by the Health and Care Act 2022) and the ICB's Constitution. It is a sub-committee of, and accountable to, the Strategic Planning and Integration Committee. The Strategic Planning and Integration Committee has authorised the Sub-Committee to: a) Investigate any activity within its terms of reference. b) Seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Sub-Committee. c) Obtain outside legal or other independent advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary.
3. Duties	a) Oversee arrangements for ensuring effective primary medical services contract management b) Oversee the design of enhanced services and local incentive schemes and recommend these for approval by the Strategic Planning and Integration Committee, ensuring compliance with any relevant mandated guidance; overseeing the subsequent commissioning/re-commissioning arrangements. c) Make decisions in relation to any discretionary payments or discretionary support to be made to providers of primary medical services, ensuring compliance with any relevant mandated guidance. d) Oversee the development of commissioning proposals for urgent care for out of area registered patients, ensuring compliance with any mandated guidance in relation to the design and commissioning of these services. e) Oversee the development of plans regarding the primary medical services provider landscape. f) Make decisions in relation to: i) Award of new primary medical services contracts, in line with the ICB's decision making limits as set out within the Delegation Agreement.

	i) Mergers and closures of primary medical services providers, ensuring all necessary consultation is undertaken and impact assessments completed. ii) Dispersing the patient lists of primary medical services providers. iii) Agreeing variations to the boundaries of primary medical services providers. g) Oversee arrangements for managing primary medical services providers providing inadequate standards of patient care. h) Oversee the commissioning of the Primary Care Network Contract Directed Enhanced Services, in line with published specifications and mandated guidance. i) Oversee arrangements for commissioning ancillary support services. j) Oversee the identification and management of risks relating to the Committee's remit. k) Monitor the quality of data that informs the work of the Committee; this includes review of the timeliness, accuracy, validity, reliability, relevance and completeness of data.
4. Membership	The Sub-Committee's membership will be comprised as follows: a) Independent GP Advisor b) Associate Director of Primary Care c) Deputy Director of Nursing d) Operational Director of Finance e) Locality Directors for Bassetlaw and Mid-Nottinghamshire, Nottingham City and South Nottinghamshire All individuals appointed as members of the Sub-Committee are required to be approved by the ICB Chair due to the Sub-Committee's role in exercising ICB commissioning functions. The ICB Chair will not approve an individual to be a member of the Sub-Committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the individual's involvement with the private healthcare sector or otherwise. *Attendees* Representatives from Healthwatch Nottingham and Nottinghamshire and the Nottinghamshire Local Medical Committee will have standing invitations to attend meetings of the Sub-Committee.

	The Sub-Committee may invite a range of Senior Managers to attend meetings to support the Sub-Committee in discharging its responsibilities.
5. Chair and deputy	The Independent GP Advisor will be Chair of the Sub-Committee. In the event of the Chair being unable to attend all or part of the meeting, a replacement from within the Sub-Committee's membership will be nominated to deputise for that meeting.
6. Quorum	The Sub-Committee will be quorate with a minimum of three members present. To ensure that the quorum can be maintained, the Associate Director of Primary Care, Deputy Director of Nursing, Operational Director of Finance and Locality Directors are able nominate a suitable deputy to attend a meeting of the Sub-Committee that they are unable to attend to speak and vote on their behalf. In line with the requirement for the ICB Chair to approve all individuals appointed as members of the Sub-Committee, all deputies must be nominated and approved by the ICB Chair in advance of the meeting. Sub-Committee members are responsible for fully briefing their nominated deputies and for informing the secretariat so that the quorum can be maintained. Ad hoc deputy arrangements are not permitted. If any Sub-Committee member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
7. Decision-making arrangements	Committee members will seek to reach decisions by consensus where possible. Should this not be possible, then a vote of the Sub-Committee members will be required, the process for which will be, as follows: a) All members of the Sub-Committee who are present at the meeting will be eligible to cast one vote each. In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote. b) A decision will be passed if more votes are cast for it than against it. c) Casting vote – If an equal number of votes are cast for and against a resolution, then the Chair of the Sub-Committee will have a casting vote. Should a vote be taken, the outcome of the vote, and any dissenting views, will be recorded in the minutes of the meeting.

8. Meeting arrangements	Meetings of the Sub-Committee will be scheduled on a monthly basis and the Sub-Committee will meet no less than ten times per year. The Sub-Committee may meet virtually using telephone, video and other electronic means. Where a virtual meeting is convened, the usual process for meetings of the Sub-Committee will apply, including those relating to the quorum (as set out in section 6 of these terms of reference). Virtual attendance at in-person meetings will be permitted at the discretion of the Chair. There is no requirement for meetings of the Sub-Committee to be open to the public. Secretariat support will be provided to the Sub-Committee to ensure the day-to-day work of the Sub-Committee is proceeding satisfactorily. Agendas and supporting papers will be circulated no later than five calendar days in advance of meetings and will be distributed by the secretary to the Sub-Committee. Any items to be placed on the agenda are to be sent to the secretary no later than seven calendar days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added on receipt of permission from the Chair. Agendas will be agreed with the Chair prior to the meeting.
9. Minutes of meetings	Minutes will be taken at all meetings and presented according to the corporate style. The minutes will be ratified by agreement of the Sub-Committee at the following meeting. The ratified minutes will be published on the ICB's website, redacted as appropriate.
10. Conflicts of interest management	In advance of any meeting of the Sub-Committee, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals. At the beginning of each Sub-Committee meeting, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declarations will be formally recorded in the minutes for the meeting. The Chair of the Sub-Committee will determine how declared interests should be managed, which is likely to involve one the following actions:

	a) Requiring the conflicted individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Sub-Committee's decision-making arrangements. b) Allowing the conflicted individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Sub-Committee's decision-making arrangements and where there is a clear benefit to the conflicted individual being included in both. d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.
11. Reporting responsibilities and review of committee effectiveness	The Sub-Committee will provide assurance to the Strategic Planning and Integration Committee that it is effectively discharging its delegated responsibilities, as set out in these terms of reference, by: a) Providing an assurance report to the Strategic Planning and Integration Committee following each of the Sub-Committee's meetings; summarising the items discussed, decisions made and any specific areas of concern that warrant the attention of the Strategic Planning and Integration Committee. b) Providing an annual report to the Strategic Planning and Integration Committee, summarising how the Sub-Committee has discharged its duties across the year, key achievements and any identified areas of required development. This report will be informed by the Sub-Committee's annual review of its effectiveness. Any items of specific concern, or which require Strategic Planning and Integration Committee approval, will be the subject of a separate report.
12. Review of terms of reference	These terms of reference will be formally reviewed on an annual basis but may be amended at any time in order to adapt to any national guidance as and when issued. An early review of these terms of reference may be required during the ICB's first year of operation, as wider system working arrangements evolve. Any proposed amendments to the terms of reference will be submitted to the Strategic Planning and Integration Committee for approval.

14. List of primary medical services providers

The following provides an up-to-date list of the eligible providers of primary medical services within the ICB Area for the purpose of nominating the Primary Care Partner Member of the ICB Board, as referenced at 3.6.2 of the ICB's constitution.

No.	Practice Code	Practice Name	Postcode
1.	C84065	Abbey Medical Centre	NG9 2QP
2.	C84037	Abbey Medical Group	NG21 0RB
3.	C84679	Acorn Medical Practice	NG18 1QA
4.	C84067	Ashfield House (Annesley)	NG17 9JB
5.	C84091	Aspley Medical Centre	NG8 5RU
6.	C84693	Bakersfield Medical Centre	NG3 7EJ
7.	Y05369	Balderton Primary Care Centre	NG24 3HJ
8.	C84009	Barnby Gate Surgery	NG24 1QD
9.	C84101	Bawtry And Blyth Medical	DN10 6RQ
10.	C84017	Belvoir Health Group	NG13 8FD
11.	Y06356	Bilborough Medical Centre	NG8 4PN
12.	C84123	Bilsthorpe Surgery	NG22 8QB
13.	C84112	Bramcote Surgery	NG9 3HF
14.	C84092	Bridgeway Practice	NG2 2JG
15.	C84077	Brierley Park Medical Centre	NG17 2NF
16.	Y06792	Broad Oak Medical Practice	NG8 6LN
17.	C84605	Castle Healthcare Practice	NG2 7SD
18.	C84120	Chilwell Valley and Meadows Practice	NG9 6DX
19.	C84034	Churchfields Medical Practice	NG6 0HD
20.	C84020	Churchside Medical Practice	NG18 1QB
21.	C84046	Clifton Medical Practice	NG11 8EW
22.	C84045	Collingham Medical Centre	NG23 7LB
23.	C84035	Crown House Surgery	DN22 7XF
24.	C84066	Daybrook Medical Practice	NG5 6HP
25.	C84044	Deer Park Family Medical Practice	NG8 2GR
26.	C84039	Derby Road Health Centre	NG7 2DW
27.	C84025	East Bridgford Medical Centre	NG13 8NY

No.	Practice Code	Practice Name	Postcode
28.	C84032	Eastwood Primary Care Centre	NG16 3BS
29.	C84011	Elmswood Surgery	NG5 4AD
30.	C84105	Fairfields Practice	NG7 5HY
31.	C84074	Family Medical Centre (Kirkby)	NG17 7BG
32.	C84018	Family Medical Centre (Sood)	NG3 2FW
33.	C84036	Forest Medical	NG19 6AB
34.	C84019	Fountain Medical Centre	NG24 1QH
35.	C84667	Giltbrook Surgery	NG16 2GE
36.	Y03124	Grange Farm Medical Centre	NG8 4HQ
37.	C84063	Greendale Primary Care Centre	NG3 7DQ
38.	C84676	Greenfields Medical Centre (Yvs Rao)	NG7 6ER
39.	C84624	Hama Medical Centre	NG16 2NB
40.	C84629	Health Care Complex, Kirkby	NG17 7BG
41.	C84705	Hickings Lane Medical Centre	NG9 8PN
42.	C84055	Highcroft Surgery	NG5 7BQ
43.	C84691	High Green Practice (Khan)	NG7 5HY
44.	C84656	Hill View Surgery	NG21 0JP
45.	C84660	Hounsfield Surgery	NG23 6PX
46.	C84078	Hucknall Road Medical Centre	NG5 1NA
47.	C84654	Jacksdale Medical Centre	NG16 5JW
48.	C84081	John Ryle Medical Practice	NG11 8EW
49.	C84704	JRB Healthcare (Beechdale Surgery)	NG8 3LF
50.	C84613	Jubilee Park Medical Partnership	NG4 3DQ
51.	C84013	Kingfisher Family Practice	DN22 7XF
52.	C84061	King's Medical Centre	NG17 1AT
53.	Y05690	Kirkby Community Primary Care Centre	NG17 7AE
54.	C84076	Kirkby Health Centre	NG17 7LG
55.	C84001	Larwood Surgery	S81 0HH
56.	C84043	Leen View Surgery	NG6 8QJ
57.	C84694	Lime Tree Surgery	NG8 6AB
58.	C84029	Lombard Medical Centre	NG24 4XG

No.	Practice Code	Practice Name	Postcode
59.	C84140	Lowmoor Road Surgery	NG17 7BG
60.	C84113	Major Oak Medical Practice	NG21 9QS
61.	C84144	Meadows Health Centre (Larner)	NG2 2JG
62.	C84658	Meden Medical Services	NG20 0BP
63.	C84116	Melbourne Park Medical Centre	NG8 5HL
64.	C84021	Middleton Lodge Practice	NG22 9SZ
65.	C84106	Mill View Surgery	NG18 5PF
66.	C84090	Musters Medical Practice	NG2 7SD
67.	C84024	Newgate Medical Group	S80 1HP
68.	C84131	Newthorpe Medical Practice	NG16 3HU
69.	C84692	North Leverton Surgery	DN22 0AB
70.	C84095	Oakenhall Medical Practice	NG15 7UA
71.	C84016	Oakwood Surgery	NG19 8BL
72.	C84051	Orchard Medical Practice	NG18 5GG
73.	C82040	Orchard Surgery	DE74 2EL
74.	C84064	Parkside Medical Centre	NG6 8QJ
75.	Y02847	Parliament Street Medical Centre	NG1 6LD
76.	Y06507	Peacock Healthcare	NG4 1JA
77.	C84115	Plains View Surgery	NG3 5LB
78.	C84057	Pleasley Surgery	NG19 7PE
79.	C84084	Radcliffe-On-Trent Health Centre	NG12 2GD
80.	C84117	Radford Medical Practice (Kaur)	NG7 3GW
81.	C84087	Rainworth Health Centre	NG21 0AD
82.	C84129	Rise Park Surgery	NG5 5EB
83.	C84127	Riverbank Medical Services	NG20 0BP
84.	C84060	Rivergreen Medical Centre	NG11 8AD
85.	C84717	Riverlyn Medical Centre	NG6 9AA
86.	C84094	Riverside Health Centre	DN22 6FB
87.	C84069	Roundwood Surgery	NG18 1QQ
88.	C84637	Sandy Lane Surgery	NG18 2LT
89.	C84042	Saxon Cross Surgery	NG9 8DA

No.	Practice Code	Practice Name	Postcode
90.	C84142	Selston Surgery	NG16 6BT
91.	C84682	Sherrington Park Medical Practice	NG5 2EJ
92.	C84059	Sherwood Medical Partnership	NG19 0FW
93.	C84628	Sherwood Rise Medical Centre	NG7 7AD
94.	C84114	Skegby Family Medical Centre	NG17 3EE
95.	Y05622	Southglade Medical Practice	NG5 5GU
96.	C84049	Southwell Medical Centre	NG25 0AL
97.	C84004	St Albans Medical Centre	NG6 8AQ
98.	C84086	St Georges Medical Practice	NG2 7PG
99.	C84031	St Peters Medical Practice	NG18 1EE
100.	C84136	St Luke's Surgery	NG7 3GW
101.	C84026	Stenhouse Medical Centre	NG5 7BP
102.	C84714	Sunrise Medical Practice	NG11 8NS
103.	C84695	The Alice Medical Centre	NG5 5HW
104.	C84047	The Calverton Practice	NG14 6FP
105.	C84103	The Forest Practice	NG7 5HY
106.	C84703	The Gamston Medical Centre	NG2 6PS
107.	C84646	The Ivy Medical Group	NG14 5BG
108.	C84107	The Linden Medical Group	NG9 8DB
109.	C84080	The Manor Surgery	NG9 1GA
110.	C84151	The Medical Centre (Irfan)	NG7 7DS
111.	C84030	The Oaks Medical Centre	NG9 2NY
112.	Y00026	The Om Surgery	NG15 7JP
113.	C84028	The Ruddington Medical Centre	NG11 6HD
114.	C84023	The University of Nottingham Health Service	NG7 2QW
115.	C84072	The Wellspring Surgery	NG3 3GG
116.	C84683	The Windmill Practice	NG2 4PJ
117.	C84053	Torkard Hill Medical Centre	NG15 6DY
118.	C84010	Trentside Medical Group	NG4 2FN
119.	C84619	Tudor House Medical Practice	NG5 3HU
120.	C84008	Tuxford Medical Centre	NG22 0HT

No.	Practice Code	Practice Name	Postcode
121.	C84150	Unity Surgery	NG3 6EU
122.	C84085	Victoria And Mapperley Practice	NG1 3LW
123.	C84005	Village Health Group	LE12 6JG
124.	C84664	Welbeck Surgery	NG5 2JJ
125.	C84621	West Bridgford Medical Centre	NG2 7PX
126.	C84696	West Oak Surgery	NG3 6EW
127.	C84033	Westdale Lane Surgery	NG4 3JA
128.	Y05346	Westwood Primary Care Centre	S80 2TR
129.	Y06443	Whyburn Medical Practice	NG15 7JE
130.	C84012	Willowbrook Medical Practice	NG17 1ES
131.	C84122	Wollaton Park Medical Centre	NG8 1FG
132.	C84014	Woodlands Medical Practice	NG17 1JW

15. Board meetings: Guidance for members of the public

Introduction

NHS Nottingham and Nottinghamshire is committed to openness and transparency and conducts as much of its business as possible in meetings that are open to members of the public.

A meeting in public is where members of the public can attend to observe a formal meeting. However, observers are not permitted to join in the discussion. These are different from public meetings, which are open forums to allow members of the public to ask questions and discuss issues, usually on a specific topic.

How do I find out about meetings?

Meeting dates, times and venues, which can be subject to change, are published on the ICB's website: www.notts.icb.nhs.uk.

Meeting agendas and supporting papers are available on the website five calendar days before each meeting.

Can members of the public ask questions during the meeting?

To assist in the management of the agenda and meeting, individuals are requested to submit written questions to the Board's email address nnicb-nn.ics@nhs.net at least 48 hours before the meeting. However, the Chair will also accept questions on the day provided that they are pertinent to items on the agenda. The Chair reserves the right to decide whether to accept the question.

Where possible, a response will be given to questions at the meeting, however if the matter is complex or requires the consideration of further information, a written response to questions will be provided within ten working days. If the number of questions raised exceeds the time allocated, questions will be taken on a first come, first served basis and any remaining questions subsequently addressed in writing.

We will not be able to discuss questions if:

- They do not relate to an item on the agenda;
- They relate to individual patient care or the performance of individual staff members; or
- They relate to issues which are the subject of current confidential discussions, legal action or any other matter not related to the roles and responsibilities of the ICB.

The Chair reserves the right to move the meeting on if they judge that no further progress is likely to result from further discussion or questioning, or to ensure that the meeting can be conducted on time.

Any questions submitted may be treated as a request under the Freedom of Information Act 2000 and treated accordingly.

Attendance at meetings

If you have any particular needs with regards to access or assistance, such as wheelchair access or an induction loop please contact nnicb-nn.ics@nhs.net and we will do our best to assist you. Please be aware that you will need to sign-in at the venue reception upon arrival, for fire safety and security reasons. A member of staff will escort everyone to the meeting room. Unfortunately, if members of the public arrive after the meeting has already started it may not be possible for them to join the meeting.

We are always interested to know who is attending our meetings and would like to encourage a wide range of organisations and individuals. To help us with this, we will ask you to sign a register when you arrive for the meeting.

At the end of meeting, all members of the public will also be escorted back to the main entrance by a member of staff.

Please note that the use of mobile phones or other electronic devices during the meeting will not be permitted if their use is deemed disruptive to the meeting. This is for the benefit of all present.

Identifying Board members

The Chair will ask members to introduce themselves at the beginning of each meeting. A name plate for each member will also be displayed on the table to help you see who is speaking during the meeting.

Discussions at meetings

The members will have been provided with copies of the agenda and papers at the same time as they are published on the website and will therefore have had the opportunity to consider the papers prior to the meeting. The Board will consider the items on the agenda in turn and each paper includes a summary cover sheet, which makes recommendations for the meeting to consider. For some items there may be a presentation whereas for others this may not be necessary. The members may not actively discuss each item in detail; this does not mean that the item has not received careful consideration but means that the members have no further questions on the matter and do not wish to challenge the recommendation(s). A formal vote will not be taken if there is a consensus on a suggested course of action.

Minutes

A record of the issues discussed and decisions taken at the meeting will be set out in the minutes, which members will be asked to approve as a correct record at its next meeting. Please note that the minutes will not be a verbatim record of everything that was discussed at the meeting.

Public order

The Chair may at any time require the public or individual members of the public or media to leave the meeting or may adjourn the meeting to a private location if they consider that those present are disrupting the proper conduct of the meeting or the business of the Board.

Will all discussion be held in open session?

The following criteria are applied in considering whether matters should be dealt with on a confidential basis.

- Material relating to a named individual;
- Information relating to contract negotiations;
- Commercially sensitive information;
- Information which may have long term legal implications or contain legal advice which, if revealed may prejudice the ICB's position;
- Other sensitive information, which, if widely available, would detrimentally affect the standing of the ICB; and
- Exceptionally, information which by reason of its nature, the ICB is satisfied should be dealt with on a confidential basis.

16. Procedure for the consideration of petitions

Criteria for Acceptance

(a) Petitions may be received in paper or electronic format (e.g. email, web based or social media).

(b) Petitions should include a statement, which should include:

- The organisation to which the petition is being addressed
- The proposition which is being promoted by the petition
- The timeframe over which the petition has been collected

(c) The name and address of the petition organiser, who must be resident within the Nottingham and Nottinghamshire ICB Area, should be provided on the first page of the petition.

(d) The following information about each petitioner should be included:

- Name
- Postcode
- Signature (in the case of a written petition)
- Email address (in the case of an electronic petition)

Acceptance

(e) An acknowledgement of receipt of the petition will be provided to the lead petitioner within five working days of receipt, with a clear explanation about what will happen next.

(f) Once received, the Chief Executive or nominated representative will ensure that the petition receives appropriate and proportionate consideration and that a response is made in writing.

(g) Where a petition, with significant support (with a minimum of 1,000 signatures) has been received by the ICB, the Chief Executive shall consult with the Chair as to whether the petition should be included as a specific item for the agenda and consideration at the next meeting of the Board to agree any appropriate actions.

(h) The following issues will be taken into account when considering a petition:

- If a petition is raised about a perceived lack of or missing service, influence will be afforded to the most cogent ideas and arguments, based upon clinical effectiveness, quality, patient safety, clinical and cost effectiveness and not necessarily to the views of the most numerous stakeholders.

- The petition's concerns will be assessed in relation to the rationale and constraints behind it. For example, a petition that proposes a realistic alternative option will normally be given greater weight than a petition that simply opposes an option that has been put forward for valid reasons.
- The petition's concerns will also be assessed in relation to the impact on other populations if these demands were accepted. This assessment could take into account views expressed in other petitions (which may conflict).

(i) The organiser of the petition will receive correspondence from the ICB, in the form of an outcome letter describing how the issues raised have or will influence the decisions of the ICB, within 40 working days of receipt of the petition.

Criteria for Non-Acceptance

(j) Petitions will not be considered if they are repeated, vexatious or if they concern issues which are outside the ICB's remit. Petitions will also not be considered if the information contained is confidential, libellous, false, defamatory or offensive.

(k) A petition will be considered as a repeat petition if:

- It covers the same or substantially similar subject matter to another petition received within the previous six months;
- It is presented by the same or similar individuals or groups as another petition received within the previous six months.

(l) A petition will be considered as a vexatious petition if:

- It focuses on individual grievances
- It focuses on the actions or decisions of an individual and not the organisation

(m) A petition will be considered as outside the ICB's' remit if:

- It focuses on a matter relevant to another organisation
- It requests information available via Freedom of Information legislation
- Its aim is to correspond on personal issue(s) with an individual(s)
- Signatories are not based in the UK

(n) A petition will be considered as confidential, libellous, false or defamatory if:

- It contains information which may be protected by an injunction or court order

- It contains material which is potentially confidential, commercially sensitive, or which may cause personal distress or loss

(o) A petition will be considered as offensive if:

- It contains language that may cause offence, is provocative or extreme in its views

(p) Where a petition does not meet the criteria for acceptance, then the ICB will respond in writing within 20 working days to advise that the petition has been rejected. The reason for rejection will be given clearly and explicitly.

Annex A: Standing Financial Instructions

The ICB's Standing Financial Instructions are published in full on the ICB's website at www.notts.icb.nhs.uk.

Annex B: Scheme of Reservation and Delegation

The ICB's Scheme of Reservation and Delegation is published in full on the ICB's website at www.notts.icb.nhs.uk.

Appendix D

Annex A: Standing Financial Instructions

Version	Effective Date	Changes
1.0	1 July 2022	First version Standing Financial Instructions on establishment of the ICB.

Contents

1. Introduction

1.1 General

1.1.1 These Standing Financial Instructions are part of the ICB's control environment for managing the organisation's financial affairs. They contribute to good corporate governance, internal control and managing risks. They enable sound administration; lessen the risk of irregularities, and support commissioning and delivery of effective, efficient and economical services. They also help the Chief Executive (as the ICB's Accountable Officer) and Director of Finance to effectively perform their responsibilities. They should be used in conjunction with the ICB's Constitution, Standing Orders and Scheme of Reservation and Delegation.

1.1.2 These Standing Financial Instructions identify the financial responsibilities which apply to members of the ICB Board, its committees and sub-committees, and the ICB's employees and other workers. It is a duty of the Chief Executive to ensure that these individuals are notified of, and put in a position to understand, their responsibilities within these Standing Financial Instructions.

1.1.3 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions, then the advice of the Director of Finance must be sought before acting.

1.2 Non-compliance with Standing Financial Instructions

1.2.1 Failure to comply with these Standing Financial Instructions may be regarded as a disciplinary matter that could result in dismissal.

1.2.2 If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit and Risk Committee for referring action or ratification. All individuals as defined at SFI 1.1.2 have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible. If the Director of Finance is responsible for the non-compliance, then this should instead be reported to the Chief Executive.

1.3 Review and amendment of Standing Financial Instructions

1.3.1 To ensure that these Standing Financial Instructions remain up-to-date and relevant, the Director of Finance will review them at least annually, reporting the outcome of the review to the Audit and Risk Committee.

1.3.2 Following consultation with the Chief Executive and scrutiny by the Audit and Risk Committee, the Director of Finance will recommend amendments, as necessary, to the Board for approval.

2. Roles and responsibilities

2.1 The Board

2.1.1 The Board exercises financial supervision and control by:

(a) Setting financial plans and budgets to meet its statutory responsibilities.

(b) Holding the executive to account for monitoring performance against core financial objectives.

(c) Setting these Standing Financial Instructions and defining specific responsibilities placed on members of the Board and other individuals as indicated in the Scheme of Reservation and Delegation.

(d) Establishing an Audit and Risk Committee to provide it with proactive support by:

(i) Advising on the effectiveness of risk management arrangements and systems of internal control.

(ii) Advising on the process for reviewing 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.

(iii) Approving the accounting policies, the accounts, and the annual report of the ICB, including the governance statement.

(e) Establishing a Finance and Performance Committee to provide oversight and assurance on the discharge of the ICB's financial duties, including its joint financial planning duties with NHS Trust and NHS Foundation Trust partners.

(f) Shaping a healthy culture for the organisation and its Integrated Care System partners.

2.2 The Chief Executive

2.2.1 The Chief Executive (as Accountable Officer) is ultimately accountable to the Board and to the Secretary of State for Health and Social Care for ensuring that the ICB meets its obligation to perform its functions within the available financial resources.

2.2.2 The Chief Executive has overall executive responsibility for the ICB's activities; is responsible to the Chair and the Board for ensuring that its financial obligations and targets are met; and has overall responsibility for the ICB's system of internal control.

2.3 The Director of Finance

2.3.1 The Director of Finance is responsible for ensuring that the ICB meets the financial targets set for it by NHS England, including living within the overall revenue and capital allocation, and the administration costs limit.

2.3.2 Jointly with the ICB's NHS Trust and NHS Foundation Trust partners, the Director of Finance has responsibility for ensuring that any joint financial objectives set by NHS England are achieved.

2.3.3 The Director of Finance is also responsible for maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these Standing Financial Instructions.

2.4 Delegation and accountability

2.4.1 The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

3. Internal and external audit

3.1 Internal audit

3.1.1 Internal audit is an independent and objective appraisal service within an organisation, which provides:

(a) An independent and objective opinion to the Chief Executive, the Board, and the Audit and Risk Committee on the degree to which risk management, control and governance, support the achievement of the organisation's agreed objectives.

(b) An independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

3.1.2 The Chief Executive, as the accountable officer, is responsible for ensuring there is appropriate internal audit provision for the ICB. For operational purposes, this responsibility is delegated to the Director of Finance. All internal audit services are provided under arrangements proposed by the Director of Finance and approved by the Audit and Risk Committee, on behalf of the Board.

3.1.3 Only the Director of Finance may commission the procurement of internal audit services, having sought the approval of the Audit and Risk Committee.

3.1.4 The Director of Finance is responsible for ensuring that the internal audit function complies with the Public Sector Internal Audit Standards and provides sufficient independent and objective assurance to the Audit and Risk Committee and the Chief Executive.

3.1.5 Internal audit will review, appraise and report upon policies, procedures and operations in place to:

(a) Establish and monitor the achievement of the organisation's objectives.

(b) Identify, assess and manage the risks to achieving the organisation's objectives.

(c) Ensure the economical, effective and efficient use of resources.

(d) Ensure compliance with established policies (including behavioural and ethical expectations), procedures, laws and regulations.

(e) Safeguard the organisation's assets and interests from losses of all kinds, including those arising from fraud, irregularity or corruption.

(f) Ensure the integrity and reliability of information, accounts and data, including internal and external reporting and accountability processes.

3.1.6 The Head of Internal Audit will provide to the Audit and Risk Committee:

(a) A risk-based plan of internal audit work, agreed with management and approved by the Audit and Risk Committee, that will enable the internal auditors to collect sufficient evidence to give an opinion on the adequacy and effective operation of the organisation.

(b) Regular updates on the progress against plan.

(c) Reports of management's progress on the implementation of action agreed as a result of internal audit findings.

(d) An annual opinion based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This opinion is used by the Chief Executive to inform their annual Governance Statement and by NHS England as part of its performance management role.

(e) Additional reports as requested by the Audit and Risk Committee.

3.1.7 Whenever any matter arises during the course of internal audit work, which involves, or is thought to involve, irregularities in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately. If the Director of Finance is thought to be involved in an irregularity, then this should instead be reported to the Chief Executive.

3.1.8 The Head of Internal Audit will normally attend Audit and Risk Committee meetings and has a right of access to the Chair of the Audit and Risk Committee and the ICB Chair and Chief Executive.

3.1.9 The Head of Internal Audit reports to the Audit and Risk Committee and is accountable to the Director of Finance. The reporting system for internal audit will be agreed between the Director of Finance, the Audit and Risk Committee and the Head of Internal Audit and will comply with the guidance on reporting contained in the Public Sector Internal Audit Standards.

3.2 External audit

3.2.1 The ICB must comply with the Local Audit and Accountability Act 2014 when procuring an external audit service. The Director of Finance is responsible for ensuring that the ICB procures external audit services in accordance with this legislation and relevant national guidance.

3.2.2 The Board is ultimately responsible for appointing the ICB's external auditor, but it will establish an Auditor Panel to advise on the selection and appointment process.

3.2.3 The Auditor Panel will:

(a) Provide assurance that procurement and contracting arrangements are appropriate and that any conflicts of interests have been effectively dealt with.

(b) Consider how the quality of the external audit service will be measured and monitored, and how that will be incorporated in the service requirements.

(c) Advise on an appropriate length of contract, noting that the ICB must appoint an external auditor at least once every five years.

(d) Advise on the maintenance of an independent relationship with the appointed external auditor.

3.2.4 The ICB must appoint an external auditor to audit its accounts for a financial year not later than 31 December in the preceding financial year. An exception to this will be the ICB's first year of establishment, when national guidance on requirements will be followed.

3.2.5 Within 28 days of an appointment being made, the ICB must publish a notice to name its external auditor and the length of the appointment.

3.2.6 The statutory responsibilities and powers of appointed auditors are set out in the Local Audit and Accountability Act 2014. The main responsibility of the ICB's appointed auditors is to meet the requirements of the National Audit Office's Code of Audit Practice.

3.2.7 The external auditors are required to provide an opinion on the ICB's financial statements. This confirms whether the Auditors believe the financial statements give a true and fair view of the financial affairs of the ICB and the income and expenditure recorded during the year.

3.2.8 The External Auditors are also required to:

(a) Form a view on the regularity of the ICB's income and expenditure i.e. that the expenditure and income included in the ICB's financial statements has been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

(b) Report by exception if the ICB has not complied with the requirements of NHS England in the preparation of its Governance Statement.

(c) Examine and report on the consistency of the schedules or returns prepared by the ICB for consolidation into the Whole of Government Accounts.

3.2.9 The External Auditors will also consider the arrangements in place for securing economy, efficiency and effectiveness (value for money) in the ICB's use of resources.

3.2.10 The Audit and Risk Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the external auditor these should

be raised with the external auditor and referred to the Audit and Risk Committee if they cannot be resolved.

3.2.11 The External Auditor will normally attend Audit and Risk Committee meetings and has a right of access to the Chair of the Audit and Risk Committee and the ICB Chair and Chief Executive.

4. Fraud, bribery and corruption (economic crime)

4.1 General

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

4.1.2 The Director of Finance is responsible for ensuring appropriate arrangements are in place to provide adequate counter fraud provision which should include reporting requirements to the Audit and Risk Committee. 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.

4.1.3 Only the Director of Finance may commission the procurement of counter fraud, bribery and corruption services, having sought the approval of the Audit and Risk Committee.

4.1.4 All members of the ICB Board, its committees and sub-committees, and the ICB's employees and other workers, severally and collectively, are responsible for ensuring ICB resources are appropriately protected from fraud, bribery and corruption.

4.1.5 Any individual that has evidence of, or reason to suspect, fraud, bribery or corruption has a duty to report these suspicions to the ICB's nominated Counter Fraud Specialist or via the NHS Counter Fraud Authority's confidential fraud, bribery and corruption reporting line.

4.1.6 Under no circumstances should any individual commence an investigation into suspected or alleged crime, as this may compromise any further investigation.

5. Resource limits and allocations, financial planning, budgetary control and grants

5.1 Funding allocations and resource limits

5.1.1 NHS England will make funding allocations to the ICB to support the delivery of its functions. Allocations will be based on a national needs-based formula and national policy on target allocations, which reflects the 'fair share' of NHS resources for the ICB. Allocations will:

(a) Include funding for acute, ambulance, community and mental health services.

(b) Include funding for the delivery of any functions delegated to the ICB by NHS England.

(c) Include a running cost allowance to cover management costs and costs of commissioning support.

5.1.2 The Director of Finance will:

(a) Periodically review the basis and assumptions used by NHS England for distributing allocations to the ICB and ensure that these are reasonable and realistic and secure the ICB's entitlement to funds.

(b) Regularly update the Board on significant changes to any initial allocations and the uses of such funds.

5.1.3 The Chief Executive has overall responsibility for ensuring that the ICB complies with its statutory obligations, including its financial and accounting obligations, and that it exercises its functions effectively, efficiently and economically and in a way which provides good value for money.

5.1.4 The Director of Finance is responsible for ensuring appropriate arrangements are in place to enable the ICB to meet the following statutory financial duties:

(a) Ensuring that the ICB's expenditure in each financial year does not exceed the aggregate of any sums received within that financial year, and that the ICB complies with any descriptions set out by NHS England of income and expenditure that should or should not be counted for the purposes of reaching financial balance, or the financial year in which they are to be counted.

(b) Ensuring that monies designated for integration are used for that purpose (i.e. Better Care Fund).

(c) Ensuring that the ICB, in conjunction with its partner NHS trusts and NHS foundation trusts, exercises its functions with a view to ensuring that, in respect of each financial year:

(i) Local capital resource use does not exceed the limit specified in a direction by NHS England.

(ii) Local revenue resource use does not exceed the limit specified in a direction by NHS England.

(iii) Any joint financial objectives set by NHS England for the ICB and its partner NHS trusts and NHS foundation trusts are achieved.

5.2 Preparation and approval of financial plans

5.2.1 Before the start of each financial year, the ICB and its partner NHS trusts and NHS foundation trusts must prepare a joint forward plan to set out how it will exercise its functions over the next five years. The joint forward plan must explain how the ICB proposes to meet its statutory financial duties.

5.2.2 Before the start of each financial year, the ICB and its partner NHS trusts and NHS foundation trusts must prepare a joint capital resource use plan. The plan must be produced in line with any directions or guidance issued by NHS England.

5.2.3 The five-year joint forward plan and joint capital resource use plan will be approved by the Board and must be published.

5.2.4 The plans must also be provided to the Integrated Care Partnership, each relevant Health and Wellbeing Board and NHS England.

5.2.5 The plans can be revised, subject to approval by the Board. Any revised plans must be published, and copies provided to the Integrated Care Partnership, each relevant Health and Wellbeing Board and NHS England.

5.2.6 The Director of Finance will provide regular reports to the Board and the Finance and Performance Committee regarding delivery of the plans.

5.3 Preparation and approval of budgets

5.3.1 Before the start of each financial year, the Director of Finance will, on behalf of the Chief Executive, prepare and submit annual budgets for approval by the Board. The annual budgets will be prepared within the limits of available funds and will identify any sums to be held in reserve and any potential risks.

5.4 Budgetary delegation

5.4.1 The Chief Executive may delegate the management of individual budgets to designated Budget Holders to enable the delivery of a defined range of activities.

5.4.2 Budget Holders may onward delegate the management of budgets within their areas of responsibility to designated Budget Managers.

5.4.3 Budget Holder and Budget Manager designations are set out in the Scheme of Reservation and Delegation.

5.4.4 All Budget Holders and Budget Managers will be required to agree their allocated budgets at the commencement of each financial year.

5.4.5 The Director of Finance is responsible for ensuring that adequate training is delivered to Budget Holders and Budget Managers to support the successful management of their budgets.

5.5 Budgetary control and reporting

5.5.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

(a) The issue of timely, accurate and comprehensible advice and financial reports to each Budget Holder and Budget Manager, covering the areas for which they are responsible.

(b) Investigation and reporting of variances from budgets and monitoring of management action to correct variances.

(c) Arrangements for the approval of budget virements.

(d) Regular budgetary reports to the Board and the Finance and Performance Committee detailing:

(i) Income and expenditure, showing the year to date actual and forecast positions.

(ii) Explanations of any material variances from budget.

(iii) Details of any corrective action where necessary and whether such actions are sufficient to correct the variance.

5.5.2 Each Budget Holder and Budget Manager is responsible for ensuring that:

(a) Any likely overspend or reduction of income which cannot be met by virement is not incurred without the prior consent of the Director of Finance or nominated officer.

(b) They review their budget reports on a monthly basis and report any anomalies.

(c) The amount provided in the agreed budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement.

5.5.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

5.5.4 Non-recurring budgets should not be used to finance recurring expenditure without approval from the Chief Executive or Director of Finance.

5.6 Capital expenditure

5.6.1 The general rules applying to budget preparation, delegation, control and reporting will also apply to capital expenditure.

5.7 Grants

5.7.1 The Director of Finance 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:

(a) Any of its partner NHS trusts or NHS foundation trusts.

(b) A voluntary organisation, by way of a grant or loan.

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

6. Banking arrangements and cash management

6.1 General

6.1.1 The Director of Finance will approve the ICB's banking arrangements and is responsible for advising the Audit and Risk Committee on the provision of banking services and operation of accounts, including the provision and use of procurement or other card services. This advice will consider any guidance and/or directions issued by NHS England on the use of specified banking facilities for any specified purposes.

6.1.2 The ICB will use the Government Banking Service as its supplier for all banking services.

6.1.3 The ICB will hold the minimum number of bank accounts required to run the organisation effectively.

6.1.4 The Director of Finance will report any new bank accounts or changes to existing bank accounts to the next meeting of the Audit and Risk Committee.

6.1.5 Designated bank account signatories are set out in the Scheme of Reservation and Delegation.

6.1.6 The Director of Finance will ensure that the ICB has effective cash management procedures in place. This will include:

(a) Ensuring money drawn from NHS England against cash forecasts is required for approved expenditure only, and is drawn only at the time of need, following best practice as set out in Managing Public Money.

(b) Ensuring payments made from the ICB's bank accounts do not exceed the amount credited to the account except where arrangements have been made.

(c) Reporting to the Audit and Risk Committee all arrangements made with the ICB's bankers for accounts to be overdrawn.

(d) Monitoring of compliance with NHS England guidance on the level of funds held at the end of each month.

6.2 Procurement and other card services

6.2.1 The Director of Finance is responsible for recommending to the Audit and Risk Committee, for approval:

(a) Whether procurement or other card services should be allowed.

(b) The types of card services that should be allowed on each account (debit, procurement, etc.).

(c) The types of transactions that should be permitted on each card.

(d) The individuals who should be issued with a card.

(e) The overall credit and individual transaction limits to be associated with each card.

6.2.2 The Director of Finance will report on the actual use of card services against authorised uses to the Audit and Risk Committee.

6.3 Payable orders, petty cash and other negotiable instruments

6.3.1 The Director of Finance is responsible for prescribing systems and procedures for the secure handling of payable orders, petty cash and other negotiable instruments should these be used or received by the ICB.

7. Income and debt recovery

7.1 Income

7.1.1 The ICB will utilise its relevant statutory powers to maximise its potential to make additional income available for improving the health service only to the extent that it does not interfere with the performance of the ICB or its functions.

7.1.2 The Director of Finance is responsible for ensuring systems are in place for the proper recording, invoicing, and collection and coding of all monies due.

7.1.3 All employees and other workers must inform the Finance Team, in accordance with notified procedures, promptly of money due arising from transactions that they initiate/deal with, including all contracts, leases, tenancy agreements and other transactions.

7.1.4 The Director of Finance will arrange to register with HM Revenue and Customs if required under money laundering legislation.

7.2 Debt management

7.2.1 The Director of Finance is responsible for ensuring systems are in place for the timely recovery of all outstanding debts. This will include:

(a) Ensuring that arrangements cover end-to-end debt management from debt creation to collection or write-off in accordance with the losses and special payment procedures.

(b) Assigning responsibility to a senior officer within the Finance Team for the operational management of debt.

(c) Reporting to the Audit and Risk Committee that debt is being managed effectively.

7.2.2 Where it is necessary to use the services of a professional debt recovery agency and/or the courts to recover an outstanding debt, the ICB will seek to recover the associated costs from the debtor concerned.

7.2.3 Income not received should be dealt with in accordance with losses procedures.

7.2.4 Overpayments should be detected (or preferably prevented) and recovery initiated.

8. Terms of service and payment of senior managers and employees

8.1 Remuneration and terms of service

8.1.1 The Board has established a Remuneration Committee to determine the remuneration and allowances for:

(a) Members of the Board, except for the Chair and non-executive members.

(b) Any members of the Board's committees and sub-committees that are not members of the Board or employees.

(c) Other very senior managers.

8.1.2 The Remuneration Committee has clearly defined terms of reference approved by the Board, specifying which roles fall within its area of responsibility.

8.2 Funded establishment

8.2.1 The workforce plan incorporated within the annual budget will form the funded establishment.

8.2.2 The funded establishment of any Directorate may not be varied without the approval of the Chief Executive or nominated officers as defined within the Scheme of Reservation and Delegation.

8.3 Staff appointments and contracts of employment

8.3.1 No Executive Director or employee may appoint employees, either on a permanent or temporary basis, or agree to changes to any aspect of remuneration, unless within the limit of their approved budget and funded establishment as defined in the Scheme of Delegation.

8.3.2 The NHS Agenda for Change terms and conditions of service will apply in full to all staff directly employed by the ICB, except for Executive Directors and other very senior managers.

8.3.3 All employees will be issued with contracts of employment in a form and timeframe that complies with employment legislation.

8.3.4 All requests for evaluations of pay bandings for new or existing posts must be approved by the relevant Budget Holder.

8.4 Processing of payroll

8.4.1 The Director of Finance is responsible for ensuring appropriate arrangements are established for:

(a) Submission of properly authorised payroll records and notifications in line with agreed timetables.

(b) Making payments on agreed dates and agreeing methods of payments.

(c) Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay.

(d) Checks to be applied to completed payroll before and after payment.

(e) Procedures for the recall of bank credits.

(f) Pay advances and their recovery.

(g) Recovery of overpayments or sums of money owed by employees or individuals leaving the employment of the ICB.

8.4.2 Officers authorised to approve payroll transactions, including new starters (and salary justifications where relevant), changes in circumstances and terminations, are set out in the Scheme of Reservation and Delegation.

8.4.3 Regardless of the arrangements for providing the payroll service, the Director of Finance will ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures, and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

8.5 Consultancy spend and off-payroll and agency workers

8.5.1 It is recognised that there may be a business need to engage with specialist skills and knowledge for temporary or substantive posts. The need for specialist knowledge and skills varies dependent upon the work and focus of the ICB at any given time, and there are a range of different types of individuals that the ICB may wish to engage with.

8.5.2 All recruiting managers will give due consideration to the costs associated with the use of consultancy, agency or off-payroll workers.

8.5.3 Appropriate business cases must be completed by the recruiting manager prior to any decision being made. Approval requirements for consultancy spend and appointment of off-payroll and agency workers are set out in the ICB's Scheme of Reservation and Delegation.

8.5.4 The ICB's Human Resources function will be responsible for providing support and advice to recruiting managers to ensure the appropriate checks are completed for all off-payroll and agency engagements. This will include, but is not limited to, the

HM Revenue and Customs (HMRC) employment status test and Status Determination Statement.

8.5.5 The ICB's Finance Directorate will be responsible for providing support and advice to recruiting managers to determine whether off-payroll working rules apply and to ensure compliance with IR35 legislation and guidance, including Understanding off-payroll working (IR35) - GOV.UK (www.gov.uk). The person providing services through their own intermediary will need to provide information to the ICB to help make this decision. If the rules apply, the ICB must deduct tax and Class 1 NICs and pay and report them to HMRC.

8.5.6 The ICB's Human Resources function will be responsible for issuing contracts in line with the outcome of the HMRC employment status test and maintaining a record of all completed employment status tests.

8.5.7 Business cases for consultancy spend and off-payroll/agency workers require prospective approval. The national business case template should be used in all instances, which will set out the:

(a) Explanation of the business need.

(b) Demonstration of the value for money of proposed engagement.

(c) Rationale for the proposed engagement.

(d) Reason for use of an off-payroll appointment as opposed to employment status.

(e) Framework compliance (i.e. the recruitment route).

(f) Recruitment strategy.

(g) Anticipated delivery.

8.5.8 Consultancy spend is defined as where an individual or team of consultants are appointed by the ICB to deliver a pre-defined project or output.

8.5.9 Off-payroll and agency workers are individuals engaged by the ICB to deliver time inputs (e.g. to cover a vacant post or a fixed term role) but not a defined output.

8.5.10 The ICB's human resources policies will be applied when an off-payroll or agency appointment is made. This includes, but is not limited to, policies relating to recruitment and selection, mandatory training and acceptable behaviours.

8.5.11 Where off-payroll workers are engaged through agencies, recruiting managers will seek to utilise agencies which are approved through a procurement framework and have adopted terms and conditions approved by NHS organisations.

8.5.12 The Director of Finance will be responsible for ensuring appropriate processes are in place to respond to any disagreements, or complaints, that are raised by off-payroll workers or agencies. Records should be maintained by the ICB of any such instances.

9. Revenue expenditure and payment of accounts

9.1 Revenue expenditure

9.1.1 For all revenue expenditure, Budget Holders and Budget Managers must ensure that they have approval to commit ICB resources before undertaking procurement. The approval routes differ according to the value and type of expenditure and the relevant delegated financial limits are set out in the Scheme of Reservation and Delegation.

9.1.2 Retrospective approval to commit revenue expenditure is not permitted, and any such breaches must be reported to the Audit and Risk Committee.

9.2 Procurement requirements

9.2.1 The ICB's Procurement Policy sets out requirements for ensuring that the ICB has a legally compliant, consistent, transparent and effective approach to the procurement, commissioning and contract management of goods, services and works.

9.2.2 Quotation and tendering limits for healthcare services and non-healthcare goods, services and works are set out in the Procurement Policy.

9.2.3 The waiving of competitive tendering procedures should be avoided and only utilised in line with the exemptions provided for in the Procurement Policy. Approval of requests for Competition Waivers shall be in accordance with the Scheme of Reservation and Delegation. All competition waivers are required to be reported retrospectively to the Audit and Risk Committee for scrutiny and review.

9.3 Contract variations and extensions

9.3.1 All extensions and variations to existing contracts must be reviewed to confirm that they are legally possible they represent best value for money, including financial and non-financial aspects, and they are not being instigated solely to avoid or delay the requirement to conduct procurement.

9.3.2 Extensions to existing contracts can only be approved where the terms and conditions of the contract make provision for an extension and contract performance is satisfactory.

9.4 Payment of accounts

9.4.1 The Director of Finance is responsible for ensuring systems are in place for the verification, recording and payment of all accounts payable by the ICB. Systems will provide for certification that:

(a) Goods have been duly received, examined, are in accordance with specification and order, are satisfactory and that the prices are correct.

(b) Work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used were of the requisite standard and that the charges are correct.

(c) In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, that the rates of labour are in accordance with appropriate rates, and that the materials have been checked regarding quantity, quality and price.

(d) Where appropriate, the expenditure is in accordance with regulations and that all necessary authorisations have been obtained.

(e) The account is arithmetically correct.

9.4.2 The Director of Finance will ensure that appropriate segregation of duties controls are established in relation to revenue and non-pay expenditure.

9.4.3 Officers authorised to approve requisitions and invoices are set out in the Scheme of Reservation and Delegation.

9.4.4 Payments should normally be made by bank credit transfer. Payment by other methods should only occur with the approval of the Director of Finance or nominated officer.

9.4.5 Payment of contract invoices should be in accordance with contract terms. All payments should comply with the Government's policy on prompt payment.

9.5 Prepayments

9.5.1 Prepayments which fall outside of normal business practice (advance payments) are only permitted in exceptional circumstances and require the approval of the Director of Finance. In such instances:

(a) The financial advantages must outweigh the disadvantages.

(b) The appropriate Budget Holder must provide a case setting out all relevant circumstances of the purchase. This must set out the effects on the ICB if the supplier is, at some time during the course of the advance payment agreement, unable to meet their commitments.

(c) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed.

(d) The Budget Holder is responsible for ensuring that all items due under an advance payment contract are received and must immediately inform the Director of Finance if problems are encountered.

10. Capital investments, asset management and property leases

10.1 Capital investment

10.1.1 For any capital investments made by the ICB, the Director of Finance is responsible for:

(a) Ensuring that there is an effective appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans.

(b) Ensuring that processes require a business case to be produced for every capital expenditure proposal, which includes evidence of availability of resources to finance all revenue consequences.

(c) Ensuring that there are processes in place for the management of all stages of capital schemes to ensure that schemes are delivered on time and to cost.

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

(a) Authority to spend capital or make a capital grant.

(b) Authority to enter leasing arrangements.

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

10.1.4 Approval requirements regarding capital investments are set out within the ICB's Scheme of Reservation and Delegation.

10.2 Asset management

10.2.1 The Director of Finance is responsible for ensuring the ICB has effective procedures in place regarding the management of assets.

10.2.2 Any capital assets held by the ICB will be recorded on an asset register, with physical checks of assets against the register to be conducted periodically.

10.2.3 Disposals of any surplus assets should be:

(a) Supported by an appraisal of the options and benefits of the disposal in the context of the wider public sector and to secure value for money.

(b) Made in line with any relevant published guidance.

10.3 Property leases

10.3.1 The Director of Finance is responsible for ensuring that the ICB has effective procedures in place regarding property leases.

10.3.2 Approval requirements regarding lease matters are set out within the ICB's Scheme of Reservation and Delegation.

11. Financial systems

11.1 General

11.1.1 The Director of Finance will ensure the ICB has suitable financial and other software to enable the production of management and financial accounts and to meet the consolidation requirements of NHS England.

11.1.2 NHS Shared Business Services provides and operates the ICB's financial ledger, known as 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.

11.1.3 The Director of Finance will:

(a) Satisfy themselves that access to financial systems is strictly controlled and delegated authorities within system approved limits are appropriately assigned.

(b) Ensure that transacting is carried out efficiently in line with current best practice (e.g. e-invoicing).

(c) Ensure that contracts for computer services for financial applications with another health organisation or any other agency clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. Contracts will also ensure rights of access for audit purposes.

(d) Periodically seek assurances that adequate controls are in operation where another health organisation or any other agency provides a computer service for financial applications.

12. Losses and special payments

12.1 General

12.1.1 The requirements set out within these Standing Financial Instructions reflect ICB Losses and Special Payments Guidance issued by NHS England, which contains further detailed operational guidance on losses and special payments.

12.1.2 Losses and special payments are items that parliament would not have contemplated when it agreed funds for NHS bodies or passed legislation. By their nature, they are items that ideally should not arise. They are, therefore, subject to special control procedures compared to the generality of payments and require special notation in the accounts to bring them to the attention of parliament.

12.1.3 HM Treasury retains the authority to approve losses and special payments which are classified as being either:

(a) Novel or contentious.

(b) Contains lessons that could be of interest to the wider community.

(c) Involves important questions of principle.

(d) Might create a precedent.

(e) Highlights the ineffectiveness of the existing control systems.

12.1.4 Therefore, 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.

12.1.5 Therefore, all cases relating to ICB losses and special payments must be submitted to NHS England for approval if the proposed transaction values exceed the delegated limits set out below or satisfy the conditions in section 12.1.2:

Expenditure type	ICB delegated limit
All losses	Up to £300,000
Special payments, including extra contractual / statutory / regulatory / compensation and ex-gratia	Up to £95,000
Special severance and retention payments	£0
Consolatory payments	£500

12.1.6 NHS England has the statutory power to require an ICB 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.

12.1.7 The Director of Finance will support a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and processes are in place to minimise risks from losses and special payments. All losses and special payments should be reported to the Director of Finance.

12.2 Losses

12.2.1 Losses refer to any case where full value has not been obtained for money or spent or committed. Managing Public Money defines losses as including, but not limited to:

(a) Cash losses (physical loss of cash and its equivalents, e.g. credit cards, electronic transfers).

(b) Bookkeeping losses (including missing items or inexplicable or erroneous debit balances).

(c) Exchange rate fluctuations.

(d) Losses of pay, allowances and superannuation benefits paid to employees (including overpayments due to miscalculation, misinterpretation or missing information; unauthorised issue; and other causes).

(e) Losses arising from overpayments.

(f) Losses from failure to make adequate charges.

(g) Losses of accountable stores (through fraud, theft, arson, other deliberate act or other cause).

(h) Fruitless payments and constructive losses.

(i) Claims waived or abandoned (including bad debts).

12.2.2 Losses that are subject to insurance cover should be accounted for on a net basis (i.e. after any insurance pay out).

12.2.3 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their Director, who must immediately inform the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Director of Finance and/or Chief Executive. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies, which may indicate fraud or corruption, the Director of Finance must inform the ICB's Local Counter Fraud Specialist.

12.2.4 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must immediately notify the Board and the external auditor.

12.2.5 The Director of Finance is authorised to take any necessary steps to safeguard the ICB's interests in bankruptcies and company liquidations.

12.2.6 For any loss, the Director of Finance should consider whether any insurance claim could be made.

12.3 Special payments

12.3.1 Managing Public Money defines special payments as:

(a) Extra-contractual payments: payments which, though not legally due under contract, appear to place an obligation on a public sector organisation which the courts might uphold. Typically, these arise from the organisation's action or inaction in relation to a contract. Payments may be extra-contractual even where there is some doubt about the organisation's liability to pay, e.g. where the contract provides for arbitration, but a settlement is reached without it. A payment made as a result of an arbitration award is contractual.

(b) Extra-statutory and extra-regulatory payments: are within the broad intention of the statute or regulation, respectively, but go beyond a strict interpretation of its terms.

(c) Compensation payments: are made to provide redress for personal injuries (except for payments under the Civil Service Injury Benefits Scheme), traffic accidents, and damage to property etc. They include other payments to those in the public service outside statutory schemes or outside contracts.

(d) Special severance payments: are paid to employees, contractors and others outside of normal statutory or contractual requirements when leaving employment in public service whether they resign, are dismissed or reach an agreed termination of contract.

(e) Ex gratia payments: go beyond statutory cover, legal liability, or administrative rules, including payments made to meet hardship caused by official failure or delay; out of court settlements to avoid legal action on grounds of official inadequacy; and payments to contractors outside a binding contract, e.g. on grounds of hardship.

12.3.2 The ICB will work with NHS England to ensure there is assurance over all exit packages, which may include special severance payments.

12.3.3 The ICB has no delegated authority for special severance payments and will refer to the guidance on that to obtain the approval of such payments.

12.3.4 All special severance payments must be reported to the Remuneration Committee.

12.3.5 The Director of Finance is responsible for ensuring an annual assurance statement is submitted to NHS England that confirms:

(a) Details of all exit packages (including special severance payments) that have been agreed and/or made during the year.

(b) That NHS England and HM Treasury approvals have been obtained (in relation to non-contractual pay elements or amounts that exceed the ICB delegated limits) before any offers, whether verbally or in writing, are made.

(c) Adherence to the special severance payments guidance as published by NHS England.

12.4 Losses and special payments register

12.4.1 The Director of Finance is responsible for ensuring that a losses and special payments register is maintained in which write-off action is recorded.

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

13. Annual reporting and accounts

13.1 Accounts

13.1.1 The ICB must keep proper records in relation to its accounts.

13.1.2 The Director of Finance, on behalf of the Chief Executive and the Board, will ensure that:

(a) Annual accounts are prepared in respect of each financial year (or for such periods as may be set out in directions issued by NHS England).

(b) The form and content of the annual accounts and the methods and principles for preparing them comply with any directions issued by NHS England.

(c) The unaudited and audited annual accounts are sent to NHS England by the date specified in any directions issued by NHS England.

13.2 Annual report

13.2.1 The ICB must prepare an annual report that describes how it has discharged its functions in the previous financial year. NHS England may give directions to the ICB as to the form and content of the annual report.

13.2.2 The annual report must explain how the ICB has:

(a) Discharged its general duties in relation to improving the quality of services, reducing inequalities, promoting the involvement of patients, enabling patient choice, obtaining appropriate advice, promoting innovation, research, education and training and integration, having regard to the wider effect of decisions and to climate change, public involvement and consultation, and keeping the experience of Board members under review.

(b) Exercised its functions in accordance with its published five-year forward plan and capital resource use plan.

(c) Exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised).

(d) Taken steps to implement its joint local health and wellbeing strategies. In producing this section of the annual report, the ICB must consult each relevant Health and Wellbeing Board.

13.2.3 The annual report must also include:

(a) A statement of the amount of expenditure incurred by the ICB during the financial year in relation to mental health.

(b) A calculation of the proportion of the expenditure incurred by the ICB during the financial year that relates to mental health.

(c) An explanation of the statement and calculation.

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

13.3 Approval and publication

13.3.1 The Audit and Risk Committee will approve the annual report and accounts, on behalf of the Board.

13.3.2 The ICB must publish a copy of its annual report and accounts.

14. Legal and insurance

14.1 Legal

14.1.1 The Chief Executive is responsible for ensuring appropriate arrangements are in place for accessing external legal advice on matters relating to the delivery of the organisation's functions and duties or potential litigations.

14.1.2 A procedure will be established to control access to and expenditure on external legal advice, and to ensure that advice is centrally held to ensure its ongoing availability and benefit to the ICB.

14.1.3 Only the Chief Executive and Director of Finance are authorised to commit or spend ICB revenue resources in relation to settling legal matters.

14.1.4 Arrangements regarding the execution of legal documents by signature are set out in the ICB's Standing Orders.

14.2 Insurance

14.2.1 Where the ICB uses the risk pooling schemes administered by NHS Resolution (for clinical, property and/or employers/third party liability), the Director of Finance is responsible for ensuring that the arrangements entered into are appropriate and that appropriate systems are in place regarding the management of claims.

14.2.2 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, three exceptions when ICBs may enter into insurance arrangements with commercial insurers. The exceptions are:

(a) Commercial arrangements for insuring motor vehicles owned or leased by the ICB including insuring third party liability arising from their use.

(b) Where the CCG is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into.

(c) Where income generation activities take place these should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the ICB for NHS purposes, the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from NHS Resolution. In any case of doubt concerning the ICB's powers to enter into commercial insurance arrangements, the Director of Finance should consult NHS England.

Appendix E

Annex B: Scheme of Reservation and Delegation

Version	Effective Date	Changes
1.0	1 July 2022	First version Scheme of Reservation and Delegation on establishment of the ICB.

Contents

1. Introduction

1.1 General

1.1.1 The NHS Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022 ("**the 2006 Act**") sets out the statutory framework in which the Integrated Care Board ("**the ICB**") operates. The ICB's statutory powers, functions and duties are conferred, in the main, by the 2006 Act; however, additional responsibilities for other functions may be conferred through delegation to the ICB from other bodies (such as NHS England or other ICBs).

1.1.2 The Board can delegate functions and decisions to a committee or sub-committee of the Board. The committees and sub-committees established for this purpose are:

(a) Audit and Risk Committee

(b) Remuneration Committee, which has established a Human Resources Sub-Committee

(c) Quality and People Committee

(d) Finance and Performance Committee

(e) Strategic Planning and Integration Committee, which has established a Primary Care Contracting Sub-Committee

(f) Auditor Panel

(g) Non-Executive Director Remuneration Panel

1.1.3 The Board can also delegate functions and decisions to an individual member of the Board or an employee.

1.1.4 ICBs can agree with certain other statutory organisations (such as NHS trusts/foundation trusts and local authorities) that they will exercise their functions on behalf of the ICB or jointly with the ICB. This power is governed by secondary legislation and by NHS England statutory guidance.

1.1.5 The default arrangement is that functions will be exercised by the ICB unless they are explicitly delegated.

1.1.6 The ICB, regardless of any delegation arrangements it has made, remains legally accountable for the exercise of its functions.

1.1.7 This Scheme of Reservation and Delegation sets out for NHS Nottingham and Nottinghamshire ICB which functions, duties and powers (including those delegated to it by other bodies) are:

(a) Reserved to the Board, so that only the Board may make these decisions.

(b) Delegated to committees and sub-committees that have been established by the Board.

(c) Delegated to individuals (Board members or ICB employees).

(d) Delegated to other statutory bodies using the ICB's legal powers (under sections 65Z5, 65Z6 and 75 of the 2006 Act) to delegate functions to one or more other organisations or to a joint committee with one or more other organisations.

1.1.8 In line with the ICB's Standing Orders, the powers that are reserved or delegated to the Board, may for an urgent decision be exercised by the Chair and Chief Executive subject to every effort having made to consult with as many members of the Board as possible in the given circumstances.

1.1.9 Where authority is delegated to executive members of the Board, they may, in certain circumstances, decide to further delegate the authority. The ICB's lead for governance shall be notified in writing in all instances where authority is further delegated.

1.1.10 Should any difficulties arise regarding the interpretation or application of any of the Scheme of Reservation and Delegation then the advice of the ICB's lead for governance must be sought before acting. The users of this Scheme of Reservation and Delegation should also be familiar with and comply with the provisions of the ICB's Constitution, Standing Orders and Standing Financial Instructions.

1.2 Non-compliance with Scheme of Reservation and Delegation

1.2.1 All members of the Board, its committees and sub-committees, and the ICB's employees and other workers are required to comply with this Scheme of Reservation and Delegation.

1.2.2 Failure to comply with this Scheme of Reservation and Delegation may be regarded as a disciplinary matter that could result in dismissal.

1.2.3 If for any reason this Scheme of Reservation and Delegation is not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit and Risk Committee. All individuals as defined at 1.2.1 have a duty to disclose any non-compliance with this Scheme of Reservation and Delegation to the Chief Executive as soon as possible. If the Chief Executive is responsible for the non-compliance, then this should instead be reported to the ICB's lead for governance.

1.3 Review and amendment of Scheme of Reservation and Delegation

1.3.1 To ensure that this Scheme of Reservation and Delegation remain up-to-date and relevant, the ICB's lead for governance will ensure that it reflects any variations made to the ICB's Constitution, Standing Orders and Standing Financial Instructions, and any delegations made by the Board, on an ongoing basis and at least annually to ensure it continues to support effective decision-making.

1.3.2 The Board will approve all amendments to the Scheme of Reservation and Delegation.

2. Matters reserved by the Board and delegated by the Board to its committees and sub-committees

Ref.	Reserved/delegated matter	Delegated to	Additional information	Reference
2.1	Review of all instances of non-compliance with Standing Orders.	Audit and Risk Committee	-	SO 3.1.6
2.2	Review of all decisions made by the Chair and Chief Executive on behalf of the Board under emergency powers.	Audit and Risk Committee	-	SO 4.9.6
2.3	Review of all instances where Standing Orders are suspended.	Audit and Risk Committee	-	SO 5.1.3
2.4	Review of all instances of non-compliance with Standing Financial Instructions.	Audit and Risk Committee	-	SFI 1.2.2
2.5	Approve arrangements for the provision of internal audit services.	Audit and Risk Committee	Arrangements to be proposed by the Director of Finance who will commission the procurement of internal audit services.	SFI 3.1.2 and 3.1.3
2.6	Approve arrangements for the provision of counter fraud, bribery and corruption services.	Audit and Risk Committee	The Director of Finance will commission the procurement of counter fraud, bribery and corruption services.	SFI 4.1.3
2.7	Approve the use of procurement or other card services by the ICB, including:	Audit and Risk Committee	See SoRD ref 5.9 for delegated financial limits.	SFI 6.2.1

Ref.	Reserved/delegated matter	Delegated to	Additional information	Reference
	• The types of card services that should be allowed on each account (debit, procurement, etc.). • The types of transactions that should be permitted on each card. • The individuals who should be issued with a card. The overall credit and individual transaction limits to be associated with each card.			
2.8	Review all instances where competitive tendering requirements have been waived.	Audit and Risk Committee	-	SFI 9.2.5
2.9	Approve the Annual Report and Accounts.	Audit and Risk Committee	To be prepared in line with legal requirements and any directions issued by NHS England. The Annual Report and Accounts must be published.	SFI 13.3.1 and 13.3.2
2.10	Approve the Policy for the Development and Management of Policy Documents (Policy on Policies).	Audit and Risk Committee	-	-
2.11	Approve the Statutory and Mandatory Training Policy.	Audit and Risk Committee	-	-
2.12	Approve Fraud, Bribery and Corruption Policy.	Audit and Risk Committee	-	-
2.13	Approve the ICB's information governance policies, including (but not limited to): • Information Governance Management Framework. • Confidentiality and Data Protection Policy.	Audit and Risk Committee	-	-

Ref.	Reserved/delegated matter	Delegated to	Additional information	Reference
	• Information Security Policy. • Internet and Email Policy. • Data Quality Policy. • Records Management Policy. • Freedom of Information (FOI) and Environmental Information Regulations (EIR) Policy.			
2.14	Approve to ICB's health and safety policies, including (but not limited to): • Health, Safety and Security Policy. • Fire Safety Policy. • Display Screen Equipment Use Policy.	Audit and Risk Committee	-	-
2.15	Approve Incident Reporting and Management Policy.	Audit and Risk Committee	-	-
2.16	Approve Emergency Preparedness, Resilience and Response (EPRR) Policy.	Audit and Risk Committee	-	-
2.17	Review of all instances of non-compliance with Scheme of Reservation and Delegation.	Audit and Risk Committee	-	SoRD 1.2.3
2.18	Endorse applications to NHS England to vary the ICB's Constitution.	Board	Formal approval required by NHS England before variations can be implemented.	Constitution, paragraph 1.6.2

Ref.	Reserved/delegated matter	Delegated to	Additional information	Reference
2.19	Endorse applications to NHS England to vary the ICB's Standing Orders.	Board	Formal approval required by NHS England before variations can be implemented.	Constitution, paragraph 1.6.2 and SO 2.1.3
2.20	Approve the Standing Financial Instructions.	Board	Following review and scrutiny by the Audit and Risk Committee	Constitution, section 1.7 and SFI 1.3.2
2.21	Approve the Scheme of Reservation and Delegation.	Board	Amendments to the SoRD to be proposed by the Chair or Chief Executive.	Constitution, paragraph 4.4.2
2.22	Review the skills, knowledge and experience of Board members (when taken together) to ensure the Board can effectively carry out its functions.	Board	-	Constitution, paragraph 2.2.5
2.23	Appoint committees of the Board, including agreement of their terms of reference.	Board	See also 3.8 of this SoRD regarding the appointment of individuals as members of committees of the Board that exercise ICB commissioning functions.	Constitution, paragraph 4.6.1
2.24	Appoint sub-committees of the Board, including agreement of their terms of reference.	Board or	Any powers to established sub-committees will be included within the relevant committees' terms of reference.	Constitution, paragraph 4.6.1

Ref.	Reserved/delegated matter	Delegated to	Additional information	Reference
		Committees of the Board, if empowered to do so by the Board	See also 3.8 of this SoRD regarding the appointment of individuals as members of sub-committees of the Board that exercise ICB commissioning functions.	
2.25	Set the vision and values for the ICB.	Board	-	-
2.26	Approve arrangements for ICB functions to be exercised by or jointly with any one or more other body as defined by the 2006 Act (another ICB, an NHS trust, an NHS foundation trust, NHS England, a local authority, combined authority or any other prescribed body) under section 65Z5 of the NHS Act 2006 (as amended).	Board	To include establishment of: • Joint committees to exercise the delegated functions; and/or • Pooled funds to fund the delegated functions (section 65Z6) Delegations will be subject to regulations.	Constitution, paragraph 4.3.2, 4.3.3 and 4.7.3
2.27	Approve arrangements for the ICB to enter into partnership arrangements with a local authority under section 75 of the 2006 Act (as amended), under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions.	Board	To include the establishment of pooled funds.	Constitution, paragraph 4.3.2 and 4.3.3
2.28	Approve the Standards of Business Conduct Policy, which incorporates the policy and procedures for the identification and management of conflicts of interest.	Board	-	Constitution, paragraph 6.1.2

Ref.	Reserved/delegated matter	Delegated to	Additional information	Reference
2.29	Appoint the Conflicts of Interest Guardian.	Board	To be a Non-Executive member.	Constitution, paragraph 6.1.6
2.30	Determine remuneration and allowances (including pension schemes) and terms and conditions for employees.	Board	Satisfied via approval of SFIs, which stipulate that the NHS Agenda for Change terms and conditions of service will apply in full to all staff directly employed by the ICB, except for Executive Directors and other very senior managers.	Constitution, paragraph 8.1.1 and SFI 8.3.2
2.31	Approve the Policy for Public Involvement and Engagement.	Board	-	Constitution, paragraph 9.1.5(c)
2.32	Appoint the external auditor.	Board	The Auditor Panel will advise the Board on the selection and appointment process in line with the Local audit and Accountability Act 2014. The Director of Finance will commission the procurement of external audit services.	SFI 3.2.1 and 3.2.2

Ref.	Reserved/delegated matter	Delegated to	Additional information	Reference
2.33	Approve the joint forward plan (and any revised plans) setting out how the ICB will exercise its functions over the next five years.	Board	Plans must be prepared with the ICB's partner NHS trusts and NHS foundation trusts in line with any directions or guidance issued by NHS England. Plans must be published and provided to the Integrated Care Partnership, each relevant Health and Wellbeing Board and NHS England.	SFI 5.2.1 and 5.2.3
2.34	Approve the joint capital resource use plan (and any revised plans).	Board	Plans must be prepared with the ICB's partner NHS trusts and NHS foundation trusts in line with any directions or guidance issued by NHS England. Plans must be published and provided to the Integrated Care Partnership, each relevant Health and Wellbeing Board and NHS England.	SFI 5.2.2 and 5.2.3
2.35	Approve the annual budgets.	Board	The annual budgets will be prepared within the limits of available funds and will identify	SFI 5.3.1

Ref.	Reserved/delegated matter	Delegated to	Additional information	Reference
			any sums to be held in reserve and any potential risks.	
2.36	Approve the Risk Management Policy.	Board	-	-
2.37	Approve the Equality, Diversity and Inclusion (EDI) Policy.	Board	-	-
2.38	Appoint Wellbeing Guardian.	Board	To be a Non-Executive member.	-
2.39	Appoint Non-Executive Lead for Freedom to Speak Up.	Board	To be a Non-Executive member.	-
2.40	Appoint Non-Executive Lead for EPRR.	Board	To be a Non-Executive member.	-
2.41	Approve the Freedom to Speak Up Policy.	Board	-	-
2.42	Approve ICB capital investments.	Finance and Performance Committee	-	SFI 10.1.4
2.43	Approve the estates plan for the GP practices within the ICB's area.	Finance and Performance Committee	In line with the Primary Medical Services Delegation Agreement	-
2.44	Make decisions in relation to the Premises Costs Directions Functions.	Finance and Performance Committee	In line with the Primary Medical Services Delegation Agreement	-
2.45	Approve ICB headquarters estate and lease arrangements	Finance and Performance Committee	-	-

Ref.	Reserved/delegated matter	Delegated to	Additional information	Reference
2.46	Approve the ICB's human resources policies, including (but not limited to): • Sickness Absence Policy. • Change Management Policy. • Disciplinary Policy. • Family Leave Policy. • Grievance Policy. • Leave Policy. • Staff Appraisal Policy. • Acceptable Behaviours Policy. • Long Service Award Policy. • Flexible Working Policy. • Professional Registration Policy. • Capability Policy. • Recruitment and Selection Policy. • Agile Working Policy. • Domestic Violence and Abuse Policy.	Human Resources Sub-Committee	-	-
2.47	Make decisions in relation to Individual Funding Requests	Individual Funding Request Panel	In line with the ICB's Individual Funding Request Policy	-
2.48	Approve policies, procedures and position statements regarding medicines management issues and pharmacy development.	Medicines Optimisation Group	-	-

Ref.	Reserved/delegated matter	Delegated to	Additional information	Reference
2.49	Formulate and agree a stance or consensus on health community wide prescribing and medicines management issues.	Medicines Optimisation Group	-	-
2.50	Make decisions in relation to mental health and learning disability funding requests	Mental Health and Learning Disability Specialist Treatment/Funding Panel	Terms of reference for the panel approved by the Strategic Planning and Integration Committee	-
2.51	Approve the remuneration, allowances and terms of appointment for Non-Executive members of the Board.	Non-Executive Director Remuneration Panel	The Chair's remuneration will be approved by NHS England.	Constitution, paragraph 3.16.1 and 3.16.3
2.52	Make decisions in relation to any discretionary payments or discretionary support to be made to providers of primary medical services.	Primary Care Contracting Sub-Committee	In line with the Primary Medical Services Delegation Agreement	-
2.53	Make decisions in relation to the award of new primary medical services contracts.	Primary Care Contracting Sub-Committee	In line with the Primary Medical Services Delegation Agreement (including specified decision-making limits for the ICB)	-
2.54	Make decisions in relation to mergers and closures of primary medical services providers.	Primary Care Contracting Sub-Committee	In line with the Primary Medical Services Delegation Agreement	-

Ref.	Reserved/delegated matter	Delegated to	Additional information	Reference
2.55	Make decisions in relation to dispersing the patient lists of primary medical services providers.	Primary Care Contracting Sub-Committee	In line with the Primary Medical Services Delegation Agreement	-
2.56	Make decisions in relation to variations to the boundaries of primary medical services providers	Primary Care Contracting Sub-Committee	In line with the Primary Medical Services Delegation Agreement	-
2.57	Make decisions in relation to the management of poorly performing PMS providers	Primary Care Contracting Sub-Committee	In line with the Primary Medical Services Delegation Agreement	-
2.58	Approve the Complaints, Concerns and Enquiries Policy.	Quality and People Committee	-	-
2.59	Approve the ICB's safeguarding policies, including (but not limited to: • Safeguarding Policy (inc. PREVENT and Safeguarding Training and Supervision Strategy). • Safeguarding Children and Adults Policy. • Mental Capacity Act 2005 Policy. Managing Allegations at Work Policy.	Quality and People Committee	-	-
2.60	Approve the remuneration, allowances and terms of appointment for: • Members of the Board, except for the Chair and Non-Executive members. • Any members of the Board's committees and sub-committees that are not members of the Board or employees.	Remuneration Committee	-	Constitution, paragraph 3.16.1, 3.16.2 and 8.1.2 and SFI 8.1.1

Ref.	Reserved/delegated matter	Delegated to	Additional information	Reference
	• Other very senior managers. • Individuals engaged on a contract for service.			
2.62	Approve exit payments, other than special severance payments.	Remuneration Committee	In line with national guidance and seeking HM Treasury pre-approval if required	-
2.63	Approve the Procurement Policy.	Strategic Planning and Integration Committee	-	-
2.64	Approve the ICB's commissioning policies, including (but not limited to): • Policy for Individual Funding Requests (IFRs). • Adults Continuing Healthcare Policy. • Children and Young People Continuing Care Policy. • After Care Policy. • Personal Health Budgets Policy. • Service Restriction Policy. • Policies relating to tertiary infertility (IVF/ICSI), secondary infertility (IUI/DI), surrogacy and gamete cryopreservation.	Strategic Planning and Integration Committee	-	-
2.65	Approve the design of any enhanced services and local incentive schemes.	Strategic Planning and Integration Committee	In line with the Primary Medical Services Delegation Agreement	-

Ref.	Reserved/delegated matter	Delegated to	Additional information	Reference
2.66	Make decisions in relation to urgent care services for out of area registered patients.	Strategic Planning and Integration Committee	In line with the Primary Medical Services Delegation Agreement	-
2.67	Approve the establishment of any new primary medical services providers in the area.	Strategic Planning and Integration Committee	In line with the Primary Medical Services Delegation Agreement	-

3. Matters delegated to individuals

Ref.	Reserved/delegated matter	Delegated to	Additional information	Reference
3.1	Approval of new GP Retention Scheme applications and renewals.	Associate Director of Primary Care	Following Primary Care Finance Team confirmation of funding availability.	-
3.2	Assign Budget Manager responsibilities.	Budget Holders	A list of designated Budget Holders is maintained by the Finance Directorate	SFI 5.4.2
3.3	Approve requests for evaluations of pay bandings for new or existing posts.	Budget Holders	Budget Holders are defined as Executive Directors	SFI 8.3.4
3.4	Appoint Deputy Caldicott Guardian.	Caldicott Guardian	-	-
3.5	Ensure that at least one Board member has knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.	Chair	-	Constitution, paragraph 2.2.4
3.6	Approve the appointments, and re-appointments where relevant, of all Ordinary Members of the Board.	Chair	The Chair is appointed by NHS England, subject to approval by the Secretary of State for Health and Social Care The Chief Executive is appointed by the Chair, subject to approval by NHS England.	Constitution, paragraphs 3.5.5(c), 3.6.5(c), 3.7.5(c), 3.8.2, 3.9.3, 3.10.3, 3.11.3, 3.12.3

Ref.	Reserved/delegated matter	Delegated to	Additional information	Reference
3.7	Appoint a Non-Executive member of the Board as Vice-Chair.	Chair	-	Constitution, paragraph 3.13.1
3.8	Approve the appointment of all individuals as members of committees and sub-committees of the Board that exercise ICB commissioning functions.	Chair	The Chair will not approve an individual to such a committee or sub-committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the individual's involvement with the private healthcare sector or otherwise.	Constitution, paragraph 4.6.6
3.9	Decision to suspend Standing Orders.	Chair or Person presiding over a meeting of the Board	A majority of Board members present at the meeting, including at least one executive member and one non-executive member, must be in favour of suspension.	SO 5.1.1
3.10	Appoint an Executive member of the Board as Deputy Chief Executive.	Chief Executive	-	Constitution, paragraph 3.14.1

Ref.	Reserved/delegated matter	Delegated to	Additional information	Reference
3.11	Execution of a document by seal.	Chief Executive or Director of Finance	-	SO 6.1.3
3.12	Execution of a document by signature.	Chief Executive or Director of Finance	Where the document is a necessary step in legal proceedings on behalf of the ICB.	SO 6.2.1
3.13	Assign Budget Holder responsibilities.	Chief Executive	A list of designated Budget Holders is maintained by the Finance Directorate	SFI 5.4.1
3.14	Approve variations to the funded establishment of any Directorate.	Chief Executive	Or by officers nominated by the Chief Executive.	SFI 8.2.2
3.15	Commit or spend revenue resources in relation to settling legal matters.	Chief Executive or Director of Finance	-	SFI 14.1.3
3.16	Appoint Accountable Emergency Officer (AEO).	Chief Executive	To be an Executive Director.	-
3.17	Appoint the Senior Information Risk Owner (SIRO).	Chief Executive	To be an Executive Director.	-
3.18	Appoint the Caldicott Guardian.	Chief Executive	To be an Executive Director.	-
3.19	Appoint the Data Protection Officer.	Chief Executive	-	-
3.20	Appoint Net Zero Lead.	Chief Executive	To be an Executive Director.	-

Ref.	Reserved/delegated matter	Delegated to	Additional information	Reference
3.21	Approve the ICB's banking arrangements.	Director of Finance	-	SFI 6.1.1
3.22	Approve designated bank account signatories.	Director of Finance	A list of designated bank account signatories is maintained by the Finance Directorate	SFI 6.1.5
3.23	Approve payment mechanisms other than by bank credit transfer.	Director of Finance	Or by officers nominated by the Director of Finance.	SFI 9.4.4
3.24	Approve of prepayments that fall outside of normal business practice (advance payments).	Director of Finance	Only permitted in exceptional circumstances.	SFI 9.5.1
3.25	Establish and maintain a register of the interests of Board members, committee and sub-committee members and employees (including individuals contracted to work on behalf of the ICB or otherwise providing services or facilities to the ICB)	Director of Nursing	The register of declared interests must be published.	Constitution, paragraph 6.3.1
3.26	Approve payroll transactions, including new starters (and salary justifications where relevant), changes in circumstances and terminations.	Executive Directors (including the Chief Executive) and Members of the Senior Leadership Team	Senior Leadership Team members are defined as postholders that report directly to the Executive Directors A list of payroll signatories is maintained by the Human Resources Team.	SFI 8.4.2

Ref.	Reserved/delegated matter	Delegated to	Additional information	Reference
3.27	Make urgent financial decisions relating to the ICB within the ICB unit of planning and other NHS organisations within the health community as appropriate during a major incident.	Gold On Call Silver On Call	The Department of Health and Social Care defines a major incident as an event or a situation which threatens serious damage to human welfare in a place in the UK, the environment of a place in the UK, or war or terrorism which threatens serious damage to the security of the UK.	-
3.28	Appoint the Deputy SIRO.	SIRO	-	-
3.29	Appoint Information Asset Owners.	SIRO	-	-

4. Functions and decisions delegated to other statutory bodies or to be exercised jointly

Ref.	Delegated matter	Delegated to	Additional information
4.1	**Agreement between Nottingham and Nottinghamshire ICB and Nottinghamshire County Council relating to the commissioning of health and social care services within the Nottinghamshire County Better Care Fund:** a) Exercise NHS functions to the extent necessary for the purposes of performing the obligations under the Agreement and management of the Nottinghamshire Better Care Pooled Fund. b) Decisions relating to the Nottinghamshire Better Care Fund Plan.	a) Nottinghamshire County Council b) Nottinghamshire County Health and Wellbeing Board	Agreement under section 75 of the NHS Act 2006 (as amended)
4.2	**Agreement between Nottingham and Nottinghamshire ICB and Nottingham City Council relating to the commissioning of health and social care services within the Nottingham City Better Care Fund:** a) Exercise NHS functions to the extent necessary for the purposes of performing the obligations under the Agreement and management of the Nottingham City Better Care Pooled Fund. b) Decisions relating to the Nottingham City Better Care Fund Plan.	a) Nottingham City Council b) Nottingham City Health and Wellbeing Board	Agreement under section 75 of the NHS Act 2006 (as amended)
4.3	**Agreement for the integration and provision of Integrated Community Equipment Loan Services:** a) Exercise NHS functions to the extent necessary for the purposes of performing the obligations under the Agreement. b) Commissioning, procurement and management of the Integrated Community Equipment Loan Services (ICELS) and management of the ICELS pooled fund and the purchasing of medical/nursing equipment.	Nottinghamshire County Council	Agreement under section 75 of the NHS Act 2006 (as amended) Decisions around significant contract variations are delegated to the ICELS Partnership Board

Ref.	Delegated matter	Delegated to	Additional information
4.4	**Agreement for the funding and management of Sexual Violence Hub and Therapy Support Service, Independent Sexual Violence Support Service (including the Survivor Support Service) and Sexual Violence Engagement Manager in Nottinghamshire:** a) Commissioning, procurement and management of sexual violence support services.	Police and Crime Commissioner for Nottinghamshire	Agreement under section 75 of the NHS Act 2006 (as amended)
4.5	**Agreement for the communication aids panel and purchasing of equipment (Children's specialist communication aids):** a) Exercise NHS functions to the extent necessary for the purposes of performing the obligations under the Agreement. b) Act as lead commissioner for the service. c) Management of the pooled fund.	Nottinghamshire County Council	Agreement under section 75 of the NHS Act 2006 (as amended)
4.6	**Community Infection Prevention Service for Nottinghamshire County:** a) Exercise NHS functions to the extent necessary for the purposes of performing the obligations under the Agreement. b) Act as lead commissioner for the service. c) Management of the pooled fund.	Nottinghamshire County Council	Agreement under section 75 of the NHS Act 2006 (as amended)

5. Delegated financial limits

5.1 Healthcare services – Resource allocations (approval of investment business cases)

Annual value (£)	Delegated to	Additional information	Reference
Up to £100,000	Director of Finance Director of Integration Director of Nursing Medical Director	Retrospectively reported to Strategic Planning and Integration Committee Decisions that are considered to set precedent, or are novel, contentious or repercussive in nature can be escalated to the Strategic Planning and Integration Committee	SFI 9.1
Up to £500,000	Chief Executive (or Deputy Chief Executive in their absence)	Retrospectively reported to Strategic Planning and Integration Committee Decisions that are considered to set precedent, or are novel, contentious or repercussive in nature can be escalated to the Strategic Planning and Integration Committee	SFI 9.1
£500,001 to £5,000,000, or where proposals below this value are considered to set precedent, or are novel, contentious or repercussive in nature	Strategic Planning and Integration Committee	Decisions that are considered to set precedent, or are novel, contentious or repercussive in nature can be escalated to the Board	SFI 9.1
£5,000,001 and above, or where proposals below this value are considered to set precedent, or are novel, contentious or repercussive in nature	Board	-	SFI 9.1

5.2 Healthcare services – Resource allocations (approval of disinvestment business cases)

Annual value (£)	Delegated to	Additional information	Reference
Up to £100,000	Chief Executive (or Deputy Chief Executive in their absence)	Retrospectively reported to Strategic Planning and Integration Committee Decisions that are considered to set precedent, or are novel, contentious or repercussive in nature can be escalated to the Strategic Planning and Integration Committee	SFI 9.1
£100,001 to £5,000,000 or where proposals below this value are considered to set precedent, or are novel, contentious or repercussive in nature	Strategic Planning and Integration Committee	Decisions that are considered to set precedent, or are novel, contentious or repercussive in nature can be escalated to the Board	SFI 9.1
£5,000,001 and above, or where proposals below this value are considered to set precedent, or are novel, contentious or repercussive in nature	Board		SFI 9.1

5.3 Healthcare services – Authorisation of contract awards

Annual value (£)	Delegated to	Additional information	Reference
Up to £100,000	Director of Finance Director of Integration Director of Nursing Medical Director	Retrospectively reported to Strategic Planning and Integration Committee	SFI 9.2 and 9.3
Up to £500,000	Chief Executive (or Deputy Chief Executive in their absence)	Retrospectively reported to Strategic Planning and Integration Committee	SFI 9.2 and 9.3
£500,001 to £5,000,000	Strategic Planning and Integration Committee	-	SFI 9.2 and 9.3

Annual value (£)	Delegated to	Additional information	Reference
£5,000,001 and above	Board	-	SFI 9.2 and 9.3

5.4 Healthcare services – Approval of individual continuing healthcare packages

Weekly value (£)	Delegated to	Additional information	Reference
Up to £1,500	CAS Team Member (Band 7)	Purchase of patient consumables only	SFI 9.1
Up to £2,000	CHC Team (Band 7)	-	SFI 9.1
Up to £3,000	CHC Team (Band 8a)	-	SFI 9.1
Up to £4,000	CHC Team (Band 8b)	-	SFI 9.1
Up to £5,000	CHC Team (Band 8c)	-	SFI 9.1
£5,001 and above	Director of Nursing Deputy Director of Nursing Operational Director of Finance	-	SFI 9.1

5.5 Healthcare services – Decisions on the use of medicines

Value (£)	Delegated to	Additional information	Reference
Up to £80,000	Area Prescribing Committee (APC)	Decisions will be reviewed through APC Annual Report	-

5.6 Non-healthcare services – Resource allocations (approval of business cases)

Annual value (£)	Delegated to	Additional information	Reference
Up to £100,000	Director of Finance Director of Integration Director of Nursing Medical Director	Retrospectively reported to Finance and Performance Committee Decisions that are considered to set precedent, or are novel, contentious or repercussive in nature can be escalated to the Finance and Performance Committee	SFI 9.1
Up to £500,000	Chief Executive (or Deputy Chief Executive in their absence)	Retrospectively reported to Finance and Performance Committee Decisions that are considered to set precedent, or are novel, contentious or repercussive in nature can be escalated to the Finance and Performance Committee	SFI 9.1
£500,001 and above, or where proposals below this value are considered to set precedent, or are novel, contentious or repercussive in nature	Finance and Performance Committee	-	SFI 9.1

5.7 Non-healthcare services – Authorisation of contract awards

Annual value (£)	Delegated to	Additional information	Reference
Up to £100,000	Director of Finance Director of Integration Director of Nursing Medical Director	Retrospectively reported to Strategic Planning and Integration Committee	SFI 9.2 and 9.3
Up to £500,000	Chief Executive (or Deputy Chief Executive in their absence)	Retrospectively reported to Strategic Planning and Integration Committee	SFI 9.2 and 9.3
£500,001 and above	Finance and Performance Committee		SFI 9.2 and 9.3

5.8 Non-healthcare services – Property leases

Lease matter	Delegated to	Additional information	Reference
ICB Headquarters: • Preparation and signature of tenancy agreements/licenses • Extensions to existing leases • Approval of rent calculation	Chief Executive **and** Director of Finance	-	SFI 10.3
General Practice: • Extensions to existing leases • Approval of rent calculation	Associate Director of Estates **and** Deputy Director of Finance	Value up to £15,000	SFI 10.3
General Practice: • Extensions to existing leases • Approval of rent calculation	Finance and Performance Committee	Value £15,001 and above	SFI 10.3

5.9 Non-healthcare services – Procurement card expenditure

Monthly limit (£)	Delegated to	Additional information	Reference
Up to £5,000	Associate Director of Procurement and Commercial Development	One card issued to named individual. Usage restricted to purchase of goods and services from one-off suppliers who will only provide such goods and services with immediate payment. No facility for cash withdrawals.	SFI 6.2.1

5.10 Authorisation of requisitions and invoices (in Oracle)

In line with budget management responsibilities and subject to procurement requirements.

Invoice/requisition value (£)	Delegated to	Additional information	Reference
Up to £1,000	Heads/Deputy Heads of Service – Band 8b	-	SFI 9.4
Up to £10,000	Individual Packages Manager (CHC) – Band 7 Director of Communications and Engagement Associate Director of Governance Associate Chief Pharmacists	-	SFI 9.4
Up to £25,000	Senior Continuing Healthcare Manager – Band 8a	-	SFI 9.4
Up to £50,000	Contract Managers – Band 7 Head of Continuing Healthcare – Band 8b Director of System Analytics and Intelligence Unit Ageing Well Programme Director – Band 8d	-	SFI 9.4
Up to £100,000	Head of Primary Care Heads of Service – Band 8c Deputy Locality Directors – Band 8c	-	SFI 9.4
Up to £500,000	Senior Contract Managers – Band 8a to Band 8c Assistant Director (CHC) – Band 8c Associate Director of Primary Care Locality Directors Associate Director of Procurement and Commercial Development Head of Primary Care IT Chief Pharmacist	-	SFI 9.4

Invoice/requisition value (£)	Delegated to	Additional information	Reference
Up to £5,000,000	Deputy Director of Nursing Associate Director of Estates Associate Director of Strategic Programmes Associate Director of Workforce Transformation Associate Directors of Commissioning – Band 9	-	SFI 9.4
Up to £20,000,000	Director of Integration Director of Nursing Medical Director Deputy Directors of Finance	-	SFI 9.4
Unlimited	Chief Executive Director of Finance	-	SFI 9.4

5.11 Off-payroll and agency worker appointments

Value (£)	Delegated to	Additional information	Reference
Less than £400 per day and less than three months engagement	Members of the Senior Leadership Team	Senior Leadership Team members are defined as postholders that report directly to the Executive Directors	SFI 8.5
Less than £600 per day and less than six months engagement	Chief Executive Director of Finance Director of Integration Director of Nursing Medical Director	Unless the role is of significant influence (see below)	SFI 8.5
Less than £600 per day and greater than six months (including where initial arrangements were for less than six months and have then been extended to greater than six months)	Human Resources Sub-Committee	Subject to NHS England approval	SFI 8.5

Value (£)	Delegated to	Additional information	Reference
More than £600 per day	Human Resources Sub-Committee	Subject to NHS England approval	SFI 8.5
Role of significant influence	Human Resources Sub-Committee	Subject to NHS England approval	SFI 8.5

5.12 Consultancy spend

Value (£)	Delegated to	Additional information	Reference
Up to £49,999	Chief Executive Director of Finance Director of Integration Director of Nursing Medical Director	-	SFI 8.5
£50,000 and above	Human Resources Sub-Committee	Subject to NHS England approval	SFI 8.5

Appendix F: Organisational policies to be adopted by NHS Nottingham and Nottinghamshire ICB

Policy Ref	Policy Title
Governance Policies (which include risk, probity, mandatory training, information governance and health and safety)	
GOV-001	**Risk Management Policy** *(sets out the arrangements for risk management across the organisation; outlining the organisation's risk appetite and approach to risk tolerance)*
GOV-002	**Standards of Business Conduct Policy** *(sets out the strict ethical standards which are expected of all employees, including for example, the principles for accepting gifts, hospitality and sponsorship. The policy will also set out the organisational requirements regarding conflicts of interest, ensuring all individuals are aware of their responsibilities)*
GOV-003	**Raising Concerns Policy** *(sets out the arrangements in place for employees to raise concerns around but not limited to unsafe working practices, potential environmental problems, fraud, bribery, corruption and bullying)*
GOV-004	**Policy for the Development and Management of Policy Documents (Policy on Policies)** *(outlines the processes in place for the development, approval, implementation and maintenance of all organisational policy documents)*
GOV-005	**Statutory and Mandatory Training Policy** *(sets out the organisation's requirements regarding statutory and mandatory training)*
GOV-006	**Information Governance Management Framework** (outlines the strategic framework for managing the information governance agenda across the organisation)
GOV-007	**Confidentiality and Data Protection Policy** *(sets out how the organisation meets its legal obligations and NHS requirements concerning confidentiality and information security standards)*
GOV-008	**Information Security Policy** *(provides a clear description of the responsibilities in respect of information, information systems and the security of these)*
GOV-009	**Internet and Email Policy** *(sets out the framework for appropriate use of internal and email, as well as consequences for misuse)*
GOV-010	**Data Quality Policy** *(sets out the data quality requirements for maintaining and increasing high levels of data quality)*
GOV-011	**Acceptable Use of the Network Policy** *(The purpose of this policy is to set out the acceptable use of NHS systems, devices, applications)*
GOV-012	**Account Management and Access Policy** *(Sets out clear guidance to prevent and control unauthorised access to the ICB's information systems and the shared network)*
GOV-013	**Removable Media Policy** *(sets out the principles and working practices in order for data to be safely stored and transferred on removable media to ensure that the use of removable media devices is controlled and managed appropriately.)*
GOV-014	**Records Management Policy** *(outlines the framework for managing corporate information in line with records management legislation)*
GOV-015	**Freedom of Information (FOI) and Environmental Information Regulations (EIR) Policy** *(sets out the mechanisms for compliance with legal and regulatory requirements of the FOI Act 2000)*
GOV-016	**Health, Safety and Security Policy** *(sets out the framework as to how the organisation fulfils its duty of care under the Health and Safety at Work Act 1974)*
GOV-017	**Fire Safety Policy** *(sets out mechanisms to ensure the organisation is compliant with fire safety legislation)*
GOV-018	**Display Screen Equipment Use Policy** *(sets out mechanisms to ensure that the organisation is compliant with the Health and Safety (Display Screen Equipment) Regulations 1992 (as amended in 2002))*
GOV-019	**Incident Reporting and Management Policy** *(sets out processes for reporting and management system of corporate incidents, accidents and near misses within the organisation)*
Involvement and Engagement Policies	

Policy Ref	Policy Title
ENG-001	**Policy for Public Involvement and Engagement** *(sets out the organisation's commitment for ensuring patient and public participation in all of its work and the mechanisms for how this is achieved)*
Commissioning Policies	
COM-01	**Procurement Policy** *(to ensure compliance with procurement legislation and outline processes to manage decision-making and procurement processes)*
COM-02	**Ethical Decision-Making Framework** *(describes the principles that will guide how decisions are made consistently and transparently on behalf of, and with, citizens)*
COM-03	**Service Benefit Review** *(sets out the standard approach, principles and guidance of the completion of the 'service benefit review' process for routine review of commissioned contracts)*
COM-04	**Commissioning Policy for Individual Funding Requests (IFRs)** *(sets out the process for considering individual requests for funding where a service, intervention or treatment falls outside existing service agreements)*
COM-05	**Continuing Healthcare (Adults and Childrens) Commissioning Policy** *(sets out the principles to ensure that high quality, cost effective care is delivered, and to support consistency and equity of access to services for individuals assessed as eligible for NHS Continuing Healthcare, a health contribution to a joint package of health and social care and Children and Young People's Continuing Care)*
COM-06	**Children and Young People Continuing Care Policy** *(sets out responsibilities to meet the continuing care needs of the children and young people and the process for assessing eligibility in line with National Framework guidance)*
COM-07	**S117 After Care Policy** *(sets out the organisation's mechanisms for complying with Section 117 requirements)*
COM-08	**Personal Health Budgets Policy** *(descries the criteria under which the organisation will authorise a personal health budget)*
Equality, Diversity and Inclusion (EDI) Policies	
EDI-01	**Equality, Diversity and Inclusion (EDI) Policy** *(sets out how the organisation meets its statutory responsibility to comply with the Public Sector Equality Duty of the Equality Act 2010 (and associated Regulations))*
Nursing and Quality Policies	
NUR-001	**Complaints and Enquiries Policy** *(sets out the organisation's mechanisms for handling complaints, concerns and enquiries in compliance with statutory requirements)*
NUR-002	**Safeguarding Policy (inc. PREVENT and Safeguarding Training and Supervision Strategy)** *(promotes the safety and welfare of children and adults with care and support needs across all commissioned and contracted services)*
NUR-003	**Safeguarding Children and Adults: Managing Allegations and Concerns Policy** *(sets out the mechanisms to ensure that any allegation or suspicion of abuse is taken seriously, and appropriate actions are taken)*
NUR-004	**Mental Capacity Act 2005 Policy** *(sets out the main provisions of the Act and mechanisms to ensure compliance)*
Finance Policies	
FIN-001	**Fraud, Bribery and Corruption Policy** (sets out the organisation's framework for managing suspected and detected fraud, bribery and corruption)
Emergency Preparedness, Resilience and Response (EPRR) Policies	
EPRR-01	**Emergency Preparedness, Resilience and Response (EPRR) Policy** *(sets out the approach to Emergency Preparedness, Resilience and Response (EPRR), including the preparation for, testing and response to business continuity and major incidents)*
Human Resources Policies	
HR-001	**Sickness Absence Policy** *(sets out the principles for ensuring sickens absence is managed fairly and consistently; supporting compliance with the Health and Safety at Work Act 1974)*

Policy Ref	Policy Title
HR-002	**Change Management Policy** *(including organisational change, redundancy and pay protection)*
HR-003	**Disciplinary Policy** *(sets out standards of conduct within the organisation; ensuring that all employees are treated fairly and consistently)*
HR-004	**Family Leave Policy** *(including maternity, parental, adoption and carers leave)*
HR-005	**Grievance Policy** *(sets out mechanism for individual employees to raise a grievance arising from their employment, ensuring they are dealt with promptly and fairly)*
HR-006	**Leave Policy** *(including annual leave, emergency leave, public duties' leave, appointments and bereavement leave)*
HR-007	**Acceptable Behaviours Policy** *(sets out principles on acceptable behaviour within the workplace)*
HR-008	**Long Service Award Policy** *(sets out a framework to celebrate service 'milestones' for long service)*
HR-009	**Flexible Working Policy** *(including employment breaks)(sets out framework to comply with the Flexible Working Regulations 2014)*
HR-010	**Professional Registration Policy** *(outlines approach to ensuring staff have appropriate professional registration to support employment)*
HR-011	**Capability Policy** *(provides a framework for managing underperformance in a fair and consistent manner)*
HR-012	**Recruitment and Selection Policy** *(including agency workers; sets out processes for recruitment and selection in line with national NHS requirements).*
HR-013	**Domestic Violence and Abuse Policy** *(sets out processes for ensuring the safety and welfare of staff members experiencing, or affected by, domestic violence)*
HR-014	**Travel and Expenses Policy** *(Sets out the respective rights and responsibilities of reimbursement of employees for mileage allowances and subsistence costs)*
HR-015	**Agency Workers Policy** *(sets out processes for ensuring that the ICB adopts good and consistent practice when engaging with staff on terms other than an employment contract.)*
HR-016	**Employment Breaks** (s*ets out the principles and terms to take an unpaid break on either a short or long term basis)*
HR-017	**Learning Education and Development (LED) Policy** *(outlines the ICB Appraisal, LED application, Levy (apprenticeship) funding and reimbursement process.)*
HR-018	**Regrading Policy** *(Details the mechanism to formally review the grade of an employee where there are significant changes to the employee's duties and responsibilities.*
HR-019	**Pay Progression Policy** *(sets out the basis upon which an individual's performance drives pay progression)*
HR-020	**Gender Reassignment Support in the Workplace Policy** *(sets out how the ICB will ensure that individuals considering or undergoing gender reassignment or who have transitioned are treated with fairness and supported in recruitment employment and career development)*

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	01/07/2022
Paper Title:	**Establishment of NHS Nottingham and Nottinghamshire Integrated Care Partnership**
Paper Reference:	ICB 22 005
Report Author:	Lucy Branson, Associate Director Governance Joanna Cooper, Assistant Director
Report Sponsor:	Kathy McLean, ICB Chair
Presenter:	Kathy McLean, ICB Chair
Recommendation(s):	The Board is asked to: 1. **APPROVE** the establishment of the Nottingham and Nottinghamshire Integrated Care Partnership, on the basis of the initial terms of reference presented. 2. **APPROVE** the appointments of the ICB's members of the Integrated Care Partnership.

Summary:

This report describes the collaborative approach that has been taken in Nottingham and Nottinghamshire to the development of proposals to establish an Integrated Care Partnership in line with Section 116ZA of the Local Government and Public Involvement in Health Act 2007 (as amended by the Health and Care Act 2022).

This work has been taken forward by a small working group comprised of the ICB's Chair and Chief Executive, the Chairs of the Nottingham City and Nottinghamshire County Health and Wellbeing Boards, and the Corporate Directors responsible for social care and health at the two councils.

An initial terms of reference has been developed for the Nottingham and Nottinghamshire Integrated Care Partnership (ICP), which is attached as Appendix A. This has been developed in partnership across the three statutory organisations in order to reflect the agreements reached by the working group. The attached report and terms of reference will be presented to the Full Council meetings of both Local Authorities during July, in addition to the ICB Board, to obtain agreement to establish the ICP. In proposing the initial terms of reference it is acknowledged that they will need to be kept under review during the first 12 months of operation as arrangements evolve, and to take account of any secondary legislation and best practice.

Members are asked to support the ICB's five allocated spaces for membership of the ICP as:

- Dr Kathy McLean, Chair
- Amanda Sullivan, Chief Executive
- Lucy Dadge, Director of Integration
- Dave Briggs, Medical Director
- Representative from the Nottingham and Nottinghamshire Provider Collaborative at Scale (to be identified following establishment of the ICP)

It is proposed that the ICP will hold its inaugural meeting in September 2022, with further meetings in December 2022 and March 2023, and the ICP Partners Assembly will meet in

October 2022. These proposals are aligned to the requirement for the Integrated Care Strategy to be developed and published by 31 December 2022.

Appendices:
Appendix A – Initial terms of reference for the Nottingham and Nottinghamshire Integrated Care Partnership.

Key Strategic Risks:
To be confirmed in line with the development of the Board's Assurance Framework.

Applicable Statutory Duties:	
Duty to promote the NHS Constitution	Yes
Duty as to effectiveness, efficiency and economy	Yes
Duty as to improvement in quality of services	Yes
Duties as to reducing inequalities	Yes
Duty to promote involvement of each patient	Yes
Duty as to patient choice	Yes
Duty to obtain appropriate advice	Yes
Duty to promote innovation	Yes
Duty in respect of research	Yes
Duty to promote education and training	Yes
Duty to promote integration	Yes
Duty to have regard to the wider effect of decisions	Yes
Duties as to climate change	Yes
Duties regarding public involvement and consultation	Yes
Public sector equalities duties	Yes

Report Previously Received By:
The former ICS Partnership Board has been oversighting the development of these proposals during 2021/22.

Are there any conflicts of interest requiring management?
No

Is this item confidential?
No

Establishing the Nottingham and Nottinghamshire Integrated Care Partnership

Summary

1. To meet the requirements for the Health and Care Act 2022 proposals have been developed for the Nottingham and Nottinghamshire Integrated Care Partnership (ICP).
2. The proposals have been informed by the legislative requirements, policy and discussion with system partners. A number of discussions have been held with system partners who are supportive of the proposals.
3. The ICP will be the 'guiding mind' of the health and care system, providing a forum for NHS leaders and Local Authorities to come together with important stakeholders from across the system and community. The ICP will lead on creating an integrated care strategy and outcomes framework for the system.
4. Nottingham City Council, Nottinghamshire County Council and NHS Nottingham and Nottinghamshire Integrated Care Board are asked to formally establish the ICP.

Purpose of the report

5. The purpose of this report is to set out key recommendations relating to the establishment of a Nottingham and Nottinghamshire Integrated Care Partnership (ICP) within statutory arrangements for Integrated Care Systems (ICSs).

Information

6. The Health and Care Act 2022 establishes Integrated Care Boards (ICBs) as new NHS bodies, and also requires that each system establish an Integrated Care Partnership (ICP).
7. The ICP will be formed by the ICB and upper tier Local Authorities (LAs) responsible for social care services as equal partners. It will be a joint committee, not a statutory body.
8. ICPs will be a critical part of ICSs and the journey towards better health and care outcomes for the people they serve. ICPs will provide a forum for NHS leaders and LAs to come together with important stakeholders from across the system and community. Together, the ICP will generate an integrated care strategy and outcomes framework to improve health and care outcomes and experiences for its populations, for which all partners will be accountable.

9. ICPs are expected to provide opportunity to align purpose and ambitions with plans to integrate care and improve health and wellbeing outcomes for local populations. ICPs will facilitate joint action to improve health and care services and to influence the wider determinants of health and broader social and economic development. Such joined-up, inclusive working is central to ensuring that ICS partners are targeting their collective action and resources at the areas which will have the greatest impact on outcomes and inequalities as England recovers from the pandemic.

10. Integrated care strategies must be developed for the whole population using best available evidence and data, covering health and social care (both children's and adult's social care), and addressing the wider determinants of health and wellbeing. The integrated care strategy should be built bottom-up from local assessments of needs and assets identified at place level. The Act also places a duty for the ICB to have regard to the Joint Strategic Needs Assessments (JSNAs), Integrated Care Strategy, and Joint Local Health and Wellbeing Strategies when exercising its functions.

Establishing the Nottingham and Nottinghamshire ICP

11. To meet the requirements for the Health and Care Act 2022, a working group was established to develop proposals for the Nottingham and Nottinghamshire ICP.

12. Proposals have been developed as informed by the legislative requirements, policy and discussion with system partners. A number of discussions have been held with system partners who are supportive of these proposals. At its 3 March meeting, the ICS Partnership Board endorsed proposals for the three statutory bodies to consider.

13. The Nottingham and Nottinghamshire ICP will be the 'guiding mind' of the health and care system, in creating an integrated care strategy and outcomes framework.

14. The ICP will be governed by a set of principles and ways of working, which are based on a combination of what has been deemed important by local stakeholders together with national expectations.

15. The membership will comprise of five nominations from each of the LAs and ICB. Membership of the ICP also includes citizen representatives and senior representatives from each of the four Place Based Partnerships.

16. Discussions between the City and County Councils are ongoing to enable the most appropriate and effective representation via the two City Partner and two County Partner places. These appointments will be progressed in consultation with relevant members, ahead of the first meeting of the ICP and in line with arrangements via the Councils' in-year appointments processes.

17. The ICP will regularly receive a report on insights gained from service users and citizens to inform its work.

18. As the ICP becomes operational, there will be a small number of formal meetings arranged and held in public at key points of the planning cycle. These will be supplemented by development sessions as needed.

19. As well as formal meetings, to enable wider engagement in, and co-production of, the integrated care strategy and outcomes framework further mechanisms will be put in place to enable all stakeholders a point of influence:

    a) A wider assembly of partners, to be held at least twice a year, to inform the creation of the integrated care strategy and outcomes framework. Broad participation will be sought to include people who rely on care and support, unpaid carers, the full range of social care and NHS providers, the voluntary and community sector, local professional committees (e.g. optical and pharmaceutical committees), the Office of the Police and Crime Commissioner etc.

    b) Linkages will be made with existing networks, groups, and governance structures, including staff forums and insights gained from place and neighbourhood engagement.

20. Initially the ICP will be chaired by the ICB Chair supported by two Vice-Chairs. The Chairs of the Nottingham City and Nottinghamshire County Health and Wellbeing Boards will act as joint Vice-Chairs of the ICP.

21. In line with the above paragraphs, an initial Terms of Reference for the ICP is presented to the ICB Board at Appendix A to seek formal approval for the establishment of the ICP.

22. These arrangements will be kept under review during the first 12 months of operation to develop and evolve, and to take account of any secondary legislation and best practice. The ICP will build on the expertise, relationships and engagement forums that already exist across local areas, building priorities from the bottom up, to ensure those outlined in the integrated care strategy resonate with people across the ICS. Any formal amendments to the Terms of Reference will need to be agreed with the statutory bodies.

Next Steps

23. It is recommended that Nottingham City Council, Nottinghamshire County Council and NHS Nottingham and Nottinghamshire ICB approve the initial Terms of Reference for the Nottingham and Nottinghamshire Integrated Care Partnership as detailed in this report.

Appendix A

Nottingham and Nottinghamshire Integrated Care Partnership

Terms of Reference

1. Description/ status	The Nottingham and Nottinghamshire Integrated Care Partnership ("**the ICP**") is a joint committee of NHS Nottingham and Nottinghamshire Integrated Care Board**,** Nottingham City Council and Nottinghamshire County Council ("**the Statutory Organisations**"), established in accordance with Section 116ZA of the Local Government and Public Involvement in Health Act 2007 (as amended by the Health and Care Act 2022). The ICP will act as the 'guiding mind' of the Nottingham and Nottinghamshire Integrated Care System (ICS) and is authorised to operate within these terms of reference, which set out its purpose, membership, authority and reporting arrangements. The ICP will not duplicate the work of the Nottingham City and Nottinghamshire County Health and Wellbeing Boards. ICP members will champion and act as ambassadors of effective partnership working for local population benefit.
2. Purpose	a) The primary purpose of the ICP is to produce an Integrated Care Strategy and Outcomes Framework for Nottingham and Nottinghamshire, setting out how the assessed health and social care needs identified by the Nottingham and Nottinghamshire Joint Strategic Needs Assessments (JSNAs) are to be met by the Statutory Organisations or NHS England, in line with their respective commissioning responsibilities. b) In preparing the Integrated Care Strategy, the ICP will: i) Involve Nottingham and Nottinghamshire Healthwatch and the people who live and work in Nottingham and Nottinghamshire. ii) Consider the extent to which health and social care needs could be met more effectively through arrangements for pooled budgets, joint commissioning and integrated delivery under

Appendix A

	section 75 of the NHS Act 2006 (as amended). iii) Have regard to the mandate published by the Secretary of State for Health and Social Care under section 13A of the NHS Act 2006 (as amended). iv) Have regard to any further guidance issued by the Secretary of State for Health and Social Care. c) The ICP may also include within the Integrated Care Strategy its views on how arrangements for the provision of health-related services in its area could be more closely integrated with arrangements for the provision of health services and social care services in the area. d) To support the development of the Integrated Care Strategy, the ICP will engage with a wider assembly of partners, at least once a year, comprising people who rely on care and support, unpaid carers, the full range of social care and NHS providers, the voluntary and community sector, local professional committees (e.g. optical and pharmaceutical committees), the Office of the Police and Crime Commissioner, etc. e) The ICP will review the impact of the Integrated Care Strategy, focusing on 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. f) The ICP will also receive reports on insights gained from service users and citizens. g) The ICP will consider the extent to which the Integrated Care Strategy needs to be revised on receipt of an updated JSNA.
3. Principles	The following principles will be used to guide the work of the ICP: a) Focus on improving outcomes for people, including improved health and wellbeing, supporting people to live more independent lives, and reduced inequalities. b) Support the triple aim (better health and wellbeing for everyone, better care for all and efficient use of the collective resource).

Appendix A

	c) Enable consistent standards and policy across the ICS (strategically sound) whilst allowing for different models of delivery in accordance with diverse populations served (locally sensitive). d) Ensure all delivery mechanisms (e.g. primary care networks, place-based partnerships and provider collaboratives at scale) are equally respected and supported, in line with the principle of subsidiarity. e) Champion co-production and inclusiveness throughout the ICS. f) Put at the forefront the experience and expertise of professional, clinical, political and community leaders, and promote strong clinical and professional system leadership. g) Create a learning system, fostering a culture of innovation, bravery, ambition and willingness to learn from mistakes. h) Optimise the role of health and care as anchor organisations within the local community. i) Utilise existing networks, groups, and governance structures, including staff forums and insights gained from place and neighbourhood engagement. j) Come together under a distributed leadership model and commit to work together equally. k) Accountable to one another and the public including through transparency and building trust.
4. Membership	The membership of the ICP will be comprised as follows: *Nottingham City Council:* a) Elected Member Representative who is the Chair of the Health and Wellbeing Board b) Corporate Director for People Services c) Director of Public Health for Nottingham d) City Partner to be identified e) City Partner to be identified *Nottinghamshire County Council:* f) Elected Member Representative who is the Chair of the Health and Wellbeing Board g) Corporate Director, Adult Social Care and Health

Appendix A

	h) Director of Public Health for Nottinghamshire i) County Partner to be identified j) County Partner to be identified *NHS Nottingham and Nottinghamshire Integrated Care Board:* k) Chair of the Integrated Care Board l) Chief Executive m) Director of Integration n) Medical Director o) Representative of the Nottingham and Nottinghamshire Provider Collaborative at Scale *Other:* p) Representative of Healthwatch Nottingham and Nottinghamshire q) Chair of the Nottingham and Nottinghamshire Voluntary, Community and Social Enterprise Alliance r) Representative of the Bassetlaw Place-based Partnership s) Representative of the Nottingham City Place-based Partnership t) Representative of the Mid-Nottinghamshire Place-based Partnership u) Representative of the South Nottinghamshire Place-based Partnership
5. Chair and vice-chair arrangements	The ICP will be Chaired by the Chair of NHS Nottingham and Nottinghamshire Integrated Care Board. The Chairs of the Nottingham City and Nottinghamshire County Health and Wellbeing Boards will act as joint Vice-Chairs of the ICP.
6. Substitutes	Members are permitted to nominate a suitable substitute to attend a meeting of the ICP on their behalf should they be unable to attend themselves. Members are responsible for fully briefing any nominated substitutes. Substitutes need to be confirmed in writing to the Chair of the ICP ahead of the meeting.
7. Quorum	The quorum will be at least one member from each of the Statutory Organisations.

Appendix A

	Nominated substitutes will count towards the quorum. Members will not count towards the quorum if attending remotely. If any member of the ICP has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may only proceed on an informal basis and no decisions may be taken.
8. Decision-making arrangements	It is expected that at the ICP's meetings, decisions will be reached by consensus and a vote will not be required. Any decisions taken will be record in the minutes of the meeting. If consensus cannot be reached and if timeframes allow, then the item will be re-scheduled for discussion at the next meeting of the ICP. Otherwise, decisions will be taken by simple majority.
9. Conflicts of interest	A register of the declared interests of ICP members will be maintained and published. In advance of any meeting of the ICP, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. At the beginning of each meeting of the ICP members will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declarations will be formally recorded in the minutes for the meeting. The Chair of the ICP will determine how any declared interests should be managed. ICP members must ensure that they comply with their organisational/ professional codes of conduct at all times.
10. Meeting arrangements	The ICP will meet at least twice per year. Extraordinary meetings may be called for a specific purpose at the discretion of the Chair in consultation with the Vice-Chairs.

Appendix A

	At least five clear working days' notice will be given when calling meetings. Meetings of the ICP shall be open to the public unless considering exempt information. The ICP is subject to the same requirements of openness and transparency as other meetings of the Statutory Organisations. As such, agendas and supporting papers, including ratified minutes of meetings, will be published. A protocol will be published separately for members of the public to set out arrangements for submitting questions to meetings of the ICP.
11. Secretariat	Secretariat support will be provided to the ICP by NHS Nottingham and Nottinghamshire Integrated Care Board. Agendas will be agreed by the Chair in consultation with the Vice-Chairs prior to each meeting. Any items to be placed on the agenda are to be sent to the secretary no later than nine clear calendar days in advance of the meeting. Items that miss the deadline for inclusion on the agenda may be added on receipt of permission from the Chair. Agendas and supporting papers will be circulated no later than five clear working days before each meeting. Minutes will be taken at all meetings and will be ratified by agreement of the ICP at the following meeting.
12. Reporting arrangements	The ICP must: a) Publish its Integrated Care Strategy (and any revised strategies). b) Provide a copy of its Integrated Care Strategy (and any revised strategies) to the Statutory Organisations.
13. Review of terms of reference	These terms of reference will be formally reviewed on an annual basis but may be amended at any time in order to adapt to any national guidance as and when issued. An early review of these terms of reference may be required during the ICP's first year of operation, as arrangements across the Nottingham and Nottinghamshire Integrated Care System evolve. Any proposed amendments to the terms of reference will be submitted to the Statutory Organisations for ratification.
14. Date approved	

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	01/07/2022
Paper Title:	**Chair's Report**
Paper Reference:	ICB 22 006
Report Author:	Dr Kathy McLean, ICB Chair
Report Sponsor:	Dr Kathy McLean, ICB Chair
Presenter:	Dr Kathy McLean, ICB Chair
Recommendation(s):	The Board is asked to **RECEIVE** this item for information.

Summary:
This report outlines my activities and actions in my role as Chair and provides a synopsis of some of the meetings I have attended on behalf of the Nottingham and Nottinghamshire Integrated Care Board.

Appendices:
N/A

Key Strategic Risks:
To be confirmed in line with the development of the Board's Assurance Framework.

Applicable Statutory Duties:	
Duty to promote the NHS Constitution	Yes
Duty as to effectiveness, efficiency and economy	Yes
Duty as to improvement in quality of services	Yes
Duties as to reducing inequalities	Yes
Duty to promote involvement of each patient	Yes
Duty as to patient choice	Yes
Duty to obtain appropriate advice	No
Duty to promote innovation	Yes
Duty in respect of research	Yes
Duty to promote education and training	Yes
Duty to promote integration	Yes
Duty to have regard to the wider effect of decisions	No
Duties as to climate change	No
Duties regarding public involvement and consultation	No
Public sector equalities duties	Yes

Report Previously Received By:
N/A

Are there any conflicts of interest requiring management?
No

Is this item confidential?
No

Chair's Report

Introduction

Today signals a moment of change as we hold the first meeting of NHS Nottingham and Nottinghamshire Integrated Care Board, as it comes into existence from 1 July, in line with the Health and Care Act 2022.

Following the boundary changes announced by the government in 2021, we formally welcome Bassetlaw into the Nottingham and Nottinghamshire Integrated Care System from 1 July 2022.

Integrated Care Boards (ICBs) now replace Clinical Commissioning Groups (CCGs) and established in law is the role of Integrated Care Partnerships as the joint committee where health, social care, the voluntary sector and other partners come together as an Integrated Care System.

Integrated Care Systems have four main functions:

- 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.

Moving forwards, NHS Nottingham and Nottinghamshire ICB, which will be known as NHS Nottingham and Nottinghamshire, will take direct responsibility for:

- The local NHS budget – planning and commissioning of services working closely with partners across the system;
- The delivery of high quality and safe local health and care services; and
- Producing a five-year delivery plan.

The ICB will also take on additional functions previously held by CCGs and some additional commissioning responsibilities as delegated by NHS England; primary medical services initially, to be followed by other primary care and specialised services from April 2023.

Bringing together all NHS organisations in the area as an NHS executive, the ICB will manage NHS delivery and facilitate the work of the Integrated Care System, including supporting the coordination and implementation of our Integrated Care Strategy.

As we move into this next phase of joined up working, I would like to acknowledge all that the CCGs have achieved since they were established, and specifically over the last two years, recognise their unfaltering commitment to leading the response to the pandemic and ensuring everyone possible is protected against Covid-19 through the vaccination programme. Teams across the CCGs have adapted at speed and

ensured a joined-up approach between NHS, local authority and the voluntary sector to deliver what is required to protect our communities.

We are all acutely aware we have challenges to tackle such as reducing the unacceptable inequalities, developing our workforce and rebalancing the books. However, I believe Nottingham and Nottinghamshire has strong foundations to build on, with much to be proud of having fostered a culture of collaboration for many years – incorporating leadership, shared values and trusting relationships.

We will continue to make good progress by building our relationships and focusing on supporting our local communities, neighbourhoods and places to make changes that will enable every citizen to enjoy their best possible health and wellbeing. I look forward to working with the talented teams across the system to improve population health and ultimately provide better outcomes for people.

ICB Board

I am pleased to confirm that all ICB Board members will be appointed formally into their roles on 1 July, following a rigorous and inclusive recruitment process.

I would like to take this opportunity to formally welcome colleagues to the Board and am very much looking forward to working with them all to meet the needs of our communities, focussing on improving outcomes and reducing inequalities.

The newly formed Board will strengthen the way the NHS and other health and care providers work together to improve the health of people across the county.

The Partner Members of our Board will be critical to the ICB, bringing their knowledge and a perspective from their sectors and playing a key role in establishing new ways of working across the system to meet the needs of our citizens.

We have held some excellent ICB Board development sessions during June to support the establishment of the ICB where we discussed and agreed plans and priorities.

Next steps

I am excited for what the future holds as we start to work together and plan in detail how we build on what is working well and make real positive changes to enable each and every citizen to enjoy their best possible health and wellbeing.

There are big opportunities in Nottingham and Nottinghamshire to improve care by making it easier to see a health or care professional, getting a faster diagnosis, and offering help quicker to people with mental ill health. By working in partnership together we can help progress these opportunities for our citizens.

Over the coming months we will be working together on agreeing the Joint Forward Plan (Five Year Plan), which will look to tackle the national and local challenges of

restoring services, meeting the new care demands and reducing the care backlogs that are a direct consequence of the pandemic.

Across all these areas we will maintain our focus on preventing ill-health and tackling health inequalities and increasing our efforts on the five priority areas*.

Reduction of health inequalities experienced by adults, children and young people is a critical element for the plans and the effective use of data is central to tackling the issues. Our population health team are making excellent headway in supporting the system to have vital data distilled and available to support decision making and address the depth of the task to ensure everyone's health is protected and improved where possible, not just treated.

Over the last few months, I have been out and about meeting teams and individuals face to face again hearing about the excellent work that is taking place across our system.

I am looking forward to hearing more on the joined-up working taking place when I attend the *Together We Are Notts: Building Our Integrated Care System Together* event for health and care professionals on 7 July. This event is open to everyone working across all organisations in our system and for more information and how to attend visit here. I hope to see you there.

* 2021/22 priorities and operational planning guidance: Implementation guidance

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	01/07/2022
Paper Title:	**Chief Executive's Report**
Paper Reference:	ICB 22 007
Report Author:	Amanda Sullivan, Chief Executive
Report Sponsor:	Amanda Sullivan, Chief Executive
Presenter:	Amanda Sullivan, Chief Executive
Recommendation(s):	The Board is asked to **RECEIVE** this item for information and **ENDORSE** the proposed approach to finalising the arrangements with NHS England for system oversight in 2022/23.

Summary:

This report provides a description of our Integrated Care System (ICS) and an update on emerging arrangements with NHS England regarding system oversight. Moving forward, Chief Executive Reports will summarise recent local and national developments and areas of interest for Integrated Care Boards (ICBs) and the wider NHS.

Appendices:

Appendix A: A description of the Nottingham and Nottinghamshire Integrated Care System

Key Strategic Risks:

To be confirmed in line with the development of the Board's Assurance Framework.

Applicable Statutory Duties:	
Duty to promote the NHS Constitution	Yes
Duty as to effectiveness, efficiency and economy	Yes
Duty as to improvement in quality of services	Yes
Duties as to reducing inequalities	Yes
Duty to promote involvement of each patient	Yes
Duty as to patient choice	Yes
Duty to obtain appropriate advice	Yes
Duty to promote innovation	Yes
Duty in respect of research	Yes
Duty to promote education and training	Yes
Duty to promote integration	Yes
Duty to have regard to the wider effect of decisions	Yes
Duties as to climate change	Yes
Duties regarding public involvement and consultation	Yes
Public sector equalities duties	Yes

Report Previously Received By:

N/A

Are there any conflicts of interest requiring management?

No.

Is this item confidential?

No

Chief Executive's Report

Introduction

1. My first report to the Board is tailored to this being the first day of the ICB's establishment and it being the inaugural meeting of the Board. As such, the report provides a description of our Integrated Care System's vision and collective ambitions, providing details of the different parts of the system and their roles and responsibilities, along with an update on emerging arrangements with NHS England regarding system oversight.
2. In future reports I will summarise recent local and national developments and areas of interest for Integrated Care Boards (ICBs) and the wider NHS.

Our vision and ambitions

3. Our ambition over the next few years is to achieve a high performing Integrated Care System (ICS) able to rival the best in the world for population health and wellbeing, quality of service delivery and use of resources. Integrated care is not new in Nottingham and Nottinghamshire, rather we have a long history of teams coming together – each and every day – across primary and secondary care; physical and mental health services; and across health, social care, the voluntary sector and wider public and community services to save lives and to support the health and wellbeing of our local population.
4. Our early establishment as an ICS has enabled us to mobilise many of the components of a high-performing system. Our focus is on building our Neighbourhoods and giving primacy to Place, with system-wide working and structures (e.g. our Integrated Care Partnership and Integrated Care Board) enabling and supporting local delivery and improvement. Our citizens and communities will be our core focus, with the ICB and ICP enabling each and every citizen to achieve their best possible health and wellbeing.
5. Our philosophy is to build on what is working well and to keep things simple. Whilst 1 July 2022 is a key milestone on the ICS journey for Nottingham and Nottinghamshire, the local System will continue to develop and evolve beyond this point in time. We recognise that organisational and structural change alone will not provide the route map to success with the importance of relationships and trust recognised.
6. Whilst we still have considerable work to do, there is renewed impetus on enabling each and every citizen to enjoy their best possible health and wellbeing. This is a critical phase for us, building on solid foundations to truly integrate care and make the best use of our collective assets for local people.

7. Appendix A details our overall vision and the principles and values that will guide us. They also provide details of all the key organisations that make up our ICS and how we will come together to work in different partnerships, or collaboratives, as well as giving an overview of the remits of these partnership arrangements.

Memorandum of Understanding with NHS England

8. The existing Memorandum of Understanding (MOU) with NHS England (NHSE) and the Integrated Care System has been rolled forward for the first quarter of 2022/23.

9. During July 2022, NHSE will work with ICBs to agree and finalise an MOU for 2022/23 based upon a nationally agreed template. The new MOU will transition more towards system oversight and outline how NHSE will operate alongside the system, articulating principles for regional oversight, ways of working and triggers for escalated support across different areas of the ICB. It will also outline when direct intervention into organisations may be required.

10. We are expecting a refreshed NHSE System Oversight Framework to be published during the last week in June 2022, which will support and inform the System Oversight Framework segmentation and levels of support required into the system or organisations by NHSE during 2022/23. This will also be factored into the MOU.

11. As the MOU will be developed and requiring agreement with the ICB during the summer period, the proposal is for the Chief Executive to agree the MOU, and for the Board to formally approve the MOU at its September 2022 meeting. Board members are requested to endorse this approach.

Enabling each and every citizen to enjoy their best possible health and wellbeing

#TogetherWeAreNotts

Integrated Care System
Nottingham & Nottinghamshire

www.healthandcarenotts.co.uk

@NHSNottingham

What is an ICS (and Why?)

Integrated care systems (ICSs) are partnerships of health and care organisations that come together to plan and deliver joined up services and to improve the health of people who live and work in their area.

They exist to achieve four aims:

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

Integrated Care System
Nottingham & Nottinghamshire

Our vision

Our neighbourhoods, places
and system will seamlessly
integrate to provide
joined up care.

Every citizen will enjoy their best possible health and wellbeing.

Our principles

The way our ICS works together will be guided by three key principles:

1. We will work with, and put the needs of, our **citizens** at the heart of the ICS
2. We will be **ambitious** for the health and wellbeing of our local population
3. We will work to the principle of **system by default**, moving from operational silos to a system wide perspective

Our values

Our principles will be underpinned by three core values:

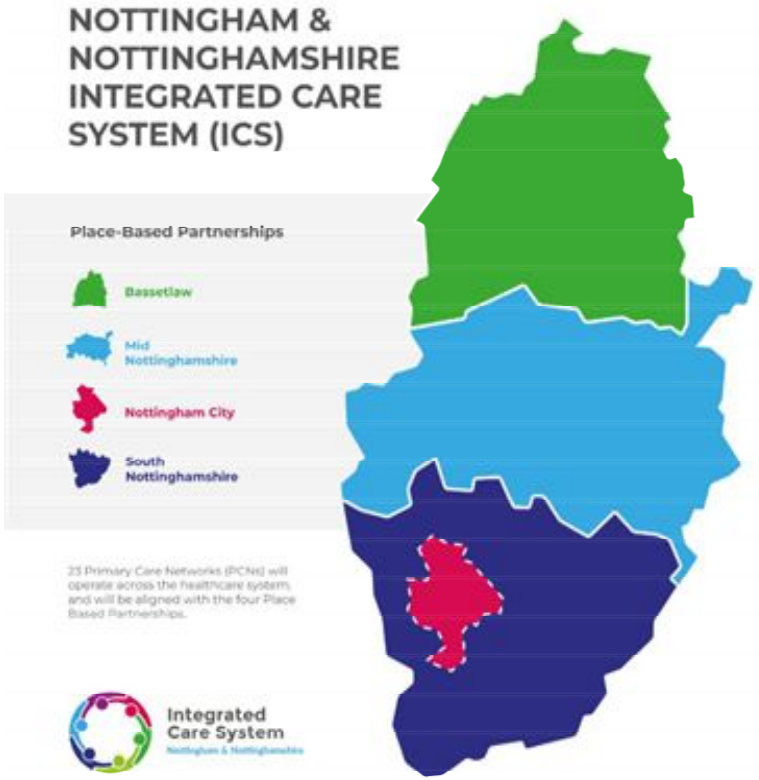
1. We will be **open** and **honest** with each other
2. We will be **respectful** in working together
3. We will be **accountable**, doing what we say we will do and following through on agree actions

Integrated Care System
Nottingham & Nottinghamshire

Our goals

In order to realise our vision, we must deliver each of the following goals effectively and efficiently:

- Serve 1.2m people
- Support 70,000 staff in NHS and social care roles
- Integrate GP Practices into 23 Primary Care Networks (PCNs)
- Create four Place Based Partnerships (PBPs)
- Develop a Provider Collaborative at Scale
- Manage an annual budget of over £3billion for the commissioning and provision of health and care services



Integrated Care System
Nottingham & Nottinghamshire

Our ICS family

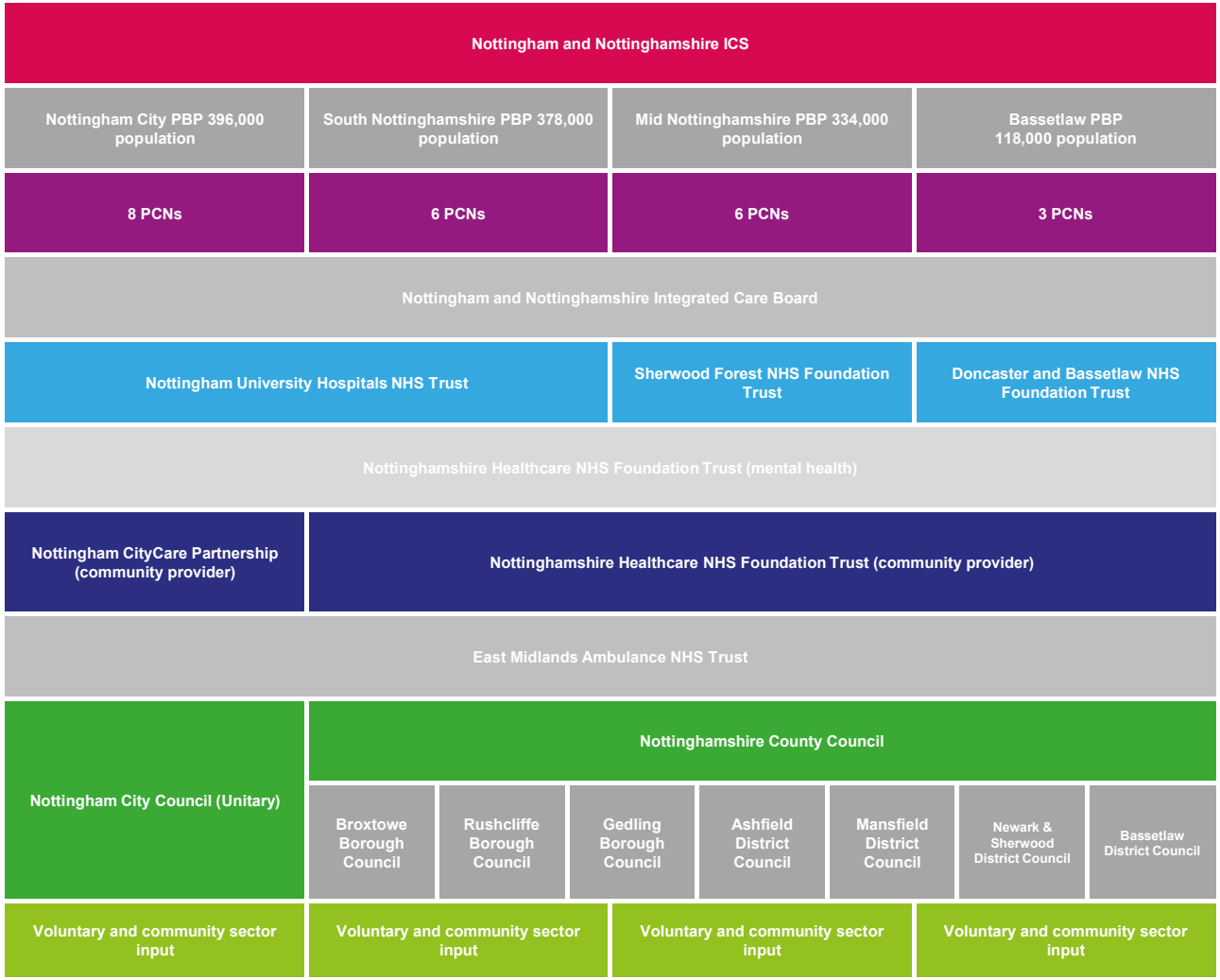
The organisations and professionals that have come together to form our ICS are now part of a family and will work together to achieve our goals.

All parts of our family have different and vital roles, all rely on each other to maximise their potential, and all are equally valued.

Integrated Care System
Nottingham & Nottinghamshire

Our family portrait

This table highlights all the key organisations that make up our ICS.



Integrated Care System
Nottingham & Nottinghamshire

Different roles within the ICS health and care family

Integrated Care Partnership: the "guiding mind" develops an integrated care strategy to address health, social care and public health needs.

Integrated Care Board: develops NHS plan (aligned to local government) and allocates NHS resources, agrees operational / service plans for the system to improve performance and quality, tackles inequalities and improves health outcomes, coordinates / supports for system working.

Hospitals work together in **Provider Collaboratives (at scale)** to provide hospital / specialist care, improve access, performance and quality.

Mental health, community and hospital services developed and delivered jointly through organisational alliances and by working with place-based partnerships.

NHS trusts host / participate in East Midlands Acute and Mental Health Provider Collaboratives and Clinical Networks for specialised services on a wider geography - mutual aid, pathway planning / delivery, resource management and quality improvement across networks.

Host / participate in East Midlands Acute and Mental Health Provider Collaboratives and Clinical Networks for specialised services on a wider geography - mutual aid, pathway planning / delivery, resource management and quality improvement across networks

Place-Based partnerships: (NHS, local government, public sector, voluntary sector) in Bassetlaw, Mid-Nottinghamshire, South Nottinghamshire and Nottingham City – partners work together to develop and deliver community-facing integrated care, join up community services across sectors and organisations / work alongside community leaders, locally tailored care for local needs, improve quality and performance, tackle inequalities and support delivery of ICS priorities.

Integrated Care System
Nottingham & Nottinghamshire

Our journey so far

The Nottingham and Nottinghamshire ICS has been created to bring together health and care organisations and professionals from across the region.

Our ICS has evolved from a long history of local health and care integration.

We believe this history of working together puts us in a strong position for the future.

2016

In 2016, health and care systems came together as Sustainability & Transformation Partnerships (STPs).

ICSs as the main mechanism for delivering integrated care and place-based systems were defining features of the national NHS Long Term Plan which was published on 7 January 2019.

ICSs have developed from STPs and are driving integration at scale and pace.

Today

ICSs established on a statutory basis across England from 1 July 2022, bringing partners together to further support the integration of health and care.

Key parts of the ICS – Primary Care Networks (PCNs)

- A PCN consists of groups of general practices working together with a range of local providers, including community services, social care and the voluntary sector. They will offer coordinated health and social care to their local populations.
- Under the leadership of Clinical Directors, PCNs will bring multidisciplinary teams together to coordinate care and take a proactive approach to managing the health of their populations.
- There are 23 PCNs across Nottingham and Nottinghamshire.

Integrated Care System
Nottingham & Nottinghamshire

Key parts of the ICS – Place Based Partnerships (PBPs)

- Place Based Partnerships are responsible for organising health and social care to deliver the outcomes set out by the strategic commissioner.
- Place Based Partnerships are established in Mid Notts, Nottingham City, South Notts and Bassetlaw.
- Place Based Partnerships are the delivery mechanism for the system and will be contracted to deliver integrated, population-based health and care. They will be held to account for the delivery of outcomes for the population.

Key parts of the ICS – Provider Collaboratives at Scale

- We have agreed that our NHS providers (e.g. Nottingham University Hospitals NHS Trust, Sherwood Forest Hospitals NHS Foundation Trust, Doncaster and Bassetlaw Hospitals NHS Foundation Trust, Nottinghamshire Healthcare NHS Foundation Trust and East Midlands Ambulance Service) will all be involved in three types of provider collaborative going forward:
    - Provider collaboratives at scale for specialised services;
    - An ICS provider collaborative at scale;
    - Placed based partnerships.
- Provider collaboratives are expected to join up provision within places through place based partnerships, and across multiple places, at scale, through a provider collaborative where similar types of provider organisations deliver common objectives. NHSEI's expectation is that all acute and mental health providers will be part of one or more provider collaborative.

Integrated Care System
Nottingham & Nottinghamshire

www.healthandcarenotts.co.uk @NHSNottingham

Key parts of the ICS – Integrated Care Board (ICB)

- A new statutory organisation established on 1 July 2022.
- Will take on CCG functions and some NHS England functions – but also new functions and duties .
- New ways of working through integration, collaboration and shared responsibility.
- New flexibilities to deliver commissioning activities differently – e.g. able to delegate functions and decision-making, has greater abilities for joint working.
- They commission providers, through Place Based Partnerships, to collectively deliver against a set of outcomes for the whole population, and hold providers to account.

Key parts of the ICS – Integrated Care Partnership (ICP)

- ICP will form 'the guiding mind,' across the Nottingham and Nottinghamshire health and care system, and work jointly with Health and Wellbeing Boards.
- Build a broader approach to planning based on population need and put JSNA insights front and centre.
- Strengthens accountability to local people; focus on healthy life expectancy and addressing inequalities and inclusion; build on collaborative approaches developed during Covid19; and maximise collective endeavours including as anchor organisations and in the use of the one 'public purse.'

What does it mean for me?

- We will pool our expertise, experience and efficiencies across acute, community and primary care so everyone benefits equally.
- Integrated service delivery will bring together skills and expertise into multi-disciplinary teams, providing scope for new and more varied career opportunities.
- The focus of service delivery will shift to become more preventative, proactive, and person-centred; focused on a specific geographic area around a common purpose to work holistically with people and communities.
- Complex change across the whole system will involve everyone working in partnership to understand and resolve different ideas and perspectives.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	01/07/2022
Paper Title:	**Business Deliverables for 2022/23**
Paper Reference:	ICB 22 008
Report Author:	Jonathan Rycroft, Associate Director of System Planning
Report Sponsor:	Stuart Poynor, Chief Executive
Presenter:	Stuart Poynor, Chief Executive
Recommendation(s):	The Board is asked to **ENDORSE** the proposed business deliverables for 2022/23 in line with the ICB's ambitions.

Summary:

NHS Nottingham and Nottinghamshire Integrated Care Board (ICB) aims to be a national centre of excellence with high performance against the four core aims of Integrated Care Systems (ICS).

This paper sets out the proposed business deliverables that have been developed to support this during 2022/23, along with the emerging monitoring and reporting arrangements being put in place to assure delivery.

Appendices:

Appendix A: Proposed business deliverables for 2022/23

Key Strategic Risks:

To be confirmed in line with the development of the Board's Assurance Framework.

Applicable Statutory Duties:	
Duty to promote the NHS Constitution	Yes
Duty as to effectiveness, efficiency and economy	Yes
Duty as to improvement in quality of services	Yes
Duties as to reducing inequalities	Yes
Duty to promote involvement of each patient	Yes
Duty as to patient choice	Yes
Duty to obtain appropriate advice	Yes
Duty to promote innovation	Yes
Duty in respect of research	Yes
Duty to promote education and training	Yes
Duty to promote integration	Yes
Duty to have regard to the wider effect of decisions	Yes
Duties as to climate change	Yes
Duties regarding public involvement and consultation	Yes
Public sector equalities duties	Yes

Report Previously Received By:

The proposed business deliverables for the ICB for 2022/23 have been developed in partnership with the ICB's Executive Team and the ICS Executive Leadership Group.

Are there any conflicts of interest requiring management?
No

Is this item confidential?
No

Business Deliverables for 2022/23

Introduction

1. NHS Nottingham and Nottinghamshire Integrated Care Board (ICB) aims to be a national centre of excellence with high performance against the four core aims of Integrated Care Systems (ICS):
    a) Improve outcomes in population health and healthcare.
    b) Tackle inequalities in outcomes, experience, and access.
    c) Enhance productivity and value for money.
    d) Help the NHS support broader social and economic development.
2. The proposed business deliverables for 2022/23 have been developed to support the ICB in this endeavour.

Proposed business deliverables for 2022/23

3. The proposed business deliverables for 2022/23 have been developed by the ICB Executive Team and reviewed by the ICB Chair. They cover national NHS operational planning priorities for 2022/23 together with additional local deliverables and have been aligned to three broad areas; ‘Managing today’, ‘Making tomorrow better’ and ‘ICS Development’.
4. The proposed business deliverables for 2022/23 are set out at Appendix A.
5. An ICB Executive Director has been identified to lead each of the proposed business deliverable and will be accountable to the Board for delivery. Consistent with the established ICS distributed leadership approach, several deliverables also identify ICS System Leads who have system responsibility for delivery.
6. ICB Associate Director leads will support ICB and ICS Leaders to enable and facilitate delivery. It is recommended that each deliverable also has an identified clinical and/or professional lead.

Next Steps

7. The ICB Planning, Performance and Programme Management Office is working in partnership with ICB Executive Directors, ICS System Leads and wider teams during July and August to systematically assure detailed delivery and milestone plans and establish progress monitoring and reporting.
8. The emerging Integrated Performance Report (IPR) for the Board will be structured around the business deliverables. The IPR will combine progress against milestones and delivery of key metrics.

9. A detailed position against each of the business deliverables will be reported to the September 2022 meeting of the Board, which is in line with the agreed timetable to develop the IPR.

Appendix A: Proposed business deliverables for 2022/23

To be a national centre of excellence with high performance against the four stated Integrated Care System (ICS) aims:

- **Improve outcomes**
- **Reduce inequalities**
- **Enhance productivity and value for money**
- **Support social and economic development**

Managing Today

2022/23 Business Deliverables	Integrated Care System (ICS) System Lead	Integrated Care Board (ICB) Executive Lead
1. Recover services and address backlogs (Elective, Cancer, Diagnostics, Mental Health, Primary and Community Care) through the lenses of inequalities and equity.	Elective, Cancer and Diagnostics – Lead from the System Acute Trusts to be confirmed and Deputy Lisa Kelly, Chief Operating Officer, Nottingham University Hospitals Trust Mental Health – John Brewin, Chief Executive, Nottinghamshire Healthcare Trust Primary Care – Dr Stephen Shortt, GP	Lucy Dadge, Director of Integration
2. Streamline Urgent and Emergency Care pathways and resolve system flow issues to reduce pressures in emergency care and create capacity for elective recovery.	Melanie Brooks, Corporate Director, Adult Social Care and Health, Nottinghamshire County Council Deputy from the System Acute Trusts to be confirmed	Lucy Dadge, Director of Integration

2022/23 Business Deliverables	Integrated Care System (ICS) System Lead	Integrated Care Board (ICB) Executive Lead
	Pathways – Richard Henderson, Chief Executive, East Midlands Ambulance Service	
3. Manage system resources, improve productivity and efficiency, live within agreed system capital and revenue limits.	Stuart Poynor, Director of Finance	Stuart Poynor, Director of Finance
4. Oversee and drive the necessary improvements in quality, including Maternity Services, Learning Disability and Autism (LDA), through the lenses of inequalities and equity.	LDA – Melanie Brooks, Corporate Director, Adult Social Care and Health, Nottinghamshire County Council and Dr Sue Elcock, Medical Director, Nottinghamshire Healthcare Trust Local Maternity and Neonatal Service – to be confirmed	Rosa Waddingham, Director of Nursing
5. A: Deliver the 2022/23 Vaccination Programme, including Covid-19 and Flu.	Amanda Sullivan, Chief Executive	Rosa Waddingham, Director of Nursing
5. B: Continue to respond effectively to Covid.	To be confirmed	

Making Tomorrow Better

2022/23 Business Deliverables	Integrated Care System (ICS) System Lead	Integrated Care Board (ICB) Executive Lead
6. Adopt a whole system approach to workforce strategy, planning and development that aligns skills, capacity and capability to the future needs of the	To be confirmed	Rosa Waddingham, Director of Nursing

2022/23 Business Deliverables	Integrated Care System (ICS) System Lead	Integrated Care Board (ICB) Executive Lead
population supported by a system people and culture approach. Ensure system functionality is developed in line with local and national requirements.		
7. Ensure that population health management approaches, reduction in inequalities are embedded in strategic and operational plans and delivery at system, place and neighbourhood population levels. Develop an ICS inequalities strategy and plan and align with ICB and Integrated Care Partnership (ICP) decision making.	John Brewin, Chief Executive, Nottinghamshire Healthcare Trust Deputies: Lucy Hubber, Director of Public Health, Nottingham City Council Jonathan Gribbin, Director of Public Health, Nottinghamshire County Council	Dave Briggs, Medical Director
8. Evolve and implement a clinically led transformation programme which aligns to the 4 stated aims of the ICS, supports delivery of operational priorities, innovation and service integration whilst also responding to productivity and benchmarking.	To be confirmed	Dave Briggs, Medical Director
9. Develop and enable the Integrated Care Partnership to develop a system Integrated Care Strategy, develop key strategic objectives and ambitions for the ICB including underpinning strategic delivery plans. Embedding the Outcomes Framework within strategic system plans and in-year delivery plans at system, provider place and neighbourhood.	Melanie Brooks, Corporate Director, Adult Social Care and Health, Nottinghamshire County Council	Lucy Dadge, Director of Integration
10. Transform community services and embed integrated working at place-based level, supporting self-care and proactive anticipatory care.	Catherine Underwood, Corporate Director for People Services, Nottingham City Council and	Lucy Dadge, Director of Integration

2022/23 Business Deliverables	Integrated Care System (ICS) System Lead	Integrated Care Board (ICB) Executive Lead
	Louise Bainbridge, Chief Executive, Nottingham CityCare Partnership	
11. Develop and deliver service reconfiguration public engagement and consultations that enable best use of resources, transformation and capital developments. Progress Tomorrow's NUH and the National Rehabilitation Centre in line with timelines for consultation and business case development. Ensure citizen engagement, coproduction and engagement approaches are developed across the ICS and are in line with best emerging practice.	Amanda Sullivan, Chief Executive	Lucy Dadge, Director of Integration
12. Recognised as a national exemplar for digital innovation; assuring a robust, resilient and secure digital infrastructure to support the delivery of care across all sectors.	Andrew Fearn, Interim Digital SRO and Maria Principe, Director, System Analytics and Intelligence Unit	Dave Briggs, Medical Director
13. Develop and deliver an Estates Strategy.	Lead and Deputy to be confirmed from NHS and Local Authority Partners	Stuart Poynor, Director of Finance
14. Deliver a greener NHS.	John Brewin, Chief Executive, Nottinghamshire Healthcare Trust Deputy to be confirmed from NHS and Local Authority Partners	Stuart Poynor, Director of Finance

Establishing the ICS

2022/23 Business Deliverables	Integrated Care System (ICS) System Lead	Integrated Care Board (ICB) Executive Lead
15. Refresh the Integrated Care System Outcomes Framework in line with strategic system plans. Ensure there is clear leadership and accountability for outcomes in the Integrated Care Board (ICB), the Integrated Care Partnership (ICP), primary care networks (PCNs), place based partnerships (PBPs) and these are understood across the Integrated Care System.	Kathy McLean, Chair, Councillor John Doddy, Chair of the Nottinghamshire Health and Wellbeing Board, and Councillor Adele Williams, Chair of the Nottingham Health and Wellbeing Board	Dave Briggs, Medical Director
16. Establish a clear system oversight framework focusing on delivery of key national requirements, the 2022/23 operational plan and our local outcomes framework.	Amanda Sullivan, Chief Executive	Stuart Poynor, Director of Finance
17. Establish the ICB and operate in line with statutory / regulatory requirements, ensuring it can execute inherited duties and new accountabilities. Develop ICB/ICS capability including adopting a structured approach to leadership and culture development, with equality, diversity and inclusion at the heart.	Amanda Sullivan, Chief Executive	Amanda Sullivan, Chief Executive
18. Develop the profile and capability of the ICS to enhance the reputation of Nottingham and Nottinghamshire ICS within and beyond the area. Ensure the ICB is an active partner in civic forums and operates in line with anchor and social value principles.	Amanda Sullivan, Chief Executive Anchor Institutions – Paul Robinson, Chief Executive, Sherwood Forest Hospitals	Amanda Sullivan, Chief Executive

2022/23 Business Deliverables	Integrated Care System (ICS) System Lead	Integrated Care Board (ICB) Executive Lead
	Communications – To be confirmed	
19. The ICB facilitates system development across primary care networks (PCNs), place based partnerships (PBPs) and the provider collaborative, with an agreed operating model from July 2022.	Amanda Sullivan, Chief Executive Mel Barrett, Nottingham City PBP John Brewin, South Nottinghamshire PBP Hayley Barsby, Mid Nottinghamshire PBP David Armiger, Bassetlaw PBP Provider Collaborative – Managing Director (to be confirmed) PCN Clinical Directors	Lucy Dadge, Director of Integration

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	01/07/2022
Paper Title:	**Delegation of Functions from NHS England to Integrated Care Boards**
Paper Reference:	ICB 22 009
Report Author:	Roz Lindridge, Regional Director of Commissioning, NHS England Lucy Branson, Associate Director of Governance
Report Sponsor:	Lucy Dadge, Director of Integration
Presenter:	Lucy Dadge, Director of Integration
Recommendation(s):	The Board is asked to **RECEIVE** this item for information and **ENDORSE** the proposed approach to finalising the workforce and operating models for future delegated functions, as detailed in the report.

Summary:

This paper provides an overview of future delegations of certain commissioning functions from NHS England to the ICB from April 2023, including arrangements for developing the associated workforce and operating models.

A delegation application is required to be submitted by the ICB by mid-September 2022 for pharmacy, optometry and dental services. This will be presented for consideration at the Board's September meeting, following review and scrutiny by the Strategic Commissioning Committee should timeframes allow. A pre-delegation assessment process will follow.

Appendices:

N/A

Key Strategic Risks:

To be confirmed in line with the development of the Board's Assurance Framework.

Applicable Statutory Duties:	
Duty to promote the NHS Constitution	Yes
Duty as to effectiveness, efficiency and economy	Yes
Duty as to improvement in quality of services	Yes
Duties as to reducing inequalities	Yes
Duty to promote involvement of each patient	Yes
Duty as to patient choice	Yes
Duty to obtain appropriate advice	Yes
Duty to promote innovation	No
Duty in respect of research	No
Duty to promote education and training	No
Duty to promote integration	Yes
Duty to have regard to the wider effect of decisions	Yes
Duties as to climate change	No
Duties regarding public involvement and consultation	No
Public sector equalities duties	Yes

Report Previously Received By:
N/A

Are there any conflicts of interest requiring management?
No

Is this item confidential?
No

Delegation of Functions from NHS England to Integrated Care Boards

Introduction and purpose of the paper

1. By delegating NHS England (NHSE) commissioning functions to Integrated Care Boards (ICBs), the aim is to break down barriers and join up fragmented pathways to deliver better health and care so that patients can receive high quality services that are planned and resourced where people need it.
2. Functions in relation to primary medical services have been previously delegated to CCGs, and as ICBs become legal entities and CCGs are disestablished, ICBs will automatically take on these delegated functions from 1 July 2022. Details in relation to this delegation agreement have been covered elsewhere on the agenda for this meeting.
3. This paper aims to support the Board with an understanding of proposals regarding future delegations of the following NHSE commissioning functions:
    a) Primary pharmacy and optometry services and primary and secondary dental services from 1 April 2023.
    b) Specified specialised services from 1 April 2023.
4. Delegation of these commissioning functions is national policy. In all cases the responsibility and liability for the planning, performance, finance, quality, and improvement will move from NHSE to ICBs upon delegation. However, in all cases, NHSE remains accountable to the Secretary of State for the services, which means that NHSE will have oversight, set standards and service specifications for the services.
5. To ensure that any transition is safe and effective, and benefits are maximised, NHSE has agreed with ICB Chief Executives to deliver a phased transition to the future state through to 2024.
6. A joint approach has been designed and developed through collaboration and co-production with ICB teams, working together to produce operating frameworks that maximise ICB decision making whilst retaining the specialist knowledge and skills of NHSE staff.
7. Through delegation ICBs must:
    a) At all times have regard to the Triple Aim.
    b) At all times act in good faith and with integrity.
    c) 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.

d) Consider how in performing their obligations they can address health inequalities.

e) At all times exercise functions effectively, efficiently and economically.

f) Act in a timely manner.

g) 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.

8. The 11 Midlands ICB Chief Executives have reviewed the NHSE commissioning portfolio over the past 12 months (whilst appointed in their designate capacities), and have agreed that:

a) Primary care decision making is best undertaken at an ICB level.

b) Specialised services decision making is best undertaken at a multi-ICB level due to the complexity and risks associated with these services.

Primary pharmacy and optometry services and primary and secondary dental services

9. NHSE and ICB Chief Executives have been working together to plan and develop a joint approach to delegation of these commissioning functions to ensure the safe and effective transition to a more integrated way of working. However, it should be noted that the ability to influence future transformation of these services is limited due to national stipulations and constraints of the contracts.

10. In order to achieve the required April 2023 timeframe for delegation of these functions, applications are required to be submitted by ICBs to NHSE by mid-September 2022. A pre-delegation assessment process will then follow to ensure the ICB is ready to assume responsibility for the functions; this will cover four domains: transformation; governance and leadership; finance; and workforce and capability.

11. Each ICB is required to sign off an operating and workforce model in advance of the pre-delegation assessment process. The principles within the proposed operating model have been developed jointly between the Midlands ICBs and NHSE.

12. Joint working groups will be in place throughout 2022/23 to manage the risks, information governance and appropriate due diligence to ensure a transparent and smooth transfer of responsibilities to ICBs.

13. There are risks to taking on these delegated functions. Specifically, workforce capacity and achieving an agreed model across the ICBs in the East and West

Midlands. Working together, mitigations will be put in place. The agreed principles for the workforce modelling are:

a) Minimum disruption for staff.

b) Ensure that where possible, NHS talent is retained and deployed to support systems in an agile way, driving forward the ‘one NHS workforce’ ambition.

c) Take steps to plan and implement the transition, encouraging best people practices throughout and enabling the right conditions for our teams to deliver the primary care function for the ICBs as responsible organisations and a team to provide oversight and assurance for the NHSE region.

14. The operating model for the delegation of pharmacy, optometry and dental services will be through two primary care teams: one East Midlands team and one West Midlands team to deliver the functions on behalf of the five East Midlands and six West Midlands ICBs.

15. The team will provide a clear and definable service detailed through a memorandum of understanding to enable the primary care delegated functions to be delivered. ICBs will provide the leadership and strategic guidance to ensure that the team can deliver the functions effectively, including:

a) Collaboration between ICBs will be key to ensure the team can fulfil day to day functions and agreement on use of the team when there are competing priorities for their capacity, e.g. procurements, service developments, etc.

b) Managing contractual relationships will be guided by nationally stipulated standardised frameworks, but there remains a need for some local judgement and flexibility. Where standard procedures are not in place, and they cannot cover every eventuality, the teams will use their judgement and be guided by the culture, values and expected behaviours promoted by the ICBs working in collaboration to deliver these services.

c) Reserved NHSE functions: the majority of policy setting comes from the national team. The regional team’s function will be improvement, assurance, and oversight, to ensure the delegated functions are successfully being delivered and to design and deliver transformation programmes in support of national priorities.

d) Interdependencies: this operating model focuses on the Primary Care Commissioning and contracting functions. The model will also apply to the complaints function that is being delegated from April 2023 and the primary care finance team, clinical advisor support and quality functions who will form part of the delegated function.

e) Transformation and service improvement in terms of service delivery will take place within the ICB within the structures and capacity developed as part of the ICB establishment.

Specified specialised services

16. Prevention, diagnosis, acute treatment, chronic management and specialised services are planned and commissioned by different organisations, with plans based on different historic views resulting in misaligned priorities. Moving to a single planning structure with aligned incentives and plans based across whole patient pathways aims to enable greater innovation and collaboration and more joined up services across the patient pathway.

17. There are circa 150 services categorised as specialised services that NHS England commissions; 65 of these services have been assessed as suitable and ready for delegation to ICBs. Due to the complexity and risks associated with these services, ICB Chief Executives and NHSE have agreed that they are best undertaken at a multi-ICB level.

18. The national 'roadmap' for specialised acute services published in May 2022 outlined the process for the delegation. The road map outlines the following:

    a) All services will continue to be prescribed specialised services.

    b) As with primary care services, NHSE retains accountability for the entire portfolio of specialised services.

    c) All specialised services will be subject to national service specifications and evidence-based clinical policies that will continue to be developed by NHSE.

    d) Universal access to provision of services across the country will be maintained no matter where patients live.

    e) Services will be commissioned on an appropriate geographical footprint, determined by factors including population base and patient flows, between NHSE and (multiple) ICBs.

    f) The clinical leadership infrastructure that supports specialised commissioning will continue and be strengthened.

    g) Patients and the public will continue to be involved in specialised commissioning.

    h) Commissioning expertise will be maintained in the NHSE national and regional teams in 2022/23, increasingly facing towards ICBs from 2023/24.

    i) Future delegation arrangements will be underpinned by robust governance and oversight arrangements.

19. For those specialised acute services that are delegated to ICBs, the ICBs will be required under the delegation agreement to come together on a multi-ICB footprint to jointly commission these services. The mechanism for this will be through formal joint committees, with NHSE retaining a seat at the table in decision making. NHSE will retain those services currently not deemed suitable for immediate delegation.
20. To support ICBs to understand current decision-making processes in acute specialised services, and to enable greater joint working in 2022/23, ICB representatives (or representatives of the agreed multi-ICB footprints) will be invited to attend the current Midlands Formal Acute Specialised Commissioning Group (FAMSCG). The name of this decision-making committee will be reviewed to enable a smooth evolution in 2023/24 when some formal delegation commences for specialised services.
21. The operating model will be co-produced with ICB representatives through two Midlands wide working groups (commissioning and finance). The working groups will model options for both a Midlands-wide and East and West Midlands options, which will be presented to ICB Chief Executives during early September. This will be informed by appropriate provider engagement.

Next steps

22. The modelling for workforce to support the delegation of pharmacy, optometry and dental services will now be completed.
23. A dedicated deep dive session on finance for ICB Chief Executives and Directors of Finance for pharmacy, optometry and dental services and specialised services will be set for early July 2022 to support the ongoing joint development of the approach to delegation.
24. Further work will be undertaken to co-produce with ICBs the operating model for specialised service delegation.
25. With ICB Chief Executive sponsors, NHSE will work though the joint working groups to develop robust governance to support delegation across all functions.
26. Work will be undertaken to jointly develop our approaches to Professional leadership with ICB medical directors and directors of nursing.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	01/07/2022
Paper Title:	**Emergency Preparedness, Resilience and Response (EPRR) – Incident Response Plan**
Paper Reference:	ICB 22 010
Report Author:	Hazel Buchanan, Associate Director of Strategic Programmes and EPRR
Report Sponsor:	Lucy Dadge, Director of Integration
Presenter:	Lucy Dadge, Director of Integration
Recommendation(s):	The Board is asked to **APPROVE** the Incident Response Plan.

Summary:

As part of the transition to new statutory arrangements, the ICB has become a category one responder as per duties set out in the Civil Contingencies Act 2004. This report provides assurance regarding the ICB's readiness to take on these responsibilities from 1 July 2022.

The ICB's Incident Response Plan, which has been developed in consultation with system partners and has been exercised, is required to be approved by the Board and is presented for this purpose.

Appendices:

Appendix A: Incident Response Plan

Key Strategic Risks:

To be confirmed in line with the development of the Board's Assurance Framework.

Applicable Statutory Duties:	
Duty to promote the NHS Constitution	Yes
Duty as to effectiveness, efficiency and economy	Yes
Duty as to improvement in quality of services	Yes
Duties as to reducing inequalities	No
Duty to promote involvement of each patient	No
Duty as to patient choice	No
Duty to obtain appropriate advice	No
Duty to promote innovation	No
Duty in respect of research	No
Duty to promote education and training	No
Duty to promote integration	No
Duty to have regard to the wider effect of decisions	No
Duties as to climate change	No
Duties regarding public involvement and consultation	No
Public sector equalities duties	No

Report Previously Received By:

N/A

Are there any conflicts of interest requiring management?
No

Is this item confidential?
No

Emergency Preparedness, Resilience and Response (EPRR) – Incident Response Plan

Introduction

1. As part of the transition to new statutory arrangements, the ICB has become a category one responder as per duties set out in the Civil Contingencies Act 2004. The ICB's Director of Integration is the Accountable Emergency Officer.
2. In preparation for the transition, an Emergency Preparedness, Resilience and Response (EPRR) readiness to operate assessment has been carried out with NHS England, which resulted in the ICB being deemed fit to undertake relevant resilience duties from 1 July 2022. This is in the context of NHS England retaining Category One duties and therefore, maintaining the relevant responsibilities in relation regional planning and response for incidents.
3. The ICB's Incident Response Plan, which has been developed in consultation with system partners and has been exercised, is required to be approved by the Board.

EPRR Policy and Infrastructure

4. In addition to the Civil Contingencies Act, the Health and Social Care Act 2012 outlines the EPRR responsibilities of NHS England, and these have been adopted by the ICB and are included in the ICB's EPRR Policy (presented for adoption as part of an earlier Board paper on the agenda).
5. The ICB will respond to its responsibilities as follows:
    a) Coordinate the local health system response to a critical or major incident, across all incident levels.
    b) Collaborate with NHS England in discharging its EPRR functions and duties regionally, including supporting NHS England in their coordination of incidents at levels three and four.
    c) Ensure contracts with all commissioned provider organisations (including independent and third sector) contain relevant EPRR elements, including business continuity.
    d) With NHS England, monitor compliance by each commissioned category one provider organisation and others identified through the framework, with their contractual obligations in respect of EPRR and with applicable Core Standards.

e) Ensure robust escalation procedures are in place so that if a commissioned provider has an incident, the provider can inform the ICB 24 hours a day, seven days a week.

f) Provide sufficient resources and funding to ensure the ICB complies with its EPRR obligations.

g) Ensure effective processes are in place for the ICB to properly prepare for and rehearse incident response arrangements with local partners and providers.

h) Management and oversight of the Local Health Resilience Partnerships (LHRP).

i) Provide a route of escalation for the LHRP in respect of commissioned provider EPRR preparedness.

j) Cooperate with other local responders through the Nottingham and Nottinghamshire Local Resilience Forum to enhance co-ordination and efficiency through common principles of action.

k) To ensure that staff receive emergency preparedness training that is commensurate with their role and responsibilities.

6. The Nottingham and Nottinghamshire EPRR planning infrastructure includes a LHRP which will be co-chaired by the ICB's Accountable Emergency Officer and a Director of Public Health. Membership on the LHRP includes NHS England, all partner organisations, primary care representation and UK Health Security Agency. Sub-groups include an operational and risk group.

7. The ICB holds responsibilities and is part of the Local Resilience Forum Incident Response Plan as per the Civil Contingencies Act 2004. This is a multi-agency partnership with responsibilities to plan, prepare and respond to incidents across Nottingham and Nottinghamshire.

8. The ICB operates gold and silver on-call arrangements 24 hours seven days per week.

9. As part of the Accountable Emergency Officer responsibilities, an annual EPRR report will be provided to the Board, and this will be supported by an annual assurance process against EPRR core standards.

Incident Response Plan

10. The Incident Response Plan (attached at Appendix A) outlines the process to develop and maintain emergency response arrangements. As an ICB, the Incident Response Plan has been developed in collaboration with all system partners and service providers. The Incident Response Plan includes the following elements:

a) Sets out roles and responsibilities for management and escalation in terms of an incident.

b) Defines what an incident and a major incident is and outline the types of emergencies that the local NHS might be expected to respond to.

c) Outlines the command, control and co-ordination arrangements both internally within in the local NHS and in the multi-agency context by identifying stakeholders and operational plans, including the decision-making process.

d) Establishes a framework within which the ICB and NHS England roles and responsibilities can be fulfilled during the response to a major incident.

e) Identifies the arrangements for communicating information to staff, patients and stakeholders both prior to, during and after a major incident.

f) Outlines the process for recovery from a major incident.

11. The ICB has consulted with and received input from system partners and NHS England on the Incident Response Plan. The Incident Response Plan has also been tested through a desk top exercise.

Conclusion

12. The transition to the ICB provides additional EPRR functions due to moving from a category two to a category one responder as per the Civil Contingencies Act. The ICB will work collaboratively with NHS England in relation to discharging these responsibilities. The ICB's EPRR Policy and the Incident Response Plan are relevant to the new duties of the ICB as per the Civil Contingencies Act and responsibilities in the NHS EPRR Framework.

Appendix A

Nottingham & Nottinghamshire ICB Incident Response Plan

In the event of an incident, go directly to the Incident Response Section

Date	Review date	Document Name	Version	Page
June 2022	November 2022	Incident Response Plan@BCL@90079309	1.2	Page 1 of 90

Document History

Version	Date issued	Nature of amendment / remarks	Authorised by	Date
0.3	May 2022	First draft for consultation with partners		
0.4	June 2002	Interim version following consulation		
1.0 & 1.1	June 2022	Final version for approval	H. Buchanan	24 June

1. Aim

The aim of this plan is to ensure that the ICB can implement an effective response to business continuity, critical or major incidents, ensuring optimum care and assistance to the victims, minimises the consequential disruption to healthcare services and facilitates a swift return to normal levels of service.

2. Objectives

The objectives of this plan are to:

- Set out roles and responsibilities of the ICB for the management of an incident.
- Define what an incident is and outline the types of emergency that the local NHS might be expected to respond to;
- Outline the command, control and co-ordination arrangements to enable the ICB to co-ordinate and lead the local NHS response for Levels 1 and 2 incidents; and support NHS England in their coordination of incidents at Level 3 and 4;
- Identify the arrangements for communicating information to staff, patients and stakeholders both prior to, during and after an incident;
- Outline the process for recovery from an Incident

3. Supporting Plans

The plan is supported by:-

- ICB On-call Handbook
- ICB Business Continuity Plan
- ICB Loggist Procedure
- ICB ICC and IMT Plan
- ICB EPRR Policy

4. Responsibilities

Under the Civil Contingencies Act (CCA), the ICB has the statutory duties of a Category 1 Responder. With regards to incident response this requires the ICB to:-

- Assess the risk of emergencies occurring and use this to inform contingency planning
- Have in place incident response plans that enable the ICB to respond to a major, critical or business continuity incident
- Maintain arrangements to warn, inform and advise the public in the event of an emergency
- Share information with and cooperate with other local responders to enhance co-ordination and efficiency

NHS England (NHSE&I), Sherwood Forest Hospitals NHS FT; Nottingham University Hospitals NHS Trust; East Midlands Ambulance Service (EMAS) and the UK Security Health Agency are also category 1 responders and are required to meet the full duties of the CCA.

Primary care, including out of hours providers, community providers, mental health service providers, specialist providers, NHS Property Services and other NHS organisations (for example NHS Blood &Transplant, NHS Supply Chain and NHS 111) are not listed in the CCA 2004 as a Category 1 or 2 responder. However, Department of Health and Social Care and NHS England EPRR guidance expects them to plan for and respond to emergencies and incidents in a manner which is relevant, necessary and proportionate to the scale and services provided.

5. Definitions

5.1. Emergencies

Under Section 1 of the Civil Contingencies Act (CCA) 2004 an "emergency" means

"(a) an event or situation which threatens serious damage to human welfare in a place in the United Kingdom;
(b) an event or situation which threatens serious damage to the environment of a place in the United Kingdom;
(c) war, or terrorism, which threatens serious damage to the security of the United Kingdom".

Definitions of NHS Incidents

Business Continuity	A **business continuity incident** is an event or occurrence that disrupts, or might disrupt normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level.
	All organisations are responsible for coordinating their response to a business continuity incident which is disrupting their service delivery **The ICB** would coordinate the health community response where a business continuity incident is disrupting the wider health economy or where one or more health organisations require support.
Critical Incident	A **critical incident** is any incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions. This could be in response to disruption to a critical service area to increased system pressures and OPEL 4 actions are not effective and the system or an organisations needs to take further action or coordinate using EPRR methods and structures.
	The ICB would coordinate the health community response where a critical incident is disrupting the wider health economy or where a health organisations requires support.
Major Incident	A **major incident** is any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented (e.g. large scale transport incident / serious fire in a healthcare setting)
	The ICB would coordinate the local health community response to a Major Incident (incidents at NHS response Level 1 and 2). NHS E&I would support the response at Level 2.
	In the event of a **major incident**, organisations involved should provide to the **ICB** a report using the **NHS England Situation Reporting Template**. The reporting organisations will be required to continue to provide updated reports at agreed intervals. Where multiple trusts are involved, the **ICB** would be required to collate these into a single sitrep. NHS England Incident situation report template can be found on Resilience Direct https://collaborate.resilience.gov.uk/RDService/home/148367/Templates
	NHS England & NHS Improvement would lead the coordination of the overall NHS response to a major incident at the regional and national level (NHS response Levels 3 and 4).

5.2. Incident Levels

As an event evolves it should be described in terms of its level as shown below. For clarity these levels must be used by all organisations across the NHS when referring to incidents.

All incidents and emergencies resulting in the activation of central government response arrangements will be managed as a Level 4 incident.

Figure 1 NHS Incident levels[1]

Incident Level	
Level 1	An incident that can be responded to and managed by a local health provider organisation within their respective business as usual capabilities and business continuity plans in liaison with local commissioners.
Level 2	An incident that requires the response of a number of health providers within a defined health economy and will require NHS coordination by the ICB. NHS England & NHS Improvement region would support the ICB.
Level 3	An incident that requires the response of a number of health organisations across geographical areas within a NHS England & NHS Improvement region. NHS England and NHS Improvement to coordinate the NHS response in collaboration with the ICB.
Level 4	An incident that requires NHS England and NHS Improvement National Command and Control to support the NHS response. NHS England and NHS Improvement regions to coordinate the NHS response, in collaboration with local commissioners, at the tactical level.

Incidents can escalate as well as de-escalate; the incident level should be frequently reviewed and amended as appropriate.

Figure 2 illustrates the criteria that may trigger an escalation and / or de-escalation of the levels

[1] Adapted from NHS England EPRR Framework: November 2015

Appendix A

Figure 2: NHS Incident Levels: Escalation and De-escalation

Appendix A

5.3. National Threat Levels

Threat levels are designed to give a broad indication of the likelihood of a terrorist attack and are set by the Joint Terrorism Analysis Centre (JTAC) and the Security Service (MI5). National Threat Levels:

- **CRITICAL** - an attack is expected imminently (see NHSE UK Terrorism Threat Level Changes for further details)
- **SEVERE** - an attack is highly likely
- **SUBSTANTIAL** - an attack is a strong possibility
- **MODERATE** - an attack is possible but not likely
- **LOW** - an attack is unlikely

5.4. UK Threat Level Escalation to Severe or Critical

National NHS England UK Terrorism Threat Level Changes outlines the immediate actions required by the NHS following a raise of the UK threat level to SEVERE or CRITICAL.

Appendix 8 provides more detail on the actions that will be followed in the event that the UK Threat Level is escalated to Severe or Critical.

5.5. Types of Incidents

The following list provides commonly used classifications for types of incidents. This list is not exhaustive and other classifications may be used as appropriate. The nature and scale of an incident will determine the appropriate Incident Level.

- **Business continuity(internal) incidents** – e.g. breakdown of utilities, significant equipment failure, hospital acquired infections
- **Big bang** – a rapid on set event such as a serious transport incident or explosion
- **Rising tide** – a developing infectious disease epidemic, or a capacity/staffing crisis or industrial action
- **Cloud on the horizon** – a serious threat such as a significant chemical or nuclear release developing elsewhere and needing preparatory action
- **Headline news** – public or media alarm about an impending situation, significant reputation management issues e.g. an unpopular patient treatment plan which gathers significant publicity
- **Chemical, biological, radiological, nuclear and explosives (CBRNe)** – CBRNe terrorism is the actual or threatened dispersal of CBRNe material (either on their own or in combination with each other or with explosives), with deliberate criminal, malicious or murderous intent
- **Hazardous materials (HAZMAT)** – accidental incident involving hazardous materials
- **Cyber security incident** – a breach of a system's security policy in order to affect its integrity or availability or the unauthorised access or attempted access to a system

- **Mass casualty** – an incident (or series of incidents) causing casualties on a scale that is beyond the normal resources of the emergency and healthcare services ability to manage
- **Evacuation** –Evacuation of a healthcare setting due to a fire or other reason warranting an evacuation. Community evacuation (e.g. flooding) requiring a response from the health system

5.6. Hazards and Risk

The Local Resilience Forum Risk Advisory Group is responsible for regularly assessing hazards to determine the level of risk they present to Nottingham and Nottinghamshire. The level of risk is based on the impact that could be caused by the hazard and the likelihood the hazard may occur. Table 3 summaries the hazards which are considered to have a Very High and High level of risk.

Very High Risk	• **Influenza like Pandemic**
	• **Fluvial (river) Flooding**
	• **Failure of the Electricity Transmission System**
	• **Terrorist / Malicious Related Risks**
	  ○ **Attack on Crowd Places**
	  ○ **Attack on Critical Infrastructure**
	  ○ **Attacks on Transport System**
	  ○ **Cyber Attack**

High Risk	• **Food Supply Contamination** • **Surface Water Flooding** • **Low Temps and Heavy Snow** • **Heatwave** • **Industrial Action (Fuel Supply)**

Appendix A

5.7. Potential Incidents – Possible Implications for the NHS

This is not an exhaustive list of incidents, but covers the highest risks as identified by the Nottingham and Nottinghamshire Local Resilience Forum (LRF), plus additional risk as identified by the LHRP Risk Assessment Processes

INCIDENT	POSSIBLE IMPLICATIONS FOR NHS	OUTLINE RESPONSE
Major Incident **resulting in casualties / disruption to communities or infrastructure**	• Casualties requiring treatment, potentially with traumatic or burns injuries • Potential public health impacts • Evacuation of vulnerable service users • Worried well attendance at primary care and A&E • Evacuated members of the public may need emergency supplies of medication • Possible need to commission additional service provision to support long term treatment (physical and mental health) to those affected by the incident	Multi-agency SCG / TCGs may be convened to coordinate response ICB would coordinate local health response - Possible need to convene an Incident Management Team and HSCETCG UK Health Security Agency would lead on the provision of public health advice ICB to alert GP practices in the locality effected concerning any risks from the smoke / chemical release ICB may be approached by local authority to provide replacement medication for evacuated members of the public who have left their medication behind – Further guidance available in the ICB On Call Handbook
Chemical Biological Radiological & Nuclear (CBRN)	• Contaminated casualties • Potential mass casualty incident • Possible contamination of NHS premises • Possible long term health needs of those contaminated	Multi-agency SCG / TCGs may be convened to coordinate response to incident ICB would coordinate local health response - Possible need to convene an Incident Management Team and HSCETCG Emergency services specialist teams (including EMAS Hazardous Area Response Teams (HART) would be utilised)

INCIDENT	POSSIBLE IMPLICATIONS FOR NHS	OUTLINE RESPONSE
Incident involving hazardous materials		**Acute hospitals de-contamination resources can be used to de-contaminate self-presenters** **Further guidance available in Appendix 10**
Mass Casualty **Incident causing large numbers of casualties**	• **Admission of seriously injured casualties to acute trusts** • **Community wide support to facilitate rapid discharge of patients from acutes to increase capacity** • **Short to long term psychological support to those affected** • **Possible need to commission additional service provision to support long term treatment (physical and mental health) to casualties and those affected by the incident**	**Multi-agency SCG / TCGs convened to coordinate response** **EMAS would implement its Mass Casualty Plan. Under this plan patients would be convened to acute hospitals throughout the East Midlands and further afield. EMAS has agreed with the acute trusts the numbers of casualties they would expect to receive. EMAS may look to acute trusts to receive additional casualties** **Nottinghamshire Mass Casualty CONOPs outlines the response in Nottinghamshire.** **NHS E&I would provide national and regional co-ordination under the NHS England Concept of Operation** **ICB would coordinate local health response - Possible need to convene an Incident Management Team and HSCETCG** **NHS E& I may require the ICB to liaise with the acutes on capacity to receive casualties** **Further guidance available in Appendix 7**
Cyber Incident **seriously disrupting NHS IT & telephony systems with resultant**	• **Loss of NHS IT systems** • **Disruption to NHS service delivery**	**Multi-agency SCG / TCGs may be convened to coordinate response if outage is widespread** **NHS Digital and NHS E&I would co-ordinate overall national NHS response** **Nottinghamshire Cyber CONOPs outlines the NHS response in Nottinghamshire.**

INCIDENT	POSSIBLE IMPLICATIONS FOR NHS	OUTLINE RESPONSE
impact on healthcare		**ICB would co-ordinate local NHS response, liaising with NHS providers and IT technical support** **Further guidance available in Appendix 6**
Business Continuity incident disrupting patient services	• **Disruption to NHS service delivery** • **Impact on patient safety and care**	**Affected NHS provider to utilise business continuity plans to respond and recover service deliver** **If the incident is affecting the wider NHS in Nottinghamshire / causing a significant disruption to NHS service delivery, the ICB would coordinate the local health response** **If ICB affected – Utilise ICB Business Continuity Plan**
Severe Weather **(Winter Weather / Flooding / Heatwave)**	**Snow and Ice** • **Disruption to community service delivery** • **Potential risk to vulnerable service users if access is not possible** • **Potential impact on patient flow out of acute hospitals** • **Impact on staffing**	**NHS providers utilise Business Continuity Plans** **Multi-agency SCG / TCGs may be convened to coordinate response (prior to and during the period of severe weather)** **Possible use of 4x4 resources and military to support response** **ICB to co-ordinate local NHS response – Further guidance in the ICB On Call Handbook**
	Heatwave • **Risk to vulnerable people** • **Increase in attendance at A&E** • **Increase fatalities**	**Communication messages to the public on staying healthy during hot weather** **ICB to co-ordinate local NHS response – Further guidance in the ICB On Call Handbook**

INCIDENT	POSSIBLE IMPLICATIONS FOR NHS	OUTLINE RESPONSE
	River / Surface Water Flooding • Evacuation of vulnerable service users • Disruption to community service delivery • Evacuated members of the public may need emergency supplies of medication • Flooding of healthcare premises	Multi-agency SCG / TCGs may be convened to coordinate response (prior to and during the period of flooding Evacuation of affected communities SCG / TCG may request NHS to identify vulnerable service users in at risk areas in support of a planned evacuation Utilise GPs / out of hours providers to prescribe replacement medication where necessary for evacuated member of the public Primary care and NHS providers would be expected to implement business continuity plans if buildings are flooded Multi-agency partners would use LRF flood maps to determine the size of the population at risk Further guidance available in the ICB On Call Handbook Need to continue community health care to evacuated community patients
Major utility failure resulting in a loss of gas, water, electricity	• Disruption to NHS service delivery • Vulnerable service users at risk	Hospitals with beds have back-up generators (do all of NHT bedded facilities) NUH bore hole ICB and affected providers would implement business continuity plans Multi-agency SCG / TCGs may be convened to coordinate response to widespread / prolonged disruption SCG / TCG may request NHS to identify vulnerable service users in affected areas so support can be provided. ICB may be called upon to co-ordinate the collation and prioritisation of service users for support

INCIDENT	POSSIBLE IMPLICATIONS FOR NHS	OUTLINE RESPONSE
		ICB to coordinate local NHS response Local authority would implement multi-agency plans to respond to a major utility failure
Infectious Disease Outbreak	• Potential public health risk from spread of infection • Possible disruption to NHS service delivery due to infection control procedures, staff shortages • Potential for increased demand on the NHS • Provision of vaccination and testing services	Further guidance available in the ICB On Call Handbook Incident UK Health Security Agency would lead response to the outbreak, calling upon NHS providers to provide resources to as outlined in the UK Health Security Agency Outbreak Management Plan Convening of Outbreak Control meeting ICB to coordinate local NHS response ICB may be called upon to approve additional financial support Further guidance available in Resilience Direct https://collaborate.resilience.gov.uk/RDService/home/145087/Library
Pandemic	• Public health risk from spread of infection • Disruption to NHS service delivery due to infection control procedures, staff shortages • Increased demand on the NHS • Provision of new services • Elective services may need to be reduced to release NHS Staff • Provision of vaccination and testing services	NHS England would lead the national & regional NHS response UK Health Security Agency would provide appropriate advice regarding the disease Multi-agency SCG / TCGs would be convened to coordinate multi-agency response ICB to coordinate local NHS response ICB Incident Management Team would be convened Specialist Cells would be established e.g. Data, Primary Care HSCETCG would be convened to provide strategic NHS Coordination

INCIDENT	POSSIBLE IMPLICATIONS FOR NHS	OUTLINE RESPONSE
		ICB may be called upon to expand / commission new services to respond to the pandemic
EVACUATION & SHELTER (Healthcare facility)	• **Evacuation of patients (within a site or evacuation from the site)** • **Dependent on which service areas have been evacuated, there may be knock on effects on the local of wider health system (e.g. evacuation and closure of an Emergency Department or maternity).**	**Under the NHS England & NHS Improvement *Evacuation and shelter guidance for the NHS in England, October 2021* all NHS organisation are required to have plans in place for the evacuation and shelter of staff, patients and visitors.** **This should include arrangements to shelter and/or evacuate, whole buildings or healthcare sites, working in conjunction with other site users where necessary.** **An organisation may declare a major incident, especially in the event of a large scale / whole site evacuation. The organisation may request mutual aid to assist In the evacuation.** **ICB would co-ordinate local NHS response** **Coordination with partner agencies may be necessary in support of the evacuation.** **Non in-patient healthcare facilities must have fire evacuation plans for evacuating staff, visitors and patients safely from a building.**

INCIDENT	POSSIBLE IMPLICATIONS FOR NHS	OUTLINE RESPONSE
Evacuation of members of the public (for example due to flooding)	• **Evacuation within the community may require support from community healthcare services , EMAS to rest centres.** • **Large scale community evacuations may impact on community health service delivery (disruption to transport routes, patients relocated).** • **Large scale evacuation of Lincolnshire residents due to severe coastal flooding – require access to primary care and possibly secondary care within Nottinghamshire.**	**Community providers may be called upon to support evacuated members of the public (e.g. in rest centres).** **ICB may be approached by local authority to provide replacement medication for evacuated members of the public who have left their medication behind – Further guidance available in the ICB On Call Handbook**

Appendix A

6. Alerting ICB to Incidents

All organisations must operate a 24/7 single point of contact and have a trained on-call senior member of staff who can lead the organisation's response to an incident.

The ICB operates a two tier on-call, with a ICB Silver & Gold On-call. The ICB Silver On-call is available 24/7 and is the ICB single point of contact.

6.1. Alerting ICB to incidents in the NHS

Organisation's On-call / ICCs / Operational Rooms, , must inform the **ICB** of a **business continuity, critical or major incident,** as well as incidents with significant local profile, including media profile. This includes informing the **ICB,** that the organisation is on "stand-by" to declaring an incident.

Figure 3 has been developed to assist organisations in determining the type of incident.

6.2. Multi-Agency / LRF incident declaration

Under the LRF incident response activation it is the responsibility of **East Midlands Ambulance Service** (**EMAS)** to alert the **ICB** to a major incident (including activation of a SCG or TCG) and acutes as receiving hospitals for casualties.

The **ICB** would alert **other health organisations** to the incident as appropriate.

6.3. Standard Alerting Messages

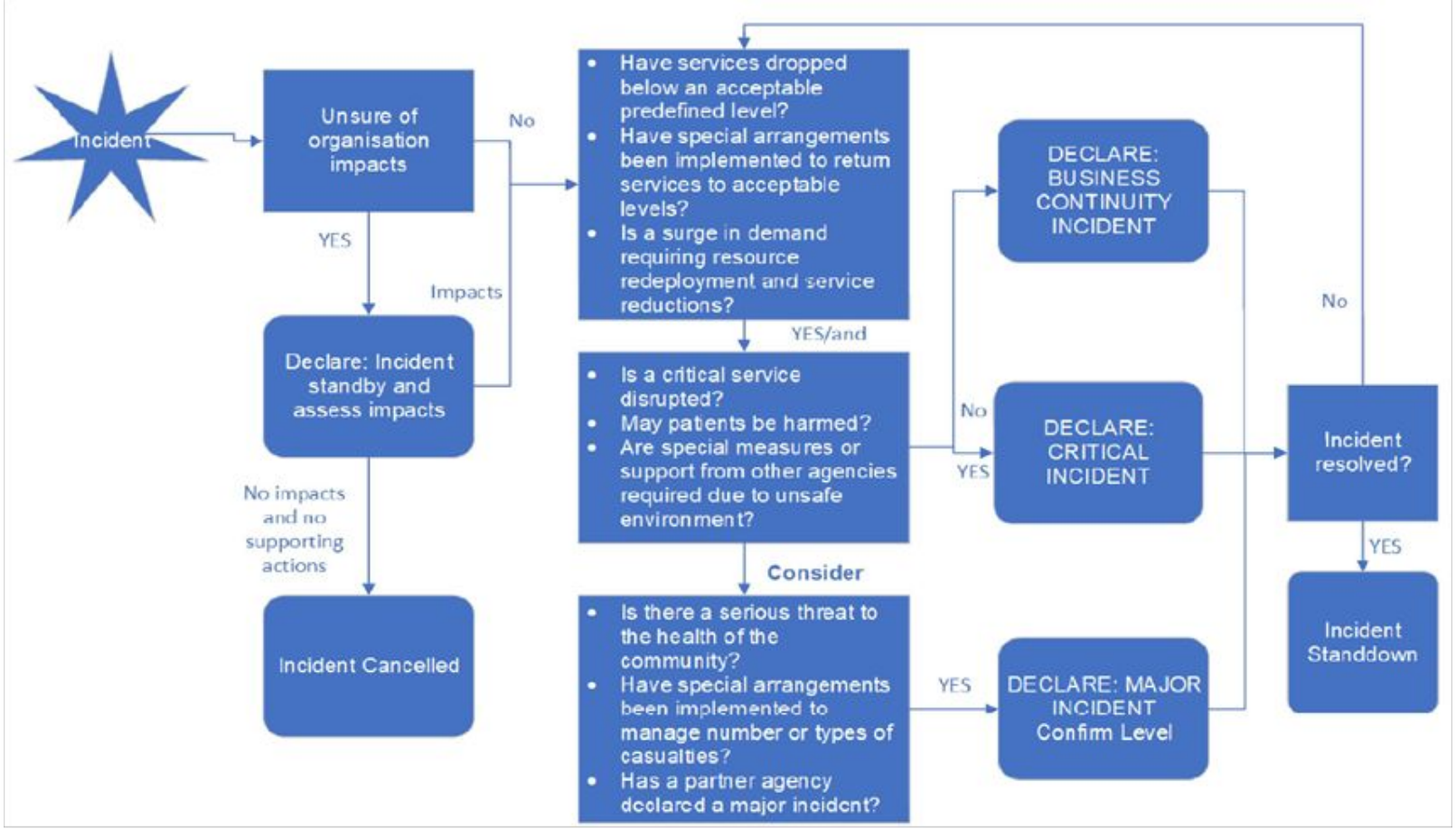
When alerting the ICB to a Major Incident, the alert must be prefixed:

Major Incident Standby	This alerts the NHS that a major incident may need to be declared. It is likely to involve NHS organisations making preparatory arrangements appropriate to the incident
Major Incident Declared	This alerts NHS organisations that they need to activate their plan and mobilise additional resources
Major Incident Cancelled	This message cancels either of the first two messages at any time
Stand Down	All receiving hospitals are alerted as soon as all live casualties have been removed from the site. It is the responsibility of each NHS organisation to assess when it is appropriate for them to stand down their own response

The standard format for the receipt of information relating to major incidents in the is the METHANE mnemonic. The template for making a METHANE report can be found in **Appendix 3** and on the ICB's Resilience Direct site https://collaborate.resilience.gov.uk/RDService/home/148367/Templates

Appendix A

Figure 3 Incident Type Flow Chart



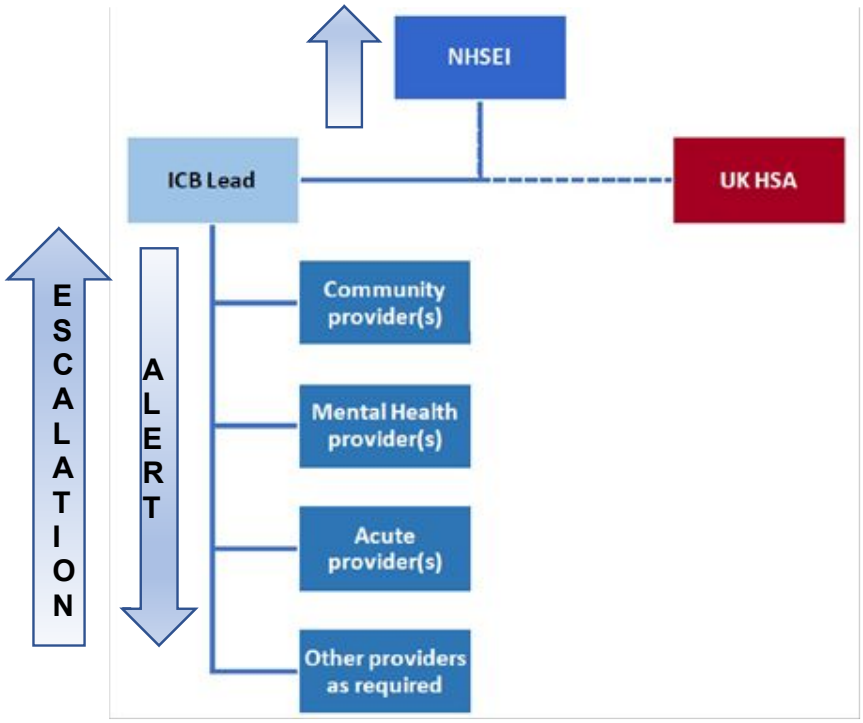
Appendix A

6.4. Alerting NHS England

The **ICB Silver On-call** will alert **NHSE&I Midlands On-call** to any declared incidents or where an organisation has placed themselves on standby.

In hours the **ICB Silver On-call should also alert the ICB EPRR Team** nnicb-nn.oncall@nhs.net and the **ICB Urgent Care Team** nnicb-nn.urgentcareteam@nhs.net

Figure 4: System Escalation



In line with the EPRR Framework, NHS England (Midlands) must be informed when ICB / providers:-
• Need to activate your Business Continuity Plans for any reason (this includes electrical failure, failure in diagnostic imaging, fire, telecoms failure). • Are involved in a major incident, declared by yourself or a partner organisation. • Anticipate difficulties, with resources becoming overwhelmed due to an incident; with the potential for mutual aid arrangements to be invoked. • Are experiencing a significant pressure surge (of which your commissioners are aware) that has the potential to impact on your ability to respond to a major incident. • Are the target of a threat (actual or perceived) involving explosives or CBRN material; or you have activated your Hazmat/CBRNe plan. • Need to invoke your Evacuation plan. • Are supporting the local authority following large scale community evacuation. • Are involved in an incident with significant casualty numbers or perceived impact. • Anticipate or are experiencing media interest relating to an incident or emergency.

6.5. Alerting Cascades by Incident Type

Type of incident/Alert	Method Alerting
Business Continuity Incident	**The organisation declaring a Business Continuity Incident would inform the ICB** **Where the business continuity disruption is having implications for the wider health service, the ICB as local health system leader would co-ordinate the health response** Where a **business continuity incident** is declared a **SBAR** report must be provided by the declaring organisation – A **SBAR** form template is included in Appendix 5
Critical Incident **(i.e. internal disruption to trust)**	**The organisation declaring Critical Incident would inform the ICB.** **The ICB as local health system leader would co-ordinate the health response** Where a **critical incident** is declared a **SBAR** report must be provided by the declaring organisation – A **SBAR** form template is included in Appendix 5
Major Incident	**The Ambulance Service would notify receiving hospitals and the ICB. Other Emergency Services may also be notified.** **The ICB would make contact with Acute Trusts to ensure the declaration has been received, understood and to confirm any actions/issues.** **The ICB would alert the following as they may be required to support the health response :** • **Notts Healthcare and CityCare Partnership (especially if incident is within the vicinity of CityCare's London Road Urgent Care Centre)** • **ERS as Patient Transport Services provider** **The ICB would alert the following as they could see an increase in presentations / surge on the system:** • **ICB Urgent Care Team (in hours)** • **NEMS as GP out of hours provider** • **DHU as NHS 111 provider** • **ICB Primary Care Team so general practices are aware (in hours)** On initial Major Incident declaration the organisation should provide a **METHANE** report. A **METHANE** form template is included in Appendix 3

Type of incident/Alert	Method Alerting
Infectious Disease Outbreak	UK Health Security Agency would follow local infectious disease action cards / plans, and alert those NHS provides required to provide resources to respond to the outbreak. UK Health Security Agency would also alert the ICB. An Outbreak Incident Management Team may be convened by UKHSA. The ICB as local health system leader would support UK Health Security Agency in co-ordinating the local health response to the outbreak.
Severe Weather (including winter weather / heatwave)	All NHS organisations should be alerted to the risk of severe weather through the receipt of Met Office weather warnings The ICB would be alerted by the Local Resilience Forum to any multi-agency agencies meetings called ahead of or in response to severe weather The ICB as local health system leader would coordinate the local health response to any impact on local health services caused by the severe weather
Flooding	All NHS organisations should be alerted to the risk of flooding by the receipt of Environment Agency flood warning The ICB would be alerted by the Local Resilience Forum to any multi-agency agencies meetings called ahead or in response to flooding The ICB as local health system leader would coordinate the local health response to any impact on local health services caused by the flooding
Evacuation and Shelter	NHS organisations would alert the ICB to an evacuation, especially if the evacuation is of such a scale support is required and / or the evacuation will have a knock on effect to the wider health system The Local Authority emergency planning teams / LRF will alert the ICB to a community evacuation where support is required.

Appendix A

7. Situation Reports & Shared Situational Awareness

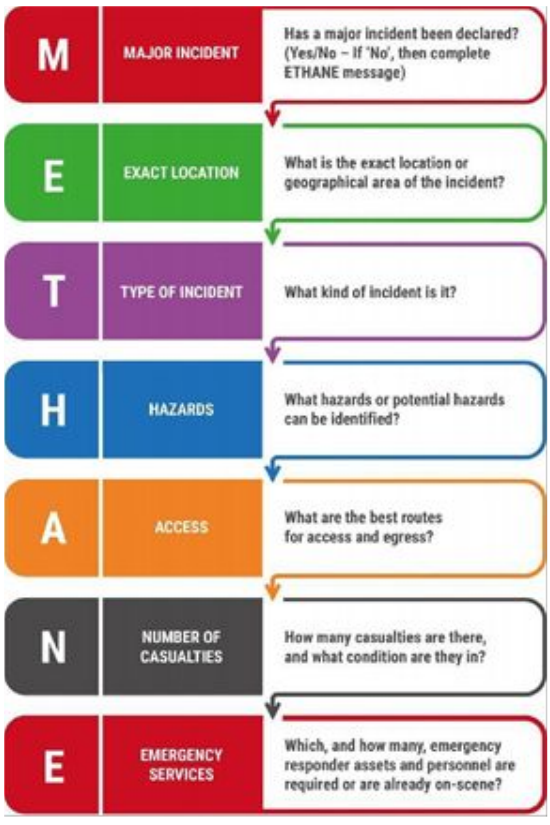
To ensure the decisions made during in incident are clear and defensible, it is vital for the **ICB** to have accurate, clear and up to date information concerning the incident. The provision of situation reports are also key in the establishment of a clear shared situational awareness which is vital in coordinating the system response.

Initial information may be limited, but the ICB On-call should aim to establish:-

- **The type of incident**
- **The current and projected impact of the incident on NHS service delivery or the nature of the required response**
- **How many casualties are involved**
- **Ability for the organisation to cope – any additional support or resources require**
- **Which other agencies/partners are involved in the incident**
- **Any media interest**

The METHANE mnemonic (see Figure 5) provides an example of the questions to ask in order to establish the incident details.

Figure 5: METHANE Mnemonic



7.1. Situation Reports by Incident Type

Where **NHS organisations** have declared an incident, they must provide a situation report to the **ICB. Figure 6** outlines the situation reports required by incident.

Figure 6: Situation Report Requirements

Type of incident/Alert	Situation Report Required
Business Continuity Incident	Where a **business continuity incident** is declared a **SBAR** report must be provided by the declaring organisation – A **SBAR** form template is included in **Appendix 5**
Critical Incident	Where a **critical incident** is declared a **SBAR** report must be provided by the declaring organisation – A **SBAR** form template is included in **Appendix 5**
Major Incident	On initial Major Incident declaration the organisation should provide a **METHANE** report. A **METHANE** form template is included in **Appendix 3**

7.2. Situation Reporting to NHS England

ICB would ensure that a situation report is forwarded to **NHS England Midlands On-call**

Once further information is available - organisation(s) responding to a **Major incident** are required to provide the **ICB** with a completed **NHS Situation Report.**

The template can be found on the **ICB Resilience Page**
https://collaborate.resilience.gov.uk/RDService/home/148367/Templates

If multiple organisations are involved and providing NHS Situation Reports, the **ICB** will be required to provide **NHS England** with a collated report as indicated by **Figure 7.**

The Regional Incident Director, Regional Head of EPRR or Regional Head of Operations may establish timetable for the submission of situation reports if not nationally driven. Additional information may be requested of organisations during an incident via a specific reporting tool.

NHS organisations will provide information as requested of them included but not limited to:

- Capacity figures and operational issues
- Casualty figures including severity of injury and status (but not patient identifiable information)
- Business continuity and incident arrangements in place
- Communications issues

Organisations receiving walk in casualties should self-report these to the region even if they have not been formally requested to submit a situation report. This allows the full scale of the incident to be understood. It should be noted in some incidents, walk-in casualties may travel to areas outside the regional boundary and other regions should be alerted to the need to notify walk in casualties.

7.3. Multi-Agency Situation Report

Multiagency partners will require updates via any sitting Strategic Coordinating Group (SCG), this should always reflect the latest NHS reported position to Department of Health and Social Care to prevent misreporting. Health representatives at SCGs are asked to ensure only formal NHS figures from the whole health service are used, and for clarity a time stamp of reporting should be added to these.

SCG members should be reminded that the reporting of casualty figures is the responsibility of NHSE&I and should not be confirmed by other agencies. Only the time stamped NHS data should be utilised.

Responsibility for reporting of deaths to the media and public may be dependent on the nature of the incident, with the Police often taking the lead in major incidents and the NHS in health incidents such as infectious diseases.

Where patient numbers are low or fall to a small number, potentially making individuals identifiable the NHS will stop reporting these publicly.

At scene, during the early stages of an incident, it is often not possible to provide accurate casualty figures. However, where indications of numbers involved are available, these should be shared but heavily caveated as a best guesstimate based on the circumstances emergency services are responding to at that time. Once a scene is cleared and all patients have been received to hospital, NHSE is responsible for the publication of patient numbers affected by the incident. Depending on the nature of the incident, this may be delegated to a local NHS organisation.

8. NHS Command, Control & Coordination

The ICB would coordinate the local health system response to a critical or a major incident, including incidents at Levels 1 and 2 (with support from NHS E&I for Level 2 incidents).

In the event of Level 3 or 4 incident the ICB would support NHS E&I in their coordination of the incident.

8.1. System Coordination

Providers are required to have 24/7 ability to provide and coordinate their response to an incident impacting on their service delivery or a major incident. Small scale incidents not causing any impact on the local system are unlikely to require ICB coordination, with responsibility on the provider to manage the response. The ICB would monitor the situation, taking up coordination of a system response if the situation deteriorated and impact on the system.

Where surge on the system or an incident is resulting in increased pressure on the health and social care system, it is the responsibility of the ICB to liaise with providers and coordinate the system response.

Out of hours this is the responsibility of the **ICB On-call**. it may be appropriate to use pre-arranged or specially convened System Calls for the coordination of the response.

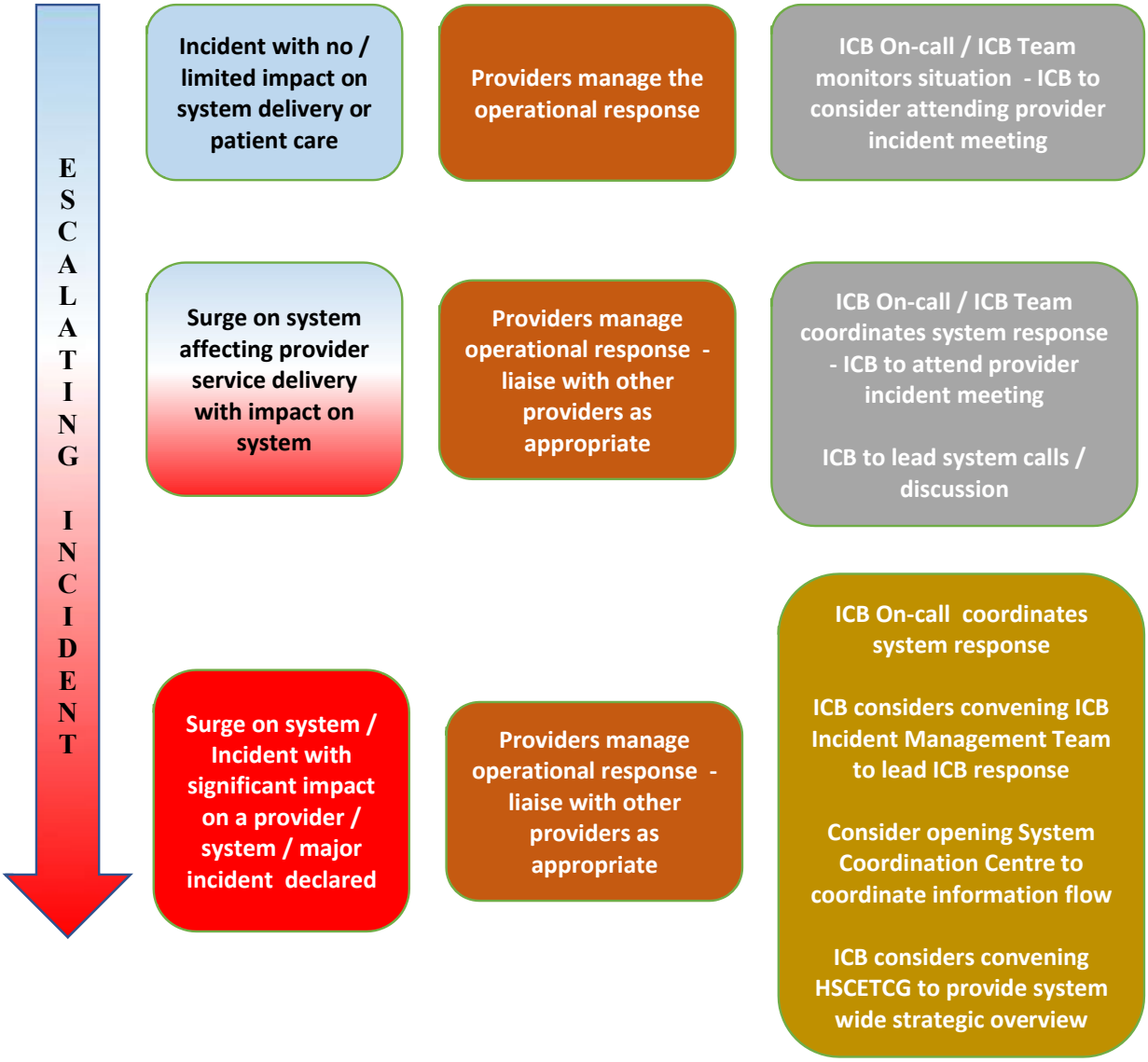
In hours the **ICB Urgent Care Team** would be expected to lead on coordinating the response to pressure on the system caused by the Incident. This would be through pre-arranged or specially convened system call.

The **ICB Urgent Care Team** would brief the **ICB On-call** on the situation. Where appropriate the **ICB On-**call would join in hours system calls.

In the event of a major incident requiring a health response or an incident causing significant impact / disruption on the system, the **ICB Accountable Emergency Officer / ICB Gold On-call** may decide that it is necessary to convene a **ICB Incident Management Team** to support system coordination.

Furthermore If the necessary system response to the incident or the disruption to the system is of such a scale, the **ICB Accountable Emergency Officer / ICB Gold On-call** may decide that health and social care coordination at an executive level is required and convene a **Health & Social Care Economy Tactical Coordination Group (HSCETCG).**

Figure 8: Schematic of ICB Incident Coordination



8.2. ICB Incident Coordination Centre

In the event of a major incident or similar disruptive event, especially if likely to be prolonged or additional resources may be required it may be necessary for the ICB to establish and maintain an Incident Coordination Centre (ICC).

The ICC comprises:-

- ICB Incident Management Team convened to oversee the ICB response
- ICB System Operations Centre (SOC) to receive and emails and calls . Incoming information will be logged and brought to the attention of the Incident Director.

The **ICB Incident Management Team** is chaired by the ICB Accountable Emergency Officer (AEO) or the ICB Gold On-call, membership depending on the incident complexity and specifics of the incident but should aim to:

- Support the AEO / Gold On-call as Incident Director in directing and co-ordinating the ICB's and the wide system's response strategy and operations.
- Provide a forward look to issues that may arise and their consequences and forecast the NHS response to mitigate these issues.
- Be the route through which tasking is actioned
- Act as the conduit for information requests
- Manage information relevant to the incident and disseminate as necessary (governances, records management)
- Provide Situation Reports (SITREP)
- Operate the **System Operations Centre (SOC)**

Recommended membership of a ICB Incident Management Team is outlined in Action Card 3.

The **SOC** would be established to support the Incident Management Team, through providing an enhanced level of operational support.

The **ICB ICC Plan** details the arrangement for establishing the SOC. In outline the SOC comprises **ICC Coordinators**, responsible for monitoring the ICC inbox and phone line, bring all enquires to the attention of the IMT and the collation and submission of reports to the **regional ICC (Midsroc).**

NHS England Midsroc and provider ICCs would need to be informed of the opening of the **ICB SOC**, including confirmation of email address and phone number to be used.

To facilitate the coordination of enquires and information flow the ICC is overseeing by the **ICC Lead / Information Manager (Action Card 5)** to, who is responsible for bringing any urgent enquires / information requests to the attention of the IMT or specialist ICB team / department or cell.

The IMT and SOC can work virtually or physically within **Sir John Robinson House, Arnold as** the primary location. A hybrid approach may be adopted with staff working remotely and other staff working in Sir John Robinson House.

Out of hours the ICB Incident Management Team may initially be restricted to the available ICB On-call members of staff, but if Gold On-call decides a formal Incident Management Team needs to be convened, the Silver On-call can use the contact numbers for all on-call staff to alert them and request they join the Incident Management Team. Contact numbers for On-Call is held in Resilience Direct under contacts.

8.3. Health & Social Care Economy Tactical Coordination Group (HSCETCG)

In the event of significant and sustained pressure on the system or in the event of a major incident, it may be necessary to convene a **Health & Social Care Economy Tactical Coordination Group (HSCETCG)**

The overarching aim of the **HSCETCG** is to coordinate the response of the local health and social care system to an incident or severe pressure on the health & social care system.

This would require Chief Executive / Gold / Director level representation from across health and social care.

The **HSCETCG** can be held either virtually (MS Teams / teleconference) or at a specific location.

It will be the responsibility of the ICB to organise and provide secretariat support to the **HSCETCG**.

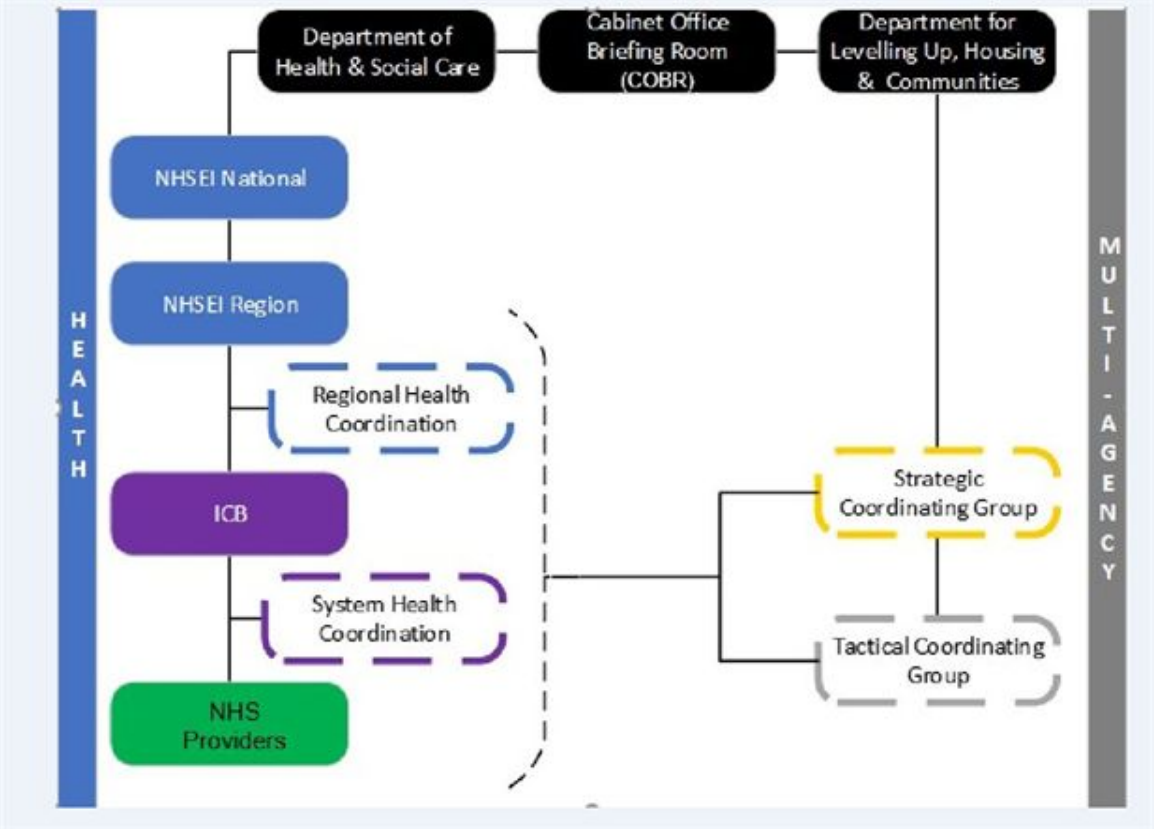
Membership on the HSCETCG may include, but is not limited to:

- ICB Gold On-Call / Accountable Emergency Officer / Chief Executive (Chair)
- Loggist (ICB)
- ICB Communications representative
- Nottingham University Hospitals NHS Trust
- Sherwood Forest Hospitals NHS Foundation Trust
- Doncaster & Bassetlaw Teaching Hospitals NHS Trust
- Nottinghamshire Healthcare NHS Foundation Trust
- CityCare
- NEMS
- NHIS
- ERS Medical (NEPTS provider)
- DHU (NHS 111 provider)
- NHS England & NHS Improvement
- EMAS
- Local Authority (Public Health & Social Care)
- UKSHA (if related to a public health incident)

A suggested agenda for a HSCETCG can be found in Action Card 4.

9. Multi-Agency Command & Control

Figure 9: Co-ordinating Groups



9.1. Strategic Coordination Group (SCG)

The role of the SCG is to take overall responsibility for an incident that requires a multi-agency response. The SCG is primarily tasked with setting strategic objectives, coordinating efforts and ensuring resources are available. The SCG is usually chaired by the Police (or local authority) and its membership includes Strategic (Gold) Commanders (i.e. Director Level or deputised attendees). Within the NHS the representative for the SCG will be the ICB. NHS England and Improvement may also attend a SCG.

The overarching aim of the strategic lead role is to protect life, property and the environment by ***setting the policy, strategy*** and the ***overall response framework*** for the incident and for both the tactical and operational levels to act on and implement

Strategic leads should jointly agree the response strategy with internal and external representatives

9.2. Tactical Coordination Group (TCG)

The role of the TCG is to coordinate the tactical response to an Incident by the development and delivery of a tactical plan. The TCG is usually chaired by the Police and its membership includes Tactical (Silver) Commanders; within the NHS the representative for the TCG will be the ICB. Other NHS Category 1 responders may attend the TCG (this is likely to be dependent on the nature of the incident).

Note EMAS will also attend the SCG and TCG.

Additional guidance can be found on the SCG and TCG in Appendix 11.

9.3. Science and Technical Advice Cell (STAC)

The Scientific and Technical Advice Cell (STAC) provides technical advice to the Strategic Coordinating Group. The STAC would be expected to advice on issues such as the impact on the health of the population, public safety, environmental protection, and sampling and monitoring of any contaminants.

In the event of a major incident the STAC is activated by the Police Gold Commander through the cell lead or relevant duty officer. However, a Director public health professional (i.e. Director of Public Health or the UKHSA Director) may recommend to the Gold Commander that a STAC needs to be established due to the potential impact on the health of the local population from an actual or evolving incident.

10. Decision Making

Decision making, especially during an incident, is often complex and decisions may be open to challenge. Decision makers will be supported in all instances where they can demonstrate that their decisions were assessed and managed reasonably in the circumstances existing at a particular point in time. Use of decision support models and processes assist in providing this evidence.

NHS E&I national guidance recommends the use of the national JESIP Joint decision model (JDM).

Figure 10: JESIP Joint Decision Model

One of the guiding principles of the JDM)is that decision makers use their professional judgement and experience in deciding any additional questions to ask and considerations to take into account, so that they can reach a jointly agreed decision.

The first stage of the JDM helps commanders gather all known information - or situational awareness – about the emergency. Commanders should ask:

- What is happening?
- What are the impacts?
- What are the risks?
- What might happen?
- What is being done about it?

The second stage of the JDM prompts commanders to ensure they have reviewed and understood all risks so that appropriate control measures can be put in place. Understanding risk is central to incident response.

The third stage of the JDM aims to ensure commanders have considered the following when planning their joint response:

- What relevant laws, standard operating procedures and policies apply?
- How do these influence joint decisions?
- How do they constrain joint decisions?

The fourth step of the JDM reminds commanders to consider all potential options when planning the joint response. For every potential option or contingency commanders should consider:

- **Suitability** – does it fit with the strategic direction?
- **Feasibility** – in resource terms, can it be done?
- **Acceptability** – Is it legal, morally defensible & justifiable?

There will almost always be more than one option to achieve the desired end state, and it is good practice that a range of options are identified and rigorously evaluated.

The fifth step of the JDM is about reviewing what has taken place and, if required, re-evaluating and amending plans. As the JDM is a continuous loop, it is essential that the results of agreed actions are fed back into the first box - Gather and share information and intelligence - which establishes shared situational awareness. This will, in turn, shape any revision to the direction and risk assessment, and the cycle continues.

10.1. Communications

Effective communication by responders can reduce negative impacts of incidents by:

- Reducing unnecessary care-seeking by unthreatened populations
- Enhancing likelihood that at-risk populations will take protective actions
- Reducing rumours and fear
- Maintaining public trust and confidence
- Increasing co-operation with authorities co-ordinating the response

The level of coordination of communications messages will reflect the NHS Incident level. In an Incident at Level 1 to 2 there should be coordination between providers affected and the ICB. At Incident Level 3 or 4, then NHS E&I should take on this coordinator role.

Where a multi-agency response to an incident is in place, media output may be coordinated by the lead agency, often the Police.

Due regard should also be paid to ensuring that ICB staff are also informed about an incident; as well as being involved as NHS staff they are also members of the public and as such useful links to the community.

Social media is an important tool to enhance the effectiveness of communications as outlined above, particularly challenging incorrect messages.

11. Record Keeping and Incident Logging

When responding to an incident it is essential that any decisions made, or actions taken, are recorded and stored in a way that can be retrieved at a later date to provide evidence. It may be necessary to provide all documentation, therefore robust and auditable systems for documentation and decision making must be maintained.

ICB on-call should maintain a personal log during an incident. A template for recording such decisions is available in Appendix 2.

If a decision is made by the ICB Gold On-call to establish an Incident Management Team, a Loggists would be required to maintain a formal log of the Incident Management Team's decision and actions **(an electronic Incident Template to record decision can be found in Appendix 13)**

A Loggist is an integral part in any incident management team. The ICB has a cohort of trained Loggists which can be found on Resilience Direct under contacts

Where significant decisions are to be made, particularly those that will affect other organisations, the record should include the following factors in addition to normal logging of decisions:

- Details about the incident, including potential for escalation or de-escalation
- A record of threats and risks including mitigation measures
- Polices, plans and procedures taken into account
- Options considered
- Decision taken, including both rationale for taken option chosen, and rationale for not taking options dismissed
- Timescale for review

Maintaining a Formal Log

- The Chair should hold a brief meeting with the Loggist prior to the Incident Team meeting to allow the Loggist an opportunity to ask any questions and to ensure both are clear on the Log is to be kept
- The loggist will be responsible for recording and documenting all key information / actions / decisions made by the Incident Director / Incident Manager
- The loggist must use the log book provided (held within the ICC Store) – The exception is where the IMT is held virtually **and the electronic Incident Template would be used to record decision (Template in Appendix 13)**
- If an Incident Management Team has been convened, then on arrival all staff must wear identification badges. If the badges are unclear the loggist must ask for clarification of who is present within the room and their job role
- The log must be clearly written, dated and initialled by the loggist at start of shift and include the location
- All persons in attendance to be recorded in the log
- The log must be a complete and continuous record of all key information / decisions / actions as directed by the Incident Director/Incident Manager

- Timings are recorded each time information is received or transmitted. If individuals are tasked with a function or role this must be documented and when the task is completed this must also be documented
- If notes or maps are utilised these must be noted within the log and retained
- At the end of each session of the Incident Team, the Incident Director will check and sign the log to formally approve the log as a fair and accurate record. If an electronic log Is taken this must be sent to the IMT Chair for checking.
- *All* documentation is to be retained for evidence for any future proceedings (left securely in the ICC store for retention by the ICB EPRR Manager). Retention should be for 30 years.
- Where something is written in error changes must be made by a single line scored through the word and the amendment made and signed by the loggist.

12. Stand Down and Recovery

As an incident develops, there will come a time when it is possible to stand down an incident and the response to it. Local incidents may be stood down by the emergency services / local authority / trusts / ICB as the lead of the local health system.

Incidents on a regional of national scale (Level 3 and 4) the decision to stand down will come from NHS E&I Incident Director. Any decision to stand down will need to be logged and communicated immediately to all relevant internal and external partners/agencies as is necessary.

Recovery and returning to normal ways of working is a crucial part of the management of all major incidents / emergencies. This process is responsibility of the Incident Director that will ensure that it happens in a timely manner. To achieve this, he/she may appoint a Recovery Lead in order to return functions and systems to business as usual. The recovery process will utilise ICB processes already in place and adapting them case by case. The transition to the recovery stage will happen as soon as is feasible

Following an incident, the ICB may need to undertake a number of organisational recovery activities which may include (but not be limited to) the following:

- Supporting the recovery of GP practices, including co-ordinating access across Nottingham and Nottinghamshire
- Identifying appropriate support mechanisms which can be made available to staff and their families, recognising that staff may be affected directly by the incident through death, illness or disability
- Temporary reallocation of staff and resources across all ICB bases
- Staffing and resources to address new locations, environments, organisational changes, reduction of resources, etc
- Reviewing key priorities for critical functions and restoration; Financial implications, remunerations and commissioning agreements
- Impact on routine performance and assurance reporting to NHS E&I
- Funerals and memorials
- The on-going need for assistance to NHS E&I

In addition, the ICB may have to commission health related functions (i.e. Clinical Services) during recovery to support the affected community or other organisations involved in recovery activities, which may include (but not be limited to) the following:

- Mid to long term community support and medical services;
- Commissioning of psychosocial support following a traumatic event (access to post incident mental health services)
- Direct or indirect support to affected communities through primary care;
- Staffing and resourcing needs to support other health organisations affected by the disaster or recovery function.

Business Continuity plans will assist in identifying priority functions and their recovery time objectives.

If a multi-agency response is in place, a multi-agency Recovery Coordinating Group may be established under the leadership of the relevant local authority.

Debriefing

A hot de-brief will be held within 24 hours of the close down of the incident – ideally at the end of incident before staff have dispersed. A full (cold) de-brief will be held within 15 working days of the incident. The initial incident report will be produced within 30 working days.

Structured debriefs should be held with involved staff as soon as possible after de-escalation and stand down. Participants must be given every opportunity to contribute their observations freely and honestly. The Incident Director must ensure that the full debriefing process is followed.

As part of the debriefing process a post incident report will be produced to reflect the actual events and actions taken throughout the response. Typically, this will include:

- Nature of incident
- Plans used or considered
- Involvement of other responding agencies
- Actions undertaken
- Chronology of events

This post incident report should be considered at an ICB Governing Body meeting.

Lessons identified process

A separate lessons identified report will focus on areas where response improvements can be made in future. This report will include the following sections:

- Introduction
- Observations
- Action Plan (detailing recommendations, actions, timescales and owner).

Throughout the incident at whatever level, there will need to be an agreed process in place to evaluate the response and recovery effort and identify lessons. The Incident Director is responsible for activating the lessons identified process and may delegate the responsibility for lessons identified to the Incident Manager. The lessons identified process will be implemented at the start of the response and continue during and after the incident until all actions are completed. The LHRP will be a useful vehicle for ensuring that all organisational learning is shared across the health community.

13. Exercise, validation and review

Approval of plan

This plan will be approved via the Directors Group and Governing Body of the ICB and subject to final signoff from the Accountable Emergency Officer.

Exercises

The ICB will carry out exercises against the Incident Response Plan The NHS E&I EPRR Framework 2015 requires NHS organisations to undertake:

- A test of ICC equipment every three months.
- A Communications exercise every six months. These exercises are to test the ability of the organisation to contact key staff and other NHS and partner organisations, 24/7. They should include testing telephone, email, paging and other communications methods in use. The communications exercise should be conducted both during the in-hours period and the out-of-hours period on a rotational basis and should be unannounced.
- A table top exercise every year. The table top exercise brings together relevant staff, and partners as required, to discuss the response, or specific element of a response, to an incident. They work through a particular scenario and can provide validation to a new or revised plan. Participants are able to interact and gain knowledge of their own, and partner organisations' roles and responsibilities.
- A 'live' exercise every 3 years. The live play exercise is a live test of arrangements and includes the operational and practical elements of an incident response.
- A Command Post Exercise every three years. The command post exercise tests the operational element of command and control and requires the setting up of the Incident Control Centre (ICC). It provides a practical test of equipment, facilities and processes and provides familiarity to those undertaking roles within the ICC. It can be incorporated into other types of exercise, such as the communications exercise or live play exercises.

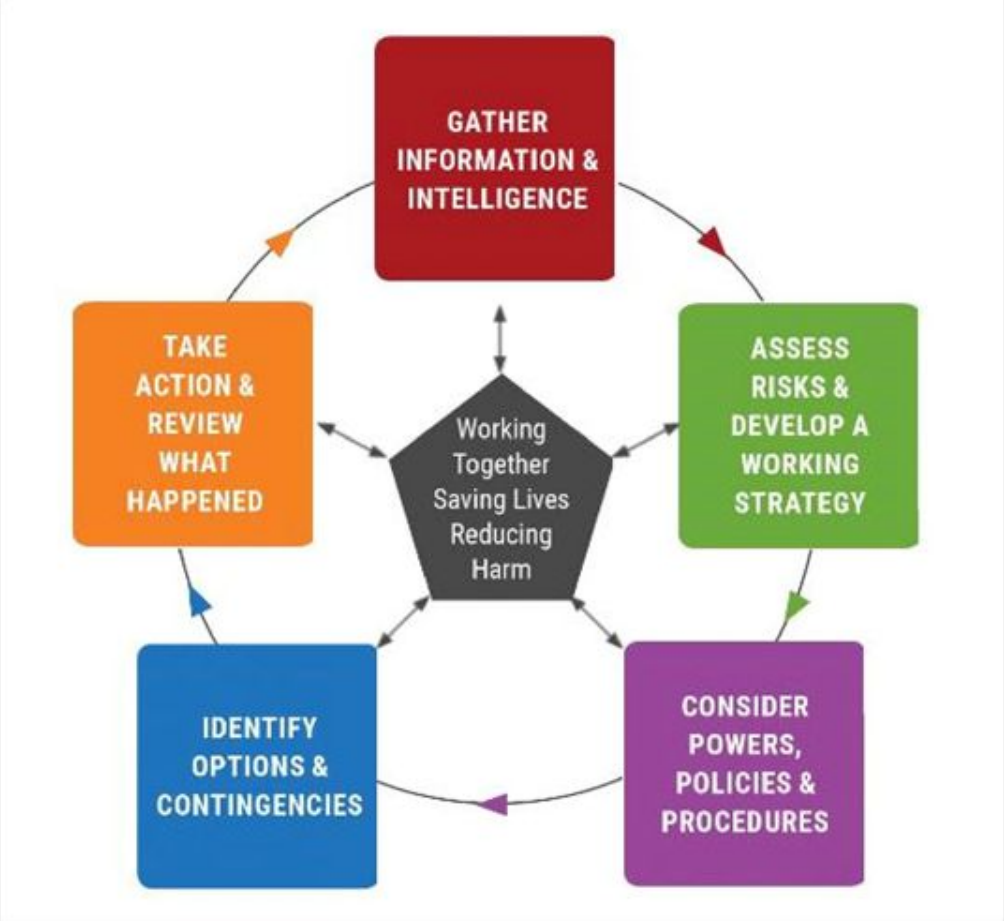
There is also an expectation that NHS funded organisations will actively participate with exercises run by multi-agency partners, including the LRF, where relevant to health. The LHRP will be the forum for coordinating such activity.

Review

This plan will be reviewed annually, unless it has been reviewed after an incident or emergency.

INCIDENT RESPONSE SECTION

To be used when alerted to an incident



Appendix 1 – Incident Response Action Cards

		BLUE	Alert Actions
		RED	Incident Management Team Role

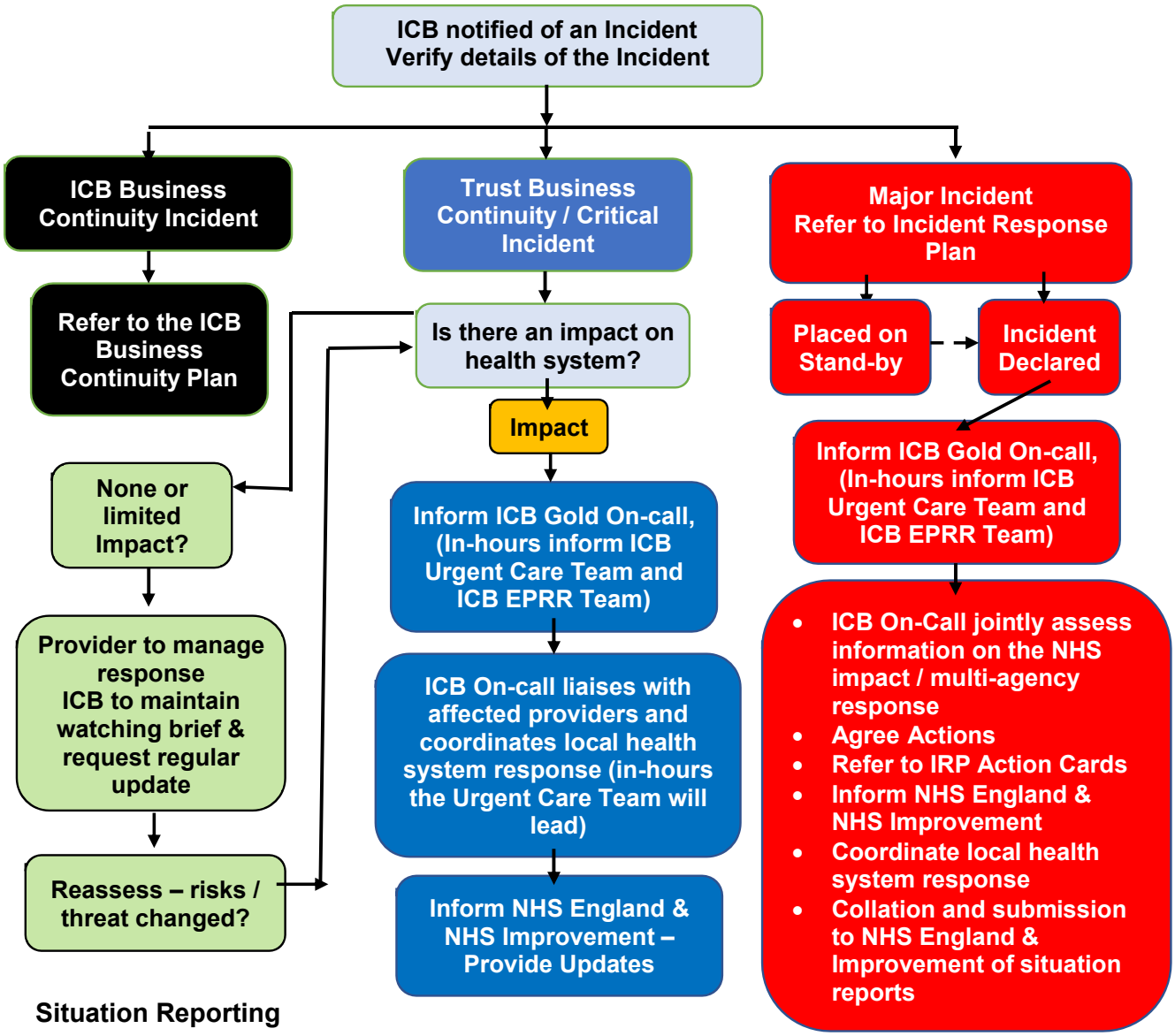
IRP Action Card		**Emergency Response Roles**
ALERTED TO AN INCIDENT		
1		(Silver on-call) – Alerted to an Incident
2		(Gold on-call) – Alerted to an Incident
ACTIVATION OF INCIDENT RESPONSE		
3		Incident Director (Gold On-call / AEO / Exec Director)
4		Incident Manager (Silver On-call / Senior Manager))
5		ICC Lead / Information Manager
6		Nursing / Quality
7		Urgent Care
8		Primary Care
9		Commissioning
10		Communication Lead
11		EPRR Advisor
12		Loggist
13		Finance
14		Meds Management
15		Service Change / Capacity
16		Human Resources
STAND DOWN FROM INCIDENT		
17		Incident Director / Incident Manager

IRP ACTION CARD 1: Silver on-call – Alerted to an Incident	
Undertaken by	ICB Silver On-call
Accountable to	ICB Gold on-call
Responsible for: Assessing the initial information received in respect of a potential or actual major incident and escalating to Gold On-Call.	

No#	Action
1	Start your personal log of all decisions and actions utilise the Incident Report Sheet
2	On being alerted to an incident or surge in pressure on the system - Confirm:- • Which organisation is declaring the incident (or going on stand-by)? • Nature of Incident - Business Continuity / Critical or Major incident? • Critical incident that is affecting the delivery of critical NHS services (e.g. fire in an acute hospital)? • Business Continuity Incident that is affecting the delivery of critical NHS services? • Major Incident – Scale / number of casualties? • Other incident affecting the NHS? • Has a TCG / SCG been convened? (EMAS should inform the ICB)
3	**Situation Reporting** Has the declaring organisation provided a Situation Report (request if not):- • SBAR (Business Continuity or Critical Incident) • METHANE (Major Incident) • NHS Situation Report (Major Incidents)
4	Determine the severity of the situation and consider the potential impact of the incident on the local health economy and if necessary Refer to Incident Decision Making Flowchart at the end of this Action Card
5	Consider the actions that the ICB needs to undertake with regards to supporting NHS Trusts and potentially coordinating the NHS response to the incident
6	Notify and liaise with:- • ICB Gold On-Call

No#	Action
	In hours:- In addition to the above notify and liaise with the ICB EPRR Team and the Urgent Care Team to ensure there is coordination of the ICB response.
7	In liaison with the ICB Gold On-call (also in hours - ICB Urgent Care and ICB EPR Team) assess the information received and consider the actions to be taken:- • Business Continuity Incident affecting the **ICB** – Refer to the **ICB Business Continuity Plan** • **Incident with no / limited impact on system:** o **Provider** to manage the operational response o **ICB Silver On-call** / **Urgent Care Team** to monitor situation. Consider joining any provider incident / operational meetings • **Surge / Incident impacting on system:** o **Provider** to manage the operational response o **ICB On-call** / **Urgent Care Team** to coordinate system response**. ICB to** attend provider incident / operational meetings • **Surge / incident causing significant impact on system or Major Incident Declared**: o **ICB On-call** coordinates system response o **ICB** consider convening I**CB Incident Management Team (IMT)** o **ICB** consider opening a System Coordination Centre to manage information flow o **ICB** consider convening a **HSCETCG** to provide system wide strategic overview and coordination
8	**If the decision is made to activate the Incident Response Plan and convene an IMT / HSCETCG – Refer to the ACTION CARD: Silver (Action Card 3)**
9	Where applicable refer to the incident specific information for additional guidance :- • Cyber Security Incident: Appendix 6 • Mass Casualty Incident: Appendix 7 • UK Terrorist Threat Level Change: Appendix 8 • Request for Military Assistance to an Incident: Appendix 9 • CBRN / Hazmat Incident: Appendix 10
10	If the incident is stood down by the alerting provider or If no further action is required, complete your personal incident log

INCIDENT DECISION MAKING FLOWCHART



Situation Reporting

Business Continuity	Where a **business continuity incident** is declared a **SBAR** report should be provided by the declaring organisation – A **SBAR** form template is included in Appendix 5
Critical Incident	Where a **critical incident** is declared a **SBAR** report should be provided by the declaring organisation – A **SBAR** form template is included in Appendix 5
Major Incident	On initial Major Incident declaration the organisation should provide a **METHANE** report. A **METHANE** form template is included in Appendix 3 NHS England will require trusts who have declared a Major Incident, to regularly submit a sitrep, using the NHS England sitrep form. Where multiple trusts are involved, the ICB may need to collate these into a single sitrep. NHS England Incident situation report template can be found on Resilience Direct https://collaborate.resilience.gov.uk/RDService/home/148367/Templates

IRP ACTION CARD 2: Gold on-call – Alerted to an Incident	
Undertaken by	ICB Gold On-call
Accountable to	ICB Accountable Officer
Responsible for: Assessing the initial information received and determining the appropriate course of action to be taken	

No#	Action
1	Start your personal log of all decisions and actions utilise the Incident Report Sheet
2	Assess information provided by the ICB Silver On-call. **Situation Reporting** Has the declaring organisation provided a Situation Report:- • SBAR (For a Business Continuity or Critical Incident) • METHANE (For a Major Incident) • NHS Situation Report
3	In light of the information received, assess the severity of the situation and consider the potential impact of the incident on the NHS. Determine any actions to be taken • Business Continuity Incident affecting the **ICB** – Refer to the **ICB Business Continuity Plan** - **Consider declaring a Business Continuity Incident** • **Incident with no / limited impact on system:** ○ **Provider** to manage the operational response ○ **ICB Silver On-call** / **Urgent Care Team** to monitor situation. Consider joining any provider incident / operational meetings • **Surge / Incident impacting on system:** ○ **Provider** to manage the operational response ○ **ICB On-call** / **Urgent Care Team** to coordinate system response**.** **ICB to** attend provider incident / operational meetings • **Surge / incident causing significant impact on system or Major Incident Declared – Implement the Incident Response Plan – Consider declaring a Critical / Major Incident** ○ **ICB On-call** coordinates system response ○ **ICB** consider convening I**CB Incident Management Team (IMT)**

No#	Action
	○ **ICB** consider opening a System Coordination Centre to manage information flow
4	Where applicable refer to the incident specific information for additional guidance :- • Business Continuity incident affecting ICB services (ICB Business Continuity Plan on Resilience Direct) • Cyber Security Incident: Appendix 6 • Mass Casualty Incident: Appendix 7 • UK Terrorist Threat Level Change: Appendix 8 • Request for Military Assistance to an Incident: Appendix 9 • CBRN / Hazmat Incident: Appendix 10
5	Ensure other NHS Trusts and partners (and multi-agency partners as appropriate) are alerted to the incident (as appropriate)
6	Confirm the **ICB Urgent Care Team & EPRR Team** (in-hours) has been informed – These teams will provide support in-hours.
7	**If the decision is made to activate the Incident Response Plan and convene an IMT / HSCETCG – Refer to the ACTION CARD: Gold (Action Card 4)** Assume the role of **Incident Director** - ICB On-call to coordinate system response Determine whether it is necessary to establish an Incident Coordination Centre - including • Convening a formal **Incident Management Team (IMT)** • Consider opening a **System Operation Centre (SOC)** - The plan for opening the ICC is available on the ICB's Resilience Direct Site under Note: If an incident is expected to be prolonged / high profile / mass casualty / terrorist incident it is advisable to open the **SOC** to provide the necessary staff and resources to co-ordinate the ICB response Task the **Silver On-Call** to call in additional staff and open the SOC (in hours the ICB EPRR Team if available can be tasked with setting up the SOC
8	Consider convening a **HSCETCG** to provide system wide strategic overview and coordination
9	Dependent on the nature and scale of the incident – Inform NHS England & NHS Improvement On-call to the incident If the alerting organisation has provided a Situation Report – was this sent to NHS England Midlands?

No#	Action
10	If the incident is stood down by the alerting provider or If no further action is required, complete your personal incident log

IRP ACTION CARD 3: Incident Response – Incident Director	
Undertaken by	ICB Gold On-call / Accountable Emergency Officer / Exec Director
Accountable to	ICB Accountable Officer
Responsible for: Co-ordinating the ICB and the local NHS response to the incident.	

No#	Action
1	Considering informing The ICB Accountable Officer & ICB Accountable Emergency Officer
2	Confirm other NHS Trusts and partners (and multi-agency partners as appropriate) are alerted to the incident
3	Consider implications of the incident on the local health system
4	Chair the ICB Incident Management Team Refer to the suggested INCIDENT MANAGEMENT TEAM / HEALTH & SOCIAL CARE ECONOMY TACTICAL COORDINATION GROUP AGENDA which is held at the end of this action card It is also recommended to use the National Joint Decision Making Model as an aid memoire which is held at the end of this action card Incident Management Team meetings should be kept short in order to enable staff to undertake actions as agreed Ensure that a detailed log of decisions and actions is kept by the loggist. It is recommended that the loggist is sat next to the chair of the Incident Management Team (for physical meetings) Check and sign off the Incident Log as maintained by the Loggist
5	Establish the battle rhythm of the Incident Management Team by agreeing time of next meetings
6	If a SCG & or TCG have been convened – determine who will attend (nominally ICB Gold attends the SCG and ICB Silver attends the TCG. Additional staff maybe required to attend on On-call behalf (or to support ICB on-call at the meetings)
7	Determine whether it is necessary to convene a **HSCETCG** to provide system wide strategic / Exec level overview and coordination Utilise health system on call contacts to help convene a **HSCETCG.**

No#	Action
8	Keep a personal record of your actions, including details of any briefing received.
9	On handover to another person- Use the IIMARCH template in Appendix 4 to provide a handover briefing

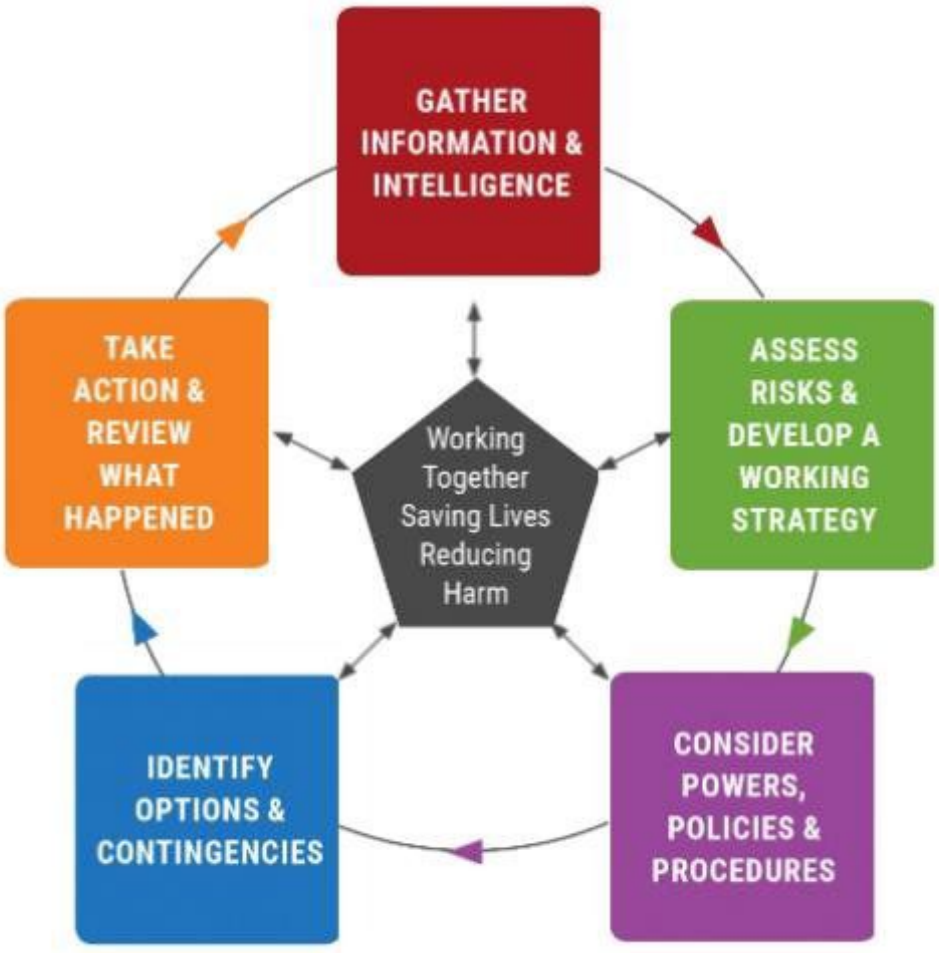
INCIDENT MANAGEMENT TEAM / HEALTH & SOCIAL CARE ECONOMY TACTICAL COORDINATION GROUP AGENDA

Item	Item Lead
Introductions (by exception and only where deemed necessary)	Chair
Declaration of items for urgent attention	Chair
Confirmation of decisions on urgent items	Chair
Adjourn as necessary to action urgent issues	
Confirm Health Strategy (Example below):- • Deliver optimum care and assistance to those affected • Minimise any disruption to healthcare services • Bring about a speedy return to normal levels of service • Work across organisational boundaries to delivery multi-agency response • Protect the health of the wider population	Chair

Following the National Joint Decision Model:-
• Situational briefing – review situation and previous actions
• Risk assessment of the incident:-
  o Impact on NHS service delivery
  o Ability of the NHS to respond
• Consider whether pre-set plans / arrangements are available to support response
• Agree options and actions
• Allocate responsibility for agreed actions
	Chair

Communications / Media • Consider public and media messages (note possible need to coordinate with comms leads from NHS England & NHS Improvement, NHS Trusts and partner agencies) • Internal NHS and staff communications	Comms Lead
Situation Reporting (Sitrep) • Confirm NHS England & NHS Improvement situation reporting requirements • Confirm whether TCG / SCG requires a situation report	Chair
Authorisation of any necessary expenditure	
Summary of actions from the meeting and review of meeting arrangements	Chair
Confirm date and time of next meeting and required attendees	Chair
Chair to review and sign off the log of the meeting	Chair

JESIP JOINT DECISION MAKING MODEL



IRP ACTION CARD 4: Incident Response – Incident Manager	
Undertaken by	ICB Silver On-call / Senior Manager
Accountable to	ICB Gold On-call
Responsible for: Supporting the Gold On-Call in their role as Incident Director and ensuring the opening of the SOC	

No#	Action
1	If directed by Gold On-Call open the System Coordination Centre (SOC) **Refer to the SOC set up guide on Resilience Direct** In hours: The ICB EPRR Team will assist in opening the SOC
2	If directed by Gold On-Call establish the ICB Incident Management Team:- In hours: The EPRR Team will assist in contacting appropriate members of staff. Out of hours: Use the ICB On call Contact details for the ICB (held on Resilience Direct) to contact and request staff to join the Incident Management Team (either in person or via teleconference) The membership will depend on the incident but a recommended core membership is:- • Incident Director (Gold On-Call) • Incident Manger (Silver On-Call) • SOC Lead / Information Manager (performed by an ICB senior manager) • Nursing / Quality • Urgent Care • Primary Care • Commissioning: Consider implications for service deliver • Communication Lead • EPRR Advisor • Loggist (drawn from a list of trained loggists – list held on Resilience Direct) Additional members that may be required to represent:- • Finance • Meds Management • Service Change / Capacity • Human Resources • Administration Support (to provide general admin support to the Incident Management Team)

No#	Action
3	Dependent on the nature of the incident, representation from NHS Trusts and providers may be request (either in person or via teleconference)
4	Task the SOC Lead /Information Manager with:- • Ensuring NHS England & NHS Improvement (MIdsroc) and Trusts and Provider ICC have a designated phone number for the SOC (in the absence of a dedicated phone please nominate a mobile phone). Also pass on the ICB generic incident inbox nnccg.nottsincidents@nhs.net • Coordinating the submission of Situation Reports (Sitreps) to NHS England & NHS Improvement; and if required the submission of Sitreps to the SCG. The NHS England Incident Situation Report Template is available from Resilience Direct https://collaborate.resilience.gov.uk/RDService/home/148367/Templates
5	Staff Welfare:- • Be mindful of staff welfare • Staff should not work for extended periods of work (if incident is likely to be prolonged establish a staff rota to cover the SOC for the foreseeable future • Staff should have access to refreshments and breaks • Loggists should not work for more than 3 hours at a time
6	Keep a log of your actions, including details of any briefing received.
7	Provide all necessary support to the incident response
8	On handover to another person, ensure that you log the handover on your personal log, including details of any briefing that you provide

IRP ACTION CARD 5: Incident Response - SOC Lead / Information Manager	
Undertaken by	Senior Manager drawn from Silver On-call List / Senior Manager
Accountable to	Incident Director

Responsible for:

- Co-ordinating the receipt of and dissemination of information to and from the SOC. This includes the collation of Sitreps and assurance returns
- Overseeing the operation of the SOC

This should be undertaken by a member of the on-call or other member of staff who has access to the ICB Incident generic inbox nnccg.nottsincidents@nhs.net and Resilience Direct (note this can be accessed via the generic on-call Resilience Direct login details)

Note:-

- NHS England & NHS Improvement may request submission of Sitreps / Information, especially with regards to number of casualties presenting at our hospitals.
- In the initial phase of a Major Incident trusts may be only able to provide limited information. Key information collate should include nature of the incident and casualties presenting to the hospitals
- Utilise the NHS England Situation Report Template – This can be found in Resilience Direct https://collaborate.resilience.gov.uk/RDService/home/148367/Templates
- If SCG / TCG has been established,
    - A Sitrep may be required via Resilience Direct
    - Silver On-call may be required to attend the TCG
    - Gold On-call may be required to attend the SCG if NHS England cannot

No#	Action
1	Ensure incoming phone number and designated email address are passed onto NHS England & NHS Improvement and NHS providers
2	**Information received by the SOC** Ensure that information / situation report or assurance request coming into the SOC is co-ordinated and brought to the attention of the Incident Director

No#	Action
3	**Information disseminated by the SOC** Support the Incident Director in co-ordinating the dissemination of Sitreps and information to NHS England & NHS Improvement and the SCG and of information requests to NHS Trusts **Sitreps must be approved by the Incident Director / Incident Manager prior to submission** Note: Requests for Sitreps / information from NHS England & NHS Improvement may come at short notice and with a short deadline SCG sitreps will be placed on the Nottinghamshire LRF RD page
4	Monitor deadlines for submission of Sitreps and information to NHS England & NHS Improvement
5	Keep a personal record of your actions, including details of any briefing received.
6	Provide all necessary support to the incident response
7	On handover to another person, ensure that you log the handover on your personal log, including details of any briefing that you provide

IRP ACTION CARD 6: Incident Response -Nursing / Quality	
Undertaken by	Senior Member of staff from Quality / Nursing
Accountable to	Incident Director
Responsible for: Providing co-ordinated and expert quality / clinical / nursing advice to allow clinically appropriate management of the incident	

No#	Action
1	Provide clinical, nursing and quality advice to the Incident Director
2	Act as the nursing liaison with NHS England & NHS Improvement and providers
3	Keep a personal record of your actions, including details of any briefing received.
4	Provide all necessary support to the incident response
5	On handover to another person, ensure that you log the handover on your personal log, including details of any briefing that you provide

IRP ACTION CARD 7: Incident Response – Urgent Care	
Undertaken by	Senior Member of staff from the Urgent Care Team
Accountable to	Incident Director
Responsible for: • Overseeing the system response to surge in attendances from any incident, system actions to free / discharge patients to support the incident	

No#	Action
1	Provide the Incident Director with updates on the urgent care system's position
2	Liaise with partners in responding to the system response and support to the incident
3	Keep a personal record of your actions, including details of any briefing received.
4	Provide all necessary support to the incident response
5	On handover to another person, ensure that you log the handover on your personal log, including details of any briefing that you provide

IRP ACTION CARD 8: Incident Response – Primary Care	
Undertaken by:	Senior Member of staff drawn from Primary Care
Accountable to	Incident Director
Responsible for: • Considering the implications for primary care of the incident • Considering the support primary care can provide to the incident response	

No#	Action
1	Provide the Incident Director with updates on the implications for primary care
2	Liaise with and support primary care
3	Keep a personal record of your actions, including details of any briefing received.
4	Provide all necessary support to the incident response
5	On handover to another person, ensure that you log the handover on your personal log, including details of any briefing that you provide

IRP ACTION CARD 9: Incident Response -Commissioning	
Undertaken by	Senior Member of staff from Commissioning
Accountable to	Incident Director
Responsible for: Providing co-ordinated commission advice to the Incident Director	

No#	Action
1	Provide commissioning advice to the Incident Director
2	Keep a personal record of your actions, including details of any briefing received.
3	Provide all necessary support to the incident response
4	On handover to another person, ensure that you log the handover on your personal log, including details of any briefing that you provide

IRP ACTION CARD 10: Incident Response – Communications	
Undertaken by:	Senior member of the ICB Communication Team
Accountable to	Gold On-Call (as Incident Director)
Responsible for: Providing communication advice and support to the Incident Director / Manager	

No#	Action
1	Assume responsibility for managing the public information and media communications in accordance with the directions of the Incident Director /
2	Ensure staff are maintained and kept informed as is necessary
3	Liaise with comms teams from NHS Trusts and partner agencies
4	Formulate and co-ordinate an integrated public information and media handling strategy on behalf of the NHS response
5	Deal with all media enquires / draft statements / calls for interviews
6	Be available to support ICB Executives during media interviews if necessary.
7	Liaise with NHS England Communications Lead on a regular basis
8	Note: If a SCG / TCG is established a Communication / Media Cell may be convened to co-ordinate media and public messages
9	Keep a personal record of your actions, including details of any briefing received.
10	Provide all necessary support to the incident response
11	On handover to another person, ensure that you log the handover on your personal log, including details of any briefing that you provide

IRP ACTION CARD 11: Incident Response - EPRR Advisor	
Undertaken by:	Associate Director of Strategy& EPRR / EPRR Manager
Accountable to	Incident Director
Responsible for: Providing Emergency Planning support and advice to the Incident Director.	

No#	Action
1	Provide EPRR advice and support to the Incident Management Team
2	Determine whether any pre-existing plans or arrangements need to be utilised
3	As required support SOC in the information flow between the ICB and NHS England & NHS Improvement, partner agencies, including TCG and SCG Monitor deadlines for submission of Sitreps and information to NHS England & NHS Improvement
4	Keep a personal record of your actions, including details of any briefing received.
5	Provide all necessary support to the incident response
6	On handover to another person, ensure that you log the handover on your personal log, including details of any briefing that you provide

IRP ACTION CARD 12: Incident Response - Loggist	
Undertaken by:	Trained Loggist from ICB Loggist List
Accountable to	Gold On-Call (as Incident Director)
Role performed by ICB trained Loggists (list held on Resilience Direct) **Responsible for**: Recording and documenting all issues/actions/decisions made by the Incident Management Team	

No#	Action
1	All persons in attendance to be recorded in the log (*attendance sheets located within the SOC cabinet/Loggist pack)* If the IMT is held remotely then please use the attendance sheet to record attendees. – electronic templates can be found on Resilience Direct under Loggist
2	The Loggist must use the log book provided *(These are stored in the SOC cupboard)* If the IMT is held remotely, please use the electronic template record the decisions of the IMT and skip to step 6 of this action card- electronic templates can be found on Resilience Direct under Loggist
3	Sit in a position near the Incident Director, and where the clock can be seen Introduce yourself to the Incident Director If any time you are unclear on what needs to be logged ask the chair for clarification
4	The Log must be clearly written in black pen, dated and initialled by the Loggist at the start of the shift and include the location. Please familiarise yourself with the Loggist best practice guide which can be found within the Loggist pack – Available on Resilience Direct https://collaborate.resilience.gov.uk/RDService/home/264761/Loggist
5	On arrival all staff must wear identification badges. If the badges are unclear the Loggist must ask for clarification of who is present within the room, including their title.
6	The log must be complete and continuous record of all issues/decisions/actions as directed by the Incident Director
7	Timings have to be accurate and recorded each time information is received or transmitted

No#	Action
8	If notes or maps are utilised these must be noted within the log
9	Where something Is written in error changes must be made by a single line scored through the work and the amendment made
10	If the log is to be handed over to a replacement loggist ensure the change of loggist is recorded in the log
11	At the end of the incident, ensure the log is checked and signed by the Chair of the SOC.
12	All documentation is to be kept safe and retained for evidence for any future proceedings. Place the log in the SOC cabinet for recovery by the EPPR & Partnership Manager

The Loggist MUST NOT:
Take minutes
Record more than one decision maker
Keep a separate chronological log
Have responsibility for the decision/action

Best practice of a Loggist can be found in the SOC cabinet within the Loggist pack

Note: Loggist should not work for longer than 3-4 hours

IRP ACTION CARD 13: Incident Response – Finance	
Undertaken by:	Senior member of staff from the ICB Finance Team
Accountable to	Gold On-Call (as Incident Director)
Responsible for: Considering the financial implications of the incident for the ICB,	

No#	Action
1	Provide the Incident Director with updates on the financial implications of the incident
2	Liaise with ICB Teams on development of new / expanded services to support the response
3	Arrange for costs incurred in the incident to be recorded and provide budget forecasts for the IRT.
4	Keep a personal record of your actions, including details of any briefing received.
5	Provide all necessary support to the incident response
6	On handover to another person, ensure that you log the handover on your personal log, including details of any briefing that you provide

IRP ACTION CARD 14: Incident Response – Meds Management	
Undertaken by:	Senior member of staff from the ICB Meds Management Team
Accountable to	Gold On-Call (as Incident Director)
Responsible for: Considering the meds management implications of the incident	

No#	Action
1	Provide the Incident Director with guidance related to Meds Management issues
2	Liaise with pharmacies colleagues across the system and with NHS England
3	Keep a personal record of your actions, including details of any briefing received.
4	Provide all necessary support to the incident response
5	On handover to another person, ensure that you log the handover on your personal log, including details of any briefing that you provide

IRP ACTION CARD 15: Incident Response – Service Change / Capacity	
Undertaken by:	Senior member of staff from the ICB Service Change / Capacity
Accountable to	Gold On-Call (as Incident Director)
Responsible for: Considering the implications of the incident on electives, capacity and possible service change	

No#	Action
1	Provide the Incident Director with guidance related to the incidents implications on provision of electives and system capacity
2	Consider possible need for service changes as a consequence of the incident
3	Keep a personal record of your actions, including details of any briefing received.
4	Provide all necessary support to the incident response
5	On handover to another person, ensure that you log the handover on your personal log, including details of any briefing that you provide

IRP ACTION CARD 16: Incident Response – Human Resources	
Undertaken by:	Senior member of staff from the ICB Human Resources Team
Accountable to	Gold On-Call (as Incident Director)
Responsible for: Considering the implications for ICB staffing and staff welfare of the incident	

No#	Action
1	Provide the Incident Director with guidance related to Human Resources
2	Consider implication of the incident on ICB staffing
3	Consider implication of the incident on ICB staff welfare
4	Keep a personal record of your actions, including details of any briefing received.
5	Provide all necessary support to the incident response
6	On handover to another person, ensure that you log the handover on your personal log, including details of any briefing that you provide

IRP ACTION CARD 17: Stand Down from Incident – Incident Director	
Undertaken by:	ICB Gold On-call / Accountable Emergency Officer / Exec Director
Accountable to	ICB Accountable Officer
Responsible for: Planning and implementing the system recovery from the incident	

No#	Action
1	Ensure a process is in place for an appropriate return to business as usual **Note: Dependent on the nature of the incident, elements of the NHS including acute, community and mental health may not be in a position to return to business as usual due to the number of casualties receiving treatment**
2	Agree when staff involved in the incident management should return to their normal duties
3	Hold a debrief with the staff in the SOC (Hot Debrief) • What worked • What didn't • Areas for improvement Note: The EPRR & Partnership Manager will organise a Cold Debrief in the following weeks to capture input from all involved
4	Incident Director to check and sign off the Incident Log as maintained by the Loggist
5	**Recovery** Consider whether there are any medium to longer term impacts / demands on the NHS Is it necessary to commission additional services to support the recovery from the incident or a new demand on the NHS Note: The local authority may convene and lead a multi-agency recovery group, which may require the membership of the ICB.
6	On handover to another person, ensure that you log the handover in your personal log, including details of any briefing that you provide

Appendix 2 – Incident Report Sheet

THIS FORM MUST BE COMPLETED FOR ALL CALLS RECEIVED

DATE CALL RECEIVED FROM NEMS:		
TIME CALL RECEIVED FROM NEMS:		(24 hour clock)
NAME OF NEMS CALLER REPORTING INCIDENT:		**NEMS NO: 0300 456 4957**
NAME OF ORGANISATION/PERSON RAISING INCIDENT:		
CONTACT PHONE NUMBER FOR THE INCIDENT:		
On Call Manager Details		
ICB ON CALL MANAGER'S NAME:		
Full details of Incident and your Actions ***Please ensure all times / Actions / Issues, are recorded on this form***		

Were there any security issues requiring police attendance?								
Yes		(✓)	**No**		(✓)	**Not sure**		(✓)
LOG COMPLETED BY:								
DATE:								

Completed forms must be emailed as soon as possible to the EPRR Team
nnestccg.oncall@nhs.net

Appendix 3 – METHANE template

Time	Date
Organisation	
Name of Caller	Tel No

M	Major incident	Has a Major Incident been declared? **YES/NO** *(If no, then complete ETHANE message)*	
E	Exact Location	What is the exact location or geographical area of incident	
T	Type of Incident	What kind of incident is it?	
H	Hazards	What hazards or potential hazards can be identified?	
A	Access	What are the best routes for access and egress?	
N	Number of casualties	How many casualties are there and what condition are they in?	
E	Emergency Services	Which and how many emergency responder assets/personnel are already on-scene?	

Signature

Appendix 4 – IIMARCH briefing template

The IIMARCH template below may help commanders in preparing a brief. When using IIMARCH, it is helpful to consider the following

- Brevity is important - if it is not relevant, leave it out
- Communicate using unambiguous language free from jargon and in terms people will understand
- Check that others understand and explain if necessary
- Consider whether an agreed information assessment tool or framework has been used

Element	Key Questions and considerations	Action
I	**Information** - What, where, when, how, how many, so what, what might? Timeline and history (if applicable), key facts reported	
I	**Intent** - Why are we here, what are we trying to achieve?	
M	**Method** - How are we going to do it?	
A	**Administration** - What is required for effective, efficient and safe implementation?	
R	**Risk assessment** - What are the relevant risks, and what measures are required to mitigate them?	
C	**Communications** - How are we going to initiate and maintain communications with all partners and interested parties?	

H	**Humanitarian issues** What humanitarian assistance and human rights issues arise or may arise from this event and the response to it?	

Appendix 5 – SBAR form

For structured and on-going communication during an incident response, such as for meeting briefings or handovers, the ICB on-call / Incident Management should consider using the SBAR communication tool. SBAR is a structured method of recording and communicating situational awareness and critical information to others.

Name:	
Date:	**Time:**
Conversation with:	
Telephone number:	
Email:	
SITUATION	Describe situation/incident that has occurred
BACKGROUND	Explain history and impact of incident on services / patient safety
ASSESSMENT	Confirm your understanding of the issues involved
RECOMMENDATION	Explain what you need, clarify expectations and what you would like to happen

Appendix 6 – Cyber Security Incident

No organisation can be completely immune from a cyber-attack and there is no room for complacency. The occurrence of cyber-attacks across the UK economy is increasing so, in the judgement of most industry experts, it is not a question of “if” but “when” the next cyber-attack strikes the health and social care system.

Definition

A cyber security incident is defined as:

- A breach of a system’s security policy in order to affect its integrity or availability
- The unauthorised access or attempted access to a system

Activities commonly recognised as security policy breaches are:

- attempts to gain unauthorised access to a system and/or to data
- the unauthorised use of systems and/or data
- modification of a system's firmware, software or hardware without the system-owner's consent
- malicious disruption and/or denial of service

The National Cyber Security Centre defines a **significant** cyber security incident as one which may have

- impact on UK’s national security or economic wellbeing
- the potential to cause major impact to the continued operation of an organisation

From this, any incident affecting the NHS would be classified as a significant cyber security incident.

Alert

The ICB On-call may be alerted to a Cyber Security Incident or significant IT disruption by:-

- NHIS, having identified a Cyber Security incident / disruptive IT incident has occurred to the ICB or wider
- A provider due an incident affecting them

The ICB may be alerted by NHS England & NHS Improvement to a cyber-incident affecting other parts of the country. ICB on-call should contact NHIS to alert them to the situation and determine whether NHIS is being affected.

In the event that a cyber-attack is affecting the NHS on a regional or national scale, NHS England & NHS Improvement may declare a Level 4 incident, with command and control initiated from NHS England & NHS Improvement at a regional or national level.

Refer to the Nottinghamshire Cyber Concept of Operations (CONOPS) for specific arrangements for responding to a Cyber Incident

Appendix 7 – Mass Casualty Incidents

A Mass Casualty incident would a serious challenge to the NHS, especially if caused by a terrorist incident or involving chemicals or other hazardous substances (CBRN).

Definition

NHS England & NHS Improvement defines a Mass Casualty incident for the health services as an incident (or series of incidents) causing casualties on a scale that is beyond the normal resources of the emergency and healthcare services' ability to manage.

A Mass Casualty incident may involve hundreds or thousands of casualties with a range of injuries, the response to which will be beyond the capacity of normal major incident procedures to cope and require further measures to appropriately deal with the casualty numbers.

In the event of a CBRN incident casualties may be contaminated. The casualties may require de-contamination at scene, or at the receiving Accident and Emergency Department

Casualties are classified as:-

P1	Casualties in need of immediate life saving measures and techniques
P2	Casualties who require treatment but some delay may be acceptable
P3	Casualties who require minimal treatment

Command and Control

EMAS are responsible for declaring a Mass Casualty Incident. EMAS would alert receiving hospitals, the ICB and other emergency services. The ICB may also be alerted by NHS England or it comes to the attention of the ICB through media / social media reports.

A Mass Casualty incident is likely to be declared as a Level 4 incident, with command and control from NHS England & NHS Improvement.

A Mass Casualty incident would lead to the convening of a multi-agency Strategic Coordination Group (NHS England & NHS Improvement to attend) and a Tactical Coordination Group (ICB to attend).

Response

EMAS has issued a Casualty Distribution Matrix (See below) which outlines the number of patients that hospitals across the East Midlands would expect to receive in the first hour.

Dependent on the scale of the incident, the trusts may be requested to receive an increased number of casualties.

The Nottinghamshire Mass Casualty Response – Concept of Operations (CONOPS) provides the response framework for Health Partners within Nottinghamshire and outlines key elements required to effectively manage a mass casualty incident. The CONOPS can be found in Resilience Direct https://collaborate.resilience.gov.uk/RDService/home/145087/Library

Under the CONOPS and in line with NHS England CONOPS for Managing Mass Casualties acute trusts must free beds up in the 12 hours after the incident to ready for the receipt of patients.

Coordination

The ICB will provide overall coordination of the local NHS response to mass casualty incident. This is likely to require the convening of a HESCTCG. NHS England will declare a mass casualty incident at Major incident Level 4.

There will be significant amounts of information flow from NHS England & NHS Improvement to local level (ICB and NHS providers). NHS England & NHS Improvement will activate a major incident process. The ICB's responsibility will be to ensure all local providers are alerted as appropriate and if requested by NHS England, the capacity available This will be delivered by coordination at both strategic and tactical level.

EMAS will be responsible for triage casualties and transporting them to the appropriate hospitals. Due to the scale of the incident, EMAS (under the National Ambulance Coordination Centre) is likely to call upon support from neighbouring ambulance services in the transportation of casualties.

Under the NHS England & NHS Improvement Mass Casualty Concept of Operations (CONOPS) a mass casualty incident is likely to lead to the use of acute hospitals on a regional/inter regional scale. With patients from an incident in Nottinghamshire being treated at acute hospitals across the East Midlands or further afield. Similarly Nottinghamshire's acute hospitals would be expected to receive casualties from incidents in neighbouring counties or regions. Queens Medical Centre as a Major Trauma Centre (MTC) would be expected to take P1 casualties from across the East Midlands.

All acute hospitals in the East Midlands have identified the number of P1 and P2 casualties that could receive within the first 2 hours of an incident (Note: EMAS may have to call upon acutes to receive numbers of casualties in addition to the agreed number – The ICB is likely to be tasked by NHS England to identify additional capacity at Nottingham University Hospitals and Sherwood Forest Hospitals.

A Mass Casualty incident may require the convening of a TCG and SCG to provide the overarching multi-agency response.

Communications

All media messages will need to be coordinated with NHS England & NHS Improvement, and providers.

ICB comms should liaise with partner agency comms teams to ensure there is a coordinated message to prevent confusion of message to the public and the media.

Other considerations

A mass casualty incident in Nottinghamshire may lead to walking wounded (known as P3 patients) self-presenting at GP practices and Urgent Care Treatment Centres. It is important that these are alerted to the incident so that can be prepared.

EMAS may also call for assistance on the sheltering of P3 patients away from the scene – this request may be made through the TCG and SCG to local authorities.

Mass casualty incidents can lead to an increase in the demand for short to long term psychological support. Under the LRF Humanitarian Plans, Nottinghamshire Healthcare NHS Trust would lead on coordinating the response.

Supporting Plans / Arrangements

- NHS England & NHS Improvement Mass Casualty Concept of Operations (CONOPS) (On the ICB Resilience Direct site)
- Nottinghamshire Health Partners Mass Casualty Response Mass Casualty – Concept of Operations
- EMAS Mass Casualty Plan
- LRF Humanitarian Assistance Plan
- Psychosocial Support plans

Appendix 8 – UK Terrorism Threat Level Changes – Move to Critical

When the UK Terrorism Threat Level has increased to Critical (usually in response to a terrorist incident where an attack is expected imminently) NHS England & NHS Improvement may issue a letter to the ICB and NHS Trusts outlining the actions that are to be followed. NHS England & NHS Improvement may contact ICB On-Call requesting assurance that the actions have been met.

Definition

The threat level to the UK from international terrorism is set by the Joint Terrorism Analysis Centre (JTAC). MI5 is responsible for setting the threat levels for domestic terrorism (including dissent republican activity) both in Northern Ireland and in Great Britain (England, Wales and Scotland).
The threat is determined based on the following factors:

- Available intelligence;
- Terrorist capability;
- Terrorist intentions;
- Timescale.

Threat levels are designed to give a broad indication of the likelihood of a terrorist attack:

- **CRITICAL** means an attack is expected imminently
- **SEVERE** means an attack is highly likely
- **SUBSTANTIA**L means an attack is a strong possibility
- **MODERATE** means an attack is possible, but not likely
- **LOW** means an attack is unlikely

The threat levels are applied to the current threat from international terrorism and the current threat from Northern Ireland-related terrorism. The threat level for Northern Ireland-related terrorism is set separately for Northern Ireland and Great Britain.
It is important to note that sector specific threat information may also be available to inform actions to be taken at the time of a change in levels.

Following a threat level increase to CRITICAL, NHS England & NHS Improvement (National) Emergency Preparedness Resilience and Response (EPRR) will seek to ensure the NHS in England has taken all steps possible to prepare itself for a potential terror attack on UK soil. At the increase to CRITICAL, the national EPRR team will issue a letter to the NHS in England.

Command and Control

Unless an incident is on-going, NHS command and control arrangements will not be implemented

Within Nottinghamshire, a multi-agency Strategic Coordination Group (SCG) may be held to review the situation / agree actions / or for the emergency services to provide reassurance to partner agencies on additional measures that have been introduced in response

Coordination

NHS England may request assurance from ICBs and NHS Trusts that actions in line with the letter have been carried out. NHS England & NHS Improvement may call upon the ICB to seek this assurance from the NHS Trusts

The full Protocol (UK Terrorism Threat Level Change) is included on the NHS Nottingham and Nottinghamshire ICB Resilience Direct Page (under Library)

Generic Actions

The expected actions that ICBs and NHS Trusts are expected to follow:-

- Immediately cascade the change in alert level to your staff
- Review relevant staffing levels and security arrangements across your health facilities, taking account of any additional advice from your local security experts in conjunction with the local police
- Ensure all staff are aware of your organisation's Incident Response Plans, business continuity arrangements and on call notification processes
- Ensure appropriate senior representation is available to join any NHS England & NHS Improvement Regional or Directorate of Commissioning Operations team teleconferences that may be called to brief on the situation
- Notify your local NHS England & NHS Improvement EPRR Liaison of any current or scheduled works or operational changes currently affecting service delivery within your organisation
- Review the Home Office advice issued in relation to this threat, and risk assess this against your own organisation, taking steps where possible to mitigate identified risks
- Review mutual aid agreements with other health services including specialist and private providers

ICBs are required to:

- Act in support of accelerated discharge and where necessary support Trusts in maintaining their contracted services

Acute care providers are required to:

- Review Emergency Care, Theatre and Support Services, paying particular attention to staff availability, stocks and current blood stock levels
- Clearly identify and review patients who could be discharged safely to create capacity if your organisation is responding to an incident
- Review availability of your Patient Transport Service (PTS) particularly in the event of the local NHS Ambulance Trust requesting mutual aid from your PTS provider

Community and Mental Health providers are required to:

- Review staffing availability for crisis intervention teams
- Prepare to support any accelerated discharge from acute care settings

Ensure any media enquiries which relate to the issuing of this letter are redirected back to NHS England & NHS Improvement

Supporting Plans / Arrangements

- NHS UK Terrorism Threat Level Change Protocol (on ICB Resilience Direct site)

Appendix 9 – Requests for Military Aid to the Civil Authorities (MACA) from the NHS

The NHS in England is generally expected to manage emergency response within its own capabilities. However, where a capacity has been exceeded or the NHS does not have the specific capability to deliver, the military may be required to augment responses.

Military support in an emergency is provided on an assistance basis, known as Military Aid to the Civil Authorities (MACA). MACA support is not guaranteed and may incur a charge for its provision unless it is in response to an immediate threat to life.

The NHS process for requesting military aid is included on the NHS Nottingham and Nottinghamshire ICB Resilience Direct Page

Such requests require NHS England & NHS Improvement Regional and, in turn, ministerial authorisation however, in very exceptional circumstances, for example, grave and sudden emergencies, where there is an urgent need to protect life, a local (Military) commander is empowered to deploy assets to deal with the situation without recourse to additional ministerial authority.

Support Available

The military have access to troop; specialist skills and equipment. For example:-

- 4x4 vehicles for assisting in the movement of staff and reaching communities in the event of severe weather
- Clinical staff experienced in dealing with blast and high velocity injuries

The Joint Regional Liaison Officer (JRLO) can provide advice and support at a local level to inform the request. The JRLO is a senior military officer that coordinates support to the civil authorities – contact can be made through the local authority emergency planners or NHS England on-call.

Note:-There can be a lead in time of a number of hours before any support can be made available

Process for Requesting Assistance

In the event of a widespread incident involving multi-agency partners then all requests should be coordinated with the appropriate Strategic Coordinating Group (NHS England attends this on behalf of the NHS).

Note:- MACA requests for the NHS must be made to NHS England & NHS Improvement On-call for submission to the Department of Health and Social Care (DHSC) as any request will require authorisation from a Health Minister prior to submission to Ministry of Defence (MoD).

Failure to do so will result in a delay to the provision of military support

Supporting Plans / Arrangements

- NHS England & NHS Improvement Requests for Military Aid to the Civil Authorities (MACA) from the NHS in England – This can be found on ICB Resilience Direct site https://collaborate.resilience.gov.uk/RDService/home/145087/Library

Appendix 10 – Chemical, Biological, Radiological or Nuclear (CBRN) / Hazardous Material Incident (HAZMAT) Incident

The response to a CBRN or Hazmat incident requires the use of specially trained members of the emergency services and NHS and specialist equipment to respond to the incident and treat the casualties.

Definition

CBRN is the term used in reference to malicious acts such as of chemicals by terrorists (e.g. radioactive substance in Salisbury) while Hazmat relates to hazardous materials released during an accident, such as a transport accident or incident at an industrial complex which results in a spillage or release of a substance.

Response

The specialist staff and resources utilised would be the same for a CBRN or Hazmat incident, but the emergency services response to a malicious act would be different to an accident. Though by the very nature of a terrorist or malicious act, this may not be initially identified as such.

In the event of a CBRN / Hazmat incident casualties may be contaminated. Regional specialist resources can be called upon to de-contaminate casualties and members of the public. However due to the lead time for deploying these resources, the emergency services may undertake more basic de-contamination at scene.

The casualties may also make their own way to an Accident and Emergency Department or other NHS site. For this reason all trusts are required to have the necessary equipment to decontaminate self-presenters. The decontamination would be undertaken by trained staff using appropriate personal protective equipment (PPE).

Once decontaminated the casualties would then be treated. Isolation of the decontaminated casualties may be necessary dependent on the nature of the casualties.

The process of decontamination takes two forms:-

- Dry decontamination (known as IOR): Where the casualties are required to remove their top level of clothing and wipe themselves down with paper towels. If necessary, they would be assisted by staff in PPE. This is the default approach for most hazardous materials and is proven to remove the majority of the contaminant.

- Wet decontamination: Where the casualty has been exposed to a caustic chemical a wet decontamination will be undertaken. In its basic form this is through the use of copious amounts of water (from bottles or buckets) to remove the substance (such as acids). Ambulance services now carry basic equipment to treat acid attacks. Where necessary, Accident and Emergency Departments would set up specialist tents within which the contaminated casualties can undress and be showered to remove the contaminant.

Command and Control

The normal NHS Command and Control structure would be implemented. It can be anticipated that a multi-agency SCG and TCG would be convened.

Where terrorist incident involves the use of a CBRN substance, it is likely that NHS England & NHS Improvement would declare a Level 4 major incident enacting national coordination of the NHS response.

In a terrorist incident, the multi-agency coordination would have central government COBR oversight and the involvement of Counter Terrorism operatives.

There will be significant amounts of information flow from NHS England & NHS Improvement to local level (ICB and NHS providers). NHS England & NHS Improvement will activate a major incident process.

Communications

All media messages will need to be coordinated with NHS England & Improvement, and providers.

ICB comms should liaise with partner agency comms teams to ensure there is a coordinated message to prevent confusion of message to the public and the media.

Supporting Plans / Arrangements – Available from Resilience Direct

- NHS England & NHS England Mass Casualty Concept of Operations (CONOPS) (On the ICB Resilience Direct site)
- Nottinghamshire Mass Casualty CONOPS
- EMAS Mass Casualty Plan
- UKHSA CBRN Handbook
- LRF CBRN Plan

Requesting and Receipt of Countermeasures

UK Health Security Agency holds some medications in reserve stocks for use in the response to incidents involving Chemical, Biological, Radiological and Nuclear (CBRN) materials. These stocks are held to be distributed in an incident within either 2 hours or 5 hours for rapid response depending on the stock and holding location. NHS England & Improvement acts as a relay in the request process to ensure that the Trust is responding to a genuine emergency and has nominated a suitable receiving location

In line with NHS England & Improvement Guidance for requesting and receipt of countermeasures (available on Resilience Direct), any provider organisation with an Emergency Department or other suitable emergency treatment centre may request that countermeasures are delivered to manage patients arriving with exposure symptoms requiring countermeasures.

The NHS providers are responsible for:

- Requesting the countermeasures from their **NHS England & NHS Improvement** Regional On-call
- Ensuring arrangements are put in place for receipt of any countermeasures, including pharmacy support, within the specified time frames for the countermeasures

- Ensuring arrangements are in place for the distribution of the countermeasures to patients, in a timely fashion, given the amount of countermeasure requested

The information required by the NHS England & NHS Improvement is outlined in NHS England & NHS Improvement Guidance for requesting and receipt of countermeasures.

Appendix 11 –Multi-Agency Command & Control (Strategic Coordination Group (SCG) / Tactical Coordination Group (TCG))

- It is the responsibility of ICB Gold On-call to attend a SCG as the NHS strategic representative.
- It is the responsibility of the ICB Silver On-call to attend a TCG as the NHS tactical representative

A SCG / TCG are likely to be held at Nottinghamshire Police HQ, Sherwood Lodge, Arnold. NG5 8PP. However an alternative venue may be used or the meeting may be held remotely via MS Teams

IF ASKED TO ATTEND A SCG / TCG
- **Confirm time & location of the SCG / TCG (or MS Teams invite)**
- **Consider taking a member of staff to assist**

REMEMBER TO TAKE
- **NHS ID**
- **Mobile phone and charger**
- **Laptop**
- **On-call Handbook**

Purpose of the SCG

To undertake the strategic level coordination of the response to a major incident, setting out the strategic priorities. The SCG is usually chaired by a senior Police officer. Membership is drawn from strategic level officers from across Category 1 responders

Role of the SCG

- Set the policy framework for the overall management of the response to the incident
- Prioritise the demands of the Tactical Coordination Group (TCG) and allocate resources accordingly
- Formulate and implement media-handling / public communication plans
- Direct planning and operations beyond the immediate response to facilitate recovery

NHS perspective

- Dependent on the nature of the incident, the NHS may request assistance to maintain NHS service delivery and response to the major incident (e.g. transport support during severe winter weather)

Purpose of the TCG

To formulate the tactical response to a major incident ensuring the on-scene commanders are given direction and have the necessary resources.

The TCG will also implement actions as set by the SCG

The TCG is usually chaired by a senior Police or Fire & Rescue officer

Role of the TCG

- Determine tactics to deliver the strategy as set by the SCG
- Determine priorities for allocating resources for the operational response
- Assess risks and instruct operational commanders accordingly

NHS perspective

- Represent the NHS at the TCG, ensure the local NHS is kept updated on the incident and relevant actions– bring to the TCG relevant information / requests from the NHS and / or a HSCETCG
- Determine the impact the incident is having on the NHS
- Determine the ICB and wider NHS role in responding to the incident
- ICB as tactical NHS representative to liaise with health providers and local authorities to coordinate capabilities and the response
- Liaise with the NHS strategic representative

Appendix 12 – Acronyms and abbreviations

BCM	Business continuity management
BTP	British Transport Police
C3	Command, Control and Communication
Carbon Steeple	Operation Carbon Steeple: Acute trusts have plans for receiving persons who are subject to armed protection and ~~and~~ who need emergency medical treatment and are suspected of being contaminated with CBRN materials
CBRN(e)	Chemical, biological, radiological and nuclear incidents (explosives)
CCA	Civil Contingencies Act 2004
CCP	Casualty Clearing Point
CCS	Casualty Clearing Station
CHEMET	Met Office specialist weather forecast requested by the Fire & Rescue Service to aid reviewing risk posed by plumes from industrial related fires or chemical releases
COBR	Cabinet Office Briefing Room
Consort	Operation Consort: Acute trusts have plans for receiving members of the Royal Family who are subject to armed protection and who need emergency medical treatment and are not suspected of being contaminated with CBRN materials
COMAH	Control of Major Accident Hazards
CRIP	Common Recognised Information Picture
CT	Counter Terrorism
DHSC	Department of Health and Social Care
DIM	Detection, Identification and Monitoring Teams (Fire Service specialists officers who have the equipment to make an initial analysis of gases or other potentially hazardous substances)
DPH	Director of Public Health
DVI	Disaster Victim Identification
EMAS	East Midlands Ambulance Service

EOC	Emergency Operations Centre
EOD	Explosive Ordinance Disposal
EPRR	Emergency Preparedness, resilience and response
HART	Hazardous Area Response Teams – each ambulance service has two HART teams. These are specialist paramedics trained to operate in hazardous areas
HAZMAT	Hazardous Materials
HSCETCG	Health & Social Care Economy Tactical Coordination Group
IED	Improvised Explosive Device
IOR	Initial Operational Response (Steps to follow in the decontamination of contaminated casualties)
JDM	Joint Decision Model – from JESIP
JESIP	Joint Emergency Services Interoperability Programme
JRLO	Joint Regional Liaison Officer (military officers who liaise with civil authorities on the provision of military support to major incidents
LHRP	Local Health Resilience Partnership
London Bridge	Central government plan that would be implement in the event of the death of the Queen (similar plans are in place for the death of the Prince of Wales). Local planning is led by the LRFs. Any specific requirement on the NHS would be issued by NHS England & NHS Improvement
LRF	Local Resilience Forum
MACA	Military Aid to Civil Authorities
METHANE	Mnemonic for briefing in incidents used by Emergency Services
MTA	Marauding Terrorist Attack – used to describe live incident where there is an active and armed terrorist
NACC	National Ambulance Coordination Centre – (Would coordinate the national provision of mutual aid to ambulance services in the event of a major incident
NARU	National Ambulance Resilience Unit – works to provide a coordinate approach to emergency panning
NCSC	National Cyber Security Centre

NHIS	Nottinghamshire Health Informatics Service
NILO	National Inter –Agency Liaison Officer. Emergency services officers that have been specially trained to support inter-agency coordination during incident response
UKHSA	Public Health England
PI IRT	Pandemic Influenza Incident Response Team
PLATO	Operation Plato is the term given to the emergency services response to a suspected marauding armed terrorist. The Police would declare Operation PLATO. In such operations, specialist Police units would seek to neutralise the terrorist threat to secure the incident scene, enabling other responders to treat any casualties.
PPE	Personal Protective Equipment
PRPS	Powered Respirator Protective Suit – All acutes hold a stock of PRPS suits to be used by trained personnel to decontaminate casualties
Resilience Direct	Secure government website for the sharing of information in the planning for and response to incidents
SAGE	Scientific Advice to Government in Emergencies (group established to advise the government during an emergency)
SBAR	Mnemonic widely used in briefing
SCG	Strategic Coordinating Group (Multi Agency Gold Commanders)
SITREP	Situation Report
SOC	ICB System Operations Centre
STAC	Scientific and Technical Advice Cell
TCG	Tactical Coordinating Group (Multi Agency Silver Commanders)
USAR	Urban Search and Rescue

Appendix 13 – Electronic Decision Incident Log

To be used to record decision by the Loggist should a virtual ICC be activated. For a physical IMT, please use the Log book which can be found in the ICC cabinet

Incident:

Date:

Loggist Name:

Incident Management Team Chair:

Location:

OPERATIONAL LOG		
		Page No:
TIME	**ITEM**	**DECISION/EVENT/ACTION/RATIONALE**