NHS South West London
Integrated Care Board

Establishing South West London Integrated Care Board

Supporting Annexes

An overview of the SWL ICS and governance processes undertaken to establish the Integrated Care Board

Paper 1 Annex A Governance Oversight Group Terms of Reference

Paper 1 Annex A

NHS South West London Clinical Commissioning Group & Integrated Care Board

Governance Oversight Group

Terms of Reference

Document management

Revision history

Version	Date	Summary of changes
0.1	03/09/21	Document created by BL
1.0	28/09/21	Inclusion of Executive Director of Strategy and Transformation as an attendee, and frequency of meetings to be more regular dependent on need. Provider Chair nominee included.

Reviewers

This document must be reviewed by the following people:

Reviewer name	Title/responsibility	Date	Version
GoG members		28/09/21	0.1

Approved by

This document must be approved by the following people:

Name	Signature	Title	Date	Version
GoG			28.09.2021	1.0

Contents

1. Purpose of the Committee

1.1. These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the Governance Oversight Group (GoG).

2. Authority

2.1. The GOG is an advisory group to the:

- CCG's Governing Body; and
- The ICS Recovery and Transition Board.

2.2. It forms part of the Governance Workstream.

3. Remit and responsibilities of the Group

3.1. The GoG's main purpose is to provide independent oversight and support with regard to:

- The creation of a new, best practice, governance framework for the Integrated Care Board; and
- The delivery of the due diligence workstream.

3.2. The group will make recommendations to the CCG's Governing Body and the ICS's Transition and Recovery Board regarding governance best practice and suggested ways forward.

3.3. The GoG will:

- Consider the effectiveness of the proposed Constitution, providing insight into best practice and suggested additions/amendments;
- Consider and recommend appropriate structures for the ICB, committees and sub committees of the ICB's Board;
- Consider the constitutional impact of conflicts of interest and its effective management within the new organisational structure;
- Consider the transitional governance arrangements required to ensure the continued effective operation of existing systems and controls (the due diligence process).

4. Attendance

4.1. The membership of the GoG will be:

Name	Role
Andrew Murray	SWL CCG Chair
Millie Banerjee	Designate SWL ICB Chair
Mike Bell	Provider Chair representative
Paul Gallagher	SWl CCG Audit Chair

David Smith	SWL Deputy CCG Chair and Finance Committee Chair
	Provider CEO
Sarah Blow	SWL CCG Accountable Officer
James Murray	SWL CCG Chief Financial Officer

4.2. The following individuals shall normally attend/ be invited to meetings:

- Internal and External Audit representatives
- Chief of Staff
- Executive Director of Strategy and Transformation
- Other directors and/or managers as appropriate;
- Representatives from other organisations, as required.

5. Secretary

5.1. The Chief of Staff shall nominate a person to act as Secretary to the Committee.

6. Frequency

6.1. The GOG will meet monthly, or more frequently, dependent on need.

7. Reporting

7.1. The group will make recommendations to the CCG Governing Body, Audit, Finance Committees and the Recovery and Transition Board as appropriate.

8. Review

8.1. These Terms of Reference will Apply up until 1 April 2022 where the ongoing requirement for the group will be determined.

9. Conflicts of Interest

9.1. Conflicts of Interest shall be dealt with in accordance with the CCG's Conflicts of Interest Policy and NHS England's statutory guidance for managing Conflicts of Interest.

NHS South West London
Integrated Care Board

South West London ICB's Constitution, Standing Orders and Core Policies

Supporting Annexes

Paper 2 Annex A SWL ICB Constitution and Standing Orders

Paper 2 Annex B NHSE Guidance notes

Paper 2 Annex C ICB Model Constitution

Paper 2 Annex D Submission letter SWL ICB Constitution

Paper 2 Annex E Letter from NHSE Approving SWL ICB Constitution

Paper 2 Annex F Scheme of Reservation and Delegation

Paper 2 Annex G SWL ICB Functions and Decisions Map

Paper 2 Annex H Standing Financial Instructions (SFIs)

Paper 2 Annex I Standards of Business Conduct Policy

Paper 2 Annex J Conflict of Interest Policy

Paper 2 Annex K Policy for Public involvement and Engagement

Paper 2 Annex L ICB Detailed Scheme of Delegation

Paper 2 Annex M SWL ICB Policies.

South West London

NHS South West London Integrated Care Board

CONSTITUTION

Document Management

Revision history

Version	Date	Summary of changes
1.0	1 July 2022	Approved by NHS England

CONTENTS

1. Introduction

1.1 Background / Foreword

1.1.1 NHSE has set out the following as the four core purposes of ICSs:

a) Improve outcomes in population health and healthcare;
b) Tackle inequalities in outcomes, experience and access;
c) Enhance productivity and value for money;
d) Help the NHS support broader social and economic development.

1.1.2 The ICB 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.

1.2 Name

1.2.1 The name of this Integrated Care Board is NHS South West London Integrated Care Board ("the ICB").

1.3 Area Covered by the Integrated Care Board

1.3.1 The area covered by the ICB is coterminous with the London Boroughs of Croydon, Kingston upon Thames, Merton, Richmond, Sutton and Wandsworth.

1.4 Statutory Framework

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

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

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

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

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

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

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

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

a) section 14Z34 (improvement in quality of services);
b) section 14Z35 (reducing inequalities);
c) section 14Z38 (obtaining appropriate advice);
d) section 14Z40 (duty in respect of research)
e) section 14Z43 (duty to have regard to effect of decisions);
f) section 14Z44 (public involvement and consultation);
g) sections 223GB to 223N (financial duties); and
h) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

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

1.5 Status of this Constitution

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

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

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

1.6 Variation of this Constitution

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

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

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

a) The Constitution will be reviewed as necessary by the CEO of the ICB. Following this review, the CEO will recommend necessary amendments to the Chair of the ICB, for agreement;
b) Proposed amendments will be put to the ICB Board for ratification;
c) Urgent amendments will be agreed by the ICB CEO and Chair;
d) Proposed amendments to this Constitution will not be implemented until an application to NHS England for variation has been approved.

1.7 Related Documents

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

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

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

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

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

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

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

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

e) **Key policy documents** - which should also be included in the Governance Handbook or linked to it - including:
    a) Standards of Business Conduct Policy;
    b) Conflicts of interest policy and procedures;
    c) Policy for public involvement and engagement.

2. Composition of the Board of the ICB

2.1 Background

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

2.1.2 Further information about the individuals who fulfil these roles can be found on our website (www.southwestlondon.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 are referred to as "Board Members") consists of:

a) a Chair;
b) a Chief Executive;
c) 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:

a) three executive members, namely:
- Chief Financial Officer;
- Executive Medical Director;
- Chief Nursing Officer;

b) 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 Section 3 below**:**

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

2.1.7 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 six Partner Members:

a) Four Partner Members – NHS Trusts and Foundation Trusts;
b) One Partner Member – Primary Medical Services; and
c) One Partner Member - Local Authorities.

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

a) Six Place Members; and
b) Deputy CEO.

2.2.3 The Board is therefore composed of the following members:

- Chair;
- Chief Executive;
- Four Partner Members - NHS and Foundation Trusts;
- One Partner Member - Primary Medical Services;
- One Partner Member - Local Authorities;
- Four Non-Executive Members;
- Chief Finance Officer;
- Executive Medical Director;
- Chief Nursing Officer;
- Six Place Members; and
- Deputy CEO.

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 Board Meetings

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

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

- All Executive Directors of the ICB who are not appointed members of

the Board; and
- A Local Authority Representative (this may be either a Chief Executive or someone who holds a relevant Executive level role, or be an elected member of one of the bodies listed at 3.6.1).

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

3.2 Disqualification Criteria for Board Membership

3.2.1 A Member of Parliament.

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

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

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

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

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

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

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

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

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

3.2.8 A person who is subject to:

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

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

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

a) section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities), or
b) section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).

3.3 Chair

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

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

a) The Chair will be independent.

3.3.3 Individuals will not be eligible if:

a) They hold a role in another health and care organisation within the ICB area;
b) Any of the disqualification criteria set out in 3.2 apply.

3.3.4 The term of office for the Chair will be 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 The Chief Executive must fulfil the following additional eligibility criteria:

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

3.4.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply;
b) Subject to clause 3.4.3(a), they hold any other employment or executive role.

3.5 Four Partner Members - NHS Trusts and Foundation Trusts

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

a) Croydon Health Services NHS Trust;
b) Central London Community Healthcare NHS Trust;
c) Epsom and St Helier University Hospital NHS Trust;
d) Hounslow and Richmond community Healthcare NHS Trust;
e) Kingston Hospital NHS Foundation Trust;
f) London Ambulance Service NHS Trust
g) St George's University Hospitals NHS Foundation Trust;
h) South London and Maudsley NHS Foundation Trust
i) South West London and St George's Mental Health NHS Trust;
j) The Royal Marsden NHS Foundation Trust.

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

a) Be the CEO of one of the NHS Trusts or FTs within the ICB's area;
b) Of the four members: one member will bring a perspective of Acute Services; one member will bring a perspective of Mental Health Services (and meet the requirements set out in para 2.2.4); one member will bring a perspective of Community Services and one member will bring a perspective of Specialised Services.

3.5.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.5.4 These members will be appointed by a panel constituted by the Chief Executive and will be subject to the approval of the ICB Chair.

3.5.5 The appointment process will be as follows:

a) Joint Nomination:
- When a vacancy arises, each eligible organisation listed at 3.5.1. will be invited to make one nomination for each of the vacant roles outlined in 3.5.2.
- Eligible organisations may nominate individuals from their own organisation or another organisation and will, at the same time, confirm that nominations have been jointly agreed.
- All eligible organisations will confirm that they approve the full list of nominees proposed

b) Assessment, selection, and appointment, will be subject to approval of the Chair under c):
- The full list of nominees will be considered by a panel convened by the Chief Executive;

- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.5.2 and 3.5.3;
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

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

3.5.6 The term of office for these Partner Members will be three years with no limit on the number of terms that can be served. At the end of each term, the eligible nominators will be asked if they jointly agree to the current members being re-nominated. If they agree and subject to members remaining eligible, the Chair will be asked to re-approve these members. If they do not agree, the nominations, selection and appointment process will be re-run.

3.6 One Partner Member - Providers of Primary Medical Services.

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

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

3.6.3 This member must fulfil the eligibility criteria set out at 3.1 and also be a practising GP in the South West London ICB's geography.

3.6.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.6.5 This member will be appointed by a panel constituted by the Chief Executive and be subject to the approval of the ICB Chair.

3.6.6 The appointment process will be as follows:

a) Joint Nomination:
- When a vacancy arises, each eligible organisation listed at 3.6.2 will be invited to make one nomination.
- The nomination of an individual must be seconded by five other eligible organisations.
- Eligible organisations may nominate individuals from their own organisation or another organisation.
- All eligible organisations will be requested to confirm whether they

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

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

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

3.6.7 The term of office for this Partner Member will be for three years. The total number of terms they may serve is three terms. At the end of each term, the eligible nominators will be asked if they jointly agree to the current member being re-nominated. If they agree and subject to the member remaining eligible, the Chair will be asked to re-approve this member. If they do not agree, the nominations, selection and appointment process will be re-run.

3.7 One Partner Member - Local Authorities

3.7.1 This Partner Member is jointly nominated by the Local Authorities whose areas coincide with, or include the whole or any part of, the ICB's area. Those local authorities are:

a) London Borough of Croydon;
b) The Royal Borough of Kingston upon Thames;
c) London Borough of Merton;
d) London Borough of Richmond upon Thames;
e) London Borough of Sutton;
f) London Borough of Wandsworth.

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

a) Be the Chief Executive or hold a relevant Executive level role, or be an elected member of one of the bodies listed at 3.7.1.

3.7.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.7.4 This member will be appointed by a panel constituted by the Chief Executive and be subject to the approval of the ICB Chair.

a) Joint Nomination:
- When a vacancy arises, each eligible organisation listed at 3.7.1. will be invited to make one nomination.
- Eligible organisations may nominate individuals from their own organisation or another organisation and will, at the same time, confirm that nominations have been jointly agreed.
- All eligible organisations will confirm that they approve the full list of nominees proposed.

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

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

3.7.5 The term of office for this Partner Member will be three years with no limit on the number of terms that can be served. At the end of each term, the eligible nominators will be asked if they jointly agree to the current member being re-nominated. If they agree and subject to the member remaining eligible, the Chair will be asked to re-approve this member. If they do not agree, the nominations, selection and appointment process will be re-run.

3.8 Executive Medical Director

3.8.1 This member will fulfil the eligibility criteria set out at 3.1 and also the followingadditional 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.

3.8.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.8.3 This member will be appointed by the Chief Executive Officer of the ICB subject to the approval of the ICB Chair.

3.9 Chief Nursing Officer

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

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

3.9.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

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

3.10 Chief Finance Officer

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

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

3.10.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

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

3.11 Deputy Chief Executive

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

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

3.11.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

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

3.12 Non-Executive Members

3.12.1 The ICB will appoint four Non-Executive Members.

3.12.2 These members will be appointed by a panel constituted by the Chair and be subject to the approval of the Chair.

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

a) Not be an employee of the ICB or a person seconded to the ICB;
b) Not hold a role in another health and care organisation in the ICS area;
c) One shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit and Risk Committee;
d) Another should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration, and Nominations Committee.

3.12.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply;
b) They hold a role in another health and care organisation within the ICB area.

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

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

3.12.7 Subject to satisfactory appraisal, the Chair may approve the re-appointment of an independent Non-Executive Member up to the maximum number of terms permitted for their role.

3.12.8 The Chair may appoint one Non-Executive Member to be the ICB Board Vice Chair. The Vice Chair will be appointed by the Board following consideration by the Remuneration and Nominations Committee, based on the recommendation from the Chair.

3.13 Other Board Members

3.13.1 The ICB will appoint six members to bring perspective and expertise on how the place arrangements operate in each of the ICB's places. While the Place Members will bring knowledge and experience from their place and will contribute the perspective of their place to the decisions of the Board, they are not to act as delegates of their place

3.13.2 These members will fulfil the eligibility criteria set out at 3.1.

3.13.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.13.4 These members will be appointed by a panel constituted by the Chief Executive and be subject to the approval of the ICB Chair.

3.13.5 The term of office for this Partner Member is three years. There is no limit to the number of terms that can be served by this member. Subject to satisfactory appraisal, the Chair may approve the re-appointment of this Board Member.

3.14 Board Members: Removal from Office.

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

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

a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this Constitution, regulations or guidance;
b) If they fail to attend a minimum of 75% of the meetings to which they are invited unless agreed with the Chair, in extenuating circumstances;
c) If they are deemed to not meet the expected standards of performance at their annual appraisal;
d) If they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the reputation 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);
e) Defamation of any member of the ICB (being slander or libel); abuse of position; non-declaration of a known conflict of interest; seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise;
f) Are deemed to have failed to uphold the Nolan Principles of Public Life;
g) Are subject to disciplinary proceedings by a regulator or professional body;
h) They materially fail to comply with the terms of the ICB's Constitution;
i) The person has refused without reasonable cause to undertake any

training which the ICB requires all staff and Board members to undertake;

j) The person, where the Chair reasonably considers (having sought appropriate clinical advice) lacks capacity, for the purposes of the Mental Capacity Act 2005, to manage and administer his/her property and/or affairs; or

k) The person is an active member of a body or organisation with policies or objectives such that his/her membership would be likely to cause the ICB to be in breach of its statutory obligations or to bring the ICB into disrepute.

3.14.3 Members may be suspended pending the outcome of an investigation into whether any of the matters in 3.14.2 apply.

3.14.4 If a Board member, other than an employee of the ICB, meets any of the criteria in 3.14.2, the following process will apply:

a) The Chair will convene a meeting of the Board, in private;

b) The approval of three quarters of the Board's membership is required to remove that individual from the Board, with the agreement of the Chair.

3.14.5 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.

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

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

a) Terminate the appointment of the ICB's Chief Executive; and

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

3.15 Terms of Appointment of Board Members

3.15.1 With the exception of the Chair, arrangements for remuneration and any allowances will be agreed by the Remuneration and Nominations 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 Chairs, will be set by NHS England. Remuneration for Non-Executive Members will be set by a specially constituted Remuneration and Nominations Committee which will not include Non-Executive Members of the ICB.

3.15.2 Other terms of appointment will be determined by the Remuneration and Nominations Committee.

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

3.16 Specific arrangements for appointment of Ordinary Members made at establishment

3.16.1 Individuals may be identified as “designate Ordinary Members” prior to the ICB being established.

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

3.16.3 Any appointment and assessment processes undertaken in advance of establishment to identify designate Ordinary Members should follow, as far as possible, the processes set out in section 3.5-3.13 of this Constitution. However, a modified process, agreed by the Chair, will be considered valid.

3.16.4 On the day of establishment, a committee consisting of the Chair, Chief Executive and the Senior HR Advisor will appoint the Ordinary Members who are expected to be all individuals who have been identified as designate appointees pre ICB establishment and the Chair will approve those appointments.

3.16.5 For the avoidance of doubt, this clause is valid only in relation to the appointments of the initial Ordinary Members and all appointments post establishment will be made in accordance with clauses 3.5 to 3.13

4. Arrangements for the Exercise of our Functions

4.1 Good Governance

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

4.1.2 The ICB has agreed a code of conduct and behaviours which sets out the expected behaviours that members of the Board and its Committees will uphold whilst undertaking ICB business. It also includes a set of principles that will guide decision making in the ICB. The ICB code of conduct and behaviours is published in the Governance Handbook.

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

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

4.3 Authority to Act

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

a) Any of its members or employees;
b) A committee or sub-committee of the ICB.

4.3.2 Under section 65Z5 of the 2006 Act, the ICB may arrange with another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority or any other body prescribed in Regulations, for the ICB's functions to be exercised by or jointly with that other body or for the functions of that other body to be exercised by or jointly with the ICB. Where the ICB and other

body enters such arrangements, they may also arrange for the functions in question to be exercised by a joint committee of theirs and/or for the establishment of a pooled fund to fund those functions (section 65Z6). In addition, under section 75 of the 2006 Act, the ICB may enter partnership arrangements with a local authority under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund.

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

4.4 Scheme of Reservation and Delegation

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

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

4.4.3 The SoRD sets out:

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

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

4.5 Functions and Decision Map

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

4.5.2 The Functions and Decision Map is published on the ICB's website (www.southwestlondon.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 section 65Z5 and 65Z6 of the 2006 Act to be exercised by, or with, another ICB, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body;

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

4.6 Committees and Sub-Committees

4.6.1 The ICB may appoint committees and arrange for its functions to be exercised by such committees. Each committee may appoint sub-committees and arrange for the functions exercisable by the committee to be exercised by those sub-committees. The Board may also create Task and Finish Groups to undertake specific, time limited pieces of work.

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

4.6.3 Each committee, sub-committee or Task and Finish Group, established by the ICB operates under terms of reference agreed by the Board. All Terms of Reference are published in the Governance Handbook.

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

a) Abide by the Terms of Reference for that committee or sub- committee, which will document the appropriate reporting and assurance arrangements.

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

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

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

4.6.8 The following committees will be maintained:

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

The Audit and Risk Committee will be chaired by a Non-Executive

Member (other than the Chair of the ICB) who has the qualifications, expertise or experience to enable them to express credible opinions on finance and audit matters.

b) **Remuneration and Nominations 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 and Nominations Committee will be chaired by a non-executive member other than the Chair or the Chair of Audit and Risk Committee.

4.6.9 The Terms of Reference for each of the above committees are published in the Governance Handbook.

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

4.7 Delegations made under section 65Z5 of the 2006 Act

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

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

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

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

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

5. Procedures for Making Decisions

5.1 Standing Orders

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

a) Conducting the business of the ICB;
b) The procedures to be followed during meetings; and
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 (SFIs)

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

5.2.2 A copy of the SFI's is published on the ICB's website (www.southwestlondon.nhs.uk).

6. Arrangements for Conflict of Interest Management and Standards of Business Conduct

6.1 Conflicts of Interest

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

6.1.2 The ICB has agreed policies and procedures for the identification and management of conflicts of interest which are published on the ICB's website (www.southwestlondon.nhs.uk).

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

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

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

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

a) Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest;
b) Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest;
c) Support the rigorous application of conflict of interest principles and policies;

d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation; and
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 as they relate to its arrangements for managing conflicts of interest:

a) The Nolan Principles;
b) Ensuring clear policy guidance is provided to all those performing a role on behalf of the ICB;
c) Monitoring compliance in accordance with published guidance;
d) Ensuring all interests are proactively declared;
e) Keeping an audit trail of actions taken; and
f) Such other principles as contained in the ICB's Conflicts of Interest policy and procedures.

6.3 Declaring and Registering Interests

6.3.1 The ICB maintains registers of the interests of:

a) Members of the ICB;
b) Members of the Board's committees and sub-committees; and
c) Its employees.

6.3.2 In accordance with section 14Z30(2) of the 2006 Act registers of interest are published on the ICB's website (www.southwestlondon.nhs.uk).

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

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

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

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

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

information.

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

6.4 Standards of Business Conduct

6.4.1 Board members, employees, committee and sub-committee members of the ICB will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should:

a) Act in good faith and in the interests of the ICB;
b) Follow the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles);
c) Comply with the ICB Standards of Business Conduct Policy, and any requirements set out in the policy for managing conflicts of interest.

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

7. Arrangements for ensuring Accountability and Transparency

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

7.2 Meetings and publications

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

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

7.2.3 Annual accounts will be externally audited and published.

7.2.4 A clear complaints process will be published.

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

7.2.6 Information will be provided to NHS England as required.

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

a) Conflicts of interest policy and procedures;
b) Registers of interests; and;
c) Those listed in 1.7.3

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

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

and

- Proposed steps to implement the South West London joint local Health and Wellbeing Strategy.

7.3 Scrutiny and Decision Making

7.3.1 The ICB will have five Non-Executive Members who will be appointed to the Board, including the Chair; and all of the Board and 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 who provides services will be made in the best interests of patients, taxpayers and the population, in line with the rules set out in the NHS Provider Selection Regime.

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

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

7.4 Annual Report

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

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

8. Arrangements for Determining the Terms and Conditions of Employees.

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

8.1.2 The Board has established a Remuneration and Nominations 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 and Nominations Committee is determined by the Board. No employees may be a member of the Remuneration and Nominations Committee but the Board ensures that the Remuneration and Nominations Committee has access to appropriate advice by:

a) Members of the HR team (including the Executive Director with responsibility for the HR function) being available to attend and advise the committee as needed;
b) The ICB's senior governance advisor, providing support, advice and attending the committee as required.

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

8.1.5 The main purpose of the Remuneration and Nominations 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 as part of the Governance Handbook on the ICB's website (www.southwestlondon.nhs.uk).

8.1.6 The duties of the Remuneration and Nominations Committee include:

a) Oversight of the nominations and appointments to Board Member roles;
b) Approve the terms and conditions of employment for all individuals directly appointed by the ICB as workers, clinical leads, office holders, including pensions, remuneration, fees and travelling or other allowances payable;
c) Set remuneration, allowances, terms and conditions for ICB Board members;
d) Agree any discretionary payments or terms and conditions for staff employed by the ICB;
e) Approve any termination or redundancy payments;
f) Approve the transfers of staff into or out of the ICB;
g) Ensuring the ICB follows national pay and terms and condition frameworks;
h) Setting remuneration, allowances and terms and conditions for the Chief Executive and Very Senior Managers (VSMs) in line with national

guidance; and

i) Any other relevant duties.

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 consultedor provided with information or in other ways) in:

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

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

a) We have six local Health and Care Plans, one for each of our Local Authority Boroughs. We will ensure these are co-developed and inform our overall system plan;
b) To ensure the local Health and Care Plans are right for our communities we co-develop them through Partner and stakeholder engagement, health and care organisations at place level, as well as key stakeholders in the borough;
c) Broad engagement – using our current community/patient group networks, and wider engagement tools such as Citizens Panels and other 'representative sample' surveys or group work;
d) Targeted engagement with communities that experience health inequalities within each borough;
e) Targeted engagement with patients and communities that have Long Term Conditions – those that are prioritised in the local health and care plans and /or are prevalent in each borough.

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

a) Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS;

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

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

9.1.5 These arrangements, include:
a) Each borough or Place has a local communications and engagement group, comprising communication and engagement professionals from all partner organisations, the NHS, Local Authorities, Healthwatch and the voluntary sector, to drive forward and deliver our priority work. These groups ensure that work and insight is coordinated across the system and that we maximise channels and reach by working in partnership;
b) These local borough groups report regularly to each place based partnership committee about past, current and planned engagement activities to contribute towards patient voice being central to influencing local decision making;
c) Informed by EHIAs, JSNAs and local insight, each borough has developed a map of key areas/communities to prioritise engagement work with. Indices of Multiple Deprivation data was overlaid with information about health inequalities. These maps will continue to be refreshed to ensure we are reaching our diverse populations working closely with the population health management team;
d) Assurance of good practice engagement happens at two levels: firstly each borough or Place has a mechanism for assuring local work;
e) Secondly we have a South West London group (including Healthwatch and the voluntary sector) to: provide assurance to the ICB that the duty to involve has been met and to provide advice on engagement plans and activities to ensure they meet best practice and are inclusive of those that are seldom heard, experience health inequalities and or/have protected characteristics;
f) Listening to local people and communities is recognised as everyone's responsibility within the ICB. Training, development and toolkits to

support good practice engagement to be delivered across teams/functions. Teams are encouraged to factor in communications and engagement requirements at an early stage of their planning so that they can be appropriately resourced and meaningfully delivered;

g) The Board will receive reports which provide an overview of the engagement activities across the ICB – noting the communities it has reached, impact that it has made, decisions it has influenced and any lessons learned;
h) To support transparent decision making, ICB papers will be published in advance of meetings, including the engagement reports, and meetings will be held in public. Our 'involving people and communities' section of our website will include opportunities for people to be involved and provide information about past, current and planned engagement activities;
i) We will use the following methodologies to reach our local people and communities;
j) Broad community engagement - working with the voluntary and community sector to host 'community conversations', to hear and respond to feedback, answer questions and gather insight. We also widen our reach through organic social media via NHS and partner channels, and paid digital adverts on platforms such as Facebook, Nextdoor and Instagram;
k) We champion 'every contact counts' supporting staff to have 'confident conversations' with local people and patients;
l) Community champions and influencers - working with key local influencers (faith leaders, community champions, health care professionals, GPs and their practices) to lead and host conversations for us building trust and confidence within our diverse communities;
m) Grassroots support programme – to improve our reach into health inclusion communities facilitating and intensifying meaningful, respectful and culturally appropriate activity in our local boroughs;
n) Surveys and questionnaires – for example working with our 'People's Panel' (a virtual group of local people who broadly reflect the population of South West London). These surveys have led to deeper dives into specific areas; and
o) Targeted focus groups and one-to-one interviews - particularly for those who are digitally excluded to help inform and shape our work.

Appendices

Appendix 1: Definitions of Terms Used in this Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022.
ICB Board	Members of the ICB.
Area	The geographical area that the ICB has responsibility for,as defined in part 2 of this Constitution.
Committee	A committee created and appointed by the ICB Board.
Sub-Committee	A committee created and appointed by and reporting to a committee.
Integrated Care Partnership	The joint committee for the ICB's area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's area.
Place-Based Partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the Integrated Care Board, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities, as well as primary care provider leadership, represented by Primary Care Network clinical directors or other relevant primary care leaders.
Ordinary Member	The Board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the Board are referred to as Ordinary Members.
Partner Members	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are and appointed in accordance with the procedures set out in Section 3 having been nominated by the following: • NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description; • the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description; and

	• the local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.
Health Service Body	Health service body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.

Appendix 2: Standing Orders

1. Introduction

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

2. Amendment and review

2.1. The Standing Orders are effective from 1 July 2022.

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

2.3. Amendments to these Standing Orders will be made as per paragraph 1.6.2 of the SWL ICB Constitution.

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

3. Interpretation, application and compliance

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

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

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

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

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

3.6. If, for any reason, these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the

circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification and the Audit and Risk Committee for review.

4. Meetings of the Integrated Care Board

4.1. Calling Board Meetings

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

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

a) The Chair may call a meeting at any time by giving not less than 14 calendar days' notice in writing;
b) One third of the members of the Board may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the Board members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the Board specifying the matters to be considered at the meeting;
c) In emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.

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

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

4.2. Chair of a meeting

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

4.2.2. If the Chair is absent, or is disqualified from participating by a conflict of interest, the Vice Chair, if present, shall preside.

4.2.3. The Board shall appoint a Chair to all committees and sub-committees that it has established. The appointed committee or sub-committee Chair will preside over the relevant meeting. Terms of

Reference for committees and sub-committees will specify arrangements for occasions when the appointed Chair is absent.

4.3. Agenda, supporting papers and business to be transacted

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

4.3.2. Except where the emergency provisions apply, supporting papers for all items must be submitted at least seven calendar days before the meeting takes place. The agenda and supporting papers will be circulated to all members of the Board at least five calendar days before the meeting.

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

4.4. Petitions

4.4.1. Where a petition has been received by the ICB it shall be included as an item for the agenda of the next meeting of the Board.

4.5. Nominated Deputies

4.5.1. With the permission of the person presiding over the meeting, the Partner Members of the Board may nominate a deputy to attend a meeting of the Board that they are unable to attend. The deputy must be of an equivalent position to the Board member they are deputising for. The deputy may speak and vote on their behalf.

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

4.6. Virtual attendance at meetings

4.6.1. The ICB Board and its committees may choose to meet physically (for example, for the purpose of an AGM), at its discretion. However, by default, the ICB Board and its committees will be held virtually.

4.7. Quorum

4.7.1. The quorum for meetings of the Board will be 50% members, including:

a) The Chair or Vice Chair;
b) Either the Chief Executive or the Chief Finance Officer;

c) Either the Executive Medical Director or the Chief Nursing Officer;
d) At least one other Non-Executive Member;
e) At least two Partner Members;
f) At least two Place Members.

4.7.2. For the sake of clarity:

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

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

4.8. Vacancies and defects in appointments

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

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

a) The quorum will remain at 50% of total Board members (i.e. no reduction in the quoracy outlined in 4.7.1 of these standing orders).

4.9. Decision making

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

4.9.2. Generally, it is expected that decisions of the ICB will be reached by consensus. Should this not be possible then a vote will be required. The process for voting, which should be considered a last resort, is set out below (except where clause 3.14.4 of the main Constitution applies):

a) All members of the Board who are present at the meeting will be eligible to cast one vote each;
b) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting,

including exercising their right to vote if eligible to do so;

c) For the sake of clarity, any additional Participants and Observers (under 2.3 of the Constitution) will not have voting rights;
d) A resolution will be passed if more votes are cast for the resolution than against it;
e) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote; and
f) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

Disputes

4.9.3. Where helpful, the Board may draw on third party support to assist them in resolving any disputes, such as peer review or support from NHS England.

Urgent decisions

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

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

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

4.10. Minutes

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

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

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

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

4.11. Admission of public and the press

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

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

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

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

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

5. Suspension of Standing Orders

5.1. In exceptional circumstances, except where it would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or NHS England, any part of these Standing Orders may be suspended by the Chair in discussion with at least 50% of those members present.

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

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

6. Use of seal and authorisation of documents.

6.1. The ICB shall have a Seal. All deeds executed by the ICB shall, unless otherwise so determined, be signed by two duly authorised members of the ICB. The Chief Executive Officer shall keep a register in which s/he, or another manager of the ICB authorised by him/her, shall enter a record of the sealing of every document.

6.2. In land transactions, the signing of certain supporting documents will be delegated to managers and set out clearly in the Scheme of Reservation and Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

ICB Model Constitution supporting notes

The purpose of the supporting notes is to provide additional information, advice and explanations for CCGs as they develop the Constitution for their ICB.

1 A mandatory statement has been included in the Model Constitution and should be adopted by all ICBs. ICBs may add further local context to the statement but should not change or remove any wording.

This section could be used to set the context for the new statutory body in an introduction or foreword. It may be helpful to set out how the ICB differs from organisations that have preceded it and to create an opportunity to introduce the partners taking part in the local arrangements. The section might also be used to introduce any local place-based arrangements and provider collaboratives if desired.

Once established, ICBs may also wish to draw out the mutual accountability agreed between the partners and make reference to the triple aim.[1] Based on expected legislation, none of these details will need to be included in the Constitution legally but there may be local benefit to signal these in a prominent place. Reference might be made here to the Integrated Care Partnership (ICP) and arrangements made to align this Constitution with its terms of reference.

2 The name used here must be the exact name used in the establishment order.

3 The legal name of the statutory body will be determined by legislation.

4 The description of the area must match that on the establishment order.

5 NHS England has written to ICSs and others to confirm the intention to delegate some of its direct commissioning functions to ICBs, and to establish joint arrangements in respect of other functions. ICB constitutions do not need

[1] A common duty for NHS bodies that plan and commission services (NHS England and ICBs) and that provide services (NHS trusts and foundation trusts) to consider the effects of their decisions on:

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

to be amended to introduce any such delegations or joint commissioning arrangements.

6 NHS England will publish a procedure for making an application to change the Constitution.

7 This section should be used to set out the procedure for variations. This should include as a minimum: who may propose a change to the Constitution and how this is done, who will be consulted on any proposed changes and how the decision (typically this will be the board) about proposed changes will be taken prior to an application being made to NHS England. These arrangements are for local determination and the process should comply with the ICB legal duties as a minimum.

8 A guide to developing a Scheme of Reservation and Delegation (SoRD) has been prepared by NHS England with support from the Healthcare Financial Management Association.

9 It will be for each ICB to determine whether, and to which committee or part of the system, its functions will be delegated; in accordance with secondary legislation and with regard to statutory guidance on delegation to other statutory bodies.

10 There is no reason why an ICB could not call the Governance Handbook by an alternative name to suit local arrangements, but it must be clear where things are published.

11 The terms of reference for committees will need to be published and easily accessible. This is to fulfil the requirement for the Constitution to specify the arrangements made by the ICB to outline the transparency of its decision-making. Terms of reference can also supplement the Functions and Decision Map and work together with any delegation arrangements that are part of the arrangements for the exercise of the ICB's functions.

12 As a minimum, a summary of the delegation arrangements and the basis on which they are agreed should be published.

13 ICBs should publish key policies relating to governance arrangements in their Governance Handbook or be clearly linked to it.

14 ICBs may choose, in line with usual practice, to publish an introduction to their board members on their websites. Details of the individuals are not required within the Constitution.

15 ‘Ordinary Members’ is the term used in the Act to describe members who are not the Chair and Chief Executive.

16 The Act requires at least one from each sector. ICBs may decide to have more.

17 These director roles may be filled in a range of possible ways. For example, different job titles may be used and individuals may hold other responsibilities as well as filling this role. ICBs can change the wording here to reflect locally- agreed arrangements within the agreed NHS England policy.

18 A minimum of two Non-executive Members are required. ICBs may appoint more.

19 ICBs may add further members beyond the statutory minimum and NHS England policy requirements. All additional members of the board must be specified in the Constitution, including any additional Partner, Executive or Non-executive Members.

When designing the board membership, there will be a need to ensure balance of perspectives on the board. This will include, for example, ensuring that the perspectives of all sectors and types of provider within the ICB’s area are included (eg acute, mental health, community and specialist). ICBs will need to ensure that the views and perspectives of patients, carers and the public are heard and included in the board decision-making process along with those from clinical and professional groups, under-represented communities and different geographical perspectives. A board made up from diverse individuals, backgrounds and perspectives will be more likely to make the best decisions for its communities.

Beyond the composition of the board itself, ICBs should ensure there are mechanisms for how the full range of perspectives is included using the decision-making model and structures that the ICB employs.

ICBs will also be expected to comply with good governance practices, eg on board size, to allow appropriate decision-making to take place. NHS England will be required to approve the constitutions, including board membership.

20 This whole section is entirely ‘optional. The clauses are crafted to help systems articulate local arrangements clearly and may require some editing. There is only a need to use them if there is local discussion proposing the idea of ‘non-voting’ members (which are not permitted). The term ‘non-voting member’ should not be used here because an individual is either a member and may vote or they are not a member and hence may not vote. ICBs that opt to use this section should use the term ‘participants and observers’.

21 Having regular participants recognises that some local partners will attend every meeting and, while they do not formally take part in decision-making, their views are sought, listened to and valued. It is recommended to limit the number of participants as most parties will play their largest role in the partnership or in operational forums and task and finish groups. A distinction is drawn here between participants and observers as some organisations have previously had difficulty being clear about roles and what behaviours, permissions and privileges are extended to such individuals. ICBs can set out the expectations clearly from the outset.

22 This is optional. It is not a requirement to list participants and observers in Constitutions.

23 This is not a requirement and suggested wording is offered for those organisations that have indicated that it would be helpful to identify specified individuals who are invited to meetings and receive papers in advance but do not have any speaking or participation rights. In practice, the status of these individuals is no different status from that of members of the public, but some organisations have found this approach useful in developing and managing local relationships.

24 Regulation 5 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014 sets out the ‘fit and proper person test’. We anticipate that regulations regarding the ‘fit and proper person test’ will apply to ICBs, so there is an expectation that designate board member appointments comply with these principles.

25 Systems should avoid designate appointments of individuals with these characteristics. Any additional locally agreed disqualification criteria should be added to the list.

Following consideration by Parliament, it was decided that being a councillor should not be a disqualification criterion. This does not alter the requirement for all ICB board members to be subject to an ICB selection process prior to the Chair approving, or not, their appointment; and for Partner Members to be jointly nominated.

26 In some cases, the Chair of the board may also be appointed to the role of Chair of the Integrated Care Partnership.

27 Please note that the appointment of designate Chairs is being separately managed as part of the ICB establishment process.

28 ICBs need to specify the term and number of terms that have been agreed by their Regional Director when the Chair designate was appointed. Good practice would be no more eight to nine years in total to ensure ongoing independence: as an example, 3 x 3 years or 2 x 4 years.

29 The appointment is made by the Chair of the board with approval from NHS England. (Please note that in the first instance the appointment of designate Chief Executives is being separately managed as part of the establishment process.)

30 NHS England will set out how Chairs and Chief Executives will be appointed and how those appointments proposed by ICBs will be approved.

31 ICBs should add any additional criteria, including those required as per NHS England guidance.

32 This refers to NHS trusts and foundation trusts that provide services within the ICB area and are of the description prescribed in the Regulations.

33 Please note the Regulations to confirm this, including setting out the forward plan condition and the level of services provided condition, will be laid before Parliament ahead of ICB establishment.

34 This guidance states this will often be the Chief Executive.

35 It is a requirement that the Constitution sets out who appoints the Ordinary Members. All appointments of Ordinary Members must (a requirement of the Act) be subject to the approval of the Chair. The Chair must always retain the right to reject/appoint individuals to result in a properly equipped board that collectively has the right skills, experience and attributes to be effective. Therefore, constitutions should not specify any criteria that result in a single individual being identified from a nomination process, such as by identifying holders of a specific role (eg it may not specify that the Chief Executive of local authority X will be appointed).

36 Describing the nomination and selection process has proven to be difficult and therefore some model wording is provided. The wording itself is not compulsory and therefore shown in green text, but a clear description of the process is required, and it must comply with the legal framework and NHS England guidance. Emergent ICBs proposing to depart from the model wording should first check these notes to see if what they are proposing will be permitted. If there are any uncertainties, advice should be sought from the relevant regional lead. The following text provides further advice:

- The Constitution must set out the appointment process in full and should be clear and unambiguous.
- All three stages of the process should be outlined, but detail, such as to which mail address nominations should be returned to, are not required.
- Enduring criteria for the roles are set out in the Constitution along with disqualification criteria. These should be combined with more detailed requirements in a role description and person specification shared with nominating organisations before the process begins.
- The Constitution should identify eligible trust/foundation trust and local authorities that may take part in the nomination process. A list of eligible GP providers should be included in the Governance Handbook (which does not form part of the constitution).
- It should specify how many nominations each eligible organisation may make.
- If there is to be a seconding requirement (this may be especially helpful when there is potential for large numbers of nominees), it should specify how many eligible organisations are required to second a nomination for it to be validated.

- The Partner Members of the board are not representatives of their sectors and rather must be selected on the basis of their suitability to fulfil the role on the ICB unitary board. Therefore, it is considered that running an election to identify a nominated individual would not be a suitable mechanism for nomination and would risk the marginalisation from the process of practices, councils or trusts in the minority.
- It should be clear how the 'joint' element of nomination will be achieved. We have suggested that a list of valid nominees is collated by the ICB and sent to all nominating organisations, and these should be asked to agree or reject the list as a whole. If this process is adopted, no response should be counted as agreement to address the risk of any eligible organisations not responding and delaying the process. Rejection or agreement applies to the whole list rather than a single nomination. If there are more agreements than rejections, the list should pass to the next stage.
- The arrangement for generating 'joint nominations' should not in effect result in the veto or cancellation of an eligible organisation's valid nomination. If a nomination is not supported by the other eligible nominating organisations, there are two recommended options: (a) the nomination is withdrawn from the list voluntarily by the nominating organisation or (b) the whole list of nominees is rejected and the process restarted.
- Reference to the appointment process being published in the Governance Handbook (or elsewhere) only is not acceptable.
- The assessment, selection and appointment part of the process must be undertaken by the ICB; it may not be outsourced, eg to a collaborative or to a local representative committee. However, there would be no reason why an ICB could not choose to invite individuals from such bodies to provide advice to a suitably balanced ICB panel.
- The assessment should be made against a person specification that is published in advance and which includes all the criteria for board membership, the specific role and disqualification criteria.

37 ICBs need to specify the term and, if limited, the number of terms permitted (for the Partner Members it is not a requirement to limit the number of terms). The details of a re-appointment process should be specified, including at what intervals. Appointments are always to be subject to the approval of the Chair.

38 For example, ICBs might refer to the nature of services provided or to the proportion of their services that are provided within the ICB area. Some ICBs have asked if they may appoint clinicians from other primary care professions (such as dentists, pharmacists and optometrists) to these roles. We can confirm that it would be in line with the proposed legislation if an ICB wished to appoint an individual who is not a GP, but that the requirement for relevant primary medical services providers (contract holders with a list) to make the nominations must be complied with.

39 The Constitution should set out who appoints the Ordinary Members. All appointments to the board of the ICB (except the Chief Executive) must by law be subject to the approval of the Chair.

40 See note 36.

41 See note 37.

42 The Constitution should set out who appoints the Ordinary Members. All appointments to the board of the ICB must by law be subject to the approval of the Chair.

43 See note 36.

44 ICBs need to specify the term and, if limited, the number of terms permitted (for the Partner Members it is not a requirement to limit the number of terms). The details of a re-appointment process should be specified including at what intervals. Appointments are always to be subject to the approval of the Chair.

45 NHS England guidance is that the board should normally include this role but recognise the role may be fulfilled in different ways, for example, they may have a different job title or hold other responsibilities with a wider portfolio.

46 This does not exclude them from also being an employee of another organisation.

47 See note 42.

48 NHS England guidance is that the board should normally include this role but recognise the role may be fulfilled in different ways; for example, they may have a different job title or hold other responsibilities with a wider portfolio.

49 This does not exclude them from also being an employee of another organisation.

50 See Note 42.

51 NHS England guidance is that the board must include this role but recognise the role may be fulfilled in different ways; for example, they may have a different job title or hold other responsibilities with a wider portfolio.

52 This does not exclude them from also being an employee of another organisation.

53 See note 42.

54 This guidance requires a minimum of two Non-executive Members (in addition to the Chair). ICBs may choose if they wish to appoint more than two Non-executive Members. The locally agreed number should be inserted into clause 3.11.1.

55 It is good practice for one Non-executive Member to be appointed as a senior Non-executive Member who would take a role in appraisal of the Chair. This role could not be fulfilled by the Chair or the Chair of the Audit committee.

56 It is a requirement that the Constitution sets out who appoints the Ordinary Members. All appointments to the board of the ICB must by law be subject to the approval of the Chair.

57 The ICB may want to add other local criteria such as requiring Non-executive Members to have a connection to (such as living or working in) the ICB area. This is entirely for local determination.

58 ICBs need to specify the term and number of terms permitted. Good practice would be no more than about nine years in total to ensure ongoing independence. For example, three terms of three years or two terms of four years would be normal. ICBs should also consider whether individuals who

have served in equivalent roles on the boards of previous and current NHS bodies locally could be sufficiently independent.

59 This is optional. The ICB can adopt this clause if they want to reduce the risk of lost continuity from mass retirement of board members.

60 Any re-appointment process should be set out along with any associated criteria.

61 There is a requirement that all the details of board appointments should be set out in the Constitution. For any additional roles (this does not include observers and participants), full details should be included as per the required roles.

62 The Constitution should set out what criteria are to be used. They are for local determination. The following are provided as suggestions:

a) If they fail to attend a minimum of xx% of the meetings to which they are invited unless agreed with the Chair in extenuating circumstances.

b) If they are deemed to not meet the expected standards of performance at their annual appraisal.

c) If they have behaved in a manner or exhibited conduct that 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 ICBs (being slander or libel); abuse of position; non-declaration of a known conflict of interest; seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise.

d) Are deemed to have failed to uphold the Nolan Principles of Public Life.

e) Are subject to disciplinary proceedings by a regulator or professional body.

63 Remuneration for board members not employed (such as the Partner Members) by the ICB is for the Board to determine but the ICB should ensure that no-one will be paid twice for the same time.

Non-executive Member remuneration cannot be determined by the Remuneration Committee if this committee's membership is entirely Non-

executive Members of the board. ICBs could consider two options: establishing a separate remuneration panel for Non-executive Member remuneration or adding further members to the Remuneration Committee such that the conflicted individuals could recluse themselves appropriately.

The reference to Non-executive Members is in green text, to facilitate ICBs establishing Remuneration Committees that can be quorate without Non-executive Members when their remuneration is being discussed if this is what is determined locally.

64 This is not a legal requirement, but if an ICB has developed such a code it could be referenced here.

65 Please note committees and sub-committees may include, or be formed from, individuals who are neither employees nor board members of the ICB. This is one of the flexibilities that will enable ICBs to exercise their functions in a collaborative way with a wide range of partners from the ICB area.

66 Terms of reference for committees will always be agreed by the board. Terms of reference for committees should specify whether or not the board is delegating the power to make further delegations to sub-committees and approve their terms of reference. It is a requirement of the proposed legislation that members of committees and sub-committees that exercise the ICB commissioning functions are to be appointed or approved by the Chair and the Chair is prohibited from doing this if they consider that appointment could reasonably be regarded to undermine the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise. If this became true for an existing member of the board, committee or sub-committee, they would be disqualified and so their appointment would end.

67 ICBs should describe their own local arrangements. This might include requiring regular decision or assurance reports from committees to be submitted to the board, requiring attendance at board meetings of the Chair, compliance with internal audit findings and committee effectiveness reviews. All terms of reference should set out the arrangements for meetings and these will usually be in line with the standing orders or specified alternative arrangements. Best practice is that terms of reference should always be approved by the board (or by the parent committee for sub-committees when the board has delegated the power to establish sub-committees) and must always be aligned with the SoRD. Membership of committees should be specified by the board.

68 Model Audit Committee terms of reference have been provided. The Audit Committee should be made up of independent people; this may include the Non-executive Members but not the Chair. Not all members of the Audit Committee should be members of the board of the ICB. The Chair of the Audit Committee should be independent, and it is not good practice for them to chair any other committees.

69 Model terms of reference have been provided. The Remuneration Committee should be chaired by a Non-executive Member other than the Audit Committee Chair. No individual should ever be involved in discussions about their own remuneration and the terms of reference should set out arrangements for ensuring this. The committee should be required to consider advice from a suitably qualified individual (such as a Director of HR or equivalent) and to ensure that suitable benchmarking informs their decisions.

70 ICBs are not required to include the terms of reference in the Constitution (as previous organisations have been required to), but they must be published.

71 ICBs are not required to include the terms of reference for all committees in the constitution, but must publish them as part of their duty to be transparent. This also forms part of specifying the arrangement for exercising the functions.

72 Example contents could include:

a) reporting arrangements to the board, at appropriate intervals, engagement events or other review sessions to consider the aims, objectives, strategy and progress of the arrangements

b) progress reporting against identified objectives

c) specify, the legal basis for such arrangements

d) identify the roles and responsibilities of all organisations that have agreed to work together

e) specify how performance will be monitored and assurance provided to the board on the discharge of responsibilities, so as to enable appropriate oversight as to how strategic intentions are being implemented

f) set out any financial arrangements that have been agreed, including identifying any pooled budgets (if applicable) and how these will be managed and reported in annual accounts

g) specify how risks will be managed and apportioned between the respective parties

h) set out how contributions from the parties, including details around assets, employees and equipment to be used, will be agreed and managed

i) identify how disputes will be resolved and the steps required to safely terminate the working arrangements

j) specify how decisions are communicated between the partners.

73 The Constitution must specify arrangements for the exercise of the ICB's functions and the procedure for making decisions and for delegation. This is ordinarily set out in the Standing Orders. ICBs that opt not to include their full Standing Orders will be required to include other clauses that satisfy the full requirements of paragraphs 10 and 11 of schedule 1B to the 2006 Act.

74 A model template for Standing Orders is provided. ICBs are free to adapt these.

75 Please see the NHS-wide guidance on conflicts of interest https://www.england.nhs.uk/ourwork/coi/

These set out minimum good practice for all NHS trusts and NHS England. As it was issued prior to their inception, ICBs are not specifically included; however, the good practice would still apply.

76 Where independent providers (including the voluntary sector) hold contracts for services (eg community services), it would be appropriate and reasonable for the body to involve them in discussions (eg about pathway design and service delivery, particularly at place level). However, this would be clearly distinct from any considerations around contracting and commissioning, from which they would be excluded.

77 ICBs are legally required to publish the registers of interest and it is good practice to ensure that members of the public have access on request.

78 The ICB should insert the names of their relevant policies.

79 This is optional – ICBs are not required to appoint a Conflict of Interests Guardian but may choose to do so as it is considered good practice. If an ICB does not appoint a Conflict of Interests Guardian, this clause should be removed.

80 The Act includes a requirement that ICBs include in their Constitution a statement of the principles to be followed in implementing the arrangements that have been made for conflicts of interest.

81 Section 14Z30 requires that ICBs maintain one or more registers of interest in relation to these categories of individuals.

82 ICBs are legally required to publish the registers of interest. It is good practice to ensure that members of the public have access on request.

83 These two clauses are not expected to be a legal requirement, but ICBs may include them as good practice.

84 The ICB may want to include a set of transparency principles.

85 The Act makes it a legal requirement that ICBs publish registers of interests or make them available to the public on request.

86 Some ICBs may have more than one Health and Wellbeing Board. The ICB is required to have regard to the local Health and Wellbeing Strategy under section 116B (1) of the Local Government and Public Involvement in Health Act.

87 ICBs will need to ensure that there are decision-making structures within the ICB that will allow for decisions around arranging healthcare services to be made in line with the NHS Provider Selection Regime. This includes ensuring that there are appropriate governance structures that will deal with any challenges that may follow decisions about provider selection. ICBs will need to evidence that they have properly exercised their responsibilities for arranging healthcare services set out in the NHS Provider Selection Regime.
This will include publishing their intentions for arranging services in advance,

publishing contracts awarded and keeping records of decision-making. ICBs will need to ensure that local audit arrangements will be capable of auditing the decisions made under the NHS Provider Selection Regime.

88 Additional information will be provided in relation to terms and conditions. Local titles may be used; for example, Remuneration and HR or Remuneration and Nominations. Terms of reference do not need to be included but should be published.

89 These should be locally determined; and might include:

a) setting the ICB pay policy (or equivalent) and standard terms and conditions

b) making arrangements to pay employees such remuneration and allowances as it may determine

c) setting remuneration and allowances for members of the board

d) setting any allowances for members of committees or sub-committees of the ICB who are not members of the board

e) any other relevant duties.

90 The Act includes a requirement for a statement of principles to be followed by the ICB in implementing its arrangements regarding public involvement to be included in the Constitution. The 10 principles are from ICS implementation guidance on working with people and communities. Each ICB should use these principles as a basis for developing a system-wide strategy for engaging with people and communities, building on the existing relationships, good practice and networks across system partners.

91 The ICB may want to add any further local principles.

92 NHS England policy expectations are set out in the ICS Design Framework and ICS implementation guidance on working with people and communities.

93 Likely to include local policies and procedures, and any commitments to regular events or structures for engagement.

94 The text is provided as a sample. ICBs will need to edit what is provided to ensure that:

a) there is consistency with local language (eg for the names used for the meetings and roles)
b) local agreements regarding, for example, quorum arrangements and voting arrangements are reflected
c) there is clarity and no room for ambiguity.

95 It is not an explicit legal requirement to include the Standing Orders in the Constitution but it is a legal requirement to include the procedure to be followed for making decisions. The drafting of the Model Constitution Template assumes that the procedure will be set out in the Standing Orders and that they are appended to the constitution. ICBs that choose not to append the Standing Orders must include additional information in their Constitution, beyond that indicated in the model.

96 In many cases, the Standing Orders are incorporated into the Constitution document so this will not be required. If the ICB decides to publish the Standing Orders as a separate document, the date from which they are effective should be added and kept up to date. The effective date is the date of approval by NHS England.

97 The ICB is subject to the Public Bodies (Admission to Meetings) Act 1960. This has a number of associated requirements that ICB governance leads will wish to familiarise themselves with. The legal requirements apply to board meetings or committees at which all board members are present or which are made up of only board members.

A body/committee that usually meets in public may, if it passes a resolution, exclude the public from all or part of a meeting if the item is of a confidential nature or for other special reasons stated in the resolution.

There is no expectation that Remuneration or Audit committees need be held in public.

98 It is good practice for a schedule of meetings to be agreed at the start of the year and to be supported by a cycle of business that sets out which recurring matters are handled at specific meetings throughout the year.

99 The ICB should publish the times and places for the meetings.

100 The experience of managing COVID-19 has shown that it is possible to convene virtual meetings with very short notice.

101 Add agreed local arrangement. There may be a deputy appointed or there may be provision for the assembled members to appoint a deputy.

102 It is good practice for the agenda to be agreed by the Chair in discussion with the lead Executive Director.

103 There is no requirement to allow deputies. The ICB can consider whether deputies will be allowed, for which roles, whether to permit them to vote or count towards the quorum.

Both ICBs and its board members should understand the accountabilities and liabilities associated with the role may not be delegated to a deputy. That means that there is accountability of the office holder, not the deputy.

The nature of the unitary board means that there are potential implications for all board members when other members delegate to a deputy.

Ideally deputies should be named in advance and the deputy role should be included in their role description. Eligibility/disqualification should also be confirmed.

Another option could be to allow the substantive office holder to confirm their nomination of a deputy in writing to the Chair in advance of the meeting. This confirmation should also provide assurance to the Chair that the nominated individual fulfils the requirements of the role and is not disqualified. Ad-hoc deputy arrangements should not normally be permitted.

If an ICB agrees to allow deputies, the following advice will be helpful:

- deputy arrangements must be set out in the standing orders
- it should be made clear which roles may appoint deputies
- members of the board or committee should understand the risks and associated liabilities
- mechanisms should be in place to ensure that any deputy is appropriately experienced, fulfils all requirements for the role and it has been confirmed that they are not disqualified.

104 ICBs will want to use the learning of COVID-19 to describe how individuals may attend meetings using technology solutions such as telephone and video attendance. Provision may be made for circumstances, where whole meetings may take place online. Consideration should be given to whether a minimum number should be physically present, under what circumstances virtual attendance will be permitted and arrangements for transparency, including the requirement for the meeting to be held in public.

105 ICBs will want to consider the balance of perspectives required for good decision-making. This is likely to include a specified number of Executive Directors, a clinical perspective, an independent perspective and partner perspective.

106 The Standing Orders needs to be unambiguous about who is eligible to vote. Proxy could be permitted if the ICB chooses, and in such circumstances the full procedures for proxy voting must be specified.

107 Not all ICBs will have these.

108 ICBs may want to add something about consultation with other board members. A balance will be needed between allowing urgent decisions in exceptional circumstances and consulting other board members.

109 Any holder of a contract for core primary care services with a list of registered patients (that is part of the ICB registered population) is expected to be eligible to take part in the nomination process.

110 Board appointments for Ordinary Members cannot be made formally until the ICB is established, but the board needs to be in place immediately on establishment. This means that arrangements need to be put in place to identify who will be appointed (ie designate members) in advance of formal appointments being made on the day of establishment. These new clauses allow the ICB to prepare to make the appointments of Ordinary Members in advance.

In many cases the designate Ordinary Members can be identified in advance using procedures that approximate to, but may not entirely align with, the procedure set out in the Constitution. For example, if the Constitution requires a panel to make the appointment, the correct panel members may not yet

have been appointed but it will be possible to constitute a similar/equivalent panel.

On the day of establishment, a panel comprising the Chair and Chief Executive and one other, if the ICB chooses, should meet to formally make the appointments prior to the Chair confirming the appointments. The board can then meet and be quorate at its first meeting.

Nomination procedures should not be affected and should be completed in full as described in the Constitution (nominations should be made after Royal Assent when there is certainty on the secondary legislation).

All procedures should be followed where it is possible to do so and this clause should only be relied on where it is otherwise impossible to comply. This clause can be deleted when the Constitution is next reviewed.

111 This ensures that the acts and decisions of the body are valid even if there are some vacancies or one of the members has been defectively appointed – this ensures that the body (or its board) does not need to be fully constituted to operate lawfully. It does not, however, allow an ICB to choose not to recruit to a vacancy; it merely affords time for the ICB to address a vacancy or defective appointment. Quorum requirements would still apply despite this clause.

112 ICBs will need to have a policy and process for managing petitions and this should be published, but the ICB but may choose to include this in the Governance Handbook rather than in the Constitution itself. There is no legal or policy guidance and ICBs are free to determine locally the content of their policy and procedures subject to compliance with other wider requirements.

113 This clause allows for any formal agreement with the NHS England Regional Director that the ICB will undertake a review of its initial constitution.

114 ICBs need to ensure that their nomination processes fulfil the requirements of being ‘jointly nominated’. A process would not be joint if the nominating organisations do not, together, have an opportunity to make the nominations, or if eligible organisations were excluded or censored. The nominations would be joint if the nominating organisations can achieve full consensus on one or more nominees, which may be possible among trusts/foundation trusts and

among local authorities, but is unlikely to be practicable when there are large numbers of organisations involved (eg primary care partners).

To be 'joint' it is not necessary for the nominating organisations to achieve full consensus on who should be nominated: the nominating organisations could approve, by majority, a list of individuals to be nominated. It is recommended that nil responses should be taken as assent to the list going forward to the ICB, to avoid a low response rate disrupting the process (particularly where there is a large number of organisations involved). ICBs could choose to add a requirement that individuals proposed for nomination should be able to demonstrate support from a sufficient (set out in the Constitution) number of nominating organisations (this could be useful, eg for GP practices, where there could be a large number of proposed nominees).

The use of elections to identify nominees is very strongly discouraged: not only does it risk marginalising organisations in the minority (eg local authorities in the political minority, mental health trusts/foundation trusts or GPs working in particular area), it also risks the nomination of individuals who are well-known rather than best suited to contributing to the ICB unitary board.

115 The Act puts beyond doubt that it is not an attempt to privatise the NHS.

It has been framed deliberately broadly, to reflect the wide range of potential circumstances that would render someone unsuitable to sit on an ICB board.

116 While the ICB is no longer responsible for the direct exercise of the function and is not liable for errors made by the body to which the function is delegated, to act lawfully when deciding to delegate, an ICB would need to show that its decision was reasonable and complied with the other usual public law duties, such as the public sector equality duty, etc. That is likely to involve carrying out due diligence, having a clear idea of what the benefits are of delegating the function and documenting the arrangements in a delegation agreement. It is also likely to involve some sort of monitoring of outcomes.

117 Green font is used to recognise that councillors may be nominated, although it is expected it will normally be a senior local authority executive.

118 The Chair is required to exercise their approval function in relation to the appointment of the Ordinary Members with a view to ensuring that at least

one of the Ordinary Members has knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness. NHS England expects, so the ICB achieves ongoing compliance, that this requirement will be met through appointment against appropriate criteria of: a Partner Member (jointly nominated by all NHS trusts/foundation trusts; additional to the minimum of one partner member of each category required by the Act); a separately appointed board member (ie not jointly nominated) likewise normally a mental health trust/foundation trust chief executive; or, where appropriate, an ICB executive director for mental health.

119 The list of primary medical services providers that nominate the Partner Member for primary care should be published as part of the Governance Handbook, which does not form part of the Constitution. This is so updates to the list, which may be frequent, do not require NHS England approval to change the Constitution.

120 If ICBs choose to add a third person, such as a local HR director.

Classification: Official

Publication approval reference: PAR1551

Guidance to clinical commissioning groups on preparing integrated care board constitutions

Annex: Integrated care board model constitution template

13 May 2022

Notes

This template is provided as a starting point for emergent ICBs to develop their constitution. It should be completed with reference to the guidance of which it forms an annex and with reference to its supporting notes: superscript numbers in red indicate which supporting note should be referred to.

Text in black indicates a legal or policy requirement and should be retained unless agreed otherwise with NHS England

Text in green indicates a clause that is optional or that requires local completion. The supporting notes explain more about what is required and may also provide examples that could be suitable.

[Insert ICB logo]

[Insert name in agreed format] Integrated Care Board

CONSTITUTION

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

Contents

1. Introduction

1.1 Background/foreword[1]

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

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

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

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

1.2 Name

1.2.1 The name of this Integrated Care Board is [insert name[2]] ('the ICB').

1.3 Area covered by the Integrated Care Board

1.3.1 The area covered by the ICB[3] is [insert appropriate description].[4]

1.4 Statutory framework

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

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

1.4.3 The main powers and duties of the ICB to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the 2006 Act).[5]

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

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

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

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

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

a) section 14Z34 (improvement in quality of services)
b) section 14Z35 (reducing inequálities)
c) section 14Z38 (obtaining appropriate advice)
d) section 14Z40 (duty in respect of research)
e) section 14Z43 (duty to have regard to effect of decisions)
f) section 14Z44 (public involvement and consultation)
g) sections 223GB to 223N (financial duties)
h) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

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

1.5 Status of this Constitution

1.5.1 The ICB was established on [date] by [*name and reference of establishment order*], 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.[113]

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[6] 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:[7]

a) add local procedure (to be determined locally in accordance with supporting notes)

b) 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 that provide further details on how governance arrangements in the ICB will operate.

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

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

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

a) **Scheme of Reservation and Delegation (SoRD)**[8] – sets out those decisions that are reserved to the board of the ICB and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the Constitution. The SoRD identifies where, or to whom, functions and decisions have been delegated to.

b) **Functions and Decision Map**[9] – a high level structural chart that sets out which key decisions are delegated and taken by which part or parts of the system. The Functions and Decision Map also includes decision-making responsibilities that are delegated to the ICB (eg from NHS England).

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

d) **The ICB Governance Handbook**[10] – this brings together all the ICB's governance documents so it is easy for interested people to navigate. It includes:

- the above documents a) – c)
- terms of reference for all committees and sub-committees of the board that exercise ICB functions[11]
- delegation arrangements[12] for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act
- terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act
- the up-to-date list of eligible providers of primary medical services under clause 3.6.2
- [add other key contents].

e) **Key policy documents**,[13] which should also be included in the governance handbook or linked to it – including:

- standards of business conduct policy
- conflicts of interest policy and procedures
- policy for public involvement and engagement.

2. Composition of the Board of the ICB

2.1 Background

2.1.1 This part of the Constitution describes the membership of the ICB. Further information about the criteria for the roles and how they are appointed is in Section xxx.

2.1.2 Further information about the individuals who fulfil these roles can be found on our website [add link].[14]

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

a) a Chair

b) a Chief Executive

c) at least three Ordinary Members.

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[17] requires the ICB to appoint the following additional Ordinary Members:

a) three Executive Members, namely:

- Director of Finance
- Medical Director
- Director of Nursing

b) At least two[18] non-executive members.

2.1.6 The ordinary[15] members include at least three members who will bring knowledge and a perspective from their sectors. These members (known as Partner Members) are nominated by the following, and appointed in accordance with the procedures set out in Section 3 below:

- NHS trusts and foundation trusts that provide services within the ICB's area and are of a prescribed description

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

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

2.2 Board membership

2.2.1 The ICB has [3][16] Partner Members:

a) Add local list

2.2.2 The ICB has also appointed the following further Ordinary Members to the board:[19]

a) List locally agreed Executive and Non-executive additional members.

2.2.3 The board is therefore composed of the following members:

a) Chair
b) Chief Executive
c) n Partner Member(s) NHS trusts and foundation trusts
d) n Partner Member(s) primary medical services
e) n Partner Member(s) local authorities
f) n Non-executive Members
g) Director of Finance
h) Medical Director
i) Director of Nursing
j) add any others.

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.[118]

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)

for the board effectively to carry out its functions and will take such steps as it considers necessary to address or mitigate any shortcoming.

2.3 Regular participants and observers at board meetings[20]

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

a) [*List invited participants*].[22]

2.3.3 Observers[23] will receive advanced copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting by the Chair. Any such person may not address the meeting and may not vote.

a) [*List invited observers*].

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'[24]

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

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

3.2 Disqualification criteria for board membership[25]

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 that 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[115].

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 UK of any offence, or

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

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

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

3.2.6 A person whose term of appointment as the Chair, a Member, a Director or a Governor of a Health Service Body has been terminated on the grounds:

a) that it was not in the interests of, or conducive to the good management of, the Health Service Body or of the health service that the person should continue to hold that office

b) that the person failed, without reasonable cause, to attend any meeting of that Health Service Body for three successive meetings

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

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

3.2.7 A healthcare 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 that 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 that had the effect of preventing the person from practising the profession in question, where that decision has not been superseded, or

d) a decision by the regulatory body that had the effect of imposing conditions on the person's practise of the profession in question, where those conditions have not been lifted.

3.2.8 A person who is subject to:

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

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

3.2.9 A person who has at any time been removed from the office of charity trustee or trustee for a charity by an order made by the Charity Commissioners for England

and Wales, the Charity Commission, the Charity Commission for Northern Ireland or the High Court, on the grounds of misconduct or mismanagement in the administration of the charity for which the person was responsible, to which the person was privy, or to which the person by their conduct contributed to or facilitated.

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

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

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

3.3 Chair[26]

3.3.1 The ICB Chair[27] 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 criteria specified at 3.1, this member must fulfil the following additional eligibility criteria:

a) the Chair will be independent

b) add any local criteria.

3.3.3 Individuals will not be eligible if:

a) they hold a role in another health and care organisation within the ICB area

b) any of the disqualification criteria set out in 3.2 apply

c) xxx.

3.3.4 The term of office for the Chair will be X years and the total number of terms a Chair may serve is X[28] 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.[29]

3.4.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England.[30]

3.4.3 The Chief Executive must fulfil the following additional eligibility criteria:

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

b) specify any further local criteria.[31]

3.4.4 Individuals will not be eligible if:

a) any of the disqualification criteria set out in 3.2 apply

b) subject to clause 3.4.3(a), they hold any other employment or executive role

c) specify any further local exclusions.

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

3.5.1 This/these Partner Member(s) is/are jointly[114] nominated by the NHS trusts and/or FTs that provide services for the purposes of the health service within the ICB's area and meet the forward plan condition or (if the forward plan condition is not met) the level of services provided condition[33]:

a) [*list trusts*] [add which[32] NHS trusts and foundation trusts provide services within the ICB area].

3.5.2 This/these member(s) must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) be an Executive Director of one of the NHS trusts or foundation trusts within the ICB's area[34]

b) specify any other criteria as may be set out in any NHS England guidance

c) specify any other criteria agreed locally by the ICB.

3.5.3 Individuals will not be eligible if:

a) any of the disqualification criteria set out in 3.2 apply

b) add any exclusion criteria set out in NHS England guidance

c) add any locally determined exclusion criteria.

3.5.4 This/these member(s) will be appointed by[35] [x] subject to the approval of the Chair.

3.5.5 The appointment process will be as follows[36]:

a) Joint Nomination:

- when a vacancy arises, each eligible organisation listed at 3.5.1.a will be invited to make Xno nominations
- the nomination of an individual must be seconded by X other eligible organisations [seconding is most suitable when there are large numbers of nominating organisations]
- eligible organisations may nominate individuals from their own organisation or another organisation
- all eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within [x] working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection and appointment subject to approval of the Chair under c):

- the full list of nominees will be considered by a panel convened by the Chief Executive
- the panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.5.2 and 3.5.3
- in the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Chair's approval:

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

3.5.6 The term of office[37] for this/ these Partner Member will be X years and the total number of terms they may serve is X terms.

3.6 Partner Member(s) – providers of primary medical services

3.6.1 This/ese Partner Member is/are jointly[114] nominated by providers of primary medical services for the purposes of the health service within the integrated care board's area, and that are primary medical services contract holders responsible for the provision of essential services, within core hours to a list of registered persons for whom the ICB has core responsibility.[109]

3.6.2 The list of relevant providers of primary medical services for this purpose is published as part of the Governance Handbook. The list will be kept up to date but does not form part of this constitution.[119]

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

a) specify any other criteria set out by NHS England's guidance

b) specify any other criteria agreed locally by the ICB.[38]

3.6.4 Individuals will not be eligible if:

a) any of the disqualification criteria set out in 3.2 apply

b) add any criteria set out in NHS England guidance

c) add any locally determined criteria.

3.6.5 This member will be appointed by[39] [x] subject to the approval of the Chair

3.6.6 The appointment process will be as follows[40]:

a) Joint Nomination:

- when a vacancy arises, each eligible organisation described at 3.6.1 and listed in the Governance Handbook will be invited to make Xno nominations
- the nomination of an individual must be seconded by X other eligible organisations [seconding is most suitable when there are large numbers of nominating organisations]
- eligible organisations may nominate individuals from their own organisation or another organisation
- all eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within [x] working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection and appointment subject to approval of the Chair under c):

- the full list of nominees will be considered by a panel convened by the Chief Executive

- the panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.6.3 and 3.6.4
- in the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Chair's approval:

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

3.6.7 The term of office[41] for this Partner Member will be x years and the total number of terms they may service is X terms.

3.7 Partner Member(s) – local authorities

3.7.1 This/hese Partner Member(s) is/are jointly[114] nominated by the local authorities whose areas coincide with, or include the whole or any part of, the ICB's area. Those local authorities are:

a) [*insert list of those LAs*].

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

a) be the Chief Executive or hold a relevant Executive level role of one of the bodies listed at 3.7.1.[117]
b) specify any other criteria set out by NHS England's guidance
c) specify any other criteria agreed locally by the ICB.

3.7.3 Individuals will not be eligible if:

a) any of the disqualification criteria set out in 3.2 apply
b) [add any locally determined criteria
c) and any criteria set out in NHS England guidance]

3.7.4 This member will be appointed by[42] [x] subject to the approval of the Chair.

3.7.5 The appointment process will be as follows:[43]

a) Joint Nomination:

- when a vacancy arises, each eligible organisation listed at 3.7.1.a will be invited to make Xno nominations
- the nomination of an individual must be seconded by X other eligible organisations [seconding is most suitable when there are large numbers of nominating organisations]
- eligible organisations may nominate individuals from their own organisation or another organisation
- all eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within [x] working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection and appointment subject to approval of the Chair under c):

- the full list of nominees will be considered by a panel convened by the Chief Executive
- the panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.7.2 and 3.7.3
- in the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Chair's approval:

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

3.7.6 The term of office[44] for this Partner Member will be x years and the total number of terms they may service is X terms.

3.8 Medical Director[45]

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

a) be an employee of the ICB[46] or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act

b) be a registered Medical Practitioner

c) specify any other criteria set out by NHS England's guidance

d) specify any other criteria agreed locally by the ICB.

3.8.2 Individuals will not be eligible if:

a) any of the disqualification criteria set out in 3.2 apply

b) add any locally determined criteria

c) and any criteria set out in NHS England guidance.

3.8.3 This member will be appointed by[47] [x] subject to the approval of the Chair.

3.9 Director of Nursing[48]

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

a) be an employee[49] of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act

b) be a registered Nurse

c) specify any other criteria set out by NHS England's guidance

d) specify any other criteria agreed locally by the ICB.

3.9.2 Individuals will not be eligible if:

a) any of the disqualification criteria set out in 3.2 apply

b) add any locally determined criteria

c) and any criteria set out in NHS England guidance.

3.9.3 This member will be appointed by[50] [x] subject to the approval of the Chair.

3.10 Director of Finance[51]

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

a) be an employee of the ICB[52] 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) specify any other criteria set out by NHS England's guidance

c) specify any other criteria agreed locally by the ICB.

3.10.2 Individuals will not be eligible if:

a) any of the disqualification criteria set out in 3.2 apply
b) [add any locally determined criteria.
c) and any criteria set out in NHS England guidance].

3.10.3 This member will be appointed by[53] [x] subject to the approval of the Chair.

3.11 [Two[54]] Non-executive Members[55]

3.11.1 The ICB will appoint [Add number] Non-executive Members.

3.11.2 These members will be appointed by[56] [x] subject to the approval of the Chair.

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

a) not be employee of the ICB or a person seconded to the ICB
b) not hold a role in another health and care organisation in the ICS area
c) one shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit Committee
d) another should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration Committee
e) specify any other criteria set out by NHS England's guidance
f) specify any other criteria agreed locally by the ICB.[57]

3.11.4 Individuals will not be eligible if:

a) any of the disqualification criteria set out in 3.2 apply
b) they hold a role in another health and care organisation within the ICB area
c) add any locally determined criteria
d) and any criteria set out in NHS England guidance.

3.11.5 The term of office for a Non-executive Member will be x years and the total number of terms an individual may serve is X[58] terms, after which they will no longer be eligible for re-appointment.

3.11.6 Initial appointments may be for a shorter period[59] to avoid all Non-executive Members retiring at once. Thereafter, new appointees will ordinarily retire on the date that the individual they replaced was due to retire, to provide continuity.

3.11.7 Subject to[60] [eg satisfactory appraisal] the Chair may approve the re-appointment of a Non-executive Member up to the maximum number of terms permitted for their role.

3.12 Other Board Members[61]

Local completion of all details for any/all Other Members is required.

3.13 Board Members: Removal from Office

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

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

a) if they no longer fulfil the requirements of their role or become ineligible for their role as set out in this Constitution, regulations or guidance

b) add further local criteria.[62]

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

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

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

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

a) terminate the appointment of the ICB's Chief Executive, and

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

3.14 Terms of appointment of Board Members

3.14.1 With the exception of the Chair and Non-executive Members, arrangements for remuneration[63] and any allowances will be agreed by the Remuneration Committee in line with the ICB remuneration policy and any other relevant

policies published [say where] and any guidance issued by NHS England or other relevant body. Remuneration for Chairs will be set by NHS England. Remuneration for Non-executive Members will be set by [*add local arrangement*].[63]

3.14.2 Other terms of appointment will be determined by the Remuneration Committee.

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

3.15 Specific arrangements for appointment of Ordinary Members made at establishment[110]

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

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

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

3.15.4 On the day of establishment, a committee consisting of the Chair, Chief Executive and [one other][120] will appoint the Ordinary Members who are expected to all be individuals who have been identified as designate appointees prior to ICB establishment and the Chair will approve those appointments.

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

4. Arrangements for the exercise of our functions

4.1 Good governance

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

4.1.2 The ICB has agreed a Code of Conduct and Behaviours,[64] which sets out the expected behaviours that members of the board and its committees will uphold while undertaking ICB business. It also includes a set of principles that will guide decision-making in the ICB. The ICB Code of Conduct and Behaviours is published in the Governance Handbook.

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 a)–f) above, documenting them as necessary in this Constitution, its Governance Handbook and other relevant policies and procedures as appropriate.

4.3 Authority to act

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

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

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

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

4.4 Scheme of Reservation and Delegation

4.4.1 The ICB has agreed a Scheme of Reservation and Delegation (SoRD), which is published in full [add where].

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

4.4.3 The SoRD sets out:

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

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

4.5 Functions and Decision Map

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

4.5.2 The Functions and Decision Map is published [add web address].

4.5.3 The map includes:

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

4.6 Committees and sub-committees[65]

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

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

4.6.3 Each committee and sub-committee established by the ICB operates under terms of reference agreed by the board.[66] All terms of reference are published in the Governance Handbook.

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

a) add local arrangements for assurance.[67]

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

4.6.6 All members of committees and sub-committees that exercise the ICB commissioning functions will be appointed/approved [*delete as appropriate*] by

the Chair.[66] The Chair will not appoint/approve [*delete as appropriate*] an individual to such a committee or sub-committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise

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

4.6.8 The following committees will be maintained:

a) **Audit Committee:**[68] This committee is accountable to the board and provides an independent and objective view of the ICB's compliance with its statutory responsibilities. The committee is responsible for arranging appropriate internal and external audit.

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

b) **Remuneration Committee:**[69] 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 a Non-executive Member other than the Chair or the Chair of Audit Committee.

4.6.9 The terms of reference for each of the above committees are published in the Governance Handbook.[70]

4.6.10 The board has also established a number of other committees to assist it with the discharge of its functions. These committees are set out in the SoRD and further information about these committees, including terms of reference, are published[71] in the Governance Handbook.

4.7 Delegations made under section 65Z5 of the 2006 Act

4.7.1 As per 4.3.2 the ICB may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other relevant bodies (another ICB,

NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body).

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

4.7.3 Each delegation made under section 65Z5 of the Act will be set out in a delegation arrangement that sets out the terms of the delegation.[72] This may, for joint arrangements, include establishing and maintaining a pooled fund. The power to approve delegation arrangements made under this provision will be reserved to the board.

4.7.4 The board remains accountable[116] for all the ICB's functions, including those that it has delegated and, therefore, appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation and these are detailed in the delegation arrangements, summaries of which will be published [*specify where* – probably the 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[73]

5.1 Standing Orders

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

- conducting the business of the ICB
- the procedures to be followed during meetings
- 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 the terms of reference that have been agreed by the board.

5.1.3 A full copy of the Standing Orders[74] 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 include the delegated limits of financial authority set out in the SoRD.

5.2.2 A copy of the SFIs is published [*specify where*].

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

6.1 Conflicts of Interest[75]

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[76] interest and do not (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

6.1.2 The ICB has agreed policies and procedures for the identification and management of conflicts of interest which are published on the website.[77]

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

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

6.1.5 Where an individual, including any individual directly involved with the business or decision-making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest that could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Constitution, the Conflicts of Interest Policy and the Standards of Business Conduct Policy.[78]

6.1.6 The ICB has appointed the Audit Chair [*edit accordingly*] to be the Conflicts of Interest Guardian.[79] In collaboration with the ICB's governance lead, their role is to:

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

6.2 Principles[80]

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

a) xxx
b) xxx.

6.3 Declaring and registering interests

6.3.1 The ICB maintains registers[81] of the interests of:

a) Members of the ICB
b) Members of the board's committees and sub-committees
c) its employees.

6.3.2 In accordance with section 14Z30(2) of the 2006 Act, registers of interest are published on the ICB website/add where.[82]

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

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

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

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

6.3.7 Interests[83] (including gifts and hospitality) of decision-making staff will remain on the public register for a minimum of six months. In addition, the ICB will retain a record of historical interests and offers/receipt of gifts and hospitality for a minimum of six years after the date on which it expired. The ICB's published register of interests states that historical interests are retained by the ICB for the specified timeframe and details who to contact to submit a request for this information.

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

6.4 Standards of business conduct

6.4.1 Board members, employees, committee and sub-committee members of the ICB will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should:

a) act in good faith and in the interests of the ICB
b) follow the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles)
c) comply with the ICB's Standards of Business Conduct Policy, and any requirements set out in the policy for managing conflicts of interest.

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

7. Arrangements for ensuring Accountability and Transparency

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

7.2 Principles[84]

7.2.1 Add local principles.

7.3 Meetings and publications

7.3.1 Board meetings, and committees composed entirely of board members or that include all board members, will be held in public[97] except where a resolution is agreed to exclude the public on the grounds that it is believed not to be in the public interest.

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

7.3.3 Annual accounts will be externally audited and published.

7.3.4 A clear complaints process will be published.

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

7.3.6 Information will be provided to NHS England as required.

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

- Conflicts of Interest Policy and procedures
- registers of interests[85]
- key policies
- add further documents.

7.3.8 The ICB will publish, with its partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to

exercise its functions during the next five years. The plan will explain how the ICB proposes to discharge its duties under:

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

and

a) proposed steps to implement the XXX joint local health and wellbeing strategy(ies).[86]

7.4 Scrutiny and decision-making

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

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

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

a) add local arrangements to describe.[87]

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

7.5 Annual Report

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

a) explain how the ICB has discharged its duties under section 14Z34 to 14Z45 and 14Z49 (general duties of integrated care boards)

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

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

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

8. Arrangements for Determining the Terms and Conditions of Employees

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

8.1.2 The board has established a Remuneration Committee,[88] which is chaired by a Non-executive Member other than the Chair or Audit 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) add local arrangements, eg HR advisers being in attendance or appointment of independent HR advice to the Remuneration Committee.

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 *indicate where*.

8.1.6 The duties of the Remuneration Committee include:[89]

a) add local points.

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 that 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 has made the following arrangements to consult its population on its system plan:

a) add local arrangements.

9.1.3 The ICB has adopted the 10 principles set out by NHS England for working with people and communities:[90]

a) put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS
b) start engagement early when developing plans, and feed back to people and communities how it has influenced activities and decisions
c) understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect
d) build relationships with excluded groups – especially those affected by inequalities
e) work with Healthwatch and the voluntary, community and social enterprise sector (VCSE) as key partners
f) provide clear and accessible public information about vision, plans and progress to build understanding and trust

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

h) use co-production, insight and engagement to achieve accountable health and care services

i) co-produce and redesign services and tackle system priorities in partnership with people and communities

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

9.1.4 In addition, the ICB has agreed the following:[91]

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

9.1.6 These arrangements include:[92]

a) ICB to specify other local arrangements.[93]

Appendix 1: Definitions of terms used in this Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022.
ICB board	Members of the ICB.
Area	The geographical area that the ICB has responsibility for, as defined in part 2 of this Constitution.
Committee	A committee created and appointed by the ICB board.
Sub-committee	A committee created and appointed by and reporting to a committee.
Integrated Care Partnership	The joint committee for the ICB's area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's area.
Place-based partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the ICB, local government, and providers of health and care services, including the VCSE sector, people and communities, as well as primary care provider leadership, represented by Primary Care Network Clinical Directors or other relevant primary care leaders.
Ordinary Member	The board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the board are referred to as Ordinary Members.
Partner Members	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are appointed in accordance with the procedures set out in section 3 having been nominated by the following: • NHS trusts and foundation trusts that provide services within the ICB's area and are of a prescribed description • the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description • the local authorities that are responsible for providing social care and whose areas coincide with or include the whole or any part of the ICB's area.

Health Service Body	Health Service Body as defined by (a) section 9(4) of the NHS Act 2006 or (b) NHS foundation trusts.
	ICBs should add local definitions as required and should always include any local terms that refer to legally prescribed roles or functions.

Appendix 2: Standing Orders

1. Introduction[94]

1.1. These Standing Orders have been drawn up to regulate the proceedings of XXX Integrated Care Board so that the ICB can fulfil its obligations as set out largely in the 2006 Act (as amended). They form part of the ICB's Constitution.[95]

2. Amendment and review

2.1. The Standing Orders are effective from xx.[96]

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

2.3. Amendments to these Standing Orders will be made as per [refer to the clause number in the Constitution for making amendments].

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

3. Interpretation, application and compliance

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

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

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

3.4. In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from [add title for senior governance adviser], will provide a settled view, which shall be final.

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

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

4. Meetings of the Integrated Care Board

4.1. Calling Board Meetings[97]

4.1.1. Meetings of the board of the ICB shall be held at regular intervals[98] at such times and places[99] as the ICB may determine.

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

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

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

c) In emergency situations the Chair may call a meeting with two[100] days' notice by setting out the reason for the urgency and the decision to be taken.

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

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

4.2. Chair of a meeting

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

4.2.2. If the Chair is absent, or is disqualified from participating by a conflict of interest, [add agreed local arrangement-there may be a deputy appointed or there may be provision for the assembled members to appoint a deputy].[101]

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

4.3. Agenda, supporting papers and business to be transacted

4.3.1. The agenda for each meeting will be drawn up and agreed by the Chair[102] of the meeting.

4.3.2. Except where the emergency provisions apply, supporting papers for all items must be submitted at least seven calendar days before the meeting takes place. The agenda and supporting papers will be circulated to all members of the board at least five calendar days before the meeting.

4.3.3. Agendas and papers for meetings open to the public, including details about meeting dates, times and venues, will be published on the ICB's website at [insert link].

4.4. Petitions[112]

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

4.5. Nominated Deputies[103]

4.5.1. With the permission of the person presiding over the meeting, the Executive Directors and the Partner Members of the board may nominate a deputy to attend a meeting of the board that they are unable to attend. The deputy may/may not, speak and vote on their behalf.

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

4.6. Virtual attendance at meetings[104]

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

4.7. Quorum[105]

4.7.1. The quorum for meetings of the board will be [agreed local number or proportion] members, including:

a) either the Chief Executive or the Director of Finance
b) either the Medical Director or the Director of Nursing
c) at least one independent member (ie the Chair or Non-executive Member)
d) at least one Partner Member.

4.7.2. For the sake of clarity:

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

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

4.8. Vacancies and defects in appointments

4.8.1. The validity of any act of the ICB is not affected by any vacancy among members or by any defect in the appointment of any member.[111]

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

- to determine locally.

4.9. Decision-making

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

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

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

b) In no circumstances may an absent member vote by proxy.[106] Absence is defined as being absent at the time of the vote, but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.

c) For the sake of clarity, any additional Participants and Observers[107] (as detailed within paragraph 5.6. of the Constitution) will not have voting rights.

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

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

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

Disputes

4.9.3. Where helpful, the board may draw on third-party support to assist them in resolving any disputes, such as peer review or support from NHS England.

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 the following will apply:

4.9.5. The powers that are reserved or delegated to the board may for an urgent decision be exercised by the Chair and Chief Executive (or relevant lead director in the case of committees),[108] subject to every effort having been made to consult with as many members as possible in the given circumstances.

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

4.10. Minutes

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

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

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

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

4.11. Admission of the public and press

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

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

4.11.3. The person presiding over the meeting shall give such directions as 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 Governing Body’s business shall be conducted without interruption and disruption.

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

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

5. Suspension of Standing Orders

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

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

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

6. Use of seal and authorisation of documents

If the organisation has a seal, arrangements made for its safe keeping and authorisation of its use should be set out here:

South West London
Clinical Commissioning Group

120 The Broadway
Wimbledon
London SW19 1RH

20 May 2022

Dear Andrew,

South West London Integrated Care Board Constitution

I am writing to formally submit South West London Integrated Care Board's (ICB) Constitution for your approval.

The Constitution has been drafted over the past six months using the NHS England Model Constitution, supporting notes and statutory guidance. We have consulted with relevant system partners over the drafting of the Constitution and their comments have been incorporated into this version. I understand that your team have been provided with further detail regarding our consultation exercise.

In September last year, we established a Governance Oversight Group to oversee our transition between the CCG and ICB. This group is made up of the Chair and two Lay Members of the CCG; our ICB designate Chair; a provider Chair; a representative from our Local Authorities and our Internal Auditors. The group have provided advice and assurance on the drafting of the Constitution through out the process.

In March this year, our Governing Body agreed to propose the Constitution to NHS England. They also agreed to delegate the power to make any further, non-substantive, amendments to myself and Millie Banerjee (as ICB designate Chair).

Therefore, I confirm that, the CCG has authorised me, as the Accountable Officer, having made a decision in accordance with its constitution and scheme of reservation and delegation, to propose this constitution as the first constitution for the NHS South West London ICB.

I would obviously be happy to answer any further questions you or your team might have.

Yours sincerely

Sarah Blow
Designate Chief Executive Officer, NHS South West London Integrated Care Board and Accountable Officer, South West London CCG.

Andrew Ridley
Regional Director – NHS London
Wellington House
133-155 Waterloo Road
London SE1 8UG

07983 574822
andrew.ridley1@nhs.net

Millie Banerjee CBE
Chair (Designate)
South West London Integrated Care Board

By email

1 June 2022

Dear Millie

South West London Integrated Care Board - Constitution

I am writing to advise that NHS England has now formally approved the constitution for South West London Integrated Care Board, as submitted and recommended by South West London CCG. The constitution should be published on the NHSE website today. The NHSE London Regional Team will confirm publication to your governance lead when this has happened and provide the link to the website.

If you or your colleagues have any issues you would like to discuss on this, please contact Brendan Carey at brendancarey@nhs.net or on 07850 883390

I would like to thank to you and your colleagues for your work in getting us to this point.

Yours sincerely

Andrew Ridley

Regional Director, NHS London

cc: Sarah Blow, Chief Executive Officer (Designate), South West London Integrated Care Board

NHS
South West London

South West London
Integrated Care Board
Scheme of Reservation and Delegation

Document management

Revision history

Version	Date	Summary of changes
.01	08/12/21	First draft by Neil McDowell
.02	24/01/22	Second draft by Ben Luscombe, amended to NHSE template
.03		
.04		
.05		
.06		
.07		
.08		

Reviewers

This document must be reviewed by the following:

Reviewer	Title/responsibility	Date	Version
James Murray (CCG CFO); Karen Broughton (Deputy Senior Responsible Officer, SWL Health and Care Partnership); Ben Luscombe (CCG Chief of Staff); Neil McDowell (CCG Director of Finance); Director of Finance (Financial Systems Management)		08/12/21 & 24/01/21	V0.1 & V0.2
Governance Oversight Group	To oversee the development of the ICB constitutions	n/a	All versions
Sarah Blow	ICS CEO Designate	n/a	All versions
Millie Banerjee	ICS Chair Designate	n/a	All versions

Approved by

This document must be approved by the following people:

Name	Signature	Title	Date	Version
Sarah Blow		ICS CEO Designate		
Millie Banerjee		ICS Chair Designate		
		ICB Chief Finance Officer		

Decisions and functions reserved to the board

	Decisions and functions reserved to the board	Reference
The board	Consideration and approval of applications to NHS England on any matter concerning changes to the ICB's constitution or standing orders.	
The board	Approval of the ICB's overarching scheme of reservation and delegation.	
The board	Approval of the ICB's operational scheme of delegation that underpins the ICB's 'overarching scheme of reservation and delegation'.	
The board	Approve detailed financial policies.	
The board	Set out who can execute a document by signature / use of the seal.	
The board	Agree the vision, values, and overall strategic direction of the ICB.	
The board	Approval of the ICB's operating structure.	
The board	Approval of the ICB's system plan.	
The board	Approval of the ICB's corporate budgets that meet the financial duties as set out in the main body of the constitution	
The board	Approval of the ICB's annual report and annual accounts.	
The board	Approve the ICB's arrangements for business continuity and emergency planning.	
The board	Approval of the arrangements for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data.	
The board	Approve decisions delegated to joint committees established under section 75 of the 2006 Act.	
The board	Approval of the arrangements for discharging the ICB's statutory duties associated with its commissioning functions, including but not limited to promoting the involvement of each patient, patient choice, reducing	

	inequalities, improvement in the quality of services, obtaining appropriate advice and public engagement and consultation.	

Decisions and functions delegated by the board to ICB committees

Committee	Decisions and functions delegated to the committee	Reference
Audit and Risk Committee	Review the adequacy and effectiveness of the system of integrated governance, risk management and internal control across the whole of the ICB's activities that support the achievement of its objectives, and to highlight any areas of weakness to the Board.	
Audit and Risk Committee	Ensure that financial systems and governance are established which facilitate compliance with DHSC's Group Accounting Manual	
Audit and Risk Committee	Review the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of the ICB's objectives, the effectiveness of the management of principal risks.	
Audit and Risk Committee	Oversight of system risks where they relate to the achievement of the ICB's objectives.	
Audit and Risk Committee	Ensure consistency that the ICB acts consistently with the principles and guidance established in HMT's Managing Public Money	
Audit and Risk Committee	Oversight of urgent decisions exercised by the Board.	
Audit and Risk Committee	Ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Board.	
Audit and Risk Committee	Review the work and findings of the external auditors and consider the implications and management's responses to their work.	
Audit and Risk Committee	Review the findings of assurance functions in the ICB, and to consider the implications for the governance of the ICB.	
Audit and Risk Committee	Review the assurance processes in place in relation to financial performance across the ICB including the completeness and accuracy of information provided.	
Audit and Risk Committee	Review the findings of external bodies and consider the implications for governance of the ICB	

Audit and Risk Committee	Approve the ICB's counter fraud arrangements.	
Audit and Risk Committee	Ensure adequate and secure Freedom to Speak Up arrangements.	
Audit and Risk Committee	Review the annual Senior Information Risk Owner (SIRO) report, the submission for the Data Security & Protection Toolkit and relevant reports and action plans.	
Audit and Risk Committee	Provide assurance to the Board that there is an effective framework in place for the management of risks associated with information governance.	
Audit and Risk Committee	Monitor the integrity of the financial statements of the ICB and any formal announcements relating to its financial performance.	
Audit and Risk Committee	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.	
Audit and Risk Committee	Review the annual report and financial statements (including accounting policies) before submission to the Board	
Audit and Risk Committee	Ensure that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective..	
Remuneration and Nominations Committee	Ensuring the ICB follows national pay and terms and condition frameworks to set the pay policy for ICB employees	
Remuneration and Nominations Committee	Setting remuneration, allowances and terms and conditions for the Chief Executive and Very Senior Managers (VSMs) in line with national guidance.	
Remuneration and Nominations Committee	Setting remuneration, allowances and terms and conditions for Integrated Care Board members.	
Remuneration and Nominations Committee	Agreeing any discretionary payments or terms and conditions for staff employed by the ICB.	

Remuneration and Nominations Committee	Approving any termination or redundancy payments.	
Remuneration and Nominations Committee	Approving TUPE or other staff transfers into or out of the ICB.	
Remuneration and Nominations Committee	Setting the ICB pay policy and standard terms and conditions of employment for all individuals appointed by the ICB as clinical leads, workers, office holders (this may include pensions, remuneration, fees, travelling or other allowances payable), and any pay awards for these individuals.	
Remuneration and Nominations Committee	Oversight of the nominations and appointments to Integrated Board member roles.	
Finance and Planning Committee	Provide assurance to the Board of performance against system control total by scrutiny of financial and planning strategy, strategic and operational financial and non-financial plans, and the current and forecast financial position of the overall ICS.	
Finance and Planning Committee	As part of the ICB's performance management role, alongside the Quality and Oversight Committee operate an ICS Performance Framework that enables the Committee to proactively manage the financial, broader performance, and savings agenda across the system, and to assess the performance against the system control total.	
Finance and Planning Committee	Oversight and approval of the process by which the ICS allocates the annual resource to stakeholders (partners), including both revenue and capital.	
Finance and Planning Committee	Ensure oversight of financial and planning performance, focusing on oversight of the delivery of ICB-wide efficiency savings, performance and system control total.	
Finance and Planning Committee	Oversee the arrangements in place for the allocation of resources and the scrutiny of all expenditure.	
Finance and Planning Committee	Review ongoing Financial Reports and the Annual Statement to be presented to the Board.	

Finance and Planning Committee	Review delivery of savings plans and initiatives through regular reports.	
Finance and Planning Committee	Provide assurance to the Board and the Audit and Risk Committee of the completeness and accuracy of the financial information provided to the Board.	
Finance and Planning Committee	Review, by exception, performance report summaries as required, and consider performance issues in so far as they impact on financial resource.	
Finance and Planning Committee	Review, scrutinise approve and/ or recommend business cases for approval to the Board in line with the detailed SoRD.	
Finance and Planning Committee	Review, and agree, procurement decisions as appropriate, in accordance with Standing Financial Instructions and the Scheme of Delegation and make recommendation to the Board.	
Finance and Planning Committee	Recommend to the Board the thresholds above which quotations or formal tenders should be obtained.	
Finance and Planning Committee	Review tender waivers and tenders from firms not on approved lists and ensure these are reported to the Board and Audit and Risk Committee.	
Finance and Planning Committee	Review the financial policies of the ICB and make appropriate recommendations to the Board	
Finance and Planning Committee	Review and monitor those risks on the ICB's BAF and Corporate Risk Register which relate to finance. Ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner.	
Finance and Planning Committee	Review and agree the termination of leases.	
Quality and Oversight Committee	Ensure that there are robust processes in place for the effective management of Quality and Performance oversight across the system.	
Quality and Oversight Committee	Scrutinise structures in place to support quality planning, performance oversight, control and improvement, to be assured that the structures operate effectively, and timely action is taken to address areas of concern	

Quality and Oversight Committee	Agree and put forward the key quality and performance priorities that are included within the ICB strategy / annual plan, including priorities to address variation / inequalities in care.	
Quality and Oversight Committee	Oversee and monitor delivery of the ICB key statutory / mandatory requirements.	
Quality and Oversight Committee	Review and monitor those risks on the BAF and Corporate Risk Register which relate to quality and system performance, and high-risk operational risks which could impact on care.	
Quality and Oversight Committee	Oversee and scrutinise the ICB's response to all relevant (as applicable to Quality and Performance oversight) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the DHSC, NHSE/I and other regulatory bodies / external agencies (e.g. CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained.	
Quality and Oversight Committee	Oversight of changes in the methodology employed by regulators and changes in legislation/regulation.	
Quality and Oversight Committee	Oversee and seek assurance on the effective and sustained delivery of the ICB Quality Improvement Programmes and broader improvement plans.	
Quality and Oversight Committee	Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place.	
Quality and Oversight Committee	Receive assurance that the ICB identifies lessons learned from all relevant sources.	
Quality and Oversight Committee	Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children.	
Quality and Oversight Committee	Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for infection prevention and control.	

Quality and Oversight Committee	Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for equality and diversity as it applies to people drawing on services.	
Quality and Oversight Committee	Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety.	
Quality and Oversight Committee	Develop the ICB Performance Oversight Framework and review this framework annually to ensure that is meets the needs of our system to support delivery of our strategic objectives.	
Quality and Oversight Committee	Oversight of NHS System Oversight Framework reviewing mitigations and assessing risk where appropriate	
Quality and Oversight Committee	Oversee the development and implementation of the system of targeted intervention, ensuring that all issues are considered and review the level and depth of intervention required.	
Quality and Oversight Committee	Oversee the triangulation of performance oversight ensuring that the right balance is struck with workforce, quality, finance and system operational metrics and risks have been fully assessed.	
Quality and Oversight Committee	Ensure that there is accurate alignment of the BAF risks and the performance risks.	
Quality and Oversight Committee	Review the proposed CQUINS for the system and ensure these are aligned to drive forward system quality and transformation objectives.	

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

Individual board member or employee	Decisions and functions delegated to the individual	Reference
Chief Executive Officer	Approve proposals for action on litigation and claims handling against or on behalf of the ICB.	
Chief Executive Officer	Approval of the ICB's contracts for any commissioning support.	
Chief Executive Officer	Approval of the ICB's contracts for corporate support (for example finance provision).	
Chief Executive Officer	Approve arrangements for co-ordinating the commissioning of services with other ICBs and or with the local authority(ies), where appropriate.	
Chief Executive Officer	Approving arrangements for handling Freedom of Information requests. Determining arrangements for handling Freedom of Information requests. Approving a comprehensive Publication Scheme for the ICB.	
Chief Financial Officer	Ensure that the ICB is in a position to produce its required monthly reporting, annual report, and accounts, as part of the setup of the new organisation.	
Chief Financial Officer	Ensure that the ICB in each financial year, prepares a report on how it has discharged its functions in the previous financial year.	
Chief Financial Officer	Responsibilities in relation to the ICB preparation and audit of annual accounts	
Chief Financial Officer	Responsibilities in relation to the ICB adherence to the directions from NHS England in relation to accounts preparation	
Chief Financial Officer	Ensuring that the allocated annual revenue and capital resource limits are not exceeded, jointly, with system partners	

Chief Financial Officer	Ensuring that there is an effective financial control framework in place to support accurate financial reporting, safeguard assets and minimise risk of financial loss	
Chief Financial Officer	Ensuring the ICB meets statutory requirements relating to taxation.	
Chief Financial Officer	Ensuring that there are suitable financial systems in place.	
Chief Financial Officer	Responsibilities in relation to the ICB meeting the financial targets set for it by NHS England	
Chief Financial Officer	Use of incidental powers such as management of ICB assets, entering commercial agreements.	
Chief Financial Officer	Ensuring the Governance Statement and Annual Accounts & Reports are signed.	
Chief Financial Officer	Ensuring planned budgets are approved by the relevant Board; developing the funding strategy for the ICB to support the Board in achieving ICB objectives, including consideration of place-based budgets	
Chief Financial Officer	Making use of benchmarking to make sure that funds are deployed as effectively as possible.	
Chief Financial Officer	Executive Members (Partner Members and Non-Executive Members) and other officers are notified of and understand their responsibilities within the SFIs.	
Chief Financial Officer	Financial leadership and financial performance of the ICB .	
Chief Financial Officer	Identification of key financial risks and issues relating to robust financial performance and leadership and working with relevant providers and partners to enable solutions.	

Chief Financial Officer	Support a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and process are in place to minimise.	
Chief Financial Officer	Prepare the ICB's operational scheme of delegation, which sets out those key operational decisions delegated to individual employees of the ICS, not for inclusion in the ICB's constitution.	
Chief Financial Officer	Prepare detailed financial policies that underpin the ICB's prime financial policies.	
Chief People Officer [CPO] (or equivalent people role in the ICB)	Lead the development and delivery of the long-term people strategy of the ICB ensuring this reflects and integrates the strategies of all relevant partner organisations within the ICS	

Decisions and functions delegated to the board by other organisations

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

Paper 2 Annex G

Functions and Decisions Map

South West London Integrated Care Board (ICB)

The ICB is 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 South West London.

The Board brings the NHS together locally to deliver shared priorities, with an emphasis on collaboration and shared responsibility for the health of the local population, and collective accountability for whole-system delivery and performance.

South West London Integrated Care Partnership (ICP)

The South West London Integrated Care Partnership (ICP) brings together organisations and representatives to reduce health inequalities and improve the care, health and wellbeing of the people in South West London.
SWL ICP is responsible for the development of an 'integrated care strategy' for the whole population to improve system-wide health and care outcomes and experiences, and influence the wider determinants of health, including healthier environments and inclusive and sustainable economies. The ICP will champion inclusion and transparency and challenge all partners to demonstrate progress in reducing inequalities and improving outcomes. It will support place-and neighbourhood-level engagement, ensuring the ICP is connected to the needs of every community.

Health & Wellbeing Boards

Health and Wellbeing Boards are responsible for setting the vision and high-level outcomes and priorities for their areas. Health and Wellbeing Boards (HWBBs) are responsible for conducting Joint Strategic Needs Assessments (JSNAs) for their areas and for setting the high level priorities and outcomes in the Joint Health and Wellbeing Strategies (JHWBs). The HWBB encourages integrated working between health, care, police and other public services in order to improve wellbeing outcomes for the local population.

Committees of the ICB

SWL Urgent and Emergency Care Committee

The UEC Board provides oversight and assurance on urgent and emergency care across SWL. It ensure that UEC pathways deliver safe, high quality, responsive care for the SWL population.

Provider Collaborative Committees

- South London Partnership
- South West London Acute Provider Collaborative
- Royal Marsden Partners

SWL Provider Collaboratives work together to continuously improve quality, efficiency and outcomes, and proactively address unwarranted variation and inequalities in access and experience across their different providers. They collaboratively lead the transformation of services and the recovery from the pandemic, ensuring shared ownership of objectives and plans across the collaborative's members.

Remuneration and Nominations Committee

The Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006. The Committee is responsible for the ICB Pay Policy including adoption of any pay frameworks for all employees including senior managers/directors (including Board Members) and Non-Executive Members, excluding the Chair.

Audit and Risk Committee

The committee provides oversight and assurance to the ICB on the adequacy of governance, risk management and internal control processes within the ICB. The duties of the Committee will be driven by the organisation's objectives and associated risks.

Finance and Planning Committee

The Committee is responsible for ensuring that there is both a robust financial strategy and planning framework in place and to oversee the system planning and broader financial management.

Quality and Oversight Committee

The Committee is responsible for ensuring that the ICB secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Bill 2021. This includes reducing inequalities in the quality of care. The Committee scrutinises the robustness of, and gains and provides assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care. The Committee will also ensure that there is system oversight of Performance including at Place and Collaborative level. The Committee's remit is to review and escalate key performance risks to the Board.

Place Committee

- One Croydon
- Wandsworth Health and Care Partnership
- Sutton Place Partnership
- Merton Health and Care together
- Kingston Place Based Partnership
- Richmond Place Based Partnership

Place Committees are responsible for the planning, coordination and delivery of shared objectives and Health and Care Plans. The Committees focus on improving health and wellbeing outcomes for the population, prevention of ill health and addressing health inequalities that exist in the boroughs.

Joint Committees of the ICB & ICP

People and Communities Engagement Assurance Committee

The SWL People and Communities Engagement Assurance Group provides assurance to the both the SWL Integrated Care Board, and Integrated Care Partnership that the duty to involve has been met. It will provide advice on engagement plans and activities to ensure they meet best practice and are inclusive of those that are seldom heard, experience health inequalities and/or have protected characteristics.

SWL People Committee

The SWL People Committee brings partners together to assess the Integrated Care System (ICS) people issues and challenges. It ensures that SWL meets the NHS National People requirements. It oversees the development of the ICS People Strategy and Priorities and agrees, oversees and drives the delivery of SWL ICSs people actions. It is responsible for ensuring a fit for purpose data collection and analytical capability is in place to asses improvement opportunities at sufficient level of granularity to design focussed objectives and workstreams.

SWL Digital Committee

The Digital Committee is responsible for developing the Digital Strategy for the ICS and setting key focus workstreams, investment prioritisation, funding approach, stakeholder engagement and supplier strategy.

SWL Clinical Senate

The Clinical Senate is responsible for setting the clinical strategy for South West London. The Senate reviews progress towards the SWL Five-Year Plan, sets clinical priorities, shares good practices and brings working groups together to assure delivery and consider cross-working group issues. The Senate explores clinical innovation opportunities and where agreed, will commission a small number of clinical reviews each year to improve care.

SWL Health Inequalities Committee

The role of the SWL Health Inequalities Committee is to set the strategic vision and goals for the health disparities programme across the ICS. It provides oversight on the implementation of the London Equity strategy and local key workstreams which will support work to reduce health inequalities. The Committee provides leadership and steer to the Equality, Diversity and Inclusion delivery group for matters escalated to the Board and embeds system partnership and community-centred approaches to health and wellbeing at Board level.

Paper 2 Annex H

NHS
South West London

Standing Financial Instructions

Policy Title: Standing Financial Instructions
Policy Number: TBC
Policy Owner: Senior Governance Advisor
Date Approved: 01/07/2022
Date for Review: 30/06/2023

Document Control

Status (Draft/Final)	Final
Policy Number / Version	1.0
Policy Author	CCG/HCP Secretary
Policy Owner	Chief Finance Officer
Ratified By and Date	Governance Oversight Group
Effective From	01/07/2022
Next Review Date	30/06/2023

Approved by

Reviewer / Committee	Audit and Risk Committee
Applies To	All individuals working for, or on behalf of SWL ICB.
Brief Description	SFIs define the purpose, responsibilities, legal framework and operating environment of the ICB. They enable sound administration, lessen the risk of irregularities and support commissioning and delivery of effective, efficient and economical services

Revision History

Latest Version	Revision
0.1	Draft SFIs to reflect establishment of SWL ICB in line with ICB guidance.

Contents

Controlled Document

The current version of this document is available electronically on the intranet and/or website. All other electronic or paper versions of this document sourced from any network drive, email or other sources are uncontrolled and should be checked against the current intranet/website version prior to use..

1. Purpose and statutory framework

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

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

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

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

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

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

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

1.8. Should any difficulties arise regarding the interpretation or application of any of these SFIs, the advice of the Chief Executive or the Chief Financial Officer must be sought before acting.

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

2. Scope

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

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

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

2.4. Unless a contrary intention is evident, or the context requires otherwise, words or

expressions contained in this document, will have the same meaning as set out in the applicable Act.

3. Roles and responsibilities

3.1. Staff

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

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

3.2. Accountable Officer

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

3.2.2 The Chief Financial Officer reports directly to the ICB Chief Executive and is professionally accountable to the NHS England regional Finance Director.

3.2.3 The Chief Executive will delegate to the Chief Financial Officer the following responsibilities in relation to the ICB:

- preparation and audit of annual accounts;
- adherence to the directions from NHS England in relation to accounts preparation;
- ensuring that the allocated annual revenue and capital resource limits are not exceeded, jointly, with system partners;
- ensuring that there is an effective financial control framework in place to support accurate financial reporting, safeguard assets and minimise risk of financial loss;
- meeting statutory requirements relating to taxation;
- ensuring that there are suitable financial systems in place (see Section 6)
- meets the financial targets set for it by NHS England;
- use of incidental powers such as management of ICB assets, entering commercial agreements;
- ensuring the Governance Statement and Annual Accounts & Reports are signed;
- ensuring planned budgets are approved by the relevant Board; developing the funding strategy for the ICB to support the Board in achieving ICB objectives, including consideration of place-based budgets;
- making use of benchmarking to make sure that funds are deployed as effectively as possible;
- Executive Members (Partner Members and Non-Executive Members) and other officers are notified of and understand their responsibilities within the SFIs;
- specific responsibilities and delegation of authority to specific job titles are confirmed;
- financial leadership and financial performance of the ICB;
- identification of key financial risks and issues relating to robust financial performance and leadership and working with relevant providers and partners to enable solutions;

and

- the Chief Financial Officer will support a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and process are in place to minimise risk.

3.3. Audit and Risk Committee

3.3.1 The Board and Accountable Officer should be supported by an Audit and Risk C Committee, which should provide proactive support to the Board in advising on:

- the management of key risks;
- the strategic processes for risk;
- the operation of internal controls;
- control and governance and the governance statement;
- the accounting policies, the accounts, and the annual report of the ICB;
- the process for reviewing of the accounts prior to submission for audit, management's letter of representation to the external auditors; and the planned activity and results of both internal and external audit.

4. Management accounting and business management

4.1. The Chief Financial Officer is responsible for maintaining policies and processes relating to the control, management and use of resources across the ICB.

4.2. The Chief Financial Officer will delegate the budgetary control responsibilities to budget holders through a formal documented process.

4.3. The Chief Financial Officer will ensure:

- the promotion of compliance to the SFIs through an assurance certification process;
- the promotion of long term financial heath for the NHS system (including ICS);
- budget holders are accountable for obtaining the necessary approvals and oversight of all expenditure incurred on the cost centres they are responsible for;
- the improvement of financial literacy of budget holders with the appropriate level of expertise and systems training;
- that the budget holders are supported in proportion to the operational risk; and
- the implementation of financial and resources plans that support the NHS Long term plan objectives.

4.4. In addition, the Chief Financial Officer should have financial leadership responsibility for the following statutory duties:

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

4.5. The Chief Financial Officer and any senior officer responsible for finance within the ICB should also promote a culture where budget holders and decision makers consult their finance business partners in key strategic decisions that carry a financial impact.

5. Income, banking statement and debt recovery

5.1. Income

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

5.1.2 The Chief Financial Officer is responsible for:

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

5.2. Banking

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

5.2.2 The Chief Financial Officer will ensure that:

- the ICB holds the minimum number of bank accounts required to run the organisation effectively. These should be raised through the government banking services contract; and
- the ICB has effective cash management policies and procedures in place.

5.3. Debt Management

5.3.1 The Chief Financial Officer is responsible for the ICB debt management strategy.

5.3.2 This includes:

- a debt management strategy that covers end-to-end debt management from debt creation to collection or write-off in accordance with the losses and special payment procedures;
- ensuring the debt management strategy covers a minimum period of 3 years and must be reviewed and endorsed by the ICB Board every 12 months to ensure relevance and provide assurance;
- accountability to the ICB Board that debt is being managed effectively;
- accountabilities and responsibilities are defined with regards to debt management to budget holders; and
- responsibility to appoint a senior officer responsible for day to day management of debt.

6. Financial systems and processes

6.1. Provision of financial systems

6.1.1 The Chief Financial Officer is responsible for ensuring systems and processes are designed and maintained for the recording and verification of finance transactions such as payments and receivables for the ICB.

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

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

6.1.4 The Chief Financial Officer will, in relation to financial systems:

- promote awareness and understanding of financial systems, value for money and commercial issues;
- ensure that transacting is carried out efficiently in line with current best practice – e.g. e-invoicing;
- ensure that the ICB meets the required financial and governance reporting requirements as a statutory body by the effective use of finance systems;
- enable the prevention and the detection of inaccuracies and fraud, and the reconstitution of any lost records;
- ensure that the financial transactions of the authority are recorded as soon as, and as accurately as, reasonably practicable;
- ensure publication and implementation of all ICB business rules and ensure that the internal finance team is appropriately resourced to deliver all statutory functions of the ICB;
- ensure that risk is appropriately managed;
- ensure identification of the duties of officers dealing with financial transactions and division of responsibilities of those officers;
- ensure the ICB has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of the ICB;
- ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes; and
- where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

7. Procurement and purchasing

7.1. Principles

7.1.1 The Chief Financial Officer will take a lead role on behalf of the ICB to ensure that there are appropriate and effective financial, contracting, monitoring and performance arrangements in place to ensure the delivery of effective health services.

7.1.2 The ICB must ensure that procurement activity is in accordance with the Public Contracts Regulations 2015 (PCR) and associated statutory requirements whilst securing value for money and sustainability.

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

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

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

7.1.6 All officers must ensure that any conflicts of interest are identified, declared and appropriately mitigated or resolved in accordance with the ICB Standards of Business Conduct Policy.

7.1.7 Budget holders are accountable for obtaining the necessary approvals and oversight of all expenditure incurred on the cost centres they are responsible for. This includes obtaining the necessary internal and external approvals which vary based on the type of spend, prior to procuring the goods, services or works.

7.1.8 Undertake any contract variations or extensions in accordance with PCR 2015 and the ICB Procurement Policy.

7.1.9 Retrospective expenditure approval should not be permitted. Any such retrospective breaches require approval from any committee responsible for approvals before the liability is settled. Such breaches must be reported to the Audit and Risk Committee.

8. Staff costs and staff related non pay expenditure

8.1. Chief People Officer

8.1.1 The Chief People Officer [CPO] (or equivalent people role in the ICB) will lead the development and delivery of the long-term people strategy of the ICB ensuring this reflects and integrates the strategies of all relevant partner organisations within the ICS.

8.1.2 Operationally the CPO will be responsible for:

- defining and delivering the organisation's overall human resources strategy and objectives; and
- overseeing delivery of human resource services to ICB employees.

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

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

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

9. Annual reporting and Accounts

9.1. The Chief Financial Officer will ensure, on behalf of the Accountable Officer and ICB Board, that:

- the ICB is in a position to produce its required monthly reporting, annual report, and accounts, as part of the setup of the new organisation; and
- the ICB, in each financial year, prepares a report on how it has discharged its functions in the previous financial year.

9.1.1 An annual report must, in particular, explain how the ICB has:

- discharged its duties in relating to improving quality of services, reducing inequalities, the triple aim and public involvement;
- review the extent to which the Board has exercised its functions in accordance with its published 5 year forward plan and capital resource use plan; and
- review any steps that the Board has taken to implement any joint local health and wellbeing strategy.

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

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

9.2. Internal Audit

9.2.1 The Chief Executive, as the accountable officer, is responsible for ensuring there is appropriate internal audit provision in the ICB. For operational purposes, this responsibility is delegated to the Chief Financial Officer to ensure that:

- all internal audit services provided under arrangements proposed by the Chief Financial Officer are approved by the Audit and Risk Committee, on behalf of the ICB Board;
- the ICB must have an internal audit charter. The internal audit charter must be prepared in accordance with the Public Sector Internal Audit Standards (PSIAS);
- the ICB internal audit charter and annual audit plan, must be endorsed by the ICB Accountable Officer, Audit and Risk Committee and Board;
- the Head of Internal Audit must provide an annual opinion on the overall adequacy and effectiveness of the ICB Board's framework of governance, risk management and internal control as they operated during the year, based on a systematic review and evaluation;

- the Head of Internal Audit should attend Audit and Risk Committee meetings and have a right of access to all Audit and Risk Committee members, the Chair and Chief Executive of the ICB.
- the appropriate and effective financial control arrangements are in place for the ICB and that accepted internal and external audit recommendations are actioned in a timely manner.

9.3. External Audit

9.3.1 The Chief Financial Officer is responsible for:

- liaising with external audit colleagues to ensure timely delivery of financial statements for audit and publication in accordance with statutory, regulatory requirements;
- ensuring that the ICB appoints an auditor in accordance with the Local Audit and Accountability Act 2014; in particular, the ICB must appoint a local auditor to audit its accounts for a financial year not later than 31 December in the preceding financial year; the ICB must appoint a local auditor at least once every 5 years (ICBs will be informed of the transitional arrangements at a later date); and
- ensuring that the appropriate and effective financial control arrangements are in place for the ICB and that accepted external audit recommendations are actioned in a timely manner.

10. Losses and Special Payments

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

10.2. The Chief Financial Officer will support a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and process are in place to minimise risks from losses and special payments.

10.3. 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.

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

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

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

11. Fraud, bribery and corruption (Economic crime)

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

11.2. The ICB Chief Financial Officer is responsible for ensuring appropriate arrangements are in place to provide adequate counter fraud provision which should include reporting requirements to the Board and Audit and Risk Committee, and defined roles and accountabilities for those involved as part of the process of providing assurance to the Board.

11.3. 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.

12. Capital Investments & security of assets and Grants

12.1. The Chief Financial Officer is responsible for:

- ensuring that at the commencement of each financial year, the ICB and its partner NHS trusts and NHS foundation trusts prepare a plan setting out their planned capital resource use;
- ensuring that the ICB and its partner NHS trusts and NHS foundation trusts exercise their functions with a view to ensuring that, in respect of each financial year local capital resource use does not exceed the limit specified in a direction by NHS England;
- ensuring the ICB has a documented property transfer scheme for the transfer of property, rights or liabilities from ICB's predecessor clinical commissioning group(s);
- ensuring that there is an effective appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
- ensuring that there are processes in place for the management of all stages of capital schemes, that will ensure that schemes are delivered on time and to cost;
- ensuring that capital investment is not authorised without evidence of availability of resources to finance all revenue consequences; and
- for every capital expenditure proposal, the Chief Financial Officer is responsible for ensuring there are processes in place to ensure that a business case is produced.

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

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

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

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

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

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

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

12.7. Grants

12.8. The Chief Financial Officer is responsible for providing robust management, governance and assurance to the ICB with regards to the use of specific powers under which it can make capital or revenue grants available to:

- any of its partner NHS trusts or NHS foundation trusts; and
- to a voluntary organisation, by way of a grant or loan.

12.9. 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.

13. Legal and insurance

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

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

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

14. Review

14.1. To ensure that these standing financial instructions remain up-to-date and relevant, the Chief Finance Officer will review them at least annually. Following consultation with the Chief Executive for the ICB and scrutiny by the ICB's Finance and Planning Committee, the Chief Finance Officer will recommend amendments, as fitting, to the ICB Board for approval.

15. Appendix One – ICB Losses and Special Payment Guide

ICB Losses and Special Payment Guidance

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Losses and Special Payments Guidance

Version number: 1.0

First published: XX-XX-2021

Next review date: 30/05/2024

Prepared by Brian Siyolwe

Document Owner; David Procter

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1 Contents

1 Introduction and guidance statement

1.1.1 The Losses and Special Payments guidance is prepared as procedural guidance for Integrated Care Boards (ICBs).

1.1.2 The purpose of this document is to establish best practice that can be incorporated into the ICBs Standing Financial Instructions.

1.1.3 It should be noted that the user of this procedural guidance should be compliant with the respective ICB SFIs. If there is a need to interpret or difficulty in application of this guidance, please send an email to the NHS England, head of assurance and counter fraud: england.assurance@nhs.net.

1.1.4 HM Treasury retains the authority to approve losses and special payments which are classified as being either:

- novel or contentious;
- contains lesson that could be of interest to the wider community;
- involves important questions of principle;
- might create a precedent; and/or
- highlights the ineffectiveness of the existing control systems.

1.1.5 Therefore, HMT 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.

1.1.6 Losses and special payments are therefore subject to special control procedures compared to the generality of payments, and, special notation in the accounts to bring them to the attention of parliament. The annual accounts reporting requirements are detailed herein.

1.1.7 For the avoidance of doubt, 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 that are detailed below or satisfy the conditions in section 1.1.4:

Expenditure type	Delegated limit
All losses	up to £300k
Special Payments including Extra-Contractual/ Statutory/ regulatory/ compensation & Ex gratia	up to £95k
Special severance & Retention payments	£0
Consolatory payments	£500

1.1.8 Losses and/or special payments that indicate or give rise to suspicion of fraud or corruption, please follow the guidance as provided by your local counter fraud specialist.

1.1.9 In dealing with individual cases, ICBs must consider the soundness of their internal control systems, the efficiency with which they have been operated, and take any necessary steps to put failings right.

1.1.10 The outcome of the review of the case under consideration (1.1.9) must be clearly indicated when submitting cases to NHS England as part of the account's consolidation process at yearend or as part of the approval process.

2 Scope

2.1.1 This procedural document is applicable to the following NHS bodies;

- Integrated Care Boards

3 Definitions

3.1.1 Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this document will have the same meaning as set out in HMT managing public money.

3.2 Losses

3.2.1 A loss refers to any case where full value has not been obtained for money spent or committed.

3.2.2 Examples of types of losses which cannot be treated as business as usual are cash losses, bookkeeping losses, fruitless payments and claims waived or abandoned.

3.3 Special Payment

3.3.1 Special Payments relate to the following;

- any compensation payments;
- extra-contractual or ex-gratia payments; and
- any payment made without specific identifiable legal power In accordance with the National Health Service Act 2006, as amended by the Health and Care Act 2022.

3.4 Special Severance and retention payments

3.4.1 ICBs have not been delegated a limit to approve the special severance or retention payments. For detailed guidance, please refer to the special severance payments document as published on the NHSEI SharePoint finance library.

3.4.2 For clarity, any non-contractual special severance payments that are being considered for approval must be submitted to NHS England HR regional advisory teams prior to settlement.

3.4.3 The table below lists all the various expenditure classifications for losses and special payments and the applicable approvals if the final settlement sum exceeds the ICB delegated limit:

Category	Classification	Approval required from	Further approvals	Description of category
Fruitless Payment	Loss	Payment Type	Classification	value exceeds delegated limit
Bookkeeping Losses	Loss	Assurance team	NHSE/ DHSC/ HMT	Bookkeeping losses (un-vouched or incompletely vouched payments) including missing items or inexplicable or erroneous debit balances
Constructive loss	Loss	Assurance team	NHSE/ DHSC/ HMT	A constructive loss is a similar form of payment to stores losses and fruitless payments, but one where procurement action itself caused the loss. For example, stores or services might be correctly ordered, delivered or provided, then paid for as correct; but later, perhaps because of a change of policy, they might prove not to be needed or to be less useful than when the order was placed
Administrative costs	Loss	Assurance team	NHSE/ DHSC/ HMT	An expense incurred in controlling and directing an organisation,
Claims Waived or Abandoned	Loss	Assurance team	NHSE/ DHSC/ HMT	Losses may arise if claims are waived or abandoned because, though properly made, it is decided not to present or pursue them
Extra-contractual payments	Special Payment	Assurance team	NHSE/ DHSC/ HMT	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
Extra-statutory	Special Payment	Assurance team	NHSE/ DHSC/ HMT	Payments which are within the broad intention of the statute or regulation but go beyond a strict interpretation of its terms.
Extra-regulatory payments	Special Payment	Assurance team	NHSE/ DHSC/ HMT	Payments which are within the broad intention of the statute or regulation but go beyond a strict interpretation of its terms.
Compensation payments	Special Payment	Assurance team	NHSE/ DHSC/ HMT	Payments made to provide redress for personal injuries, traffic accidents, and damage to property They include other payments to those in the public service outside statutory schemes or outside contracts
Special severance payments	Special Payment	NHSE Regional Director of Workforce and OD	EHRSG DHSC GAC HMT	Payments made to employees, contractors and others beyond above normal statutory or contractual requirements when leaving employment in public service whether they resign, are dismissed or reach an agreed termination of contract

				Regional and further Approval is required regardless of the value of the non contractual pay package.
Ex gratia payments	Special Payment	Assurance team	NHSE/ DHSC/ HMT	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
Retention payments	Special Payment	Regional Director of Workforce and OD		Payments, designed to encourage staff to delay their departures, particularly where transformations of ALBs are being negotiated, are also classified as novel and contentious. Such payments always require explicit Treasury approval, whether proposed in individual cases or in groups. Treasury approval must be obtained before any commitment, whether oral or in writing, is made.

3.5 Annual assurance statements

3.5.1 As part of the new compliance and control procedures over exit packages, ICBs must submit an annual assurance statement confirming the following:

- details of all[1] exit packages (including special severance payments) that have been agreed and/or made during the year;
- that NHS England and HMT [2]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; and
- adherence to the special severance payments guidance as published by NHS England.

3.5.2 Further guidance will be provided to ICBs on this process.

3.6 Interpretation

3.6.1 Should any difficulties arise regarding the interpretation or application of any part of this losses and special payment guidance, the advice of the NHS England Head of assurance and counter fraud (england.assurance@nhs.net) must be sought before acting.

3.7 Delegation of Function, Duties and Powers

3.7.1 The ICB Constitution must have a governing body that makes provision for the appointment of the Audit Committee.

3.7.2 The ICB standing financial instructions should clearly indicate the role that the audit committee has in reviewing and approving losses and special payments.

3.7.3 The ICB standing financial instructions should indicate the delegated limits that have been agreed by the governing body for operational purposes.

[1] The assurance statement must include all exit packages, thus, contractual and non contractual.
[2] This is only applicable to elements of the exit packages that are classified as non contractual

4 Integrated care board reporting requirements

4.1 Capturing of losses and special payments

4.1.1 The ICB chief financial officer is responsible for ensuring that processes and procedures that facilitate the capturing and reporting of losses and special payments are in place and ensure that a losses and special payments register is maintained.

4.1.2 All losses and special payments for ICBs must be recorded in the register and reviewed as part of the internal controls process.

4.2 Parliamentary accountability and audit report

4.2.1 The ICB must maintain a losses and special payments register that provides the requested information to complete the NHS England group accounts.

4.2.2 It should be noted that ICBs do not have a mandatory requirement to produce a Parliamentary accountability and audit report as other entities that report directly to Parliament. However, it is a mandatory requirement that ICBs produce an audit certificate and report.

There will be a need to collect data for the NHS England consolidated account. NHS England will also use this information to complete the DHSC summarisation schedule for the DHSC consolidated account. Therefore, regardless of applicability of this report, all ICBs must ensure the summarisation schedule is completed.

4.2.3 If there are any individual cases or a group of losses or special payments that exceed or the aggregate value of £100,000, the related payment should be noted separately on the ICB yearend template completed for the NHS England group account.

5 Roles and responsibilities

5.1 Financial Control

5.1.1 Chief Financial Officer

5.1.2 It is noted and acknowledged that the roles and responsibilities for the chief financial officer vary in all the ICBs. The chief financial officer should implement a system of internal control that details the process for reporting losses, recording losses, monitoring and reporting the losses and special payments to the ICB's audit committee based on existing reporting cycles.

5.1.3 The reporting cycle should also clarify the delegated sum that the chief financial officer can authorise as a loss or special payment. The delegated sum should be in line with the ICB escalation process for losses and special payments.

Paper 2 Annex I

NHS
South West London

Standards of Business Conduct Policy

Policy Title: Standard of Business Conduct Policy
Policy Number: TBC
Policy Owner: Senior Governance Advisor
Date Approved: 01/07/2022
Date for Review: 30/06/2023

Document Control

Status (Draft/Final)	Final
Policy Number / Version	TBC
Policy Author	CCG/HCP Secretary
Policy Owner	Senior Governance Advisor (Chief of Staff)
Ratified By and Date	Governance Oversight Group
Effective From	01/07/2022
Next Review Date	30/06/2023

Approved by

Reviewer / Committee	Audit Committee
Applies To	All individuals working for, or on behalf of SWL ICB.
Brief Description	This policy describes the standards and public service values which underpin the work of the NHS and reflects current guidance and best practice which is applicable to everyone who works for or on behalf of the ICB. Through this policy individuals will be aware of their own responsibilities as well as the ICB's responsibilities as a corporate body.

Revision History

Latest Version	Revision
0.1	Draft ICB SoBC Policy supersedes SWLCCG/CG04. Updated to reflect naming conventions and strengthen context around personal conduct responsibilities (sections 9 – 14) in line with NHSE/I SoBC Policy. Additionally, removal of previous content relating to Elected posts, and canvassing of votes from the Membership Body as part of Clinical Leadership roles.

Contents

Controlled Document

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1. Introduction

1.1. The Standards of Business Conduct policy describes the standards and public service values which underpin the work of the NHS and reflects current guidance and best practice which all NHS South West London Integrated Care Board (hereby known as the ICB) Board members, committee and sub-committee members, and everyone who works for or on behalf of the ICB must follow. Through this policy individuals will be aware of their own responsibilities as well as the ICB's responsibilities as a corporate body.

1.2. Importantly, the policy draws attention to the consequences of non-compliance with the requirements which may include disciplinary action and/or legal action.

1.3. As well as promoting the standards of business conduct expected of public bodies, this policy aims to protect the ICB and everyone who works for or on behalf of the ICB from any suggestion of corruption, partiality or dishonesty by providing a clear framework through which the organisation can provide guidance and assurance that individuals conduct themselves with honesty, integrity and probity.

1.4. As a publicly funded organisation, we have a duty to set and maintain the highest standards of conduct and integrity. We expect the highest standards of corporate behaviour and responsibility from Board members and everyone who works for or on behalf of the ICB.

1.5. The policy should be read in conjunction with all relevant organisational policies which are developed and agreed in line with the principles set out in this policy.

1.6. The NHS Constitution sets out some of the key responsibilities of NHS staff. The ICB endorses the three crucial public service values which must underpin the work of the health service:

- **Accountability** - everything done by those who work in the NHS must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct;
- **Probity** - there should be an absolute standard of honesty in dealing with the assets of the NHS: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of NHS duties and
- **Openness** - there should be sufficient transparency about NHS activities to promote confidence between the NHS body and its staff, patients and the public.

1.7. In addition to the public service values described above, all individuals within the scope of this policy are expected to act in accordance with the 'Seven Principles of Public Life' (Nolan Principles) which apply to all in the public service, and which are embodied within the ICB's Constitution. These are attached at Appendix 1.

1.8. Under the Prevention of Corruption Act (1916) any money, gift or consideration received by a public service employee from a person or organisation holding or seeking to obtain a contract will be deemed by the Courts to have been received corruptly, unless the employee can prove to the contrary.

2. Scope

2.1. Everyone who works for or on behalf of the ICB is within the scope of the policy. This includes but is not limited to staff (interims, secondees, agency staff, contractors, sub-contractors, students, trainees and apprentices) and employees of partner organisations who are members of the Board, sub-committees or other decision-making groups.

2.2. It is recognised that some individuals are more likely than others to have a decision making influence on the use of taxpayers' money, because of the requirements of their role. For the purposes of this guidance these people are referred to as 'decision making staff'.

2.3. Decision making staff are:

- Executive and non-executive members (or equivalent roles) of SWL ICB;
- Members of the Board, committees, sub-committees and advisory groups which contribute to direct or delegated decision making;
- Staff at AfC band 8d and above;
- Staff who have the power to enter into contracts on behalf of the organisation and / or involved in decision making concerning the procurement of services, purchasing of good, medicines, medical devices or equipment, and formulary decisions.

3. Responsibilities

3.1. The ICB is responsible for ensuring that the requirements of this policy and supporting documents are brought to the attention of all staff and that systems are put in place for ensuring that the guidelines are effectively implemented. These responsibilities are particularly important given the corporate responsibility set out in the Bribery Act (2010) for organisations to ensure that their anti-fraud and bribery procedures are robust. Such awareness will be promoted in:

- A clause statement written in Job Descriptions; and
- Publication of this policy on the intranet for staff.

3.2. In line with the Managing Conflicts of Interest (including Gifts & Hospitality) Policy, the guiding principle is to ensure that decisions are made in the public interest by avoiding any undue influence.

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

3.4. A conflict of interest may be:

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

3.5. Interests fall into the following categories:

- **Financial interests** - Where an individual may get direct financial benefit from the consequences of a decision they are involved in making;
- **Non-financial professional interests** - Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career;
- **Non-financial personal interests** - Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career;
- **Indirect interests** - Where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making;
- **Gifts and hospitality** - acceptance of hospitality from current or prospective business contacts, and acceptance of gifts.

3.6. **All staff** must apply the following principles in the conduct of their employment:

- They must not accept gifts, hospitality or benefits of any kind from a third party which might be perceived as compromising their personal judgement or integrity;
- They must not make use of their official position to further their private interests or those of others;
- They must declare any private interests which are relevant and material relating to the position they hold in the NHS.

3.7. In addition they staff must:

- Base all purchasing decisions and negotiations of contracts solely on achieving best value for money for the taxpayer;
- Refer to their line manager when faced with a situation for which the guidance available requires further interpretation;

3.8. If in any doubt, they must seek advice from the ICB's Senior Governance Advisor.

3.9. It is the responsibility of all staff to raise any concerns regarding staff business conduct.

3.10. All staff should ensure that they are not placed in a position that risks, or appears to risk, conflict between their private interests and their NHS duties.

3.11. The **Local Counter Fraud Specialist** (LCFS) is responsible for taking forward all anti-fraud work locally in accordance with national NHS Counter Fraud Authority standards and reports directly to the Chief Finance Officer. Adherence to the NHS Counter Fraud Authority counter fraud standards is important in ensuring that the organisation has appropriate counter fraud, bribery and corruption arrangements in place.

3.12. The LCFS works with key colleagues and stakeholders to promote anti-fraud work and effectively respond to system weaknesses and investigate allegations of fraud and corruption. This will include the undertaking of risk assessments to identify fraud,

bribery and corruption risks at the ICB.

3.13. Suspected fraud, bribery and corruption can be reported to:
- The LCFS: Matt Wilson who can be contacted on 07484 040691 or matt.wilson@rsmuk.com and Ruth Goddard on ruth.goddard@rsmuk.com; or
- Using the NHS Fraud and Corruption Reporting Line on Freephone 0800 028 40 60 or by filling in an online form at www.reportnhsfraud.nhs.uk, as an alternative to internal reporting procedures and if staff wish to remain anonymous.

3.14. Board, Committee/Sub-Committee Members and individuals acting on behalf of the ICB, must act in accordance with this policy in circumstances whether they are either employed fully by the ICB, hold appointments with the ICB, are employed on a sessional basis or on an honorary contract, or provide services under a service level agreement with the ICB.

4. The Guidance in Practice

4.1. Overriding Principle

4.1.1. As a public body, the ICB has a duty to ensure fairness and honesty in its relationships with suppliers, contractors, service providers and service users or any other person or organisation with whom the ICB has or might have business connections.

4.1.2. All employees and others acting on behalf of the ICB must uphold the highest standards of business conduct within such relationships. This is important to ensure that no employee, especially those responsible for making decisions in relation to purchases and procurement, acts in any way that is inconsistent with the organisation's objectives or compromises the integrity of the business by accepting a gift in circumstances where it could influence, or be perceived to influence, that employee's business actions or decisions.

4.1.3. Everyone who works for or on behalf of the ICB, including its Board, Committee or sub-committee members must not accept any fee or reward for work done whilst on ICB matters other than that agreed under their terms and conditions of employment. As a general rule, employees should not accept gifts or hospitality arising from their employment or appointment with the ICB, except where these are of a token nature only, in which case employees should inform their manager. Further information is provided in the Managing Conflicts of Interest (including Gifts & Hospitality) Policy.

4.2. Commercial sponsorship

4.2.1. In recognition that NHS bodies work together, and in collaboration with other agencies, to improve health services for the populations they serve, the Department of Health published guidance 'Commercial Sponsorship: Ethical Standards for the NHS' (2000).

4.2.2. The guidance acknowledges that collaborative partnerships with industry can have a number of benefits. It advises that it is important to have a transparent approach about any proposed sponsorship which would benefit the ICB and for the ICB to consider fully the implications of a proposed sponsorship deal before entering into

any arrangement. If any such partnership is to work, there must be trust and reasonable contact between the sponsoring company and the NHS.

4.2.3. For the purpose of this policy, commercial sponsorship is defined as:

'NHS funding from an external source, including of all, or part of, the costs of a member of staff, NHS research, staff training, pharmaceuticals, equipment, meeting rooms, costs associated with meetings, meals, gifts, hospitality, hotel and transport costs (including trips abroad), provision of free services (speakers), buildings or premises'.

4.3. Procurement processes

4.3.1. When testing the market for potential providers of services and when initiating a procurement process to invite expressions of interest, tenders, or applications to an Any Qualified Provider framework, the ICB will ensure compliant notices are published on Contracts Finder and where required by the Public Contract Regulations 2015 (as amended), and where applicable on the Find a Tender Service.

- No private, public or voluntary organisation or company which may bid for ICB business should be given any advantage over its competitors, such as advance notice of ICB requirements. This applies to all potential contractors, whether or not there is a relationship between them and the ICB, such as a long-running series of previous contracts;
- Each new contract should be awarded solely on merit, taking into account the requirements of the ICB and the ability of the contractors to fulfil them; and
- No special favour is to be shown to current or former employees or their close relatives or associates in awarding contracts to private or other businesses run by them or employing them in any capacity. Contracts may be awarded to such businesses when they are won in fair competition against other tenders, but scrupulous care must be taken to ensure that the selection process is conducted impartially, and that staff who are known to have a relevant interest play no part in the selection.

4.3.2. Public procurement ethics must be observed to avoid accusations of impropriety and it is, therefore, essential to maintain a complete audit trail.

4.3.3. Anyone participating in procurement processes will be required to make a declaration of interest, in line with contract and policy processes. Declarations should be made when the interest arises, annually and at the start of each tending process. Where individuals do not have any declarations, a nil declaration must be made.

4.4. Private Transactions

4.4.1. Anyone working for or on behalf of the ICB, must not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of the ICB. (This does not apply to concessionary agreements, negotiated with companies by NHS management, or by recognised staff interests, on behalf of all staff – for example, NHS staff benefits schemes).

4.5. Employees' outside employment

4.5.1. The standard contract used across the ICB sets out terms concerning outside employment: 'Staff employed by SWL ICB are not precluded by their Contracts of Employment from accepting other employment outside of their working hours. However, staff must seek prior approval from their manager before accepting such employment and ensure that the employment does not in any way hinder or conflict with the interest of their employment with the SWL ICB or in any way contravene the Working Time Regulations. New staff already working elsewhere must inform their immediate manager on commencement of employment with SWL ICB'.

4.5.2. Any employee who may be considering outside employment should discuss this in the first instance with their line manager or director before undertaking the employment.

4.5.3. If staff wish to take on additional paid work, such as panel membership, speaking at conferences, undertaking peer review, which is directly related to their role in the NHS, the following process will apply:

- All requests to participate in additional activities must be submitted in writing to their Director;
- If agreed, the assumption will be made that in these cases staff will be released for additional activities during work time with any remuneration to be paid directly to the ICB;
- Any participation in additional activities must be explicitly agreed with the relevant director and recorded; and
- In all cases staff must declare any additional paid work as part of the Declaration of Interests process.

4.5.4. Employees must not engage in outside employment during any periods of sickness absence from the ICB. To do so may lead to a referral being made to the Local Counter Fraud Specialist for investigation which may lead to criminal and/or disciplinary action in accordance with the ICB's policy in relation to Anti-Fraud.

4.6. Donations in relation to the organisation

4.6.1. Employees must check with their line manager or director before making any requests for donations (e.g. to Charitable Funds) to clarify appropriateness and/or financial or contractual consequences of acquisition. Requests for equipment or services should not be made without the express permission of a senior manager.

4.6.2. Further guidance regarding Charitable Funds and gifts and donations can be requested from the Chief Finance Officer.

4.6.3. Any gifts to the organisation should be managed in accordance with the Managing Conflicts of Interest (including Gifts & Hospitality) Policy.

4.7. Patents and Intellectual Property

4.7.1. Individuals should declare other intellectual property rights they hold (either individually or by virtue of their association with a commercial or other organisation)

relating to goods and services which are, or might reasonably be expected to be, procured or used by the ICB.

4.7.2. Any patents, designs, trademarks or copyright resulting from the work (e.g. research) of an officer carried out as part of their employment shall be the Intellectual Property of the ICB.

4.7.3. Where the undertaking of external work, gaining patent or copyright or the involvement in innovative work, benefits or enhances our reputation or results in financial gain, consideration will be given to rewarding officers subject to any relevant guidance for the management of Intellectual Property in the NHS issued by the Department of Health and Social Care (DHSC).

4.7.4. Individuals must seek prior permission through their line manager before entering into any agreement with bodies regarding product development where this impacts on normal working time or uses our equipment and/or resources.

4.7.5. Where holding of patents and other intellectual property rights give rise to a conflict of interest, then this must be declared in accordance with the Managing Conflicts of Interest (including Gifts & Hospitality) Policy.

4.8. Candidates for appointment

4.8.1. Candidates for any appointment with the ICB must disclose in writing if they are related to, or in a significant relationship with (e.g. spouse or partner), any Board member or employee of the ICB. The application form requests this information and therefore must be disclosed before submission.

4.8.2. A member of an appointment panel which is to consider the employment of a person to whom he/she is related must declare the relationship before an interview is held.

4.8.3. Candidates for any appointment with the ICB shall, when applying, also disclose cases where they or their close relatives or associates have a controlling and/or significant financial interest in a business (including a private company, public sector organisation, other NHS employer and/or voluntary organisation), or in any other activity or pursuit, which may compete for an NHS contract to supply either goods or services to the ICB.

4.9. Canvassing for appointments

4.9.1. It is acknowledged that informal discussions concerning an advertised post can be part of the recruitment process. However, canvassing or lobbying of ICB employees, Board members or any members of an appointments committee, either directly or indirectly, shall disqualify a candidate. This shall not preclude a member from giving a written reference or testimonial of a candidate's ability, experience or character for submission to an appointments panel. Jobs will be awarded on the merit of the individual candidate.

4.10. Trade or discount cards

4.10.1. Trade or discount cards, by which personal benefit is obtained from the ICB's purchase of goods or services at a reduced price gives rise to the potential for real or

perceived conflicts of interest. If offered or received, such cards are classified as gifts and should be politely declined and/or returned to the sender. The exceptions to this are benefits negotiated by the ICB on behalf of its staff.

4.11. Awards or prizes

4.11.1. Staff should consult their line manager or Chief Finance Officer if they are offered an award or prize in connection with their official duties. They will normally be allowed to receive it, provided:

- there is no risk of public criticism;
- it is offered strictly in accordance with personal achievement;
- it is not in the nature of a gift nor can be construed as a gift, inducement of payment for publication or invention to which other rules apply.

5. Recording of Gifts, Hospitality and Sponsorship

5.1. All offers of gifts and hospitality must be declared and recorded in accordance with the Managing Conflicts of Interest (including Gifts & Hospitality) Policy. Failure to comply with the policy may lead to disciplinary action.

5.2. No gifts from suppliers above a value of £6 can be accepted and nor can gifts with a value in excess of £50 per item, either individually or cumulatively (from the same or closely related source) in a 12-month period.

5.3. It is acknowledged that there may be circumstances where hospitality may be offered by an organisation, as an integral element of a strategic partnership relationship. Acceptance of such hospitality and associated funding agreement will be authorised by the ICB CEO and recorded in the Register of Gifts and Hospitality.

6. Declaration of Interests

6.1. All individuals must ensure that any declarations of interest are identified, declared and appropriately mitigated or resolved in accordance with the ICB's Managing Conflicts of Interest (including Gifts & Hospitality) Policy.

6.2. Where an individual becomes aware of an interest which could lead to a conflict of interest in the event of the ICB considering an action or decision in relation to that interest, that interest must be declared and managed in line with the ICBs policy.

7. Raising Concerns

7.1. The ICB's Raising Concerns (Whistleblowing Policy) is an appropriate route for staff to raise legitimate and genuine concerns about conflicts of interest, criminal activity, breach of a legal obligation (including negligence, breach of contract or breach of administrative law), miscarriage of justice, danger to health and safety or the environment, and other financial integrity and business conduct issues raised by this policy. The Raising Concerns Policy gives full details of how such concerns should be raised and the legal protection afforded staff who raise concerns based on a genuine belief.

8. Confidentiality[1]

8.1. Everyone who works for or on behalf of the ICB must, at all times, operate in accordance with the General Data Protection Regulation and Data Protection Act (2018) and maintain the confidentiality of information of any type, including but not restricted to patient information; personal information relating to officers; commercial information. This duty of confidence remains after staff (however employed) leave the ICB.

8.2. For the avoidance of doubt, this does not prevent the disclosure or information where there is a lawful basis for doing so (e.g. consent). Staff should refer to the suite of Information Governance and ICT policies for detailed information.

8.3. Disclosure of information which counts as "commercial in confidence" and which might prejudice the principle of a purchasing system based on fair competition may be subject to scrutiny and disciplinary or criminal action, or both.

8.4. This does not affect the ICB's grievance or complaints procedures in terms of freedom of expression and is not intended to restrict any of the freedoms protected under Article 10 of the Human Rights Act (1998). It is designed to complement professional and ethical rules, guidelines and codes of conduct on an individual's freedom of expression.

8.5. An employee or individual who has exhausted all the locally established procedures, including reference to the Whistleblowing Policy, and who has taken account of advice which may have been given, may wish to consult their MP or the Secretary of State for Health in confidence.

8.6. Section 43B (1) of the Public Interest Disclosure Act (1998) provides protection for disclosure of information where the worker making the disclosure has a reasonable belief that the disclosure is in the public interest, and tends to show that:

- a criminal offence has been committed, is being committed or is likely to committed;
- a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject;
- a miscarriage of justice has occurred, is occurring or is likely to occur;
- the health or safety of any individual has been, is being or is likely to be endangered;
- the environment has been, is being or is likely to be damaged; or
- information tending to show any matter falling within points a) to e) has been, is being or is likely to be deliberately concealed.

8.7. Disclosure must be made to either the employer or to a prescribed third party, such as the Health & Safety Executive or HM Revenue & Customs. Wider disclosure, for instance to the media, is only protected if the worker believes the information is substantially true, is in the public interest, and not for their own personal gain.

[1] Refer to Raising Concerns Policy

9. Personal Conduct

9.1. Corporate Responsibility

9.1.1. As an organisation made up of partners, our ability to make collective decisions through our agreed governance processes is key to ensure consistency of approach. Therefore we expect everyone who works for or on behalf of the ICB has a responsibility to respect and promote the corporate or collective decision of the ICB, even though this may conflict with their personal views. Directors and staff commenting as individuals should make it clear that they are expressing their personal view and not the view of the ICB.

9.1.2. **When speaking as a member of the ICB**, whether to the media, in a public forum or in a private or informal discussion, individuals should ensure that they reflect the current policies or view of the organisation.

9.1.3. For any public forum or media interview, opportunities should be discussed in advance:

- In the case of the Board, with the ICB CEO / Chair or their nominated deputy, and Communications Team;
- In the case of all other individuals, with the Communications Team.

9.1.4. When this is not possible, they should report their action to the ICB CEO / Chair or their nominated deputy, as soon as possible.

9.1.5. All individuals must ensure their comments are informed and made in the public interest and that they aim to enhance and protect the reputation of the ICB. This does not affect whistleblowing rights.

9.1.6. Failure to follow the guidance for communication with the media may result in disciplinary action.

9.2. Use of Social Media

9.2.1. Everyone who works for or on behalf of the ICB is expected to comply with the ICB's Social Media Policy. They should be aware that social networking websites are public forums and should not assume that their entries will remain private. Individuals communicating via social media must comply with the relevant organisational social media and associated policies. All individuals must not:

- Make false, misleading or defamatory statements, and must not promote hate or discrimination against any group or individual on the grounds of race, religious belief, gender or sexuality;
- Encourage or endorse behaviour that could be linked to safeguarding issues;
- Post anything that is disparaging about a group or individual on social media;
- Post anything that is factually inaccurate or defamatory, or incite people to act
- Illegally or present negative behaviours;
- Air grievances or publish anything that risks bringing their organisation or any
- Partner organisations into disrepute;
- Include materials in their posts that are copyrighted;

- Post images containing patient information on personal social media accounts that could identify the patient or lead the patient to identify themselves.

9.3. Gambling

9.3.1. No individual is permitted to bet or gamble when on duty or on ICB premises, with the exception of small lottery syndicates or sweepstakes related to national events such as the World Cup or Grand National among immediate colleagues within the same offices where no profits are made or the lottery is wholly for purposes that are not for private or commercial gain (e.g. to raise funds to support a charity).

9.4. Lending and Borrowing

9.4.1. The lending or borrowing of money between individuals should be avoided, whether informally or as a business, particularly where the amounts are significant.

9.4.2. It is a particularly serious breach of discipline for any individual to use their position to place pressure on someone in a lower payband, a business contact, or a member of the public to loan them money.

9.5. Trading on NHS premises

9.5.1. Trading on official premises is prohibited, whether for personal gain or on behalf of others. This includes, but is not limited to:

- Flyers advertising services/products in common areas; and
- Catalogues in common areas.

9.5.2. Canvassing within the office by, or on behalf of, outside bodies or firms (including non-ICB interests of individuals or their relatives) is also prohibited. Trading does not include small tea or refreshment arrangements solely for individuals.

9.6. Individual Voluntary Arrangements, County Court Judgment (CCJ), Bankruptcy / Insolvency

9.6.1. Any individual who becomes bankrupt, insolvent, has active CCJ, or made individual voluntary arrangements with organisations must inform their line manager and the HR team as soon as possible. Officers who are bankrupt or insolvent cannot be employed, or otherwise engaged, in posts that involve duties which might permit the misappropriation of public funds or involve the approval of orders or handling of money.

9.7. Use of Resources

9.7.1. Under the Code of Conduct for NHS Managers, all managers are required to use the resources available to them in an effective, efficient and timely manner having proper regard to the best interests of the public and patients.

9.8. Suspicions of Fraud/Theft

9.8.1. Staff should not be afraid of raising concerns and will not experience any blame or

recrimination as a result of making any reasonably held suspicion known. Further information is available in the Anti-Fraud and Bribery Policy and Fraud Response Plan.

9.8.2. Where a suspected breach also includes suspected commission of fraud or bribery, this should be reported to the ICB's Local Counter Fraud Specialist team or directly to the NHS Counter Fraud Authority.

9.8.3. The ICB is committed to fostering an environment that encourages individuals to raise concerns relating to malpractice within the ICB, and to investigate matters raised thoroughly, promptly, and confidentially.

10. Non-Compliance with Policy

10.1. Failure to comply

10.1.1. Failure by an employee to comply with the requirements set out in this policy may include disciplinary action and/or legal action where appropriate.

10.2. Failure to Disclose or Declare

10.2.1. There will be situations when interests, and offers of gifts, hospitality and sponsorship will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of the policy these situations are referred to as 'breaches'.

10.2.2. Failing to respond to a request for information in relation to the policy, including a request to submit a declaration, will also be considered a breach of the policy.

10.2.3. The ICB takes the failure to comply with this and other policies seriously. If an individual fails to declare an interest or the full details of an interest, and/or offers of gifts, hospitality and sponsorship, or otherwise breach the policy this may result in disciplinary action being undertaken. Please see the Disciplinary Policy for more information.

10.2.4. It is an offence under the Fraud Act (2006) for personnel to fail to disclose information to the ICB in order to make a gain for themselves or another, or to cause a loss or expose the organisation to a loss. Therefore, if an individual becomes aware of any financial or other irregularities or impropriety which involve evidence or suspicion of fraud, bribery or corruption they should contact the Local Counter Fraud Specialist in accordance with the Anti-Fraud and Bribery Policy with a view to an appropriate investigation being conducted and potential prosecution being sought.

10.2.5. Breaches of this policy addressed internally may result in a Board member being removed from office in line with the ICB's Constitution. A contractor may be prevented from obtaining further work with the ICB or an employee may face disciplinary action and dismissal. Breaches which amount to criminal offences may result in criminal prosecution and civil recovery action.

10.3. Identifying and Reporting Breaches

10.3.1. Staff who are aware of actual breaches of the policy, or who are concerned that there has been, or may be, a breach, should report these concerns to the Senior Governance Advisor.

10.3.2. To ensure that interests are effectively managed, staff are encouraged to discuss actual or perceived breaches. Every individual has a responsibility to do this.

10.3.3. The ICB will investigate each reported breach according to its own specific facts and merits and give relevant parties the opportunity to explain and clarify any relevant circumstances. For further information about how concerns should be raised please see the Whistleblowing Policy.

10.3.4. Following investigation, the ICB will:

- Decide if there has been or is potential for a breach and if so what the severity of the breach is;
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum;
- Consider who else inside (and outside, e.g. the CQC, GMC, NMC, etc) the ICB should be made aware; and
- Take appropriate action.

10.4. Taking Action in Response to Breaches

10.4.1. Action taken in response to breaches of the policy will be in accordance with the disciplinary procedures of the ICB and could involve organisational leads for staff support (e.g. Human Resources), fraud (e.g. Local Counter Fraud Specialists), members of the management or executive teams and the ICB's auditors.

10.4.2. Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process and procedures;
- Consideration as to whether HR/employment law/contractual action should be taken against staff or others; and
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, the NHS Counter Fraud Authority, the Police, statutory health bodies (such as NHS England, NHS Improvement or the CQC), and/or health professional regulatory bodies.

10.4.3. Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrongdoing or fault then the ICB can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach. This includes:

- Informal action (such as reprimand or signposting to training and/or guidance);
- Formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal);
- Reporting incidents to the external parties described above for them to consider what further investigations or sanctions might be;

- Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach and
- Legal action, such as investigation and prosecution under fraud, bribery and corruption legislation.

10.5. Learning and Transparency Concerning Breaches.

10.5.1. Reports on any breaches, the impact of these, and action taken will be considered by the Audit and Risk Committee.

10.6. Criminal Implications

10.6.1. Failure to manage conflicts of interest could lead to criminal proceedings including for offences such as fraud, bribery and corruption. This could have implications for the ICB and any linked organisations, and the individuals who are engaged by them.

10.6.2. An essential ingredient of the offences defined within the Fraud Act (2006) is that the offender's conduct must be dishonest, and their intention must be to make a gain, or cause a loss (or the risk of a loss) to another. Fraud carries a maximum sentence of 10 years imprisonment and /or a fine if convicted in the Crown Court or 6 months imprisonment and/or a fine in the Magistrates' Court. The offences can be committed by a body corporate.

10.6.3. The Bribery Act (2010) makes it a criminal offence to give or offer a bribe, or to request, offer to receive or accept a bribe. The Act introduced a corporate offence which means that organisations, including NHS bodies, will be exposed to criminal liability, punishable by an unlimited fine, for failing to prevent bribery.

10.6.4. Anyone working for or on behalf of the ICB should be aware that in committing an act of bribery they may be subject to a penalty of up to ten years' imprisonment, a fine, or both.

10.6.5. They should also be aware that a breach of the Bribery Act (2010), or of this guidance, renders them liable to disciplinary action by the ICB whether or not the breach leads to prosecution. Where a material breach of this guidance is found to have occurred, the likely sanction will be dismissal.

10.6.6. In short, the offences cover the offering, promising or giving of a financial or other advantage and the requesting, agreeing to receive or accepting of a financial or other advantage where the overall intention of such an action is to bring about an improper performance or a relevant function or activity.

10.6.7. The ICB will have a defence to the corporate offence if it can show that, despite a particular case of bribery, it nevertheless had 'adequate procedures' in place to prevent persons associated with it from committing bribery offences in line with the Ministry of Justice guidance. The declaration of interest process is a key part of these adequate procedures.

10.6.8. Full compliance with the requirements of this policy is expected by everyone who works for or on behalf of the ICB in order to demonstrate the ICB's commitment to openness and transparency, in the spirit of the Act.

11. Monitoring and Review

11.1. The Audit and Risk Committee is responsible for reviewing this policy and ensuring its implementation. If you have any suggestions for the improvement of this policy, please contact the Governance Team.

11.2. This policy will be reviewed in in the first year following the establishment of the ICB and every 2 years thereafter, or earlier if there are significant changes to national guidance affecting Standards of Business Conduct across the organisation.

12. Equality Impact Assessment

12.1. An Equality Impact Assessment must be carried out as part of the development of each policy, this can be found in Appendix 2.

13. Related Documents

- ICB Constitution
- Managing Conflicts of Interest (including Gifts & Hospitality) Policy
- Prime Financial Policies, Scheme of Reservation and Delegation
- Anti-Fraud and Bribery Policy
- Raising Concerns (Whistleblowing Policy)
- Contract and Procurement Policy
- Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England
- Code of Conduct for NHS Managers
- Principles of Public Life drawn up by the Nolan Committee – Appendix 1
- Department of Health's guidance (2000) - Commercial Sponsorship – Ethical Standards for the NHS

Appendix 1 - The Nolan Principles on Standards in Public Life

The Nolan Committee was set up in 1994 to examine concerns about standards of conduct of all holders of public office, including arrangements relating to financial and commercial activities, and make recommendations as to any changes in arrangements which might be required to ensure the highest standards of propriety in public life. The committee published “Seven principles of Public Life”, which it believes should apply to all those operating in the public sector. These principles should be adopted by ICB staff and are as follows:

Selflessness
Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

Integrity
Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity
In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability
Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness
Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership
Holders of public office should promote and support these principles by leadership and example.

All staff will be expected to adopt these principles when conducting official business for and on behalf of the ICB so that appropriate ethical standards can be demonstrated at all times.

Appendix 2 – Equality Impact Assessment

	Mandatory Questions	Yes/No/NA	Comments
1.	Does the Policy affect any group less or more favourably than another on the basis of:		
	Age?	No	
	Disability?	No	
	Gender?	No	
	Gender identity?	No	
	Marriage or civil partnership?	No	
	Pregnancy and maternity or paternity?	No	
	Race?	No	
	Religion or belief?	No	
	Sexual orientation?	No	
2.	Is there any evidence that any groups are affected differently by the Policy and if so, what is the evidence?	No	
3.	Is any impact of the Policy likely to be negative?	No	
4.	If any impact of the Policy is likely to be negative, can the impact be avoided and if so, how?	NA	
5.	If a negative impact can't be avoided, what, if any, are the reasons the Policy should continue in its current form?	NA	
6.	Where relevant, does the Policy support the FREDA principles: Fairness, Respect, Equality, Dignity and Autonomy?	Yes	

If you have identified a potential discriminatory impact of this Policy, please contact Senior Governance Advisor.

Paper 2 Annex J

NHS
South West London

Managing Conflicts of Interest (including Gifts & Hospitality) Policy

Policy Title: Managing Conflicts of Interest (including Gifts & Hospitality) Policy
Policy Number: TBC
Policy Owner: Senior Governance Advisor
Date Approved: 01/07/2022
Date for Review: 30/06/2023

Document Control

Status (Draft/Final)	Final
Policy Number / Version	TBC
Policy Author	CCG/HCP Secretary
Policy Owner	Senior Governance Advisor (Chief of Staff)
Ratified By and Date	Governance Oversight Group
Effective From	01/07/2022
Next Review Date	30/06/2023

Approved by

Reviewer / Committee	Audit Committee
Applies To	All individuals working for, or on behalf of SWL ICB.
Brief Description	This policy supports the declaration and management of Conflicts of Interest, including Gifts & Hospitality.

Revision History

Latest Version	Revision
0.4	Draft ICB Conflicts of Interest (including Gifts & Hospitality) Policy supersedes respective individual legacy CCG policies. Updated to reflect governance structure, establishment of online declaration system and ICB guidance.

Contents

Controlled Document

The current version of this document is available electronically on the intranet and/or website. All other electronic or paper versions of this document sourced from any network drive, email or other sources are uncontrolled and should be checked against the current intranet/website version prior to use..

1. Introduction

1.1. South West London ICB (SWL ICB) and the people who work with and for us, collaborate closely with other organisations, delivering high quality care for our patients. These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely. But there is a risk that Conflicts of Interest may arise.

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

2. Purpose and principles

2.1. SWL ICB has a statutory duty to manage Conflicts of Interest. In line with NHS England (NHSE) policy, including the NHSE Standards of Business Conduct and Managing Conflicts of Interest in the NHS guidance, arrangements have been established to seek declarations of interest and maintain a register of declared interests. To help individuals understand what they need to do and how the guidance applies to them NHSE have published some Q&A guides.

2.2. This policy is in line with arrangements outlined within the SWL ICB constitution to support the integrity of decision making processes and will help our staff manage Conflicts of Interest risks effectively. It:

- Introduces consistent principles and rules;
- Provides simple advice about what to do in common situations; and
- Supports good judgement about how to approach and manage interests.

2.3. The purpose of the policy is to protect both SWL ICB and those working for and on behalf of the organisation, in particular those who have an ability to influence decision making processes, from possible accusations that they have acted less than properly, without sufficient probity. In some cases, failure to manage Conflicts of Interest could result in disciplinary action in accordance with the ICB's Disciplinary Policy or even a legal challenge or criminal action, including for offences such as fraud, bribery and corruption.

2.4. All individuals within the scope of this policy are expected to act in accordance with its sprit which also reflect the seven Nolan principles of public life.

2.5. To support the management of Conflicts of Interest, in discharging our functions the ICB will abide by the following principles:

- **Do business appropriately** - Conflicts of Interest become much easier to identify, avoid and/or manage when the processes for needs assessments, consultation mechanisms, commissioning strategies and procurement procedures are right from the outset, because the rationale for all decision-making will be clear and transparent and should withstand scrutiny;
- **Be proactive, not reactive** - Seek to identify and minimise the risk of Conflicts of Interest at the earliest possible opportunity;

- **Be balanced, sensible and proportionate** - Rules should be clear and robust but not overly prescriptive or restrictive. They should ensure that decision-making is transparent and fair whilst not being overly constraining, complex or cumbersome.
- **Be transparent** - Document clearly the approach and decisions taken at every stage in the commissioning cycle so that a clear audit trail is evident; and
- Create an **environment and culture** where individuals feel supported and confident in declaring relevant information and raising any concerns.

2.6. This policy should be considered alongside the Standards of Business Conduct, Anti-Fraud and Bribery and Procurement policies.

3. Scope

3.1. This policy is applicable to all individuals working for or on behalf of SWL ICB. This includes but is not limited to staff (interims, secondees, agency staff, contractors, sub-contractors, students, trainees, apprentices and prospective employees) and employees of partner organisations who are members of the Board, committees, sub-committees, advisory groups or other decision-making groups.

3.2. Given the duality of their roles in the ICB, in addition to abiding by this policy, members of the Board, committees or sub-committees from partner organisations will also need to abide by their own organisation's Conflicts of Interest policies.

3.3. For all decisions, the ICB will need to carefully consider whether an individual's role in another organisation could result in actual or perceived Conflicts of Interest and whether or not that outweighs the value of the knowledge they bring to the process.

4. Key terms

4.1. NHSE define a Conflict of Interest as:

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

4.2. A Conflict of Interest may be:

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

4.3. Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived Conflicts of Interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct. If staff have any questions or concerns relating to Conflicts of Interest, they should contact the ICB Secretary who can provide guidance on what should be declared and how to manage potential or actual conflicts.

4.4. Under the Bribery Act (2010), it is a criminal offence for an employee to:
- offer, promise or give a bribe;

- request, agree to receive or accept a bribe;
- bribe a foreign public official to obtain or retain business; and
- make a representation that is false for personal or other gain or that puts the ICB at risk of loss.

4.5. It is also a criminal offence for the ICB to fail to prevent bribery.

4.6. Bribery can be money, gifts, hospitality or anything else that may be of benefit to the person, which in turn creates a conflict between his/her own interests and the interests of those that he/she is expecting to be serving (e.g. the ICB and its patients).

4.7. The Bribery Act (2010) also covers individuals who have an association with an organisation - an 'associated person'. This term is not just limited to ICB staff or board members, but any person, company or legal entity the carries out a service under the Trust's name, represents the ICB in an official capacity, acts on behalf of the ICB or in the place of other ICB staff or representatives. The maximum penalty for bribery is 10 years imprisonment for individuals engaging in bribery and an unlimited fine for the ICB.

5. Roles and Responsibilities

5.1. **Audit and Risk Committee;** The Committee will satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to Conflicts of Interest.

5.2. **ICB CEO;** Is responsible for ensuring effective governance arrangements and controls are put in place to support delivery of the ICB's objectives and regulatory responsibilities. This is delegated to the Senior Governance Advisor. They also have responsibility for ensuring the ICB applies the principles of this policy and that there are suitable resources to support its implementation.

5.3. **Conflicts of Interest Guardian;** The ICB has appointed the Audit Chair to be the Conflicts of Interest Guardian. In collaboration with the ICB's Senior Governance Advisor, their role is to:

- Act as a conduit for members of the public and members of the partnership who have any concerns with regards to Conflicts of Interest;
- Be a safe point of contact for employees or workers to raise any concerns in relation to Conflicts of Interest; and
- Support the rigorous application of Conflicts of Interest principles and policies.

5.4. **All line managers;** Responsible for reviewing declarations for staff they manage and give due consideration to any actions required to mitigate conflicts in the individual circumstances.

5.5. **All staff;** All individuals working for, or on behalf of SWL ICB, are responsible for complying with this policy. As a minimum all staff must provide an annual Conflicts of Interest declaration.

6. Decision Making Staff

6.1. It is recognised that some individuals are more likely than others to have a decision

making influence on the use of taxpayers' money, because of the requirements of their role. For the purposes of this guidance these people are referred to as 'decision making staff'.

6.2. Decision making staff are:

- Executive and non-executive directors (or equivalent roles) of SWL ICB;
- Members of the Board, committees, sub-committees and advisory groups which contribute to direct or delegated decision making;
- Staff at AfC band 8d and above;
- Staff who have the power to enter into contracts on behalf of the organisation and / or involved in decision making concerning the procurement of services, purchasing of good, medicines, medical devices or equipment, and formulary decisions.

7. Identification and declaration interests (including Gifts and Hospitality)

7.1. Declarations are expected to be registered through the individuals' online declarations account. Paper versions of Conflicts of Interest or Gifts and Hospitality forms are not valid.

7.2. All staff should complete their Conflicts of Interest declaration upon appointment / as part of the local induction process. Declarations should be completed within 28 days from the point at which staff have access to the online declarations system or as soon as they become aware of it.

7.3. Failure to complete a declaration within the agreed timeframe will be escalated to the respective line manager and Executive Director. This could result in disciplinary action in accordance with the ICB's Disciplinary Policy.

7.4. It is also the responsibility of staff to ensure that they do not:

- abuse their official position for personal gain or to benefit their family or friends; or
- seek to advantage or further private business or other interests, in the course of their official duties.

7.5. Individuals are responsible for reviewing their declaration in accordance with the table below ensuring that any changes to their interests are declared as soon as possible, or within one month of becoming aware of these.

Individual	**Frequency** (including nil returns)	**Published**
Decision Making Staff	• On appointment. • Through an annual review. • When moving to a new role, or responsibilities change significantly. • In formal meetings.	Yes (on SWL ICB website)
All other staff*		No (made available upon request)

*This information may be subject to FOI requests. SWL ICB will decide whether or not it shares the register at the time of such requests.

7.6. Interests (including gifts and hospitality) of decision-making staff will remain on the public register for a minimum of six months. In addition, the ICB will retain a record of historic interests and offers/receipt of gifts and hospitality for a minimum of six years after the date on which it expired.

8. Interests

8.1. Interests can generally be considered in the following categories:

- **Financial interests** - Where an individual may get direct financial benefit from the consequences of a decision they are involved in making;
- **Non-financial professional interests** - Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making;
- **Non-financial personal interests** - Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career;
- **Indirect interests** - Where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making[1];
- **Loyalty interests[2]** - Loyalty interests should be declared by staff involved in decision making where they;
- Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role;
- Sit on advisory groups or other paid or unpaid decision making forums that can influence how an organisation spends taxpayers' money;
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners;
- Are aware that their organisation does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

8.2. Any individual involved in decisions relating to ICB functions must be acting clearly in the interests of the ICB and of the public, rather than furthering direct or indirect financial, personal, professional or organisational interests.

8.3. Examples of potential and actual conflicts which should be regarded as relevant and material include but are not limited to:

- Consultancies and/or direct employment;
- Directorships, including non-executive directorships, held in private companies or PLCs (who do, will or could conduct their business in the field of Health and Social Care);
- Fee Paid work, e.g. for work conducted outside employment or as part of private practice. (Permission to engage in outside employment/private practice must first be

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

[2] As part of their role, individuals may need to build strong relationships with colleagues across the NHS and in other sectors. These relationships can be hard to define as they may often fall into the category of indirect interests. They are unlikely to be directed by any formal process or managed via any contractual means, however these 'loyalty' interests can influence decision making.

obtained from SWL ICB);

- Shareholdings (more than 5%) of companies in the field of health and social care;
- Any connection with an organisation (public, private or voluntary) contracting for NHS services;
- A position of authority in an organisation (e.g. charity or voluntary organisation) in the field of health and social care;
- Research funding / grants that may be received by the individual or any organisation they have an interest or role in;
- Involved or could be involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners;
- Patents and Intellectual property held either individually or by virtue of their association with a commercial or other organisation) relating to goods and services which are, or might reasonably be expected to be procured, or used by SWL ICB;
- Any other role or relationship which the public could perceive would impair or otherwise influence the individual's judgement or actions in their role within SWL ICB;
- Non-personal interests, e.g. fellowships held by close family member, or any payment, other support or sponsorship by industry which does not convey any pecuniary or material benefit to an individual personally, but which does benefit their position.

9. Completing the Declaration form

9.1. Relevant and material interests as specified in Section 8 should be declared (including a nil return where no interests are applicable), whether such interests are those of the individual themselves, a family member, or close friend of the individual.

9.2. Individuals must provide sufficient detail of each interest so that a member of the public would be able to clearly understand the nature of the interest and the circumstances in which a Conflict of Interest with the business or running of SWL ICB might arise.

9.3. If in doubt as to whether a Conflict of Interest could arise, a declaration of the interest should be made.

10. Management of interests – general

10.1. If an interest is declared but there is no risk of a conflict arising, then no action is warranted. However, if a material interest is declared then the general management actions that could be applied include:

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

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

10.3. All declarations must be reviewed by the respective line manager with consideration

given to any actions required to mitigate the conflict in the individual circumstances.

10.4. Mitigating action put in place must be monitored by the line manager.

11. Management of interests – common situations

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

11.2. Gifts from suppliers or contractors:
- Gifts from suppliers or contractors doing business (or likely to do business) with the organisation should be declined, whatever their value;
- Low cost branded promotional aids such as pens or post-it notes may, however, be accepted where they are under the value of £6[3] in total and need not be declared.

11.3. Gifts from other sources (e.g. patients, families, service users):
- Gifts of cash and vouchers to individuals should always be declined;
- Staff should not ask for any gifts;
- Gifts valued at over £50 should be treated with caution and only be accepted on behalf of SWL ICB and not in a personal capacity. These should be declared by staff;
- Modest gifts accepted under a value of £50 do not need to be declared;
- A common sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value);
- Multiple gifts from the same source over a 12 month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50.

11.4. The online declarations system will require staff to provide:
- A description of the nature and value of the gift, including its source;
- Date of receipt; and
- Any other relevant information (e.g. circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.5. Hospitality:
- Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement;
- Hospitality must only be accepted when there is a legitimate business reason, and it is proportionate to the nature and purpose of the event;
- Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. This can be accepted, and must be declared, if modest and reasonable. Senior approval must be obtained.

11.6. Meals and refreshments:
- Under a value of £25 - may be accepted and need not be declared;

[3] The £6 value has been selected with reference to existing industry guidance issued by the ABPI: http://www.pmcpa.org.uk/thecode/Pages/default.aspx

- Of a value between £25 and £75[4] - may be accepted and must be declared;
- Over a value of £75 - should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on the organisation's register(s) of interest as to why it was permissible to accept;
- A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or a reasonable estimate).

11.7. Travel and accommodation:

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

11.8. The online declarations system will require staff to provide details of:

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

11.9. Outside Employment:

- Staff should declare any existing outside employment on appointment and any new outside employment when it arises;
- Where a risk of Conflicts of Interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks;
- Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from the organisation to engage in outside employment.

11.10. The organisation may also have legitimate reasons within employment law for knowing about outside employment of staff, even when this does not give rise to risk of a conflict.

11.11. Shareholdings and other ownership issues:

- Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the organisation;
- Where shareholdings or other ownership interests are declared and give rise to risk of Conflicts of Interest then the general management actions outlined in this policy should be considered and applied to mitigate risks;
- There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

[4] The £75 value has been selected with reference to existing industry guidance issued by the ABPI http://www.pmcpa.org.uk/thecode/Pages/default.aspx

11.12. Patents:

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

11.13. Donations:

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

11.14. Sponsored Events:

- Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit the organisations and the NHS;
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation;
- No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied;
- At the organisation's discretion, sponsors or their representatives may attend or take part in the event, but they should not have a dominant influence over the content or the main purpose of the event;
- The involvement of a sponsor in an event should always be clearly identified;
- Staff within the organisation involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event;

- Staff arranging sponsored events must declare this to the organisation.

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

11.16. Sponsored research:
- Funding sources for research purposes must be transparent;
- Any proposed research must go through the relevant health research authority or other approvals process;
- There must be a written protocol and written contract between staff, the organisation, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services;
- The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service;
- Staff should declare involvement with sponsored research to the organisation.

11.17. The organisation will retain written records of sponsorship of research, in line with the above principles and rules.

11.18. Sponsored posts:
- External sponsorship of a post requires prior approval from the organisation;
- Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and withdraw if appropriate;
- Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if Conflicts of Interest which cannot be managed arise;
- Sponsored post holders must not promote or favour the sponsor's products, and information about alternative products and suppliers should be provided;
- Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

11.19. The organisation will retain written records of sponsorship of posts, in line with the above principles and rules.

11.20. Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content in the rest of this policy.

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

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

11.22. Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

- Seek prior approval of their organisation before taking up private practice;
- Ensure that, where there would otherwise be a conflict or potential Conflicts of Interest, NHS commitments take precedence over private work;
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines.

11.23. Hospital Consultants should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on their behalf.

12. Management of Interests – advice in specific contexts

12.1. **Strategic decision making groups**: In common with other NHS bodies, SWL ICB uses a variety of different groups to make key strategic decisions. The interests of those who are involved in these groups should be well known so that they can be managed effectively. These groups include the ICB Board, committees and sub-committees.

12.2. These groups should adopt the following principles:

- Chairs should consider any known interests of members in advance and begin each meeting by asking for declaration of relevant material interests;
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise;
- Any new interests identified should be added to the organisation's register(s);
- The vice chair (or other non-conflicted member) should chair all or part of the meeting if the chair has an interest that may prejudice their judgement. If the Vice Chair is also conflicted, then the remaining non-conflicted voting members of the meeting should agree how to manage the conflict(s).

12.3. If a member has an actual or potential interest, the Chair should consider the following approaches and ensure that the reason for the chosen action is documented in the minutes:

- Including a conflicted person in the discussion but not in decision making;
- Excluding a conflicted person from both the discussion and the decision making;
- Including a conflicted person in the discussion and decision where there is a clear benefit to them being included in both – however, including the conflicted person in the actual decision should be done after careful consideration of the risk and with proper mitigation in place. The rationale for inclusion should also be properly documented and included in minutes;
- Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source;
- Excluding the member from all or part of the relevant discussion and decision;
- Removing the member from the group or process all together;
- Ensuring that the individual does not receive the supporting papers or minutes of the meeting which relate to the matter(s) which give rise to the conflict.

12.4. Transparency in decision making is crucial in the management of Conflicts of Interest. For example, it could be appropriate for a conflicted person to be involved in discussions around a particular decision, but not be involved in actually taking the decision (i.e. not included where there could be a voting process related to that decision). In these

circumstances, it is crucial that, the justification and rationale for including a conflicted person in discussions is clearly documented.

12.5. The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. Good judgement is required to ensure proportionate management of risk.

12.6. **Procurement**

12.6.1 Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour - which is against the interest of patients and the public.

12.6.2 Those involved in procurement exercises for and on behalf of the organisation should keep records that show a clear audit trail of how Conflicts of Interest have been identified and managed as part of procurement processes. At every stage of procurement steps should be taken to identify and manage Conflicts of Interest to ensure and to protect the integrity of the process.

12.7. **Contractors**

12.7.1 Anyone seeking information in relation to procurement, or participating in procurement, or otherwise engaging with SWL ICB in relation to the potential provision of services or facilities to SWL ICB, will be required to make a declaration of interest.

12.7.2 Anyone contracted to provide services or facilities directly to SWL ICB will be subject to the same provisions in relation to managing Conflicts of Interest. This requirement will be set out in the contract for their services.

12.8. **Transparency in procuring services**

12.8.1 SWL ICB recognises the importance in making decisions about the services it procures in a way that does not call into question the motives behind the procurement decision that has been made. SWL ICB will procure services in a manner that is open, transparent, non-discriminatory and fair to all potential providers.

12.8.2 SWL ICB will publish a Procurement Strategy, which will ensure that:

- All relevant clinicians and potential providers, together with local members of the public, are engaged in the decision-making processes used to procure services; and
- Service redesign and procurement processes are conducted in an open, transparent, non-discriminatory and fair way.

12.9. **Procurement issues**

12.9.1 SWL ICB will need to be able to recognise and manage any conflicts or potential Conflicts of Interest that may arise in relation to procurement.

12.9.2 The NHS Act, the Health and Social Care Act (2012) and associated regulations set out the statutory rules which require when procuring and contracting for the provision of

clinical services. They need to be considered alongside the Public Contract Regulations and, where appropriate, EU procurement rules. NHSI's statutory guidance, the Procurement, Patient Choice and Competition Regulations, advises that the requirements within these create a framework for decision making that will assist organisations to comply with a range of other relevant legislative requirements.

12.9.3 The Procurement, Patient Choice and Competition Regulations place requirements on organisations to ensure that they adhere to good practice in relation to procurement, do not engage in anti-competitive behaviour that is against the interest of patients, and protect the right of patients to make choices about their healthcare.

12.9.4 The regulations set out that organisations must:

- Manage conflicts and potential Conflicts of Interest when awarding a contract by prohibiting the award of a contract where the integrity of the award has been, or appears to have been, affected by a conflict;
- Keep appropriate records of how they have managed any conflicts in individual cases;
- Furthermore, the management of Conflicts of Interest is an important element of the ICB's procedures to prevent bribery, in accordance with the adequate procedures as defined by the Ministry of Justice.

12.10. General considerations and use of the procurement template

12.10.1 The ICB will address potential or actual conflicts in the procurement of healthcare services with the completion of the procurement template at Appendix 1 when considering plans to procure healthcare services from providers (including GP practices).

12.10.2 SWL ICB will evidence its deliberations on Conflicts of Interest. The template is one way of evidencing this and will support SWL ICB in fulfilling their duty in relation to public involvement. It will further provide appropriate assurance that SWL ICB is seeking and encouraging scrutiny of its decision-making process:

- To Health and Wellbeing Boards, local Healthwatch and to local communities that the proposed service meets local needs and priorities. It will enable them to raise questions if they have concerns about the approach being taken;
- To the Audit and Risk Committee and, where necessary, external auditors, that a robust procurement process has been followed; and
- To NHS England in their assurance role.

12.10.3 Procurement decisions relating to delegated commissioning will be made by an appropriate SWL ICB committee.

12.11. Record keeping

12.11.1 SWL ICB must ensure that it records procurement decisions made, and details of how any conflicts that arose in the context of the decision have been managed. These registers should be available for public inspection.

12.11.2 ICBs should ensure that details of all contracts, including the contract value, are

published on their website as soon as contracts are agreed. Where ICBs decide to commission services through Any Qualified Provider (AQP), they should publish on their website the type of services they are commissioning and the agreed price for each service. Further, ICBs should ensure that such details are also set out in their annual report. Where services are commissioned through an AQP approach, they should ensure that there is information publicly available about those providers who qualify to provide the service.

12.12. **Templates / Forms**

12.12.1 For any procurement exercises for the commissioning of healthcare services involving providers (including GP practices), there is a standard proforma for completion included at Appendix 1. Appendix 2 provides a declaration proforma for bidders / potential contractors / service providers.

13. Dealing with breaches

13.1. There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as 'breaches'.

13.2. **Identifying and reporting breaches**

13.2.1 Staff who are aware about actual breaches of this policy, or who are concerned that there has been, or may be, a breach, should report these concerns to the ICB's Senior Governance Advisor or Conflicts of Interest Guardian by emailing swlccg.corporateoffice@swlondon.nhs.uk [update email address following transition].

13.2.2 To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Every individual has a responsibility to do this. For further information about how concerns should be raised refer to the Freedom to Speak-Up: Raising Concerns (Whistleblowing Policy).

13.2.3 Reports on any breaches, the impact of these, and action taken will be considered by the Audit and Risk Committee.

13.2.4 The organisation will investigate each reported breach according to its own specific facts and merits and give relevant parties the opportunity to explain and clarify any relevant circumstances.

13.2.5 Following investigation the organisation will:

- Decide if there has been or is potential for a breach and if so what the severity of the breach is;
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum;
- Consider who else inside and outside the organisation should be made aware;
- Take appropriate action as set out in the next section.

13.3. **Taking action in response to breaches**

13.3.1 Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of the organisation and could involve organisational leads for staff support (e.g. Human Resources), fraud (e.g. Local Counter Fraud Specialists), members of the management or executive teams and organisational auditors.

13.3.2 Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process and procedures;
- Consideration as to whether HR / employment law / contractual action should be taken against staff or others;
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, the NHS Counter Fraud Authority, the Police, statutory health bodies (such as NHS England or the CQC), and/or health professional regulatory bodies.

13.3.4 Inappropriate or ineffective management of interests can have serious implications for the organisation and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

13.3.5 Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the organisation can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach. This includes employment law action against staff, which might include:

- Informal action (such as reprimand or signposting to training and/or guidance);
- Formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal);
- Reporting incidents to the external parties described above for them to consider what further investigations or sanctions might be;
- Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach;
- Legal action, such as investigation and prosecution under fraud and bribery legislation.

14. Review and monitoring compliance

14.1. This policy will be reviewed in in the first year following the establishment of SWL ICB and every 2 years thereafter, or earlier if there are significant changes to national guidance affecting the management of Conflicts of Interest across the organisation.

14.2. The process for monitoring compliance with the effectiveness of this Policy is as follows:

Aspect being monitored	Monitoring Methodology	Reporting

(What)	(How)	**Presented by** (Who)	**Committee** (Where)	**Frequency** (How often)
Review of Interests declared	Report, to include: • Updates to the Board of Directors Register of Interests • Updates to the Register of Staff Interests • Updates to the Register of Gifts and Hospitality • Known breaches, the impact of these, and action taken	ICB Secretary	Audit and Risk Committee	Six-monthly
Policy compliance and effective use of Policy	• Review of the Standards of Business Conduct policy • Sample testing of staff compliance with the policy • Any potential of fraud or bribery being committed against the ICB • Any system weaknesses	Local Counter Fraud Specialist	Audit and Risk Committee	Annually/as detailed in LCFS Work Plan

15. Records and Publication

15.1. The organisation will maintain a Conflicts of Interest register, distinct from a Register of Gifts, Hospitality and Sponsorship.

15.2. We will publish the interests declared by decision making staff in the Conflicts of Interest, and the Gifts and Hospitality Registers available on the ICB website.

15.3. Publication of the register will be carried out in accordance with the table set out in section 7.

15.4. If decision making staff have substantial grounds for believing that publication of their interests should not take place then they should contact the Corporate Governance Team, the ICB's Senior Governance Advisor or the Conflicts of Interest Guardian (Audit Chair) to explain why. In exceptional circumstances, for instance where publication of information might put a member of staff at risk of harm, information may be withheld or redacted on public registers. However, this would be the exception and information will not be withheld or redacted merely because of a personal preference.

16. Wider transparency initiatives

16.1. SWL ICB fully supports wider transparency initiatives in healthcare, and we encourage staff to engage actively with these.

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

- Speaking at and chairing meetings;
- Training services;

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

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

17. Associated Documentation

- Freedom of Information Act (2000)
- ABPI: The Code of Practice for the Pharmaceutical Industry (2014)
- ABHI Code of Business Practice
- NHS Code of Conduct and Accountability (July 2004)
- Gifts and Hospitality Policy
- Anti-Fraud and Bribery Procedures
- Procurement Policies

Appendix 1 – Procurement Template

[To be used when procuring healthcare services from providers (including GP practices)]

Service:	
Question	**Comment/Evidence**
Questions for all procurement routes	
How does the proposal deliver good or improved outcomes and value for money – what are the estimated costs and the estimated benefits? How does it reflect SWL ICB's proposed commissioning priorities? How does it comply with SWL ICB's commissioning obligations?	
How have you involved the public in the decision to commission this service?	
What range of health professionals have been involved in designing the proposed service?	
What range of potential providers have been involved in considering the proposals?	
How have you involved your Health and Wellbeing Board(s)? How does the proposal support the priorities in the relevant joint health and wellbeing strategy (or strategies)?	
What are the proposals for monitoring the quality of the service?	
What systems will there be to monitor and publish data on referral patterns?	
Have all conflicts and potential Conflicts of Interest been appropriately declared and entered in registers which are publicly available Have you recorded how you have managed any conflict or potential conflict?	

Why have you chosen this procurement route? [5]	
What additional external involvement will there be in scrutinising the proposed decisions?	
How will SWL ICB make its final commissioning decision in ways that preserve the integrity of the decision-making process and award of any contract?	
Additional question when qualifying a provider on a list or framework or preselection for tender (including but not limited to any qualified provider) or direct award (for services where national tariffs do not apply)	
How have you determined a fair price for the service?	
Additional questions when qualifying a provider on a list or framework or pre-selection for tender (including but not limited to any qualified provider) where GP practices are likely to be qualified providers	
How will you ensure that patients are aware of the full range of qualified providers from whom they can choose?	

Additional questions for proposed direct awards to providers	
What steps have been taken to demonstrate that there are no other providers that could deliver this service?	
In what ways does the proposed service go above and beyond what the provider should be expected to provide under the provider contract?	
What assurances will there be that a provider is providing high-quality services under the provider contract before it has the opportunity to provide any new services?	

[5] Taking into account all relevant regulations (e.g. the NHS (Procurement, patient choice and competition) (No 2) Regulations 2013 and existing procurement rules

Appendix 2 - Declaration of Conflicts of Interest for bidders / contractors / service providers template

Bidders / potential contractors / service providers declaration form: financial and other interests

This form is required to be completed in accordance with s140 of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) and the NHS (Procurement, Patient Choice and Competition) (No2) Regulations 2013 and related guidance.

Notes:

- All potential bidders/contractors/service providers, including sub-contractors, members of a consortium, advisers or other associated parties (Relevant Organisation) are required to identify any potential Conflicts of Interest that could arise if the Relevant Organisation were to take part in any procurement process and/or provide services under, or otherwise enter into any contract with, SWL ICB, or with NHS England in circumstances where SWL ICB is jointly commissioning the service with, or acting under a delegation from, NHS England. If any assistance is required in order to complete this form, then the Relevant Organisation should contact [*SWL ICB to specify*].
- The completed form should be sent to [*SWL ICB to specify*].
- Any changes to interests declared either during the procurement process or during the term of any contract subsequently entered into by the Relevant Organisation and SWL ICB must be notified to SWL ICB by completing a new declaration form and submitting it to [*SWL ICB to specify*].
- Relevant Organisations completing this declaration form must provide sufficient detail of each interest so that the SWL ICB, NHS England and also a member of the public would be able to clearly understand the sort of financial or other interest the person concerned has and the circumstances in which a Conflict of Interest with the business or running of SWL ICB or NHS England (including the award of a contract) might arise.
- If in doubt as to whether a Conflict of Interest could arise, a declaration of the interest should be made.

Interests that must be declared (whether such interests are those of the Relevant Person themselves or of a family member, close friend or other acquaintance of the Relevant Person), include the following:

- The Relevant Organisation or any person employed or engaged by or otherwise connected with a Relevant Organisation (Relevant Person) has provided or is providing services or other work for SWL ICB or NHS England.
- A Relevant Organisation or Relevant Person is providing services or other work for any other potential bidder in respect of this project or procurement process;
- The Relevant Organisation or any Relevant Person has any other connection with SWL ICB or NHS England, whether personal or professional, which the public; or
- Could perceive, may impair or otherwise influence SWL ICB's or any of its members' or employees' judgements, decisions or actions.

Name of Organisation:	
Details of interests held:	
Type of Interest	**Details**
Provision of services or other work for SWL ICB or NHS England	
Provision of services or other work for any other potential bidder in respect of this project or procurement process	
Any other connection with SWL ICB or NHS England, whether personal or professional, which the public could perceive may impair or otherwise influence SWL ICB's or any of its members' or employees' judgements, decisions or actions	

Name of Relevant Person	[*complete for all Relevant Persons*]	
Details of interests held:		
Type of Interest	Details	Personal interest or that of a family member, close friend or other acquaintance?
Provision of services or other work for SWL ICB or NHS England		
Provision of services or other work for any other potential bidder in respect of this project or procurement process		

Any other connection with SWL ICB or NHS England, whether personal or professional, which the public could perceive may impair or otherwise influence the ICB's or any of its members' or employees' judgements, decisions or actions		

By completing this form, I confirm that the information that had been written within this form is true and correct. I can confirm that I have complied with the ICB's Conflicts of Interest policy. I understand that is an offence to make false declarations of interest and I confirm by my signature that I have correctly declared any actual or potential interests.

I understand that if I have knowingly provided false information or made false statement, that I may be subject to disciplinary and/or criminal action

Signed:

On behalf of:

Date:

Appendix 3 - Equality Impact Assessment

	Mandatory Questions	Yes/No/NA	Comments
1.	Does the Policy affect any group less or more favourably than another on the basis of:		
	Age?	No	
	Disability?	No	
	Gender?	No	
	Gender identity?	No	
	Marriage or civil partnership?	No	
	Pregnancy and maternity or paternity?	No	
	Race?	No	
	Religion or belief?	No	
	Sexual orientation?	No	
2.	Is there any evidence that any groups are affected differently by the Policy and if so, what is the evidence?	No	
3.	Is any impact of the Policy likely to be negative?	No	
4.	If any impact of the Policy is likely to be negative, can the impact be avoided and if so, how?	NA	
5.	If a negative impact can't be avoided, what, if any, are the reasons the Policy should continue in its current form?	NA	
6.	Where relevant, does the Policy support the FREDA principles: Fairness, Respect, Equality, Dignity and Autonomy?	Yes	

If you have identified a potential discriminatory impact of this Policy, please contact the Senior Governance Advisor.

NHS
South West London

SW London People and Communities Engagement Strategy

May 2022

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NHS
South West London

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1.1. Message from our Chair

Millie Banerjee CBE
Chair Designate
South West London Integrated Care System

‘ We will only know if our services are meeting the real needs of our citizens and communities by speaking to the people who use them and their families . Most importantly, we need to work hard to hear from those with poor health, understanding the context of people’s lives, their social histories and how we can work with them to improve their health and wellbeing.

Becoming an ICS is an opportunity to do this better, by coming together across organisational boundaries to share our knowledge, data, insight and connections we can listen and learn how to do better together. The pandemic has clearly shown us the huge value that our voluntary and community sector partners can bring in supporting local people. Building trust with all our communities is essential in reducing health inequalities and our voluntary and community partners hold the key to supporting us to embrace more community-led approaches and to build trust through continuous conversations. I am committed to ensuring that their voice is significant in our work, so we become stronger strategic partners.

We have worked with partners to develop this strategy and set out the systems we have put in place to ensure that the voices of people and communities are at the heart of our SW London partnership working. This responsibility sits across all the organisations and teams in our system, and we are keen to build on the enthusiasm of our health and care staff to develop this culture of citizen engagement as an everyday way of working.’

1.2 Summary

NHS South West London

This document explains our approach to making sure that the voice of people and communities is heard and influences how we plan and deliver health and care services in south west London. It shows: the principles that we can be held to; the ways we involve people; the processes in place to ensure that their views influence decision making and the systems in place to provide assurance that this happens.

By working more closely with each ICS partner, we can better understand people's needs and hopes, provide more responsive, safe and effective services and support local people to access the services they need, at the right time and in the right place.

We know this will take time to get right. However, we have strong relationships and practise to build on. Our approach will be strengthened by bringing together engagement and insight from across all partners, to help achieve equity and improve the quality of health and care services for local people.

1.3 The vision for what we want to achieve

NHS South West London

We aim to:

- Ensure the **voice of people and communities is central** to all levels of our work – and that we have inclusive ways of reaching and listening to our diverse populations
- **Reduce health inequalities** by better understanding the needs and aspirations of our local people and communities, and responding to them in how we plan and deliver services
- **Develop a culture** where talking and engaging with local people and communities is embraced as part of **everyone's role**.
- **Plan** how we listen to local people and communities at the beginning of any project that might change how services are delivered to ensure it is **well resourced and appropriately delivered**
- **Invest in community led engagement** that will strengthen our understanding of our communities and their experiences
- **Build on the strong communications and engagement** delivered across our partnership over the last 4 years and review resource to support each element of the new system
- Continue to **review and adapt** our approach as our system matures and evolves. This strategy is just the start…

1.4 Companion documents

South West London

Our people and communities engagement strategy sets out our high level approach to ensuring that people are communities are at the heart of everything we do. It will be accompanied by the following companion documents to support delivery. These will be developed, with local people, from April 2022, and will include:

- An explanation of how local people can get involved – outlining the opportunities – 'Guide to having your say in the SWL ICS: what matters most to you?'
- People and communities charter/pledge – what our engagement strategy means for local people
- Evaluation framework – a detailed approach to evaluating the impact of what we do
- Toolkit and resources to support staff to engage with local people and communities
- Valuing voices - remuneration policy
- Co-produced delivery plans for SWL, Place and Provider Collaboratives

Communications documents to support transparent working and wider stakeholder engagement:

- Social media policy
- Staff engagement plan + day 1 communications plan
- ICB and ICS brand and style guide
- Regular press release and stakeholder updates published on ICB and ICS websites

1.5 Understanding South West London

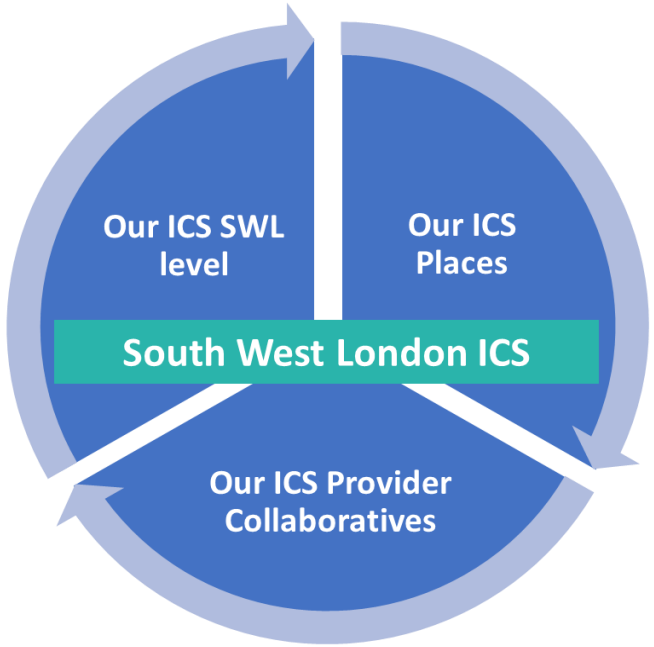
NHS
South West London

- South West London covers 296 square kilometres and six London boroughs; Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth.
- The resident population of South West London is 1,505,000 people – a population density of 5,050 people per square kilometre, although this ranges widely across the area from 3,430 people per km2 in Richmond to 9,528 people per km2 in Wandsworth. Although the resident population is under 1.5 million the NHS in South West London treats many more people than this.
- A fifth (21%) of the population were under the age of 16. Just over a tenth (13%) of the population were aged 65 or above. The population is projected to grow by 10% over the next ten years (by 2029) and a further 6% in the ten years after that resulting in a population of 1,774,270 in 2039.
- The younger population is increasing at the slowest rate, with the number of those aged under 16 estimated to grow by 3% and make up 18% of the total population in 2039.
- The older population is increasing at a faster rate, with the number of those aged 65 and above increasing 59% over the next twenty years and estimated to make up 17% of the population in 2039.
- In 2019, an estimated 35% of the population were from a Black, Asian or Minority Ethnic group (BAME). This community is also projected to increase considerably, increasing 29% over the next twenty years and estimated to make up 39% of the population in 2039.

1.6 Understanding our South West London ICS

NHS South West London

Our SWL ISC is made up of 3 parts: SWL ICS Places; SWL ICS Provider Collaboratives; and ICS SWL Level



ICS South West London

The role of the ICS SWL London is to

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

South West London ICS Place

Within South West London ICS Places there are six Places: Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth. These six Places are co-terminus with our six Local Authority boroughs.

The purpose of our places is to:

- **support and develop primary care networks** (PCNs) which join up primary and community services across local neighbourhoods.
- **simplify, modernise and join up health and care** (including through technology and by joining up primary and secondary care where appropriate).
- **understand and identify** – using population health management techniques and other intelligence – **people and families at risk of being left behind** and to organise proactive support for them; and
- **coordinate the local contribution to health, social and economic development** to prevent future risks to ill-health within different population groups.

South West London ICS Provider Collaboratives

There are three Provider Collaboratives in South West London:

- **South London Mental Health Partnership** - comprising Oxleas NHS Foundation Trust, South London and Maudsley NHS Trust and South West London and St. George's NHS Trust.
- The **Acute Provider Collaborative** - comprising Croydon Health Services NHS Trust, Epsom and St. Helier University Hospitals NHS Trust, Kingston Hospital NHS Foundation Trust, St. George's University Hospitals NHS Foundation Trust.
- **Royal Marsden Partners** - all South West London and North West London Acute Trusts providing cancer services.

The purpose of provider collaboratives is to better enable their members to work together to continuously improve quality, efficiency and outcomes, including proactively addressing unwarranted variation and inequalities in access and experience across different providers. They are expected to enable trusts to collaboratively lead the transformation of services and the recovery from the pandemic, ensuring shared ownership of objectives and plans across all parties.

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South West London

2. Developing our people and communities engagement strategy

2.1 How we developed this strategy

2.2 How it has been built on what we have learned from engaging with our communities

2.1 How we developed this strategy

NHS
South West London

To shape our approach to developing the people and communities engagement strategy, we discussed it with 40 groups and over 500 people including:

- Community Engagement Steering Group (Healthwatch, VCSE and PPE leads from each borough)
- Communications and engagement colleagues – SWL NHS Providers and Local Authorities & Borough Communication & Engagement Groups
- Borough patient engagement groups in each borough
- Place Leaders Group
- Borough Transition Teams
- ICS Delivery Group
- Chief nurse meeting and trust patient experience leads and directors of quality
- NHS Provider Chief Execs and NHS Provider Chairs
- Collaborative Leadership Group

We developed the strategy over two phases.

During phase 1 we: tested our vision for what it should be; sought views on the companion documents and asked for feedback on key governance questions including assurance, resourcing and delivery. We also mapped how engagement works at place and within provider collaboratives.

During phase 2 we went back to review the themes that came out of phase 1, and which informed our aims, and discussed our recommendations about assurance, resourcing and delivery.

Lessons learned about engagement

There was positive support for ensuring that this strategy is informed by the lessons learned from engaging with local people over the last 18-24 months. We discussed these lessons during phase 1, adding and amending them so they reflect what we learned across the system. These can be seen in the next slide.

2.2 What we have learned about engagement

NHS South West London

BE CREATIVE

Use local champions

Use creative methods to extend reach particularly to communities experiencing health inequalities and poorer health outcomes e.g. work with community champions, influencers and faith leaders, use films, media and social media

BE CONNECTED

Find community leaders

Work with trusted leaders to speak with local people and communities

BE PROACTIVE

Make the first move

Go to local communities – rather than expecting them to come to you – provide translations and interpreters

BE OPEN

Listen and understand

Develop ongoing conversations and sustainable relationships and build on those established relationships

BE BOLD

Go beyond traditional boundaries

Work across borough boundaries to engage with particular communities

BE INFORMED

Gather data and insight

Use population health data and insight to inform, adapt and shape our approach

BE RESPONSIVE

Community first

Be led by the community and their needs – ask and respond to how they would like to be engaged/involved

People and communities

BE RESOURCEFUL

Use partners' networks

Continue close partnership working with LA and NHS – share resources and contacts – coordinate not duplicate to maximise reach

BE INCLUSIVE

Create maximum impact

Co-design messages/adapt and iterate with local people to have maximum impact

BE REPRESENTATIVE

Reflect the population

Co-deliver engagement sessions with clinicians that reflect local populations

BE PURPOSEFUL

Join forces

Build collaborative and resilient network of communications and engagement professionals to deliver common goals

BE COLLABORATIVE

Work with VCSEs

Work closely with and invest in the VCSE sector to strengthen their capacity and extend our reach

BE PROUD

Reflect and share

Celebrate success and feedback – show the impact of everyone's contributions

NHS
South West London

3. Ten principles for how we work with people and communities

3. Ten principles for how we work with people and communities

NHS South West London

1. Put the **voices** of people and communities at the **centre of decision-making** and governance, at every level of the ICS.
2. **Start engagement early** when developing plans **and feed back** to people and communities how their engagement has influenced activities and decisions.
3. **Understand your communities:** their relevant social histories, their experiences and their aspirations for health and care. Engage to find out if change is having the desired effect.
4. Build relationships with excluded groups, especially those **affected by inequalities**.
5. Work with **Healthwatch and the voluntary**, community and social enterprise (VCSE) sector as key partners
6. Provide **clear and accessible public information** about vision, plans and progress, to build understanding and trust.
7. Use community development approaches that **empower people and communities**, making connections to social action (bottom up) – what local people determine are community priorities.
8. Use **co-production, insight** and engagement to achieve **accountable health and care services.** By working jointly with people – accountable to local people.
9. Co-produce and redesign services and **tackle system priorities** in partnership with people and communities (top down)
10. Learn from what works and **build on the assets of all ICS partners** – networks, relationships, activity in local places.

NHS
South West London

4. How we deliver and resource communications and engagement in our ICS

4.1 Delivery model – borough/Place communications and engagement groups
4.2 Overview of how we will resource communications and engagement
4.3 Budget and engagement team structure
4.4 Diagram of how we will deliver communications and engagement work across SWL
4.5 Above diagram explained

4.1 Delivery model – communications and engagement groups

NHS South West London

Borough/Place communications and engagement groups

We have set up multi-stakeholder borough communications and engagement groups. These were established 4 years ago and are key to ensuring that good practice communications and engagement is delivered across our ICS.

Their role is to:

- Coordinate and manage the delivery of engagement and communications work supporting priorities and work plans at Place; provider collaboratives and SWL level
- Bring together insight from across partners and ensure it informs priorities and strategic decision making
- Agree resource to deliver work – and develop clear work plans to share the delivery

Membership

The detail of who sits on each group will be locally agreed. However, the minimum membership will include:

- NHS Providers – acute, mental health and community (communications and patient experience leads)
- SWL NHS communications and engagement
- Local authority (communications and engagement)
- VCSE sector (locally informed)
- Healthwatch
- Link to borough engagement assurance mechanism

4.2 Overview of how we will resource communications and engagement

NHS South West London

Below sets out our initial approach to how communications and engagement will be resourced across our ICS. It is subject to review and refinement as our work and system develops.

Leadership

- The executive director for communications and engagement will be professionally accountable for communications and engagement activity across the SWL ICS – and responsible for leading the work
- There is a communications and engagement lead for SWL, Place and each Provider Collaborative – who will attend the most senior decision making meeting to advise on citizen engagement, legal duty to involve and communications issues throughout policy development and implementation. These C&E leads have dual reporting lines to Leader for Place/SWL/Provider Collab with support and professional accountability from ICS exec director of communications and engagement.

SW London

The SWL delivery team will continue to:

- support the system and provide specialist advice, guidance, co-ordination and resource for – patient and public engagement, media and issues management, stakeholder and public affairs, campaigns & digital and staff engagement
- deliver SWL C&E activity for programmes that spans all south west London boroughs e.g. vaccine, support to clinical networks, and SWL transformation programmes (workforce, digital, mental health)

Place

- **Each place will has a Comms & Eng leader who will:**
  - manage local team/drives work plans, and aligns comms/eng work with partner organisations
  - attend, supports and advises place committee
  - chair and lead borough C&E group
  - bring together engagement and comms specialists in one team – with engagement professional leadership and support from SWL

Provider collaboratives

- **We are supporting provider collaboratives and considering future resourcing as they develop, in particular around engagement expertise for the acute provider collaborative,** around service change, and new models of care and pathway redesign. Engagement resource is currently in each place via south west London team.

4.3 Budget and engagement team structure

NHS South West London

Budget – non-pay

- We are currently working through next year's budget with the finance team and the balance between place and SWLondon funding. Our agreed approach is that engagement is part of all work programmes rather than an additional activity that is SWL funded.
- Our clinical programmes and work streams have funded engagement to support their work. For example:
  - Teledermatology clinical network funded an external organisation to conduct 2 focus groups and one to one interviews with the digitally excluded to inform the development of a new portal to support patients to understand skin conditions and take good quality photos.
  - To support the development of Community Diagnostic Centres our acute provider collaborative funded an organisation who specialises in reaching - young people, minority ethnic groups, culturally diverse communities, people with protected characteristics and those who often go unheard – to further understand the experiences of people seeking health/diagnostic services, such as blood tests, urine tests, imaging, endoscopy and pathology.
- Where possible we look to invest in our VCSE sector and Healthwatch to support engagement work – drawing on their specialist skills and reach into local communities. For example:
  - To support our covid 19 insight work we developed a grassroots community grant scheme where local organisations could apply for funding (from a collective pot of £160k) to: help extend our reach into seldom heard communities; co-create appropriate and accessible materials for communities and enable culturally authentic conversations and two-way dialogue. This model enabled us to build trust with our local communities, strengthen our relationships with the VCSE sector and hear from people experiencing health inequalities to develop a vaccine service that better meets their needs.

4.3 Engagement team structure

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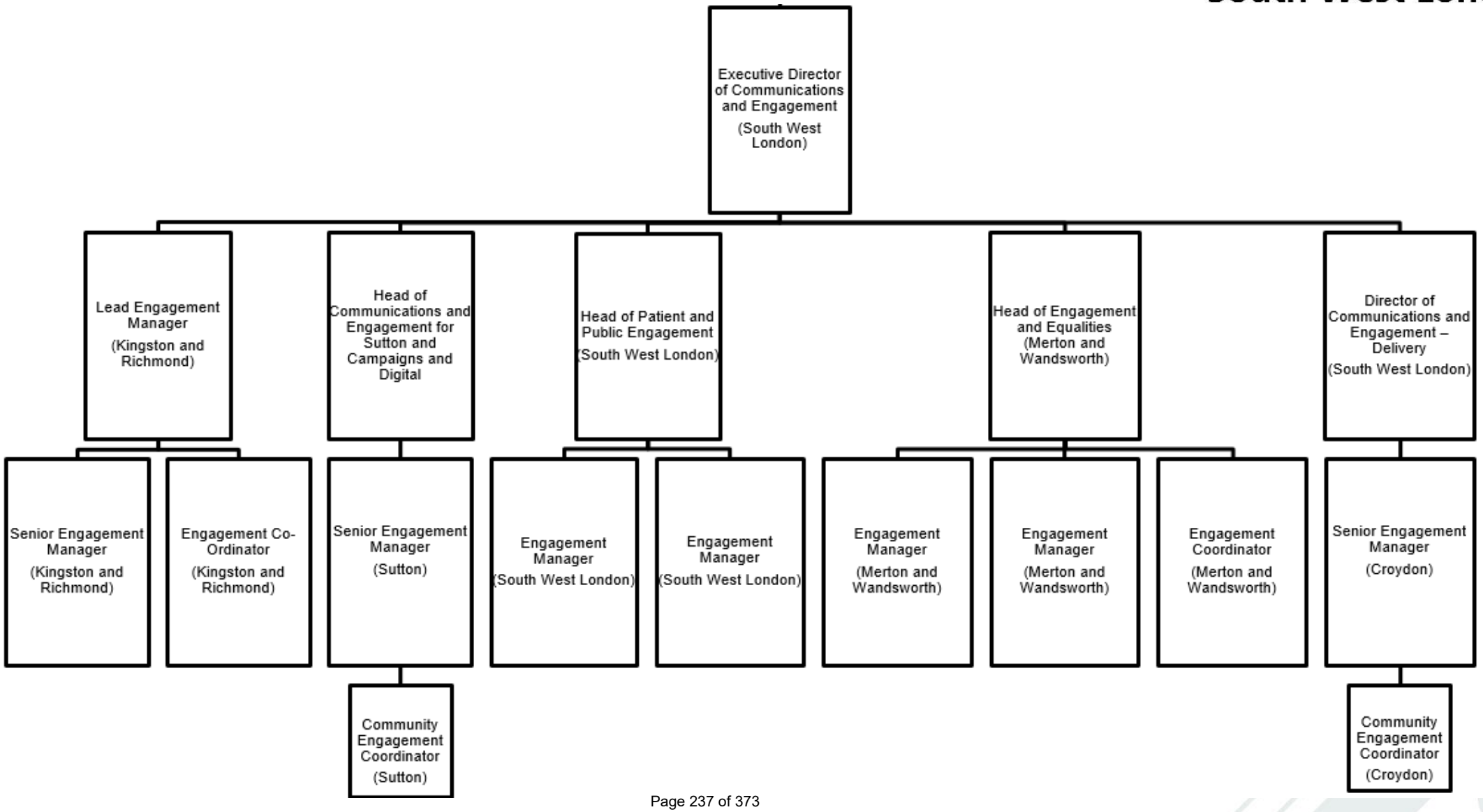
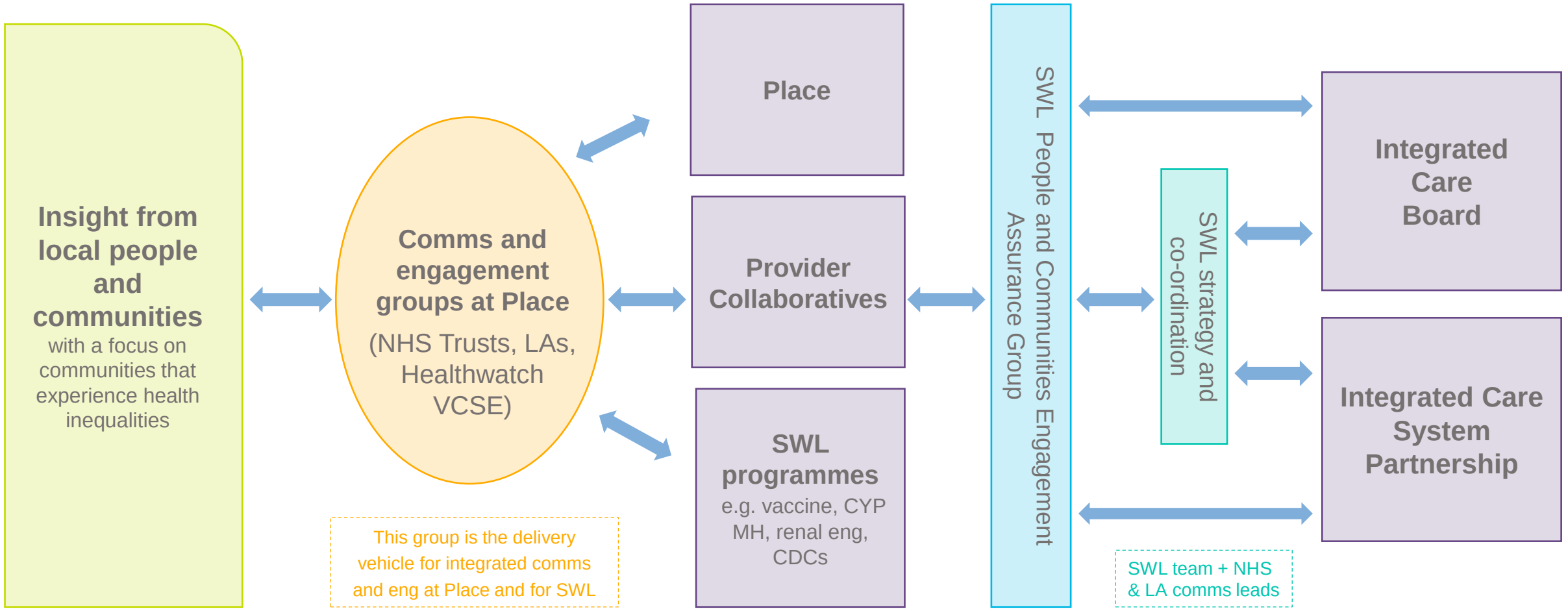
South West London



4.4 How we deliver comms & engagement work across south west London

NHS South West London



4.5 How we deliver communications & engagement work across SWL – explained

NHS South West London

The above diagram shows how we will make sure our **Integrated Care Board** and **Integrated Care Partnership** have the information they need from local people to inform decision making and feel assured that patient voice has been heard.

- **Insight from local people and communities –** the lime green box depicts the sources of all engagement activities/channels (Healthwatch reports, targeted engagement, trust feedback, patient experience data from NHS Trusts, surveys, Business Intelligence data etc). These insights will inform our communication and engagement groups to ensure that the voice of local people is heard. They will also be drawn upon when local and SWL priorities need the insight from local people and communities.
- **Borough/Place communication and engagement groups**– this orange egg is the delivery group which manages and coordinates work across system and comprises representatives from all partners. It ensures two way dialogue with the three purple boxes – ensuring all are informed and part of process. They will be responsible for ensuring the key groups are aware of the local needs and aspirations emerging from the sources of insight.
- **SWL People and Communities Engagement Assurance Group** - provides assurance to the SWL ICB (and reports to ICP) that the legal duty to involve has been met. It will provide advice on engagement plans and activities to ensure they meet best practice and are inclusive of those that are seldom heard, experience health inequalities and/or have protected characteristics. It will review the engagement reports from Place, SWL and Provider Collaboratives before they are submitted to the ICB and ICP.
- **SWL strategy and co-ordination –** comprising communications and engagement colleagues from the NHS and Local Authority to ensure ICB and ICP priorities are fed to relevant groups for consideration and integrated into work plans.

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5. People & communities in ICB governance & work-streams

5.1 System wide approach for engagement in governance

5.2 How the ICB will assure itself that its legal duty to involve the public is being met

5.3 Summary of insight and feedback infrastructure and approaches across the system

5.1 System-wide approach for engagement in governance

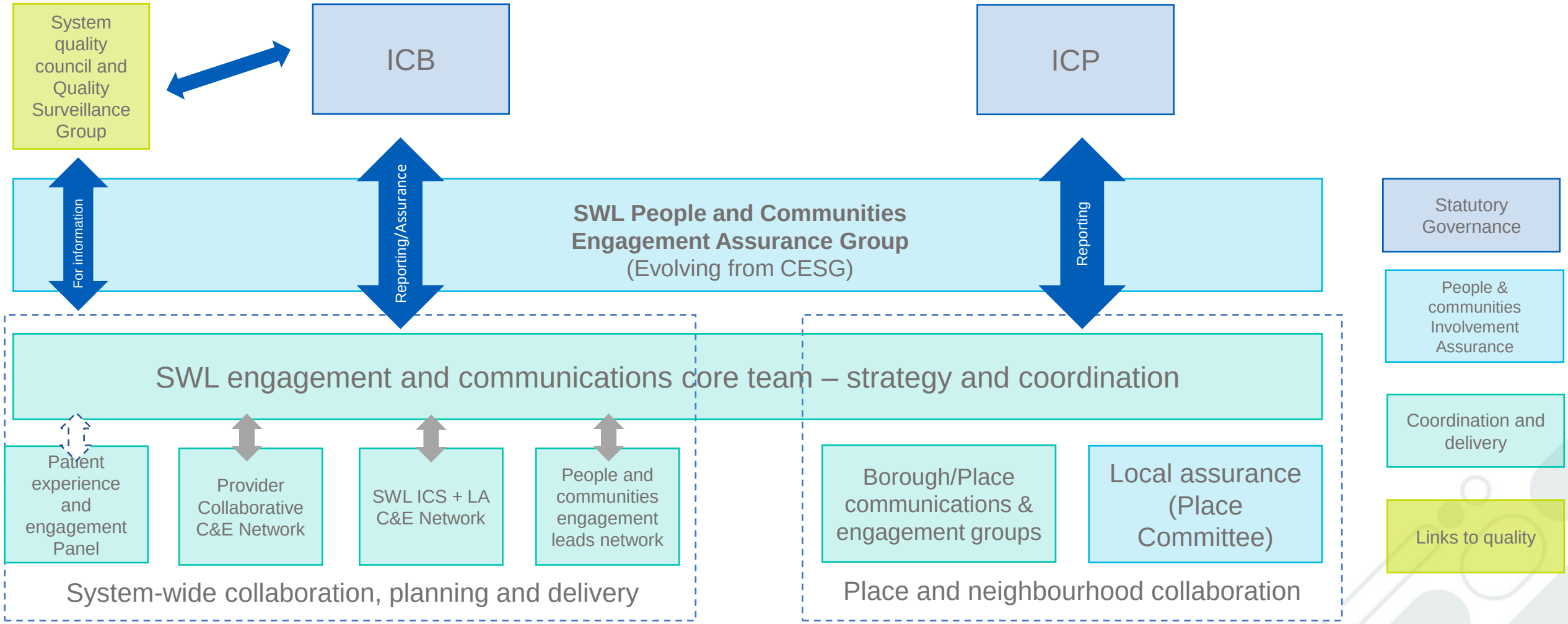
NHS South West London

5.1.1 Summary of how the voice of people and communities will be a core part of our ICS governance.

- Our ICB, ICP and System Quality Group will receive regular engagement reports which will outline engagement activities and impact across SWL, Place and within Provider Collaboratives. We have recommended that board report cover sheets include a section on the involvement of people and communities to ensure it is considered within each programme of work.
- The engagement reports will be reviewed by our 'People and Communities Engagement Assurance Group' (PCEAG) before being submitted to both our ICB and ICP
- As the ICB holds formal responsibility for ensuring legal and mandatory guidance is adhered to, our intention is for the Chair of the People and Communities Engagement Assurance Group to be an ICB NEM, in addition to the meetings being attended by the executive director for communications and engagement and programme director for Quality.
- The diagram in the next slide (5.1.2) explains the assurance mechanisms at place and across SWL and how they link to the groups that support, coordinate and deliver the work.
- We have developed a model for engagement in our formal subcommittees which ensures each relevant sub-committee has a champion for the voice of local people and communities (5.1.5)
- We will support our SWL work streams to openly recruit people with lived experience, and have developed a programme of support and training to ensure individuals are able to meaningfully participate. Bespoke support will be given to individuals being asked to conduct specific pieces of work – such as linking in with other people with lived experience.

5.1.2 People and communities engagement in governance

NHS South West London



5.1.3 People and communities engagement in Governance – explained

NHS South West London

- The Integrated Care Board is responsible for ensuring that the public involvement duties have been met
- In order to ensure strong working relationships between engagement and quality, our aim is for the PCEAG and the Patient Engagement and Experience Leads Panel to be chaired by the same person. In addition, to ensure coordination between groups and work, our executive director for communications and engagement and our Director for Quality will be members of the: Patient Engagement and Experience Leads Panel; SWL People and Communities Engagement Assurance Group; System Quality Council and will attend the ICB and ICP board meetings
- **System wide work** will be guided by:
  - **SWL People and Communities Engagement Leads Network** – comprising place based leads for engagement. This network shares best practice across boroughs, supports the local delivery of the engagement strategy and enables the sharing of insight and consistent approaches across the ICS
  - **SWL ICS and Local Authority communications and engagement network –** comprising colleagues from the SWL NHS and local authorities this network iterates our SWL C&E plans, supports the sharing of best practice, brings together insight and maximises reach deep into communities and with their staff
  - **SWL ICS and NHS provider communications and engagement network –** comprising colleagues from the NHS in the ICS and providers, as above, this network iterates our SWL C&E plans, supports the sharing of best practice, brings together insight and maximises reach deep into communities and with their staff
  - **SWL Patient Engagement and Experience Leads Panel** – is a new group that will comprise patient experience and engagement leads and quality leads for the NHS system – as well as patient safety partners. It aims to ensure that patients, residents and carers are actively involved in how we are shaping, developing and improving the quality of health services in SWL. It will focus on collaboration at scale to improve experiences of care that improve outcomes – by triangulating patient experience data and intelligence with wider feedback and insight.
- **System wide assurance** of our duty to involve
  - The **SWL People and Communities Engagement Assurance Group** provides assurance to the SWL ICB (reports to ICP and Quality Council) that the duty to involve has been met. It will provide advice on engagement plans and activities to ensure they meet best practice and are inclusive of those that are seldom heard, experience health inequalities and/or have protected characteristics
- **Place based work** will be guided by:
  - **Borough/place communications and engagement groups**. These will comprise colleagues from the NHS, LA, Providers, Healthwatch and VCSE sector. And will be the delivery vehicle for integrated communications and engagement at Place and for SWL
- **Place based assurance** of the duty to involve
  - **Assurance for Place based public involvement,** including work that is centrally coordinated and locally delivered, will be done by the place based committee.

5.1.4 Model for how the voice of people and communities can be championed in relevant sub-committees

NHS South West London

- Each relevant formal subcommittee will have a champion for the voice of people and communities.

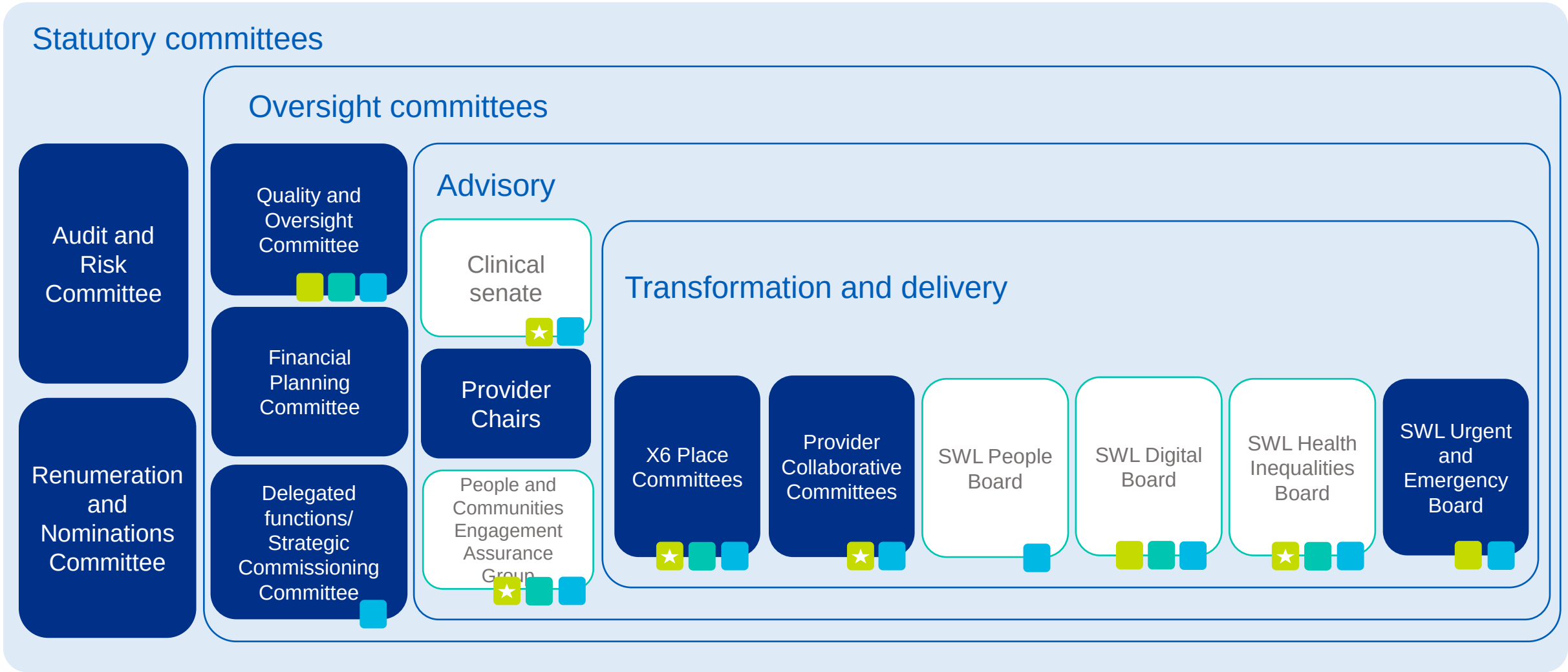
Their role is to:

  - flag opportunities for where further engagement could enhance the work
  - escalate issues to C&E team if changes are more significant
  - speak up for or represent patient/public views in relevant discussions

- Options (to be agreed by each sub-committee) -champions will come from one or more of the following:
  - **existing member of the committee to have a role in raising patient voice issues for consideration (minimum)**
  - **openly recruited member of the public with relevant experience/interest** (particularly relevant for service specific programmes & workstreams)
  - **VCSE alliance member and or Healthwatch organisation, with relevant experience/interest (capacity permitting)**
- Training or support provided for all options to support people to fulfil their role

5.1.5 Diagram of how the voice of people and communities will be embedded in each relevant formal sub-committee

NHS South West London



5.2 How the ICB will assure itself that its legal duty to involve the public is being met

NHS South West London

5.2.1 Summary of ways the ICB will be assured that the duty to involve has been met:

- The People and Communities Engagement Assurance Group will have a key role in providing assurance to the ICB that the duty to involve has been met. More information about this group can be found in 5.2.2
- The ICB, ICP and Quality Council, will receive regular engagement reports which will outline engagement activities and impact across SWL, Place and within Provider Collaboratives. We recommend that board report cover sheets include a section on the involvement of people and communities to ensure it is considered within each programme of work.
- The SWL Oversight Framework will include an element regarding the voice of people and communities and the legal duty to involve
- Assurance for Place based public involvement, including work that is centrally coordinated and locally delivered, will be done by the place based committee
- Each Trust has a dedicated Patient Experience Committee responsible for reviewing and gaining assurance of how patient experience data and insight is acted on through Trust improvement and transformation initiatives. Oversight is provided through Trust governance systems, including internal assurance, Non-Executive Director led committees and Board.
- Place leaders and the Provider Collaborative leaders will be represented on the ICB.

5.2.2 People and Communities Engagement Assurance Group

NHS South West London

Purpose

- Assurance mechanism for SWL level engagement including provider collaboratives.
- Provide **assurance** to the SWL ICB (and report to ICP) that duty to involve has been met
- Provide **advice** on engagement plans and activities to ensure they meet best practice and are inclusive of those that are seldom heard, experience health inequalities and/or have protected characteristics

Role/Focus/Work

- Review and advise on:
  - implementation of people and communities engagement strategy;
  - engagement work plan based on key priorities for ICB;
- Review and advise on annual engagement submissions to NHS E/I
- Receive engagement reports, before submitted to ICB, to review and feel assured that best practice engagement has been undertaken. Make recommendations for further work where required.

Providing timely updates

- Two way communication between the ICS, Healthwatch and the VCSE will now continue through: dedicated meetings; the VCSE alliance and at borough communications and engagement group meetings

Chair

- Our intention is for an ICB NEM to chair the group

Proposed membership

Group/organisation	Proposed representative
VCSE sector	1 – Member of SWL VCSE alliance
Healthwatch	1 – SWL Healthwatch role
Health inequalities	1 – TBC Chair of health inequalities group
ICS Communications and Engagement Team	2 – SWL Executive director and Head of Engagement for SWL
Quality	1 – Member of system quality group
Clinical	1 – Exec medical director or nominee
Acute Provider Collaborative	2 – APC programme director AND NED or service user/lived experience
Mental Health Collaborative	2 Collaborative director AND NED or service user/lived experience
Primary Care	2 – Primary Care rep AND service user/lived experience
Cancer collaborative	2 – Collab director AND NED or service user/lived experience
Local Authority	1 – nominated rep TBC
Total number of members	16

5.3 Summary of insight and feedback mechanisms across the system to inform priorities and improve services

Place	SWL	Acute Provider Collaborative	South London Partnership (Mental Health Collaborative)
• Local priorities will be set by the place committee. The borough communications and engagement groups will coordinate and manage the delivery of local engagement activities. Each borough uses a wide range of engagement mechanisms to reach their diverse communities. These include: • **Broad community engagement** - working with the voluntary and community sector to hold 'community conversations', to hear and respond to feedback, answer questions and gather insight. • **Community champions and influencers** - Work with key local influencers (faith leaders, community champions, health care professionals, GPs and their practices) to lead and host conversations, building trust and confidence within our diverse communities • **Grassroots grants programme** – centrally funded and locally delivered, each borough has been delivering a grants programme to improve our reach into health inclusion communities • **Targeted focus groups and one-to-one interviews** - focus groups and one to one interviews (for those who are digitally excluded) to understand people's experiences and improve the quality of services such as pathway redesign work	• System wide priorities are agreed by our ICB and ICP • Our SWL communications and engagement team discuss how best to resource and deliver the activities, and this approach is taken to the People and Communities Engagement Assurance Group for review. • Engagement will either be centrally coordinated and conducted at a borough level (using the methodologies outlined in the place column), or **specialist organisations are commissioned** to deliver on behalf of SWL. • A key mechanism that is used to inform deeper dives into particular topics, is our **people's panel**. Through this virtual group of 3,000 people, who broadly reflect the population of south west London, we run questionnaires and surveys.	• Transformation work and priorities are informed by insight gathered through **national surveys.** • This is complemented by a range of other approaches for listening to patient voices – these include Patient Experience, Engagement and Involvement Groups, and patient staff improvement forums. These forums increase involvement and inform decision making in service changes or developments • **'People's reader panels'** are used across the Trusts to support the co-production of patient facing information, policies and strategies and user testing of patient information • **Dedicated Patient Experience** teams that support Trusts to gather data, gain insight and use this to improve services. These include: operational delivery of the FFT system; Coordination of national surveys and Trust level responses to the findings of these; Involvement in Trust level strategy, policy and transformation to ensure patient voice insights are fully embedded in our approaches; Leading on work to involve Patient Partners in our governance and safety structures – through the national Patient Safety Partner programme; Patient feedback or complaints sent to the Complaints/Compliments service;	• The SLP has established process for having service users and carers in each **programme partnership group** • The SLP works with each partners service users and reference group to understand and shape priorities • Each of the partnership committees includes a **real patient story** which shapes the agenda and discussion and forms the basis of improvement actions • Existing engagement groups across each Trust (e.g. Patient and Carers Forums) are maintained, and linked in with SLP structures • **Working groups** are developed as required with membership drawn from relevant partners' service user groups • Programme dashboards such as Complex Care feature outcome measures that ensure the experience of people using the services are reported

5.3.1 Summary of how we reach people experiencing health inequalities

Place	SWL	Provider Collaboratives	South London Partnership (Mental Health Collaborative)
• All boroughs have worked across the local partnerships to develop a shared understanding of communities experiencing health inequalities. Data from JSNA, Business Intelligence, Indices of Multiple Deprivation and ongoing engagement have informed the development of local maps which highlight those groups who live in areas of multiple deprivation and identify communities of focus who experience health inequalities. • Health inequalities has also been prioritised within local health and care plans and other work programmes • Engagement is done alongside teams and groups/individuals who have trusted relationships with communities and population groups; using diverse methodologies including – health and community champions, local influencers, partnership with VCSE. • Where possible, Place will invest in community capacity to deliver	• Much engagement on SWL priorities is done through Place. • Where work is commissioned at a SWL level we work with specialist organisations who have experience of reaching our target groups. • To ensure we speak to people who reflect our diverse communities and experience health inequalities, we use incentives to encourage people to attend focus groups, promoting them through culturally appropriate channels and contacts, and via paid media. • We conduct on street recruitment when holding large scale events, to ensure we speak to reflective samples of our local populations.	• Close work with borough communications and engagement to share insights, channels and plan activity at a place and provider level to reach and involve diverse communities (eg COVID vaccine) • Linked with place engagement to build relationships and widen reach with community leaders / groups in local neighbourhoods and established outreach work (ie Council and CCG community networks) • Systems for collecting patient experience insights are inclusive (offering access to people with a range of accessibility needs). • Trusts' Patient Experience Teams offer a range of tools and approaches to support specialities and departments to hear their patients' voice (e.g. via local surveys, support for engagement events or focus	• Across south London, the SLP's mental health trusts have led South London Listens - a community engagement programme which has sought feedback from around 6000 members of the community. The community's 'asks' are shaping much of our work around health inequalities. • Each partner has a number workstreams looking at health inequalities including Ethnicity and Mental Health Improvement Project (EMHIP) • Well established links with community organisations, healthwatch and VCO groups through regular engagement forums shape our work on this. • The SLP Forensic Programme has appointed a specific Equalities Lead to support the development of new community-based services as an alternative to inpatient care. This model of improving health inequalities is being evaluated and is likely to be shared further.

5.3.2 Summary of how these mechanisms, for patient voice, connect into governance and decision making

Place	SWL	Provider Collaboratives	South London Partnership (Mental Health Collaborative)
• Sources of local insight, from across all mechanisms, will feed into the borough communications and engagement groups • The chair of the borough C&E group (place lead for communications and engagement) will sit on the place committee to ensure that the work of the group informs decision making. • Questions about what engagement and quality/equality impact assessments have been undertaken and how they have informed decision making are included in all governance papers. • Healthwatch and VCSE are represented on place committee/leaders group and on Health and Wellbeing Boards – feeding into priority setting and decision making. • Community voice and lived experience built into work programmes.	• Regular engagement reports detailing the engagement activities across the system, and their impact are reviewed by the People and Communities Engagement Assurance group before being submitted to the ICP and ICP. • Each formal sub-committee has a champion for community engagement and whose role includes ensuring that the committee consider relevant insight work when taking decisions.	• Through service transformation groups, informing priorities, decisions and delivery • Oversight through Trust governance systems, including internal assurance, Non-Executive Director led committees and Board • Each Trust has a dedicated Patient Experience Committee dedicated to reviewing and gaining assurance of how patient experience data and insight is acted on through Trust improvement and transformation initiatives. • Feedback from patient surveys, complaints and PALS are collated and analysed by the patient experience and quality teams, and reported to the Board.	• Under SLP the Head of Quality is responsible for all quality governance including patient experience. Each Programme (via PPG) receives quality reports and feedback from service users. • Programme partnership groups are part of the formal SLP governance – to Portfolio Board and on to Partnership Committees. • Programme Partnership Groups have representatives from SW and SE London CCGs • The SLP Partnership Committee consists of non-executive and executive members with input from service user and carers groups • The value of beginning SLP Partnership Committee with a patient story has enabled real experiences to be prioritised and led to ‘you said we did’ improvements

5.3.3 Summary of how we work at neighbourhood level

How Place connects with Primary Care Networks, PPGs and neighbourhood teams to: work with people and communities to strengthen health prevention and treatment and to understand needs and design solutions	Each place has developed strong connections to primary care networks and PPGs, strengthening local work around prevention and understanding of need by: • Developing strong community led engagement channels and activities by working in partnership with local councils and VCSE. • Linking in with PPGs and regularly attending PRG meetings • Working closely with social prescribers • Building on networks of community/health champions to reach more deeply into local communities
How Place creates the right conditions for volunteering and social action that support health and wellbeing	• Local investment in VCSE – through community grants and other initiatives • Funding to local CVSs to enable them to release capacity to further work to establish the SWL VCSE alliance • Look to collaborate on funding/grants to community and voluntary sector across health and LA • Ensure partners support collaborative spaces for open dialogue, social investment, and action and build upon current programmes in progress

NHS
South West London

6. Achieving health equity

6.1 Approach to supporting narrowing health inequalities with engagement
6.2 Our commitment to tackling Health Inequalities

6.1 Approach to narrowing health inequalities with engagement

NHS South West London

We know there are unjustifiable differences in outcomes for people who experience health inequalities. Our Core20plus5 work has supported our understanding of people we need to reach in order to progress our work to achieving health equity. We will actively seek out affected communities and understand their current situation and past histories.

Slide 31 details how, as a system, we identify and engage with people who experience health inequalities. Further details about which communities are most affected in each borough, and how we reach them can be found in the appendices.

As set out in the ICS implementation guidance for working with people and communities, we will do the following to narrow the health inequalities across SWL.

- **Prioritise building relationships with people who are excluded from services** or for whom services are not meeting their care and support needs, and who have the poorest experience and outcomes. This will help counter the 'inverse care law' which highlights that disadvantaged populations need more healthcare than advantaged populations but tend to receive less.
- Take the opportunities presented by collaboration to **mobilise the strengths and experience of all partners**: build and strengthen relationships with people and communities who experience inequalities, and tackle agreed inequalities targets.
- **Involve people in agreeing targets for reducing health inequalities**, to help ensure that they are appropriate, and monitor and evaluate how we have achieved our intended purpose.
- **Work with the VCSE** sector as an essential partner in tackling inequalities.
- **Build trust with local communities** for local decision-making and local leadership through transparency supported by clear communications.
- **Keep developing our skills, channels and capabilities** for giving clear information and facts so our citizens can make informed decisions. Improving how we give particular communities bespoke information, and use different channels for different cohorts within communities.
- **Build on the community mobilisation and reciprocity demonstrated during COVID-19** in supporting vulnerable community members and increasing vaccine take-up. Transfer the learning to other priority areas, e.g. tackling the backlog of care or accelerating cancer diagnosis.
- Use **population health management approaches** to better understand local population needs and demonstrate how these impact on future commissioning and service delivery
- Audit, monitor, and – when necessary – **seek the participation of equalities protected groups** and groups and communities who experience inequalities, e.g. in events, surveys and formal governance roles.

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6.2 Our commitment to tackling Health Inequalities

ICB System Board & Delivery Group

We have developed and created a space that allows leaders and organisations from across our system to come together to focus on inequity *(using the learning from COVID-19)* and fighting for fairer health and care for all

Place based work

We have invested in a number of programmes led by the Community and Voluntary Care Sector that target our most deprived communities through proactive support, advocacy, prevention and community connections

Core20PLUS5 & its relationship with Population Health Management

We are working towards using data relating to health outcomes, plus local insight, to inform the allocation of resources to the areas of our population that have the greatest need. Starting with the CORE20PLUS5 programme

Asset Based Community Development

We use the ABCD methodology to educate and empower the most vulnerable people in our communities regarding their health. We co-produce and co-deliver culturally sensitive health checks and prevention programmes in local communities.

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7. What we do to ensure the information we provide is accessible to all

7.1 Providing clear and accessible information
7.2 What we do to make sure our website is accessible

7.1 Providing clear and accessible information

NHS South West London

We believe that providing accessible information will help to improve access to services, promote social inclusion and enable people to make more informed choices about their care. Providing accessible information is one of the ways that we reduce health inequalities

How we **communicate in an clear and accessible way**:

- Always use plain English
- Co-design culturally appropriate messages with local people and communities
- Use different ways to speak to people: in person; via social media; in newsletters; via direct email; through text messages
- Provide translations and alternative formats, including Easy Read, for specific audiences
- Always offer to provide information in alternative formats
- Offer and provide interpreters, language and BSL, for face to face or virtual engagement sessions

Plain English training and accessibility training are part of core modules provided to our communications and engagement team

How we keep local people, communities and stakeholders **regularly informed** about our work:

- SWL message from Millie and Sarah to SWL staff, partners and, stakeholders and PPE contacts
- Borough stakeholder updates from Place Based Leaders for Health to borough staff, partners, stakeholders and PPE contacts
- From 1 July 2022, meetings of the ICP and ICB will both be available to view on MS Teams, papers and meeting dates will be available in advance
- We issue regular media releases and work with local media that can be found on our NHS South West London website
- Local people can also follow our social media channels to be kept up to date with developments

7.2 What we do to make sure our website is accessible

NHS South West London

- We are developing websites for the ICB and ICS, and accessibility is at the heart of the design. These will be launched on 1 July 2022.
- Current accessibility regulations say that public sector websites must meet at least level AA of the Web Content Accessibility Guidelines (WCAG 2.1) - and aim for AAA where possible
- All content must be accessible to everyone who needs it – if it isn't we may be breaking the 2010 Equality Act
- Everything we publish must be in a format that the public, and in particular people with low health literacy, can access and understand easily. This means we:
    - Use plain English and do research to find out which words work best for our audience.
    - Aim for a reading age of 9 to 11 years old or, when it comes to medical information, 11 to 14 years old.
    - Avoid medical jargon and technical terms – or explain them in simple terms if we have to use them.
    - Use the same style for all our audiences, including specialist audiences like health professionals.
    - Organise content based around the information needs of the user, not the structure of our organisations.
    - Avoid using PDFs – which aren't accessible to everyone – and publish information in HTML webpages instead.
    - Manually check our content regularly using the most common accessibility checkers.
    - Make sure our content works on the most commonly used assistive technologies - including screen magnifiers.
    - Design our websites and content for mobile devices first – the most common device people use to access our content.
    - Use a high contrast colour palette in our design to make sure people can read what's on the screen.
    - Only use images where it helps someone to understand the information – not for decorative purposes - and always include 'alt tags' - a text description of the image - so that those using text readers are read the description of what a viewer sees
- We follow the principles and guidance published in the NHS Digital Service Manual, published to ensure that all NHS organisations build consistent, usable services that put people first.
- We're using a design framework that has been developed to meet the latest accessibility guidance, and accessibility testing is embedded in the development cycle.

NHS
South West London

8. How we will work with Healthwatch and VCSE sector

9. How we work with Healthwatch and VCSE sector

NHS South West London

Healthwatch and the VCSE sector are valued partners in our system. Below provides an overview of how we work together to make sure local people have access to the best health and care possible:

Governance and influence

- Healthwatch and the VCSE sector (including the SWL VCSE alliance) have a seat on key governance groups at Place and SWL levels – including the ICP. To further support this we are finalising what funding can be given to the VCSE sector and Healthwatch to enable working and collaborating together at SWL level as we are aware their focus is primarily, and rightly, at Place level.

Assurance and 'critical friend' challenge

- Healthwatch and the VCSE sector are key members of our assurance groups and mechanisms at SWL and Place levels– providing 'critical friend' challenge to our plans and activities

Two way communication

- We will ensure that we have regular meetings with Healthwatch colleagues and the VCSE, in addition to meetings at Place, to provide two way communication between the ICS and their work and to give early sight of key programmes of work and upcoming priorities – enabling due consideration and input.

Reach and insight

- Recognising their skills and significant reach into local communities, we will look for opportunities to commission local Healthwatch organisations to conduct specific pieces of engagement work to support our ICB and ICP priorities, subject to their priorities and capacity
- We will seek opportunities to invest in community led approaches to engagement that benefit from the evidenced and extensive reach that our VCSE has with local people and communities, including those who experience health inequalities.

NHS
South West London

9. Engaging on the priorities of the ICB

9. Engaging on the priorities of the ICB

NHS South West London

ICS priorities are still in development, and we plan to prioritise our engagement efforts on supporting the delivery of the small number jointly agreed at system priorities to ensure these are informed and implemented with evidence of what matters most to local people particularly those that experience health inequalities. However, drawing on our local health and care plans, and from the 2022/23 planning guidance, we know that our engagement work will include focus on the following:

- **Achieving health equity.** Current initiatives include: insight work to understand the challenges facing people who experience health inequalities to ensure that our interventions are targeting, and measuring, what is important to local people; supporting our core20 connectors work; and working with colleagues in maternity to coproduce interventions to deliver equitable services - improving the outcomes for our local people.
- Continuing to engage and build on the priorities within each of the **Place health and care plans**
- Supporting the **covid 19 vaccination programme and childhood immunisations programmes** through understanding the views of people living in low uptake areas and communities – especially those experiencing health inequalities and new cohorts of eligible people
- Using feedback and insight with local people to reduce the pressure on **urgent and emergency care services,** especially over winter and in summer months, by supporting insight-led behaviour change campaigns e.g. using pharmacies, mental health crisis and IAPT services, 111 etc
- Delivering more **elective care** – by gaining insight into people experiences of services and views of improved models of care such as Community Diagnostic Centres
- Improving access to **mental health services**. Current work includes: understanding the experiences of people with Severe Mental Illness to gather views annual physical health checks – feeding into the SWL SMI improvement programme; seeking insight from local people and communities about prevention and early intervention to inform our SWL Mental Health strategy.
- Supporting our approach to **Population Health Management** programmes – ensuring that local insight is triangulated with data and analytics to inform service redesign work
- Improving access to **primary care** – by working closely with colleagues at a neighbourhood and PCN level, including PPGs, to understand the experiences of local people.

10. Monitoring and evaluating the strategy

10. Monitoring and evaluating the strategy

NHS South West London

We will put in place the following measures to monitor and help evaluate whether we are delivering against what is set out in this strategy.

We will:

- Systematically produce engagement reports that detail engagement activities across the ICS. These will be reviewed by our People and Communities Engagement Assurance Group and submitted to our ICB and ICP on a regular basis
- Evaluate the success and impact of our engagement activities by using our evaluation framework (evolution of CCG framework)
- Seek feedback from people and communities about our engagement activities using different evaluation methodologies (e.g. real time polls, survey work)
- Produce regular You Said, We Did reports and ensure we feedback to the people who shared their views with us – these will be published on our website as well as directly communicated to those involved
- Include questions around engagement in our perception audits for stakeholders
- Be assessed by the ICB and NHS England in the annual compliance report

NHS
South West London

Appendices

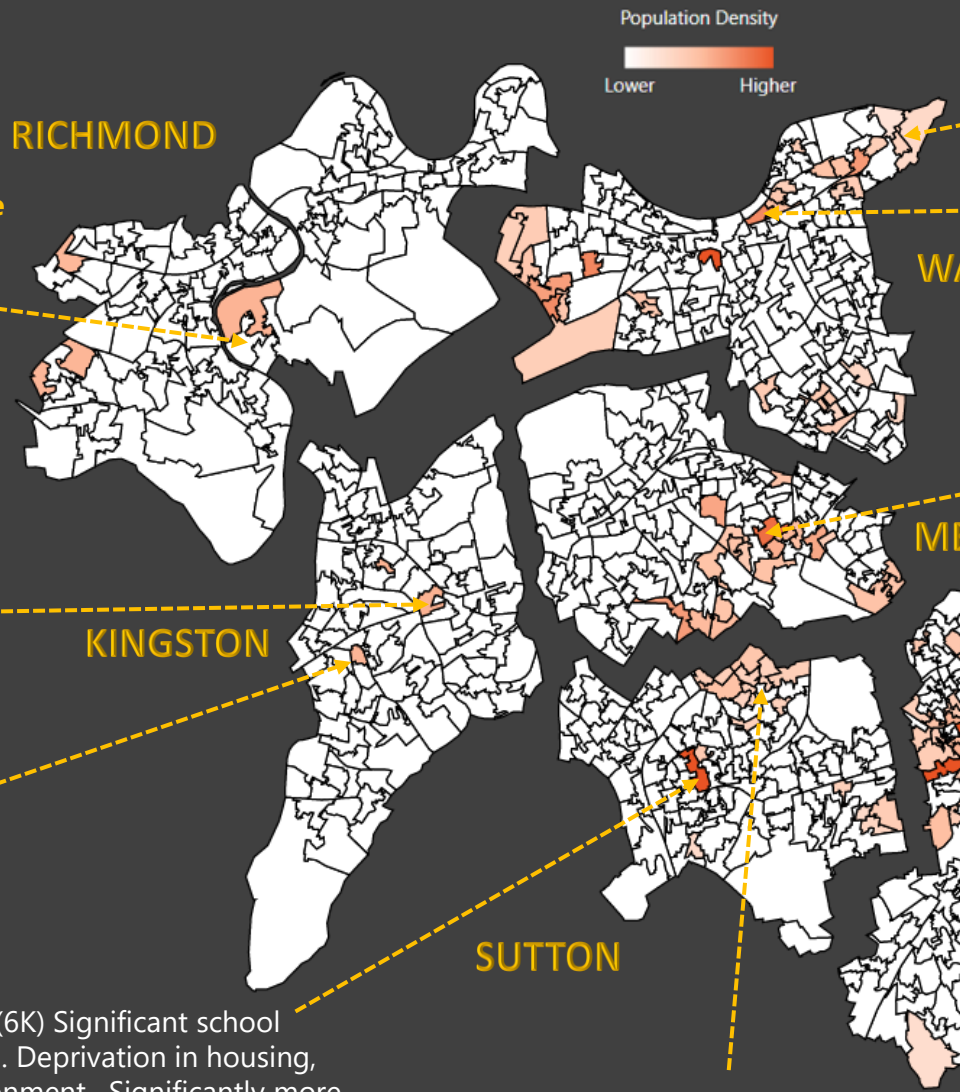
1. Core20 populations for South West London
2. What do we mean by ‘insight from local people and communities’
3. How we engage with communities that experience health inequalities in each borough

In partnership with South West London Health & Care Partnership

Where are our Core20 population of 340k located?

NHS

Main features of population:



- **Ham, Petersham and Richmond Riverside** (2K) Older population. Significant White British population.
- **Beverley** (2K) More school and young working aged population. More of the Asian & Mixed ethnicities.
- **Berrylands** (2K) More young working age population. More of the Arab/Middle Eastern ethnicities.
- **Sutton Central** (6K) Significant school aged population. Deprivation in housing, income & environment. Significantly more South Asian & Chinese ethnicities.
- **St Helier & Wandle Valley** (14K) More school & retirement aged population. Significantly more White British and Eastern European ethnicities.
- **Fairfield** (21k) Young adult to working age (15-44), adversity in living environment, housing & crime. Significant Indian ethnicities.
- **Addington** (24k) High school aged population. Very high deprivation driven by income, employment, education and barriers to housing. Significantly White British and Black African
- **Croydon North** (89K) School and working aged population. Significantly more Black & Asian ethnicities. Barriers to housing.
- **East Merton** (29K) Deprivation in housing and environment. Significant school aged and older working age (44-64) population. Ethnically diverse.
- **Latchmere** (14K) Younger working age population. More Black ethnicities. Barriers to housing
- **Queenstown** (9K) Young adult to working age population (15-44). Significantly more Black & Chinese ethnicities. Barriers to housing and living environments

Opportunity for change KEY: High Medium Low

In partnership with South West London Health & Care Partnership

Appendix 1

Core20
(339k population)

Remaining80
(1.35m population)

NHS

Age

35 | 38 Median

64 | 70 Healthy Life Expectancy

82 | 84 Life Expectancy

Ethnicity

16% | 14% Asian

2 in 10 are in C20

24% | 7% Black

4.5 in 10 are in C20

12% | 11% Other

2 in 10 are in C20

48% | 68% White

1.5 in 10 are in C20

Borough

50% of C20 population are **Croydon** residents.

40% of **Croydon** residents are in C20

In contrast, only **4%** of residents in **Richmond** and **2%** in **Kingston** are in C20

Long-Term Conditions

29.5%
have a Long-term Condition

28.6%
have a Long-term Condition

Appendix 2 – what do we mean by ‘insight from local people and communities’

Borough patient engagement groups e.g. Thinking Partners, Community Involvement Group, Patient Engagement Group

SWL Citizen’s panel

Business intelligence data

Primary care - Patient participation groups and patient reference groups, GP surveys

NHS Providers
Patient experience data, PALS, Friends and Family, complaints etc

Voluntary community social enterprise sector
Insight and feedback

Continuous outreach with local communities

Healthwatch
Reports, Surveys Feedback

Local authority
Citizen forums and feedback

Media and social media
Twitter feeds Facebook groups etc local and national coverage

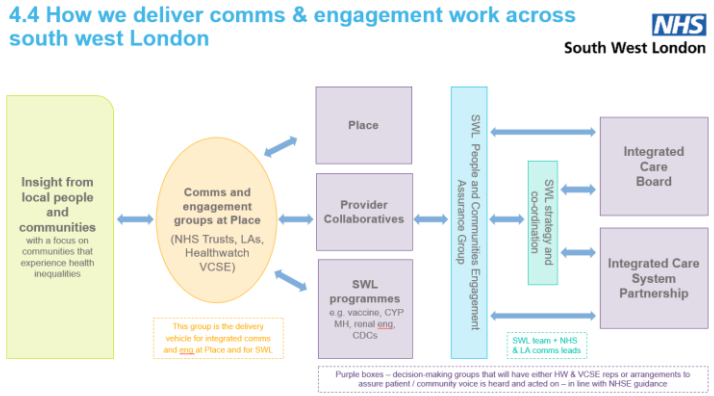
Public representatives
dialogue with councillors and MPs

Staff feedback including provider, local authorities, primary care and trade unions

Project specific engagement work e.g. CDH, Renal

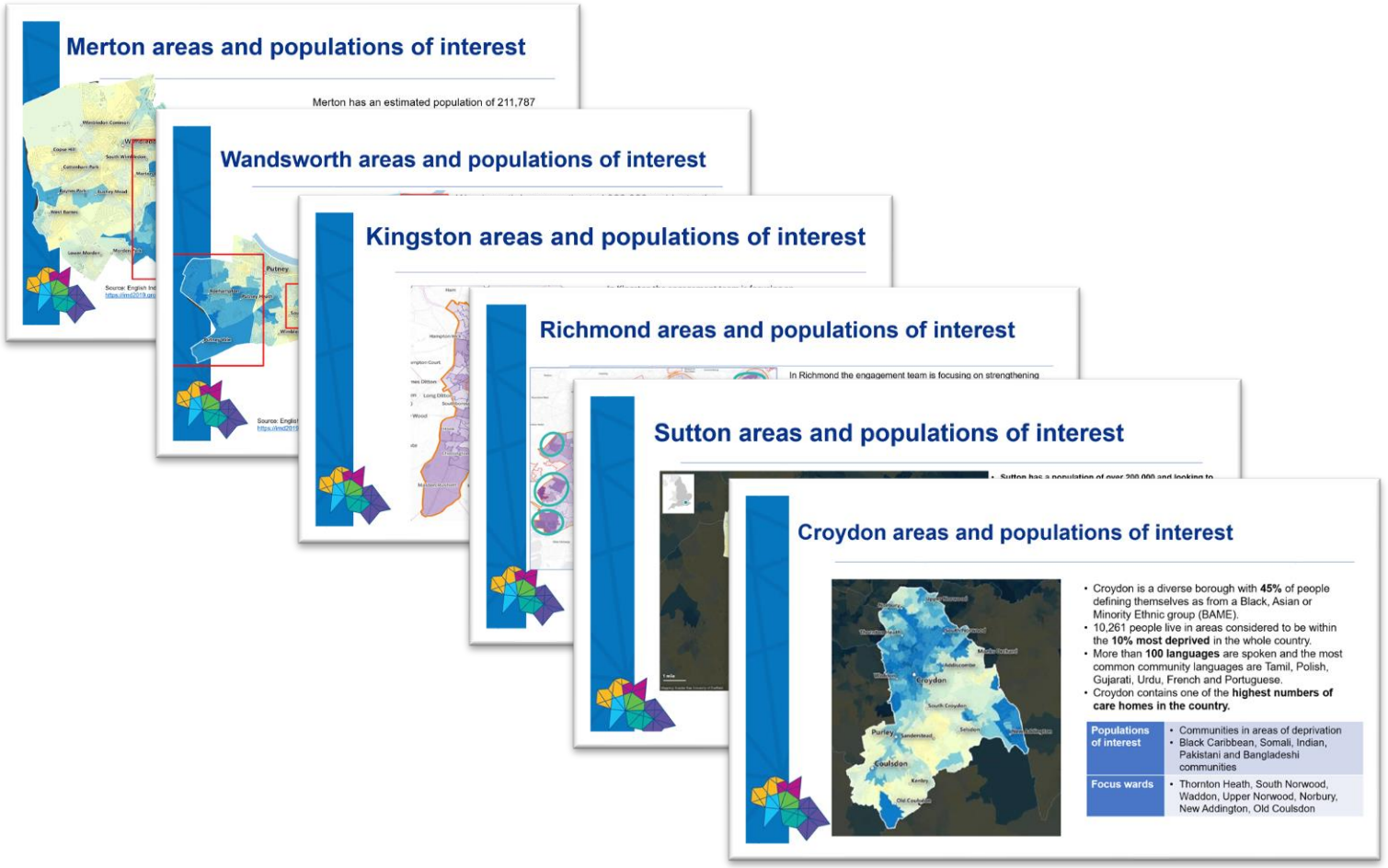
FT Governors, NEDs, Lay Members

Insight from local people and communities
with a focus on communities that experience health inequalities



Appendix 3 – how we engage with communities that experience health inequalities in each borough

NHS South West London



Successful engagement is dependent on understanding our diverse populations.

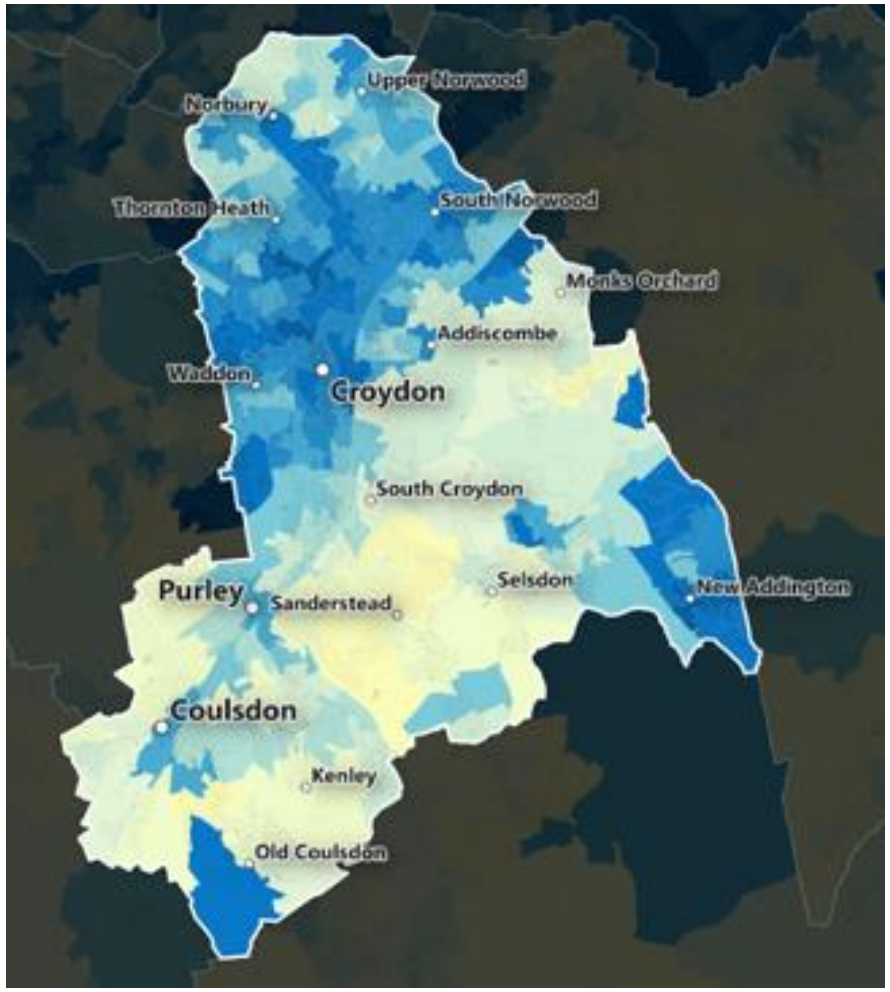
We prioritise holding conversations with communities who experience health inequalities and have worse health outcomes.

Informed by EHIAs, JSNAs and local insight, each borough has worked with local authority leads and VCSE partners to develop a map of key areas/communities to focus on.

IMD data was overlaid with information about health inequalities including identifying communities from Black, Asian and Minority Ethnic backgrounds.

Croydon areas and populations of interest

South West London



- Croydon is a diverse borough with **45%** of people defining themselves as from a Black, Asian or Minority Ethnic group (BAME).
- 10,261 people live in areas considered to be within the **10% most deprived** in the whole country.
- More than **100 languages** are spoken and the most common community languages are Tamil, Polish, Gujarati, Urdu, French and Portuguese.
- Croydon contains one of the **highest numbers of care homes in the country.**

Populations of interest	• Communities in areas of deprivation • Black Caribbean, Somali, Indian, Pakistani and Bangladeshi communities
Focus wards	• Thornton Heath, South Norwood, Waddon, Upper Norwood, Norbury, New Addington, Old Coulsdon

Channels to reach borough populations of interest in Croydon

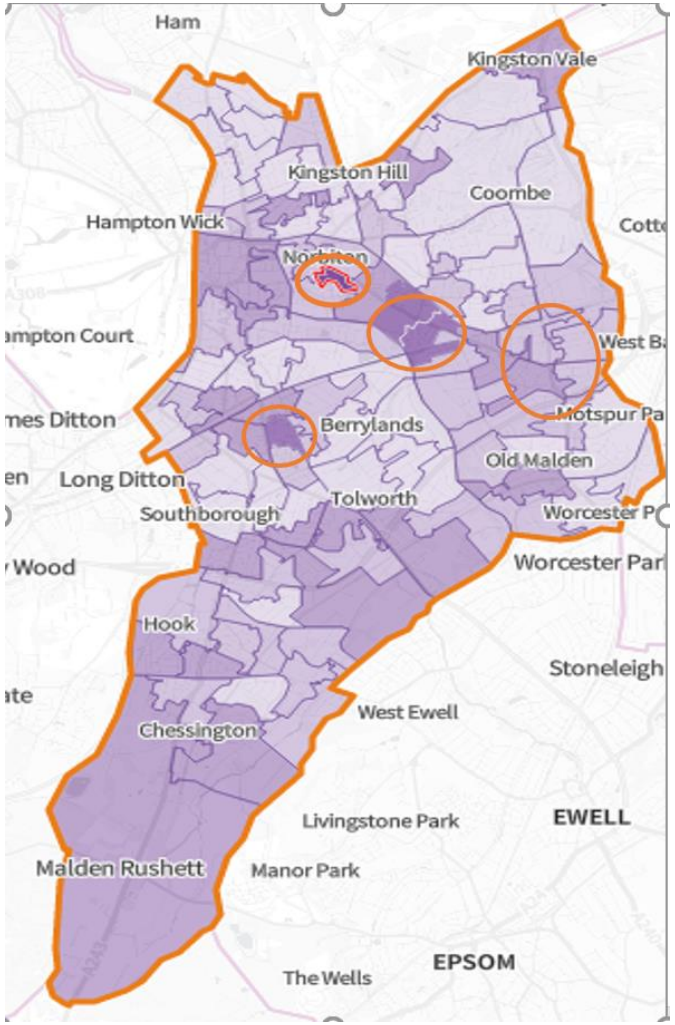
Borough	Highlighted Populations of interest	Key organisations/Influencers	Channels we use to communicate and engage e.g. Facebook	Reach
Croydon	Communities in areas of deprivation (Thornton Heath, South Norwood, Waddon, Upper Norwood, Norbury, New Addington, Old Coulsdon)	• Croydon Participation Network • Residents Association • Just be • Link workers • Food banks / soup kitchens / nightstop • Neighbourhood Watch • Personal Independence Coordinators • Covid Information Officers • CVA 'ask me' team • One Croydon Service users and carers group • Palace for Life • Covid Champions • Faith's Together • Croydon EMHIP • Thornton Heath Community Action Trust	• Email • Covid whatsapp group • Facebook groups • Twitter • Tiktok • Instagram • Next Door • Face to Face – attending events in the area, information stalls at bump spots etc. • Leaflets • Council newsletters • Letters / emails through local schools	20,000 95 + shares Varies Varies Varies Varies 4,000 Varies Varies 80,000 Varies
	Black Caribbean communities	• Ministry of Empowerment • Croydon Welderlies • Croydon BME Forum • Local businesses e.g. barbers • Link workers • Personal Independence Coordinators • Covid Information Officers • CVA 'ask me team • Palace for Life • CHS / council BAME Staff network Covid Champions • New Life Croydon • Masked Men • The Amen Project • Faith's Together • Croydon EMHIP	• Email • Covid whatsapp group • Facebook • Tiktok • Instagram • Next Door • Face to Face – attending community events, information stalls at bump spots etc. • Leaflets • Council newsletters • Letters / emails through local schools	20,000 95 + shares Varies Varies Varies Varies 4,000 Varies Varies 80,000 Varies

Borough	Highlighted Populations of interest	Key organisations/Influencers	Channels we use to communicate and engage e.g. Facebook	Reach
Croydon	Black African communities	• His Grace Evangelical Church • Trinity Oasis Baptist Church • Palace for Life • CHS / council BAME Staff network Covid Champions • The Amen Project • Masked Men • Young at Heart Group • Croydon Wellderlies • Health Champions • Faith's Together • Croydon EMHIP • Croydon Tabernacle Church	• Email • Covid whatsapp group • Facebook groups • Twitter • Tiktok • Instagram • Next Door • Face to Face – attending events in the area, information stalls at bump spots etc. • Leaflets • Council newsletters • Letters / emails through local schools	20,000 95 + shares Varies Varies Varies Varies 4,000 Varies Varies 80,000 Varies
	Indian communities	• Asian Resource Centre of Croydon • Purley Mosque • Croydon Mosque • Palace for Life • CHS / council BAME Staff network (over 70% local residents) • Covid Champions • Masked Men • Health Champions • Faith's Together • Croydon EMHIP • Tamil Help Line • Dialogue Society • Sakthy Ghanapathy Temple	• Email • Covid whatsapp group • Facebook groups • Twitter • Tiktok • Instagram • Next Door • Face to Face – attending events in the area, information stalls at bump spots etc. • Leaflets • Council newsletters • Letters / emails through local schools	20,000 95 + shares Varies Varies Varies Varies 4,000 Varies Varies 80,000 Varies

Borough	Highlighted Populations of interest	Key organisations/Influencers	Channels we use to communicate and engage e.g. Facebook	Reach
Croydon	Bangladeshi community	• Asian Resource Centre of Croydon • Purley Mosque • Croydon Mosque • Palace for Life • CHS / council BAME Staff network • Cllr Kabir's network • Masked Men • Covid Champions • Health Champions • Faith's Together • Croydon EMHIP • Dialogue Society	• Email • Covid whatsapp group • Facebook groups • Twitter • Tiktok • Instagram • Next Door • Face to Face – attending events in the area, information stalls at bump spots etc. • Leaflets • Council newsletters • Letters / emails through local schools	20,000 95 + shares Varies Varies Varies Varies 4,000 Varies Varies 80,000 Varies
	Pakistani communities	• Asian Resource Centre of Croydon • Purley Mosque • Croydon Mosque • Palace for Life • CHS / council BAME Staff network (over 70% local residents • Masked Men • Covid Champions • Health Champions • Faith's Together • Croydon EMHIP • Dialogue Society	• Email • Covid whatsapp group • Facebook groups • Twitter • Tiktok • Instagram • Next Door • Face to Face – attending events in the area, information stalls at bump spots etc. • Leaflets • Council newsletters • Letters / emails through local schools	20,000 95 + shares Varies Varies Varies Varies 4,000 Varies Varies 80,000 Varies

Kingston areas and populations of interest

NHS South West London



There are approximately 176,000 people living in Kingston – a relatively small population compared to other London boroughs. 69% of residents are white, 20% from an Asian background, 5% from a mixed ethic background, 3.1% from a black background.
Kingston has a relatively young population with a median age of 36.2 – however there are a considerable number of residents living into their 90s.
There are pockets of significant deprivation, as well as very affluent areas.

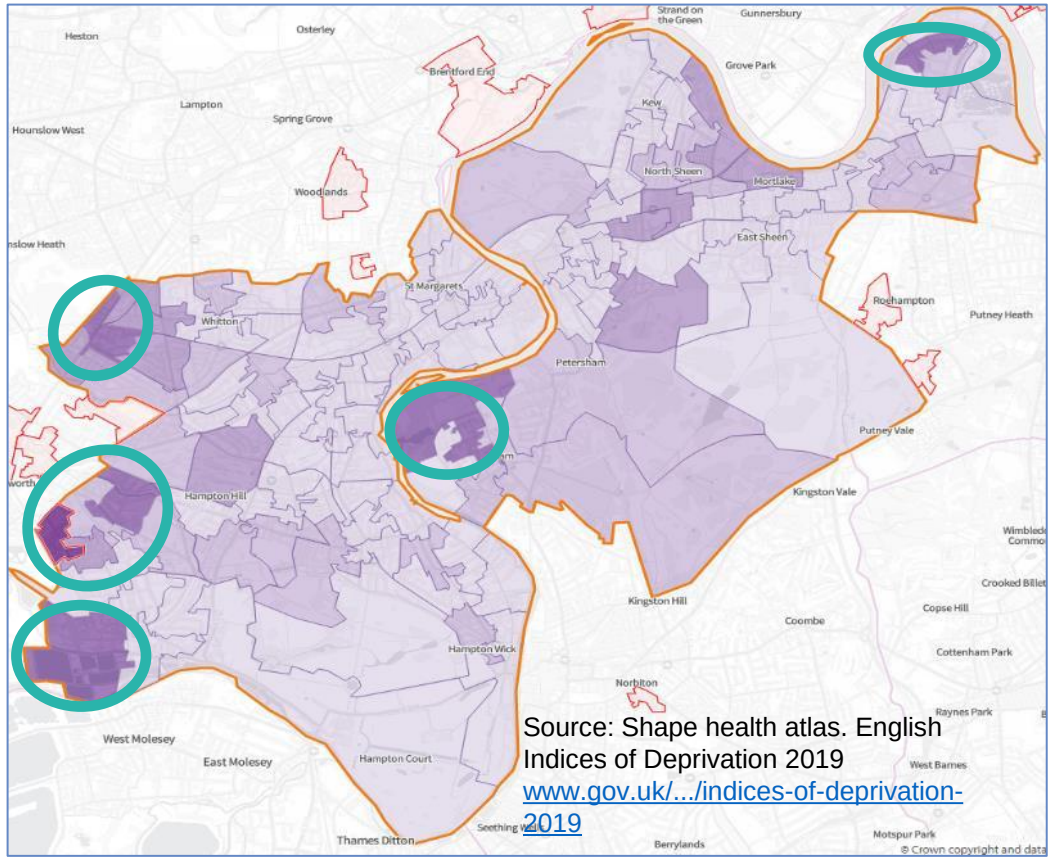
Highlighted populations of interest	• Those with the worst health outcomes/life expectancy e.g. learning disability and mental health • Communities in areas of deprivation • Korean community – New Malden • Travellers
Focus wards	Norbiton – Cambridge Road estate Beverley – Potters Grove/California Rd area Berrylands – Alpha Road estate

Channels to reach borough populations of interest in **Kingston**

Borough	Highlighted Populations of interest	Key organisations/Influencers	Channels we use to communicate and engage e.g. Facebook	Reach
Kingston	Communities in areas of deprivation (Norbiton – Cambridge Road Estate, Beverley – Potters Grove/California Road, Berrylands – Alpha Road Estate	• Kingston Voluntary Action • Council's community engagement team • RBK housing officers, neighbourhood communities teams • RBK community champions • Children's centres and Kingston Welcare • Residents Associations • Local community associations and centres • PCN social prescribing link workers • Food banks	Work with and alongside organisations/groups listed. Where appropriate join their forums/activities and use their communication channels, e.g. regular email outs; newsletters. Leaflets and attendance at food banks. Community champions Whatsapp groups	TBC
	Black & minority ethnic communities Korean Community	• RBK PH community engagement team (focus on health inequalities) • RBK community champions • Kingston Inter-faith forum • Kingston Mosque • Kingston BME forum • Kingston Migrant Advocacy Service • Refugee Action Kingston • LEAH • Milaap Centre • Korean community – Nanoon, Korean Residents Society, Connect North Korea • Kingston Muslim Women's Association & Islamic resource centre	• Korean community – via community influencers, schools, Korean businesses & shops in New Malden • Work with and alongside organisations/groups listed. Where appropriate join their forums/activities and use their communication channels, e.g. regular email outs; newsletters. • Social media (twitter, facebook) • Community champions Whatsapp groups	TBC
	Travellers	• RBK PH community engagement team • Surrey Community Action (work with Swallow Park travellers site in Kingston)	Work with and alongside organisations/groups listed. Where appropriate join their forums/activities and use their communication channels, e.g. regular email outs; newsletters	TBC
	Those with worst health outcomes/life expectancy e.g. Mental Health, Learning disabilities	• RBK PH community engagement team (focus on health inequalities) • Homeless – Kingston Churches Action Against Homelessness, SPEAR • Kingston Mencap • TAG Youth Club • ADHD Kingston & Richmond • Your Healthcare • Kingston MIND	Work with and alongside organisations/groups listed. Where appropriate join their forums/activities and use their communication channels, e.g. regular email outs; newsletters.	TBC

Richmond areas and populations of interest

NHS South West London



Source: Shape health atlas. English Indices of Deprivation 2019 www.gov.uk/.../indices-of-deprivation-2019

In Richmond the engagement team is focusing on strengthening connections with formal and informal leaders in our populations of interest.

Recently this outreach has included organising winter conversations in partnership with local clinicians, and community groups to talk to residents about what matters to them

Winter conversations are also providing support to NHS is Still Here for You, Flu, and Think 111 First campaigns and is gathering valuable insight to inform the COVID-19 vaccination campaign.

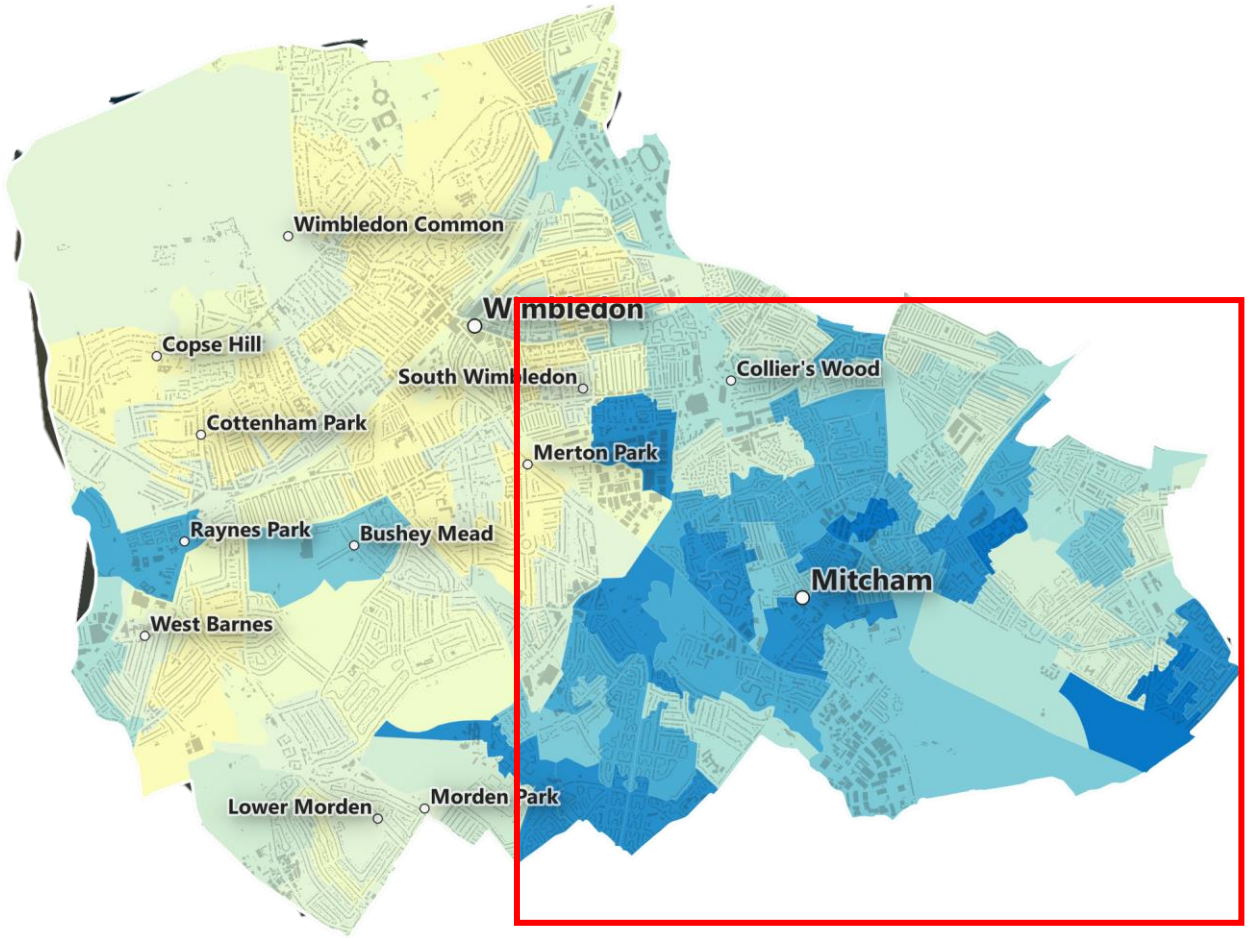
Highlighted populations of interest	• Those with the worst health outcomes/life expectancy e.g. learning disability, mental health (and unpaid carers) • Communities in areas of relative deprivation • Polish, Punjabi and Farsi speaking communities and Gypsy, Roma & Traveller community
Areas of interest	Areas in Hampton North, Ham, Heathfield, Mortlake and Barnes Common, and Whitton

Channels to reach borough populations of interest in **Richmond**

Borough	Highlighted Populations of interest	Key organisations/Influencers	Channels we use to communicate and engage e.g. Facebook	Reach
Richmond	Communities in areas of relative deprivation in Hampton North, Ham, Heathfield, Mortlake and Barnes Common, and Whitton	• LBRuT's community engagement team and neighbourhood forums • Children's centres and Homestart • PCN social prescribing team • Neighbourhood Care Groups e.g. Ham & Petersham SOS • Local community groups and centres e.g. Castlenau Community Centre, Whitton Community Association • Food banks • Housing associations, tenant champions and residents associations	Work with and alongside organisations/groups listed. Where appropriate join their forums/activities and use their communication channels, e.g. regular email outs; newsletters.	
	Those with the worst health outcomes/life expectancy e.g. learning disability, mental health (and unpaid carers)	• Richmond Mencap & The Working Together Group • True Access and TAG Youth Club • ADHD Kingston & Richmond • Your Healthcare • Learning Disability partnership board • Spear and The Vineyard • Richmond Carers Centre & Carers Hub • Crossroads Care & The Carers Café • Richmond parent carer forum • Mind	Work with and alongside organisations/groups listed. Where appropriate join their forums/activities and use their communication channels, e.g. regular email outs; newsletters.	
	Black and ethnic minority communities: Polish Communities Punjabi speaking communities Farsi speaking communities	• Multicultural Richmond • LEAH (Learn English at Home) • Richmond EAL • Richmond Inter-faith forum • Kingston Mosque (exploring similar in Hounslow) • Richmond Council's community engagement team (local businesses and groups) • Black and ethnic community groups and networks in Kingston (exploring similar in Hounslow) • Explore contacts with Catholic churches and across boroughs for Polish speaking community. • Healthwatch Richmond	Work with and alongside organisations/groups listed. Where appropriate join their forums/activities and use their communication channels, e.g. regular email outs; newsletters.	
	Gypsy, Roma & Traveller communities	Richmond Housing Partnership	Face to face working with RHP support worker	

Merton areas and populations of interest

NHS
South West London



Source: English Indices of Deprivation
https://imd2019.group.shef.ac.uk/ last accessed 10/09/2020

Merton has an estimated population of 211,787 residents. Significant social inequalities exist within Merton. The eastern half has a younger, poorer and more ethnically mixed population, with more areas of high deprivation. The western half is whiter, older, and richer.

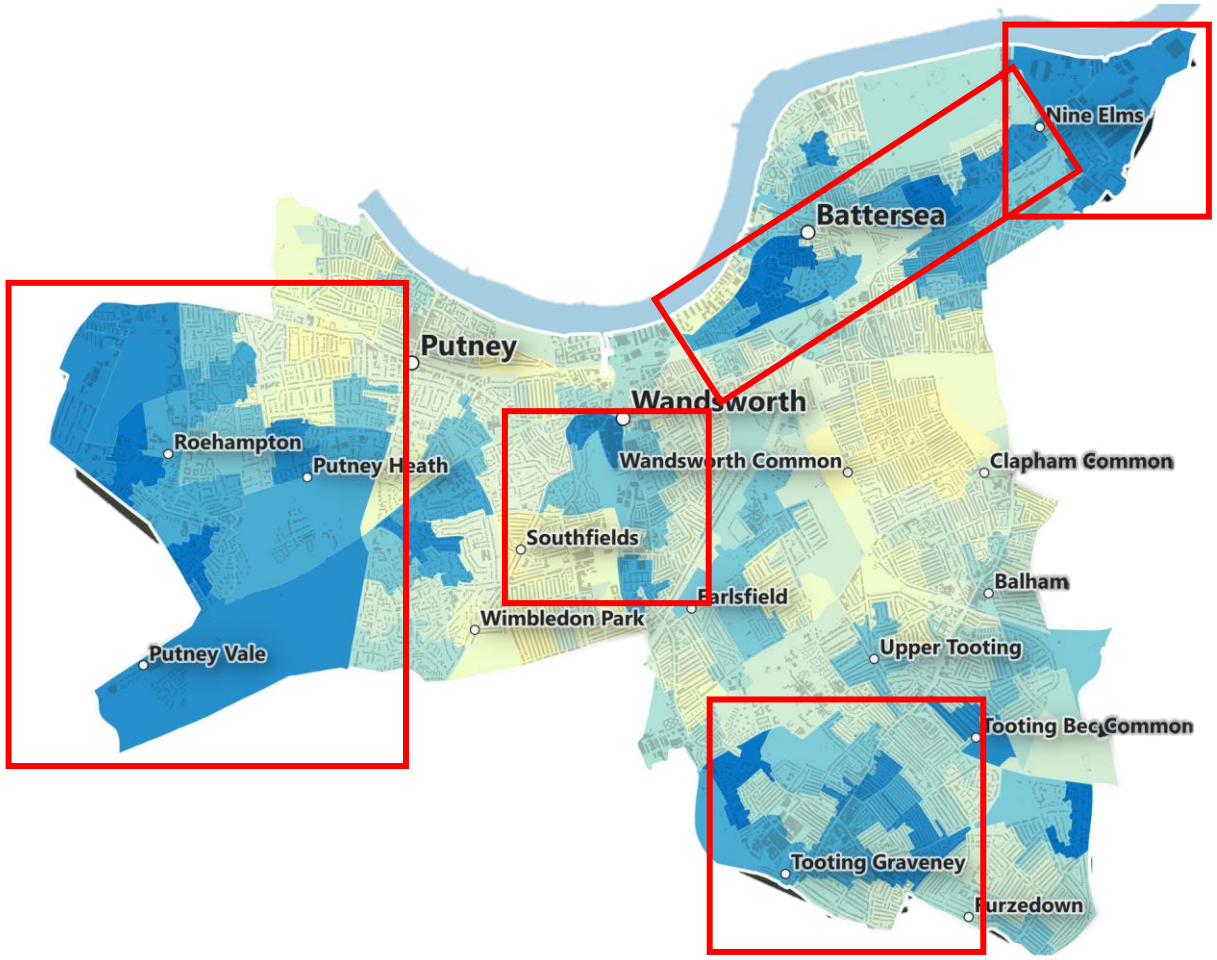
Populations of interest	• Communities in areas of deprivation • Communities with Ghanaian, Polish, Somali, Tamil, Gypsy, Roma and Traveller backgrounds
Focus wards	• East Merton; esp. Figges Marsh, Pollards Hill, Lavender Fields, St Helier. • Gypsy, Roma and Traveller population in Wimbledon Park.

Channels to reach borough populations of interest in **Merton**

Borough	Highlighted Populations of interest	Key organisations/Influencers	How we communicate e.g. channels	Reach
Merton	Communities in areas of deprivation (East Merton – Figges Marsh, Pollards Hill, Lavender Fields, St Helier)	• Merton Connected • Polish Family Association • BAME Voice • Ethnic Minority Centre • Merton COVID-19 Champions • Focus 4 One • Merton Carers • Power Centre Food Bank	Email, community connectors, information sessions, newsletters Champions – face-to-face conversations, social media	~ 8,000
	Gypsy, Roma and Traveller Population	• Merton Local Authority • Friends & Families of Travellers	Community connectors/meetings	TBC
	Ghanaian Communities	- Faith and Belief Forum - Sedina Agama	Community connectors	TBC
	Polish Communities	• Polish Family Association	Email, Facebook	
	Somali Communities	• Joint Consultative Committee: Ethnic Minorities • Faith and Belief Forum • Good Goal Relief • Somali CIC	Leaflets, social media community connectors	~3000
	Tamil Communities	• Shree Ganapathy Temple • Tamil Welfare Association • Joint Consultative Committee: Ethnic Minorities	Leaflets, newsletters social media	~ 500

Wandsworth areas and populations of interest

NHS
South West London



Wandsworth has an estimated 328,828 residents, the second highest in inner London, and a growing population. Nearly half of all people living in Wandsworth are aged between 25 and 44 years old.
There are significant social inequalities affecting young people and the elderly. 36% of children are living in poverty when housing costs are accounted for.

2016 research highlighted that a quarter of people over 60 were experiencing income deprivation.

Populations of interest	• Communities in areas of deprivation • Communities with Caribbean, Indian, Pakistani, and Somali backgrounds
Focus wards	Roehampton and Putney Heath, Southfields, Graveney, Latchmere, Queenstown

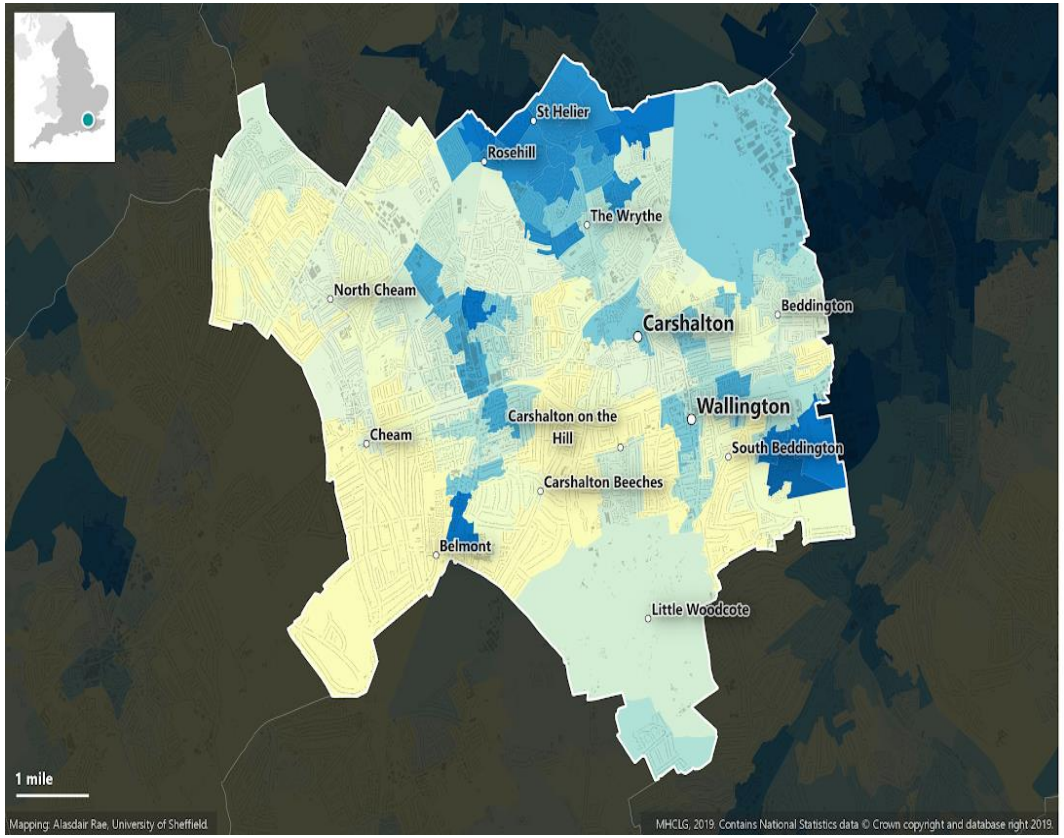
Source: English Indices of Deprivation
https://imd2019.group.shef.ac.uk/ last accessed 10/09/2020

Channels to reach borough populations of interest in **Wandsworth**

Borough	Highlighted Populations of interest	Key organisations/Influencers	How we communicate e.g. channels	Reach
Wandsworth	Communities in areas of deprivation: Roehampton and Putney Heath, Southfields, Graveney, Latchmere, Queenstown	Roehampton response Network Wandsworth Community Empowerment Network (WCEN), Wandsworth Care Alliance, MACWO, Battersea Zoomers	Councillors, local activists – face-to-face meetings and email. Council newsletters, social media, community newsletters	~10,000
	Caribbean communities	NTA Church, WCEN, A2ndVoice	Community meetings, email	~ 1000
	Indian communities	WCEN, Wandsworth Asian Carers, Khalsa Centre - Tooting	Community meetings, email, newsletters	~ 800
	Pakistani communities	WCEN, Tooting Islamic Centre, Balham Masjid, Mushkil Asaan	Community meetings, email, newsletters, social media	~ 1000
	Somali communities	Love2Learn, Elays Network, MACWO	Email, social media, community meetings	100

Sutton areas and populations of interest

NHS
South West London



- **Sutton has a population of over 200,000 and looking to increase to around 233,300 by 2024**. Growth is expected in all age bracket especially working age population of 20 – 64. Greatest change is expected in age band (75-84) followed by people aged 85 and over.
- **In Sutton, 2% of population accounts for people aged 85 and over** and working population 20–64 is projected to increase by 2024. Older people live in the more deprived
- **Sutton has become more ethnically diverse over the last decade**, with White 79%, 12% of people for Asian or Asian British ethnic groups and 9% Black or Black British from other ethnic group
- **Around 18,298 carers who live in Sutton** can be found in the most deprived wards–**St Helier, Wandle Valley and Wallington South**. Around 3,550 of carers can be classed as older carers with health conditions than majority of London Boroughs. **Sutton has the 26th highest out of 32 London Councils.**

Populations of interest	• Communities in areas of deprivation • Communities with Black British African, Indian, Polish & Bulgarian, Somali, Tamil, Gypsy, Roma and Traveller backgrounds
Focus wards	• Beddington South (inc. Roundshaw), St Helier, The Wrythe, Wandle Valley, Sutton Central, Wallington South

Channels to reach borough populations of interest in **Sutton**

Borough	Highlighted Populations of interest	Key organisations/Influencers	How we communicate e.g. channels	Reach
Sutton	Communities in areas of deprivation (Beddington South (inc. Roundshaw), St Helier, The Wrythe, Wandle Valley, Sutton Central, Wallington South)	Neighbourhood Co-ordinators	Email, Newsletter and Door to door leaflets Sutton Health Champions – via social media and watsapp	5402
	Communities in areas of deprivation (Beddington South (inc. Roundshaw), St Helier, The Wrythe, Wandle Valley, Sutton Central, Wallington South)	Neighbourhood Watch Co-ordinators	No emails, face to face and leaflet drops	1633
	Black British, Black African Communities	Sutton Community Champions SACCO	Community Connectors – Watsapp	440 500
	Indian Communities	Asian Sports & Cultural Club	Facebook	150
	Polish & Bulgarian Communities	People Arise Now	Email and meetings	100+
	Somali Communities	Sutton Tamil School & Elders	Email distribution	200

Detailed schedule to operational/financial scheme of delegation

- The delegation limits contained in this document are **the lowest level to which authority is delegated**. Delegation to lower levels is only permitted with written approval of the ICB Chief Executive Officer (CEO) who will, before authorising such delegation, consult with other senior officers as appropriate.
- Review of this Scheme of Delegation should take place at least annually and any changes approved by the Board.
- The Board remains accountable for all of its functions, including those that it has delegated. All those with delegated authority are accountable to the Board for the exercise of their delegated functions.
- The Chief Finance Officer (CFO) and Chief Nurse Officer (CNO) are noted and abbreviated where appropriate.
- Some matters require authorisation of more than one authority, for example the CEO and CFO. Where appropriate, these are indicated within the same line. Otherwise, the lowest level to which authority is delegated is taken throughout.

Reference document TBC following publications and agreement of SFIs, SOs etc	Delegated matter	Authority						
		Board	Committee	CEO	CFO	Executive directors	Heads of Service (above Band 8b)	Authorised budget holders (Band 7–8a)
	1. Management of Budgets Responsibility of keeping expenditure within budgets and agreed operating plan. Authority to spend is only extended where approved budget is available. A South West London (SWL) Integrated Care System / Place (ICS / Place) budget plan will be signed off at the beginning of each financial year which will show, where the ICS / Place has obligatory budget requirements, these are adhered to. This annual review process will also approve the financial responsibilities at Borough level, Place level and SWL level where appropriate							
	A. At individual budget level (Pay and Non-Pay)							X
	B. At service level						X	
	C. For the totality of services covered by the ICS / Place			X				
	D. For all other areas							X

	E. Approving expenditure where there is a variation to agreed operating plan or in the tender price up to 10% or £100,000 whichever is the higher					X		
	F. Approving expenditure where there is a variation to agreed operating plan or in the tender price greater than 10% or £100,000 tender price and less than 20% or £250,000, whichever is the higher			X	X			
	G. Approving expenditure where there is a variation to agreed operating plan or in the tender price greater than 20% or £250,000, whichever is the higher	X						
	2. Virements Virements may not be used to create new budgets. (For Service Level Agreement see section 9)							
	A. At individual budget level within a service up to £10,000							X
	B. At individual budget level within a service over £10,000 and < £100,000					X		
	C. Between Services up to £500,000			X	X			
	D. Services greater than £500,000	X						
	3. Business case approvals Business cases must be prepared for changes to services and/or expenditure including capital or revenue investments, procurement of services and pathway redesigns. Business cases seeking external funding must be approved by the relevant body prior to making the external request for funds.							
	A. Estimated annual cost up to £100,000					X		
	B. Estimated annual cost from £100,001 - £500,000				X			
	C. Estimated annual cost from £500,001 - £999,999		Finance Committee					
	D. Estimated annual cost from £1m above	X						
	4. Maintenance / Operation of Bank Accounts							

					X			
5. Non-Pay Revenue and Capital Expenditure Requisitioning/Ordering/payment of Goods & Services. (NB see section 9 for SLAs)								
	A. Requisitions and Orders							
	I. Stock/non stock requisitions up to £25,000							X
	II. All requisitions from £25,000 - £99,000					X		
	III. All requisitions from £99,000 - £150,000				X			
	IV. All requisitions from £150,000 - £250,000			X				
	V. All requisitions over £250,000	X						
	VI. Approval of requisitions or monthly invoices in line with signed contracts / head of terms (NB See Commissioning Expenditure section 10)							
	VII. Pharmacy orders up to £74,999					X (CNO)		
	VIII. Pharmacy orders £75,000 - £249,999					X (CNO)		
	IX. Works orders up to £74,999				X			
	X. Works orders £75,000 - £249,999				X			
	XI. Pharmacy and works orders over £250,000			X	X			
	B. Non pay expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement (subject to the limits specified above in (a))			X	X			
	C. Orders exceeding 12 month period (other than under contract)				X			
	6. Capital Schemes							
	A. Selection of architects, quantity surveyors, consultant engineer and other professional advisers within EU regulations					X		

	B. Financial monitoring and reporting on all capital scheme expenditure				X			
	C. Granting and termination of leases with annual rent <£100k				X			
	D. Granting and termination of leases with annual rent >£100k		Under Seal in consultation with Finance Committee[1]	X_1	X			
	7. Quotation, Tendering & Contract Procedures							
	A. Goods/services up to £20,000 * (Minimum of 2 verbal quotes required)						X	
	B. Goods/services from £20,000 - £75,000 * (Minimum of 3 written quotations required)					X		
	C. Goods/services from £75,000 - £100,000 * (Minimum of 3 competitive tenders required)				X	X		
	D. Goods/services from £100,000 - £200,000 * (Minimum of 3 competitive tenders required)			X and NEM under Seal				
	E. Goods/services over £200,000 * (Minimum of 6 competitive tenders required)			X and NEM under Seal				
	F. Waiving of quotations and tenders subject to Standing Financial Instructions		Waiver's >£100,000 approved by the ICB Finance Committee and reported to Audit and Risk Committee		X Waiver's <£100,000 approved by the CFO and reported to Audit and Risk Committee			
	G. Opening Tenders and Quotations							

	I. Estimated value up to £50,000						Two senior officers/managers designated by the CEO / CFO and not from the originating department	
	II. Estimated value over £50,000						Two senior officers/managers designated by the CEO / CFO and not from the originating department	
	H. Authorisation of payments to public partnership schemes under existing contracts				X			
	I. Contract variations							
	I. Variation of +/- 20% of contract value and less than £100,000					X		
	II. Variation of over 20% of contract value and/or more than £100,000				X			
	8. Setting of Fees and Charges (Income generation)							
					X			
	9. Discretionary Grants to Local Authorities/Voluntary Bodies							
	A. Discretionary Grants < £250,000					X		
	B. Discretionary Grants > £250,000 and < £500,000			X				
	C. Discretionary Grants > £500,000	X						
	10. Commissioning Expenditure							
	A. Signing Service Level Agreements (including Continuing Care) approved within Annual Budget (See					X		

	detailed financial policy for CHC authorisation limits)							
	B. NHS service level agreements: Approval of annual requisitions in line with signed service level agreements and or heads of terms < £120,000,000						X	
	C. Service level agreements: Regular monthly invoices including invoices supported by purchase orders of approved Service Level Agreements:							
	• Up to £25,000							X
	• £25,000 - £250,000					X		
	• Over £250,000				X			
	D. Further reimbursement of expenditure within approved allocation							
	• Up to £25,000							X
	• £25,000 - £99,000					X		
	• Over £99,000				X			
	E. Over / under performance of commissioning contracts							
	I. Agreement of over/under performance						X	
	II. Authorisation of over/under performance payments					X		
	F. Continuing Care							
	I. Approval of invoices < £25,000						X	
	II. Approval of invoices > £25,000					X		
	G. Non contracted activity: also subject to Section 75 where Local Authority needs to approve							
	I. Approval of invoices < £1,000							X
	II. Approval of invoices > £1,000					X		
	H. Individual Funding Requests:							

	I. < £50,000						X	
	II. > £50,000					X		
	I. GMS and PMS Expenditure							
	I. Notifying GP practices of approved annual allocation					X		
	Regular Monthly instalments schedules of approved reimbursements: II. <£20,000,000						X	
	III. >£20,000,001					X		
	IV. Further reimbursement of expenditure within approved allocation:	Further reimbursement includes. Locum Reimbursement Notional Rent Reimbursements Rent Reimbursements Extended Hours Enhanced services not on CQRS						
	• Up to £25,000							X
	• £25,000 - £99,000						X	
	• Over £99,000					X		
	V. Other Expenditure	As per non-pay delegated limits						
	J. Other Expenditure						X	
	11. Staff Posts Not On the Establishment							
	A. Permanent / Fixed Term contracts							
	I. Where aggregate commitment is less than £74,999					X		X
	II. Where aggregate commitment in any one year is more than £74,999				X			
	III. Where aggregate commitment in any one year is more than £100,000		Remuneration Committee					
	B. Appointment of Agency, Interim and Consultants				X	X		
	12. Agreements/Licences							
	A. Preparation and signature of all tenancy agreements/licences for all				X			

	staff subject to ICS / Place policy on accommodation for staff							
	B. Extensions to existing leases				X			
	C. Letting of premises to/from outside organisations			X	X			
	D. Approval of rent based on professional assessment				X			
	13. Condemning & Disposal							
	A. Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively							
	I. with current/estimated purchase price < £500					X		
	II. with current/estimated purchase price > £500 – £1,000				X			
	III. disposal of mechanical and engineering plant (subject to estimated income of less than £1,000 per sale)					X		
	IV. disposal of mechanical and engineering plant (subject to estimated income exceeding £1,000 per sale)				X			
	14. Losses, Write-off & Compensation							
	A. Losses and cash due to theft, fraud, overpayment, and others up to £50,000				X			
	B. Fruitless Payments (including abandoned Capital Schemes)							
	• up to £100,000				X			
	• Greater than 100,000 and less than £250,000			X	X			
	• Over £250,000	X						

	C. Bad Debts and Claims Abandoned. Private Patients, Overseas Visitors & Other Up to £50,000				X			
	D. damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to: Culpable causes (e.g. fraud, theft, arson) or other up to £50,000				X			
	E. Compensation payments made under legal obligation			X	X			
	F. Extra contractual payments to contractors up to £50,000				X			
	G. Extra contractual payments to contractors over £50,000	X						
	Ex gratia payments							
	H. Visitors and staff for loss of personal effects							
	• Less than £500					X		
	• Between £500 and £5,000				X			
	• Between £5,000 and £50,000			X	X			
	I. For clinical negligence up to £1,000,000 (negotiated settlements)	X						
	J. For personal injury claims involving negligence where legal advice has been obtained and guidance applied Up to £1,000,000 (including plaintiff's costs)	X						
	K. Other, except cases of maladministration where there was no financial loss by claimant - £50,000			X	X			
	L. Write off NHS debtors							
	I. Up to £250,000		Audit and Risk Committee		X			

	II. Greater than £250,000		Audit and Risk Committee	X	X			
	M. Write off Non-NHS debtors							
	I. Up to £250,000		Audit and Risk Committee		X			
	II. Greater than £250,000		Audit and Risk Committee	X	X			
	15. Reporting of Incidents to the Police							
	A. Where a criminal offence is suspected							
	I. Criminal offence of a violent nature			X		X		
	II. Theft					X		
	III. Other					X		
	B. Where a fraud is involved (following referral to the Counter Fraud service)				X			
	C. Where an incident occurs out of normal working hours						X	
	16. Receiving Hospitality							
	Applies to both individual and collective hospitality receipt items. In excess of £25 per item received.	Declaration required in Gifts and Hospitality Register						
	17. Implementation of Internal and External Audit Recommendations							
						X		
	18. Maintenance & Update of ICS / Place Financial Procedures							
						X		
	19. Investment of Funds							
						X		
	20. Personnel & Pay							

	A. Authority to fill funded post on the establishment with permanent staff					X		X
	B. Authority to appoint staff not on the formal establishment	In line with limits set out at section 11						
	C. Additional Increments							
	I. The granting of additional increments to staff within budget				X		X	
	D. Regrading (upgrading and downgrading)							
	I. All requests for regrading shall be dealt with in accordance with ICS / Place Establishment Control procedures				X		X	
	E. Establishments							
	I. Authority to complete forms affecting pay, new starters, variations and leavers				X	X		
	II. Authority to complete and authorise sick absence reporting forms							X
	III. Authority to authorise overtime					X		
	IV. Authority to authorise travel and subsistence expenses							X
	V. Approval of Pay Awards (AfC and non AfC)		Non AfC pay awards - Remuneration Committee / Board			X - AfC pay awards		
	F. Payroll Deductions							
	I. PAYE, NIC & Pension Payments < £500k						X	
	II. Payment requests < £100,000						X	
	G. Leave							
	I. Approval of annual leave							X - Line/Departmental Manager

	II. Annual leave – approval of carry forward up to a maximum of 5 days							X - Line/Departmental Manager
	III. Annual Leave – approval of carry forward in excess of 5 days but less than 10 days (except maternity and sickness accruals)					X		
	IV. Annual Leave – approval to carry forward 10 days or more (except maternity and sickness accruals)			X				
	V. Annual Leave – payment in Place of carry forward			X				
	VI. Compassionate leave up to 3 days							X - Line/Departmental Manager
	VII. Compassionate leave up to 5 days					X		
	VIII. Special leave arrangements							
	• Statutory / National Terms and Conditions for Parental Leave (includes maternity, adoption, parental and shared parental leave) – Paid and Unpaid							X - Line Manager within guidance
	• Carers leave (up to 5 days)							X - Line/Departmental Manager
	IX. Leave without pay					X		X - Line/Departmental Manager
	X. Time off in lieu							X - Line/Departmental Manager
	H. Sick Leave							
	I. Extension of sick pay outside national terms and conditions			X	X			
	II. Phased return to work part time on full pay to assist recovery					X		
	I. Study Leave							

	I. Study Leave outside the UK			X				
	II. All other study leave (UK)					X		
	J. Authorisation of mobile devices Requests for mobile telephones					X		
	K. Renewal of Fixed Term Contract • Under two years • Over two years			X (over 2 years)	X (over 2 years)	X (under 2 years)		
	L. Staff Retirement Policy							
	Authorisation of retire and return or any other retirement options					X		
	M. Redundancy							
	• Estimated cost up to £10,000				X			
	• Estimated cost over £10,000			X				
	N. Ill Health Retirement							
	Decision to pursue retirement on the grounds of ill-health					X		
	O. Dismissal					X		
	21. Authorisation of New Drugs							
	• Estimated total yearly cost up to £25,000						X	
	• Estimated total yearly cost above £25,000					X	X	
	22. Authorisation of Sponsorship Deals							
				X				
	23. Authorisation of Research Projects							
				X				
	24. Authorisation of Clinical Trials							
				X				
	25. Insurance Policies and Risk Management							
				X	X			

	26. Patients' and Relatives' Complaints In conjunction with complaints policy							
	A. Overall responsibility for ensuring that all complaints are dealt with effectively			X				
	B. Responsibility for ensuring complaints relating to a Directorate are investigated thoroughly						X	
	C. Medico-Legal Complaints – Co-ordination of their management						X	
	27. Infectious Diseases and Notifiable Outbreaks							
				X		X		
	28. Extended Role Activities							
	Approval of Nurses to undertake duties/procedures which can properly be described as beyond the normal scope of Nursing Practice			X		X		
	29. Facilities for staff not employed by the ICS / Place e.g. honorary contract or work experience							
	I. Honorary Contracts and other Memorandums of Understanding						X	
	II. Work Experience students						X	
	30. Review of Fire Precautions							
							X	
	31. Review of all statutory compliance legislation and Health & Safety requirements							
							X	
	32. Review of Medicines Inspectorate Regulations							
						X		
	33. Review of compliance with environmental regulations							
							X	
	34. Review of ICS / Place's compliance with the Data Protection Act and General Data Protection Regulations							

				X				
	35. Monitor proposals for contractual arrangements between the ICS / Place and outside bodies							
				X	X			
	36. Review the ICS / Place's compliance with the Access to Records Act							
				X				
	37. Review of the ICS / Place's compliance with the Code of Practice for handling confidential information in the contracting environment and the compliance with "safe haven" per EL 92/60							
				X				
	38. The Keeping of a Declaration of Interests Register							
							X	
	39. Attestation of Sealings in accordance with Standing Orders							
		X		X				
	40. The Keeping of a register of Sealings							
							X	
	41. The Keeping of the Hospitality Register							
							X	
	42. Retention of Records							
							X	
	43. Clinical Audit							
						X		
	44. Responsible officers for medical revalidation, evaluation of fitness to practice and monitoring the conduct and performance of doctors							
						X		
	45. Responsible officers for other clinical revalidation, evaluation of fitness to practice and monitoring the conduct and performance of clinical staff							
						X		

NHS South West London
Integrated Care Board

List of SWL policies

ICB Policy review and development

1. The table below provides a list of all of the policies the ICB will adopt from 1 July 2022.

2. All policies have been reviewed as part of the transition process to the ICB. The majority of policies have simply been updated to reflect the transition between CCG and ICB, in particular to incorporate ICB-related language. Over the six months of operation all Executive Director leads will be asked to review their policies to ensure they are up to date and fit for purpose following the creation of the ICB.

Executive Lead	Policy
Chief Nursing Officer	Safeguarding Adults Policy
	Safeguarding Children Policy
	Continuing Healthcare Operational Policy
	Patient Choice Policy
	Continuing Healthcare Choice & Equity Policy
	Serious Incident Policy
	Personal Health Budget Policy
	Mental Capacity Act and Deprivation of Liberty Policy
Chief Operating Officer	Individual Funding Requests Policy
	Evidence Based Interventions Policy
Deputy Chief Executive Officer and Director of People and Transformation	Managing Conflicts of Interests (including Gifts and Hospitality) Policy
	Standards of Business Conduct Policy
	Scheme of Reservation and Delegation
	Risk Management Framework
	Complaints Policy
	Health & Safety Policy
	Fire Policy
	Grievance Policy
	Maternity, Paternity and Adoption Leave Policy
	Recruitment & Selection Policy
	Sickness Absence Policy
	Smart Working Policy
	Alcohol & Substance Misuse
	Annual Leave & Special Leave Policy
	Capability Policy & Procedure
	Dignity at Work Policy (incorporating Bullying and Harassment at Work)
	Disciplinary Policy and Procedure
	Flexible Working Policy
	Freedom to Speak Up: Raising Concerns (Whistleblowing Policy)
	Change Management Policy
	IT Security Policy
	IT Acceptable Use Policy
	Mobile Device & Sim Card Policy

	Information Governance Framework
	Information Security Policy
	Information Quality Policy
	Information Governance Policy
	Information Management Policy
	Confidentiality Policy
	Confidentiality Code of Conduct
	IG Incident Reporting Policy
	Freedom of Information Policy
Executive Director of Communications, Engagement and Strategic Stakeholder Relations	Social Media Policy
Chief Finance Officer	SFIs / Prime Financial Policies
	Anti-Fraud and Bribery Policy
	Contract & Procurement Policy
	Detailed Scheme of Delegation

NHS South West London
Integrated Care Board

South West London ICB Board Membership and Appointments

Supporting Annexes

Paper 3 Annex A Letter seeking approval to appoint the Board Partner Members

Paper 3 Annex B Letter confirming appointment of the Board Partner Members

Paper 3 Annex A

South West London
Clinical Commissioning Group

120 The Broadway
Wimbledon
London SW19 1RH

10 June 2022

Dear Millie,

Recommendation of appointment: Partner and Place Members for the ICB Board

As you know, we launched the process to appoint our Partner Member Board roles on the 12th of May. The nominations process for NHS and Place members closed on the 27th of May and the selection panel met to consider these applications on the 1st and 9th of June. Following this process, please find below a breakdown of the panel's recommended candidates by role.

Interviews for the Local Authorities and Place Member (Sutton) roles will conclude in the week commencing 27 June 2022. I will update you following the conclusion of that process.

Role	Recommended candidate	Title / Organisation
Partner Member – Primary Medical Services	Dr Nicola Jones	GP Partner in Wandsworth, Transition Place Lead, Wandsworth Clinical Lead for Primary Care, and Cardiology Network, SW London.
Partner Member – Specialised Services	Dame Cally Palmer	Chief Executive Officer, The Royal Marsden NHS FT.
Partner Member – Acute Services	Jacqueline Totterdell	Chief Executive Officer. St George's University Hospitals NHS FT, and Epsom and St Helier University Hospital NHS Trust.
Partner Member – Mental Health Services	Vanessa Ford	Chief Executive, South West London and St George's Mental Health NHS Trust.
Partner Member – Community Services	Jo Farrar	Chief Executive, Hounslow and Richmond Community Healthcare NHS Trust.
Place Member - Croydon	Matthew Kershaw	Chief Executive, Croydon Health Services and Place-based Leader for Health.

Place Member - Kingston	Dr Annette Pautz	GP Partner in Kingston and Kingston Place Provider Lead for Primary Care.
Place Member - Merton	Dr Dagmar Zeuner	Director of Public Health, London Borough of Merton.
Place Member - Richmond	Ian Dodds	Director of Children's Services, Royal Borough of Kingston upon Thames and London Borough of Richmond of Thames.

I would be grateful if you can confirm your agreement, as Chair, to the appointment of these designate Partner Members, prior to the Board members being substantively appointed on 1 July 2022.

Yours sincerely

Sarah Blow
Designate Chief Executive Officer, NHS South West London Integrated Care Board and Accountable Officer, South West London CCG.

Paper 3 Annex B

South West London
Clinical Commissioning Group

120 The Broadway
Wimbledon
London
SW19 1RH

17 June 2022

Dear Sarah,

Appointment of Partner and Place Members for the SWL Integrated Care Board

Thank you for your letter of 10 June 2022 which listed the Appointment Panel's recommendations for the Integrated Care Board's designate Partner and Place Members.

I am writing to confirm my agreement, as ICB Designate Chair, to the appointment of all recommended candidates. I note that we have not been able to appoint to all of roles as yet but that processes are underway to fill these vacancies.

I will arrange for letters of appointment to be sent to all successful candidates with effect from 1 July 2022.

Thank you to you and the panel members for your work to support the creation of the ICB.

Yours sincerely

Millie Banerjee
Designate Chair,
NHS South West London Integrated Care Board

NHS South West London
Integrated Care Board

Committee Structure and Terms of Reference

Supporting Annexes

Paper 4 Annex A Remuneration & Nominations Committee Terms of Reference

Paper 4 Annex B Audit and Risk Committee Terms of Reference

Paper 4 Annex C Finance and Planning Committee Terms of Reference

Paper 4 Annex D Quality and Oversight Committee Terms of Reference

Paper 4 Annex E Place Committee Terms of Reference

Paper 4 Annex A

NHS South West London
Integrated Care Board

NHS South West London Integrated Care Board

Remuneration and Nominations Committee

Terms of Reference

Document Management

Revision history

Version	Date	Summary of changes
1.0	07.06.22	ToR presented to GoG

Reviewers

This document must be reviewed by the following:

Reviewer	Title / responsibility	Date	Version
Governance Oversight Group	To oversee the development of the ICB constitutions	n/a	All versions

Approved by

This document must be approved by the following people:

Name	Signature	Title	Date	Version
ICB Board				
Sarah Blow		ICS CEO Designate	07.06.22	1.0
Millie Banerjee		ICS Chair Designate	07.06.22	1.0

Contents

1. Constitution

1.1 The Remuneration and Nominations Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution, Standing Financial Instructions, Standing Orders and Scheme of Reservation and Delegation (SoRD).

1.2 These Terms of Reference (ToR) set out the membership, remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the Board. They will be published as part of the Governance Handbook on the ICB's website.

1.3 The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. Authority

2.1 The Committee is authorised by the Board to:

- Investigate any activity within its ToR;
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the committee) within its remit as outlined in these terms of reference;
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by the ICB for obtaining legal or professional advice;
- Create task and finish sub-groups, if required, in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and SoRD but may not delegate any decisions to such groups.

2.2 For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the SoRD will prevail over these ToR other than the Committee being permitted to meet in private.

2.3 The Committee does not have authority to set the Chair remuneration or terms of appointment. These will be determined by NHS England.

3. Purpose

3.1 The Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006. In summary:

- Confirm the ICB Pay Policy including adoption of any pay frameworks for all employees including very senior managers/directors (including board members) and Non-Executive Members[1] excluding the Chair.

The Board has also delegated the following functions to the Committee:

- Ensuring the ICB follows national pay and terms and condition frameworks to set the pay policy for ICB employees.
- Setting remuneration, allowances and terms and conditions for the Chief Executive and Very Senior Managers (VSMs) in line with national guidance.
- Setting remuneration, allowances and terms and conditions for Integrated Care Board members.
- Agreeing any discretionary payments or terms and conditions for staff employed by the ICB.
- Approving any termination or redundancy payments.
- Approving TUPE or other staff transfers into or out of the ICB.
- Setting the ICB pay policy and standard terms and conditions of employment for all individuals appointed by the ICB as clinical leads, workers, office holders (this may include pensions, remuneration, fees, travelling or other allowances payable), and any pay awards for these individuals.
- Oversight of the nominations and appointments to Integrated Board member roles.

3.2 As outlined in section 2, the Committee may choose to delegate some of these functions to Task and Finish or Working Groups

4. Responsibilities of the Committee

Specific responsibilities of the Committee include:

For the Chief Executive, Directors and other Very Senior Managers:

4.1 Determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses, and other additional benefits.

4.2 Through the Chairman provide feedback on the Chief Executive's performance so as to support the monitoring and evaluation of their performance.

4.3 Through the Chief Executive provide feedback on Directors' performance so as to support the monitoring and evaluation of their performance.

[1] When determining SWL non-executive Board member remuneration the ICB Chair, Chief Executive and either a NHSE or SWL System representative will meet. Non Executive Members will not be involved in discussion about their own pay.

4.4 To consider and approve proposals to establish any new management posts at Band 9 of the NHS national pay band.

4.5 To oversee and advise the Board on arrangements for redundancy, termination payments, the use of Pay in Lieu of Notice proposals or any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate.

For ICB Board Members:

4.6 Determine remuneration, allowances and terms and conditions for Integrated Care Board members.

4.7 To be responsible for determining which Executive Directors are members of the ICB Board.

4.8 To assess and then agree the specialist experience and skills required for Non-Executive appointments on behalf of the Board before advertisement.

For all staff:

4.9 Determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change).

4.10 Determine the arrangements for redundancy, termination payments, the use of Pay in Lieu of Notice proposals or any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate.

4.11 Agree any discretionary payments or terms and conditions for staff employed by the ICB.

Additional functions included in the scope of the committee include:

4.12 Setting the ICB pay policy and standard terms and conditions of employment for all individuals appointed by the ICB as clinical leads, workers, office holders (this will include pensions, remuneration, fees, travelling or other allowances payable), and any pay awards for these individuals.

4.13 Assurance in relation to ICB statutory duties relating to people such as compliance with employment legislation including such as Fit and proper person regulation (FPPR).

4.14 To act as a nominations committee for appointments to the Chief Executive and other Executive Director posts.

4.15 Approving TUPE or other staff transfers into or out of the ICB.

5. Membership and attendance

Membership

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

5.2 The Board will appoint no fewer than three members of the Committee including two independent Non-Executive Members of the Board. Other members of the Committee need not be members of the board, but they may be.

5.3 The Chair of the Audit and Risk Committee may not be a member of the Committee.

5.4 The Chair of the Board will be a member of the Committee but will not be appointed as the Chair.

5.5 Members are required to attend a minimum of 75% of meetings, other than absence due to sickness.

5.6 Members will possess between them knowledge, skills and experience in the issues pertinent to the Committee's business. When determining the membership of the Committee, active consideration will be made to equality and diversity.

Chair and vice chair

5.7 The Committee will be chaired by an independent Non-Executive Member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.

5.8 Committee members may appoint a Vice Chair from amongst the members.

5.9 The Vice Chair will be nominated by the Chair of the Committee. If the Committee Chair is absent or is disqualified from participating by a conflict of interest, the Vice Chair, if present, shall preside. If the Chair or Vice Chair are absent from any meeting, a Chair shall be nominated by other members attending that meeting.

5.10 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

Attendees

5.11 Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

5.12 Meetings of the Committee may also be attended by the following individuals who are not members of the Committee for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote:

- The ICB's most senior HR Advisor or their nominated deputy;

- Chief Finance Officer or their nominated deputy;
- Chief Executive or their nominated deputy;
- Executive Director with responsibility for workforce.

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

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

5.15 No individual should be present during any discussion relating to:

a. Any aspect of their own pay;

b. Any aspect of the pay of others when it has an impact on them

6. Meeting Frequency, Quoracy and Decisions

6.1 The Committee will meet in private.

6.2 The Committee will meet at least once each year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

6.3 The Board, Chair or Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

6.4 The Committee may choose to meet physically, at its discretion. However, by default, the Committees will be held virtually. Meetings, unless previously agreed by the Chair, will be held virtually via MS Teams or suitable alternative platform.

Quorum

6.5 For a meeting to be quorate a minimum of two of the Non-Executive Members is required, including the Chair or Vice Chair.

6.6 When considering Non-Executive Member remuneration, for a meeting to be quorate a minimum of the ICB Chair, Chief Executive and the ICB's most senior HR Advisor or their nominated deputy are required for the purpose of these discussions. Non-Executive Members will not be present for these discussions.

6.7 If any member of the Committee has been disqualified from participating on item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

6.8 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

6.9 Decisions will be guided by national NHS policy and best practice to ensure that staff are fairly motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency.

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

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

6.12 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

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

7. Accountability and reporting

7.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

7.2 The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board (in the private session) in accordance with the Standing Orders.

7.3 The Committee will submit copies of its minutes and a report to the Board following each of its meetings. Where minutes and reports identify individuals, they will not be made public and will be presented at part B (in the private session) of the Board. Public reports will be made as appropriate to satisfy any requirements in relation to disclosure of public sector executive pay.

7.4 The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

8. Conflicts of Interest

8.1 Conflicts of Interest shall be dealt with in accordance with the ICB Conflicts of Interest Policy.

8.2 The Committee will have a Conflicts of Interest Register that will be presented as a standing item on the agenda.

8.3 All members and attendees of the Committee must declare any relevant personal, non-personal, pecuniary or potential interests at the commencement of any meeting. The Committee Chair will determine if there is a conflict of interest such that the member and/or attendee will be required not to participate in a discussion.

9. Behaviours and Conduct

Benchmarking and guidance

9.1 The Committee will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

ICB values

9.2 Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

9.3 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

9.4 Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

10. Secretariat and Administration

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

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

11. Review

11.1 The Committee will review its effectiveness at least annually and recommend any changes it considers necessary to the Board.

11.2 These ToR will be reviewed at least annually and more frequently if required. Any proposed amendments to the ToR will be submitted to the Board for approval.

Date of approval: 1 July 2022

Date of next review: 30 June 2023

Paper 4 Annex B

NHS South West London
Integrated Care Board

NHS South West London Integrated Care Board

Audit and Risk Committee

Terms of Reference

Document Management

Revision history

Version	Date	Summary of changes
1.0	07.06.22	ToR presented to GoG

Reviewers

This document must be reviewed by the following:

Reviewer	Title / responsibility	Date	Version
Governance Oversight Group	To oversee the development of the ICB constitutions	n/a	All versions

Approved by

This document must be approved by the following people:

Name	Signature	Title	Date	Version
ICB Board				
Sarah Blow		ICS CEO Designate	07.06.22	1.0
Millie Banerjee		ICS Chair Designate	07.06.22	1.0

Contents

1. Constitution

1.1 The Audit and Risk Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution, Standing Financial Instructions, Standing Orders and Scheme of Reservation and Delegation (SoRD).

1.2 These Terms of Reference (ToR) set out the membership, remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the Board. They will be published as part of the Governance Handbook on the ICB's website.

1.3 The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. Authority

2.1 The Committee is authorised by the Board to:

- Investigate any activity within its ToR;
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these ToR;
- Commission any reports it deems necessary to help fulfil its obligations;
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so, the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice;
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and ToR of any such task and finish sub-groups in accordance with the ICB's Constitution, Standing Orders and SoRD but may not delegate any decisions to such groups.

2.2 For the avoidance of doubt, the Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD,.

2.3 The Committee has no executive powers, other than those delegated in the SoRD and specified in these ToR

3. Purpose

3.1 To contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.

3.2 The duties of the Committee will be driven by the organisation's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year; however this will be flexible to new and emerging priorities and risks.

4. Responsibilities of the Committee

4.1 The Committee's duties are as follows:

Integrated governance, risk management and internal control

4.2 To review the adequacy and effectiveness of the system of integrated governance, risk management and internal control across the whole of the ICB's activities that support the achievement of its objectives, and to highlight any areas of weakness to the Board.

4.3 To ensure that financial systems and governance are established which facilitate compliance with DHSC's Group Accounting Manual.

4.4 To review the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of the ICB's objectives, the effectiveness of the management of principal risks.

4.5 To have oversight of system risks where they relate to the achievement of the ICB's objectives.

4.6 To ensure consistency that the ICB acts consistently with the principles and guidance established in HMT's Managing Public Money.

4.7 To seek reports and assurance from directors and managers as appropriate, concentrating on the systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

4.8 To identify opportunities to improve governance, risk management and internal control processes across the ICB.

4.9 To have oversight of urgent decisions exercised by the Board.

Internal Audit

4.10 To ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved;
- Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework;
- Considering the major findings of internal audit work, including the Head of Internal Audit Opinion, (and management's response), and ensure coordination between the internal and external auditors to optimise the

use of audit resources;

- Approve the appointment of the ICB's internal auditor service;
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation; and
- Monitoring the effectiveness of internal audit and carrying out an annual review.

External Audit

4.11 To review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit;
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan;
- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee; and
- Reviewing all external audit reports, including to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

Other assurance functions

4.12 To review the findings of assurance functions in the ICB, and to consider the implications for the governance of the ICB.

4.13 To review the work of other committees in the ICB, whose work can provide relevant assurance to the Audit and Risk Committee's own areas of responsibility.

4.14 To review the assurance processes in place in relation to financial performance across the ICB including the completeness and accuracy of information provided.

4.15 To review the findings of external bodies and consider the implications for governance of the ICB. These will include, but will not be limited to:

- Reviews and reports issued by arm's length bodies or regulators and inspectors: e.g. National Audit Office, Select Committees, NHS Resolution, CQC; and
- Reviews and reports issued by professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges and accreditation bodies).

Counter fraud

4.16 To assure itself that the ICB has adequate arrangements in place for counter fraud, bribery and corruption (including cyber security) that meet NHS Counter Fraud Authority's (NHSCFA) standards and shall review the outcomes of work in these areas.

4.17 To review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans, provide direct access and liaison with those responsible for counter fraud, review annual reports on counter fraud, and discuss NHSCFA quality assessment reports.

4.18 To ensure that the counter fraud service provides appropriate progress reports and that these are scrutinised and challenged where appropriate.

4.19 To be responsible for ensuring that the counter fraud service submits an Annual Report and Self-Review Assessment, outlining key work undertaken during each financial year to meet the NHS Standards for Commissioners; Fraud, Bribery and Corruption.

4.20 To report concerns of suspected fraud, bribery and corruption to the NHSCFA.

Freedom to Speak Up

4.21 To review the adequacy and security of the ICB's arrangements for its employees, contractors and external parties to raise concerns, in confidence, in relation to financial, clinical management, or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.

Information Governance (IG)

4.22 To receive regular updates on IG compliance (including uptake & completion of data security training), data breaches and any related issues and risks.

4.23 To review the annual Senior Information Risk Owner (SIRO) report, the submission for the Data Security & Protection Toolkit and relevant reports and action plans.

4.24 To receive reports on audits to assess information and IT security arrangements, including the annual Data Security & Protection Toolkit audit.

4.25 To provide assurance to the Board that there is an effective framework in place for the management of risks associated with information governance.

Financial reporting

4.26 To monitor the integrity of the financial statements of the ICB and any formal announcements relating to its financial performance.

4.27 To ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

4.28 To review the annual report and financial statements (including accounting policies) before submission to the Board focusing particularly on:

- The wording in the Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
- Changes in accounting policies, practices and estimation techniques;
- Unadjusted mis-statements in the Financial Statements;
- Significant judgements and estimates made in preparing of the Financial Statements;
- Significant adjustments resulting from the audit;
- Letter of representation; and
- Qualitative aspects of financial reporting.

Conflicts of Interest

4.29 The Chair of the Audit and Risk Committee will be the nominated Conflicts of Interest Guardian.

4.30 The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

Management

4.31 To request and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

4.32 The Committee may also request specific reports from individual functions within the ICB as they may be appropriate to the overall arrangements.

4.33 To receive reports of breaches of policy and normal procedure or proceedings, including such as suspensions of the ICB's standing orders, in order provide assurance in relation to the appropriateness of decisions and to derive future learning.

Communication

4.34 To co-ordinate and manage communications on governance, risk management and internal control with stakeholders internally and externally

4.35 To develop an approach with other committees, including the Integrated Care Partnership, to ensure the relationship between them is understood.

5. Membership and attendance

Membership

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

5.2 The Board will appoint no fewer than three members of the Committee comprising three Non-Executive Members of the Board. Other members of the Committee need not be members of the Board, but they may be.

5.3 Members are required to attend a minimum of 75% of meetings, other than absence due to sickness.

5.4 Members may nominate deputies to represent them in their absence and make decisions on their behalf, subject to the approval of the Chair.

5.5 Neither the Chair of the Board, nor employees of the ICB will be members of the Committee.

5.6 Members will possess between them knowledge, skills and experience in: accounting, risk management, internal, external audit; and technical or specialist issues pertinent to the ICB's business. When determining the membership of the Committee, active consideration will be made to diversity and equality.

Chair and vice chair

5.7 The Committee will be chaired by a Non-Executive Member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.

5.8 The Chair of the Committee shall be independent and therefore may not chair any other committees. In so far as it is possible, they will not be a member of any other committee.

5.9 Committee members may appoint a Vice Chair who will be nominated by the Chair of the Committee. If the Committee Chair is absent or is disqualified from participating by a conflict of interest, the Vice Chair, if present, shall preside. If the Chair or Vice Chair are absent from any meeting, a Chair shall be nominated by other members attending that meeting.

5.10 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

Attendees

5.11 The Committee shall have the following non-voting attendees (as and when required):

- Chief Finance Officer or their nominated deputy;
- Senior Governance Advisor;
- Representatives of both internal and external audit;

- Individuals who lead on risk management and counter fraud matters;
- Other directors and/or managers as appropriate.

5.12 Attendees may present at meetings and contribute to the relevant discussions but are not allowed to participate in any formal vote.

5.13 Attendees may nominate deputies to represent them in their absence, with agreement of the Chair.

5.14 Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Board(s), Secondary and Community Providers.

5.15 The Committee may invite or allow people to attend meetings as observers. Observers may not present at meetings, contribute to any discussion or participate in any formal vote.

5.16 The Chief Executive should be invited to attend the meeting at least annually.

5.17 The Chair of the ICB may also be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.

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

Access

5.19 Regardless of attendance, External Audit, Internal Audit, Local Counter Fraud and Security Management providers will have full and unrestricted rights of access to the Committee.

6. Meeting Frequency, Quoracy and Decisions

6.1 The Committee will meet five times in its first year and arrangements and notice for calling meetings are set out in the Standing Orders. After the first year the Committee will meet a minimum of 4 times a year. Additional meetings may take place as required.

6.2 The Board, Chair or Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

6.3 The Committees may choose to meet physically, at its discretion. However, by default, the Committees will be held virtually. Meetings, unless previously agreed by the Chair, will be held virtually via MS Teams or suitable alternative platform.

Quorum

6.4 For a meeting to be quorate a minimum of two Non-Executive Members of the Board are required, including the Chair or Vice Chair of the Committee.

6.5 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

6.6 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

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

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

6.9 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

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

7. Accountability and reporting

7.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

7.2 The Committee shall make any such recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.

7.3 The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board (in the private session) in accordance with the Standing Orders.

7.4 The Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

7.5 The Committee will provide the Board with an Annual Report, timed to support finalisation of the accounts and the Governance Statement. The report will summarise its conclusions from the work it has done during the year specifically commenting on:

- The fitness for purpose of the assurance framework;
- The completeness and 'embeddedness' of risk management in the organisation;

- The integration of governance arrangements;
- The appropriateness of the evidence that shows the organisation is fulfilling its regulatory requirements; and
- The robustness of the processes behind the quality accounts.

8. Conflicts of Interest

8.1 Conflicts of Interest shall be dealt with in accordance with the ICB Conflicts of Interest Policy.

8.2 The Committee will have a Conflicts of Interest Register that will be presented as a standing item on the agenda.

8.3 All members and attendees of the Committee must declare any relevant personal, non-personal, pecuniary or potential interests at the commencement of any meeting. The Committee Chair will determine if there is a conflict of interest such that the member and/or attendee will be required not to participate in a discussion.

9. Behaviours and Conduct

ICB values

9.1 Members will be expected to conduct business in line with the ICB values and objectives.

9.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

9.3 Members must demonstrably consider the equality and diversity implications of decisions they make.

10. Secretariat and Administration

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

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
- Good quality minutes are taken in accordance with the Standing Orders

and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward between meetings, and progress against those actions is monitored;

- The Chair is supported to prepare and deliver reports to the Board; and
- The Committee is updated on pertinent issues / areas of interest / policy developments;

11. Review

11.1 The Committee will review its effectiveness at least annually and recommend any changes it considers necessary to the Board.

11.2 These ToR will be reviewed at least annually and more frequently if required. Any proposed amendments to the ToR will be submitted to the Board for approval.

11.3 In the first year the committee will review the ToR after 6 months to ensure they are fit for purpose.

Date of approval: 1 July 2022

Date of next review: 31 December 2022

Paper 4 Annex C

NHS South West London
Integrated Care Board

NHS South West London Integrated Care Board

Finance and Planning Committee

Terms of Reference

Document Management

Revision history

Version	Date	Summary of changes
1.0	07.06.22	ToR presented to GoG

Reviewers

This document must be reviewed by the following:

Reviewer	Title / responsibility	Date	Version
Governance Oversight Group	To oversee the development of the ICB constitutions	n/a	All versions

Approved by

This document must be approved by the following people:

Name	Signature	Title	Date	Version
ICB Board				
Sarah Blow		ICS CEO Designate	07.06.22	1.0
Millie Banerjee		ICS Chair Designate	07.06.22	1.0

Contents

1. Constitution

1.1 The Finance and Planning Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution, Standing Financial Instructions, Standing Orders and Scheme of Reservation and Delegation (SoRD).

1.2 These Terms of Reference (ToR) set out the membership, remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the Board. They will be published as part of the Governance Handbook on the ICB's website.

2. Authority

2.1 The Committee is authorised by the Board to:

- Investigate any activity within its ToR;
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these ToR;
- Commission any reports it deems necessary to help fulfil its obligations;
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so, the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice;
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and ToR of any such task and finish sub-groups in accordance with the ICB's Constitution, Standing Orders and SoRD but may not delegate any decisions to such groups.

2.2 For the avoidance of doubt, the Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD, except as outlined in these ToR.

2.3 The Committee has no executive powers, other than those delegated in the SoRD and specified in these ToR.

3. Purpose

3.1 The Committee is established to ensure that there is both a robust financial strategy and planning framework in place and to oversee the system planning and broader financial management.

3.2 The duties of the Committee will be driven by the organisation's objectives and the associated risks. An annual programme of business will be agreed before

the start of the financial year; however this will be flexible to new and emerging priorities and risks.

4. Responsibilities of the Committee

4.1 The Committee's duties can be categorised as follows:

System responsibilities

4.2 Provide assurance to the Board of performance against system control total by scrutiny of financial and planning strategy, strategic and operational financial and non-financial plans, and the current and forecast financial position of the overall ICS.

4.3 As part of the ICB's performance management role, alongside the Quality and Oversight Committee operate an ICS Performance Framework that enables the Committee to proactively manage the financial, broader performance, and savings agenda across the system, and to assess the performance against the system control total, including:

- Receiving a report of the in-year financial position, performance and progress towards meeting targets within each organisation's / collaborative's financial plans (both revenue and capital); and
- Review the delivery of the system plans at least on a 6 monthly basis to ensure that plans are being achieved and where not review the proposed mitigations: review of plans would be more frequent where targets are not being met.

4.4 Oversight and approval of the process by which the ICS allocates the annual resource to stakeholders (partners), including both revenue and capital.

4.5 As part of the annual planning process alongside the Quality and Oversight Committee ensure oversight of financial and planning performance, focusing on oversight of the delivery of ICB-wide efficiency savings, performance and system control total, including:

- With the Quality and Oversight Committee ensure that workforce, finance, quality plans are sufficiently aligned and balanced to meet the needs of the system and system risks identified sufficiently early with the planning process;
- Ensure that the system has a clear and robust approach to planning incorporating both Place and Providers/Collaboratives to jointly own and agree the system planning principles and associated planning cycle;
- Review the system annual report to ensure that this accurately reflects planning delivery, any outstanding items are reflected in the following years planning cycle and where necessary reviewed;
- Ensure that the balance of system planning priorities are considered at a strategic level and where necessary consideration of the risks to the

system are fully considered and reported to the Board and ICP; and

- Ensure that the annual business planning process for the system is aligned to the annual planning process assessing Place and Collaborative plans and that these are sufficient to meet the overall agreed system strategic objectives.

ICB responsibilities

4.6 Oversee the arrangements in place for the allocation of resources and the scrutiny of all expenditure. This will include actual and forecast expenditure and activity on commissioning contracts, ensuring budgets are set, in line with planning cycle and managed in an appropriate and timely manner. This will also include planning for the year ahead.

4.7 Consider and review ongoing Financial Reports and the Annual Statement to be presented to the Board, incorporating financial and planning performance against budget, targets, financial risk analysis, forecasts, and statements on the rigor of underlying assumptions, to ensure statutory financial duties are met.

4.8 Review delivery of savings plans and initiatives through regular reports. Understand the drivers behind any variances against the plans, and ensure any risks have been identified, and mitigating actions have been taken to address these.

4.9 With the Quality and Oversight Committee operate a Performance Framework that enables the Committee to proactively manage the financial, broader performance, and savings agenda, including:

- Receiving a report of the in-year financial position and progress towards meeting targets within each Place;
- Overseeing savings schemes and updates on both the financial and activity performance of each scheme;
- Overseeing implementation of investments/transformation schemes, receiving updates outlining financial activity and delivery against KPIs for each scheme;
- Management of system risks to mitigate their impact; and
- Providing assurance to the Board about delivery and sustained performance in these areas.

4.10 Proactively identify from reports where remedial action is required, and ensure appropriate action is taken.

4.11 Where plans are in place to improve performance or reduce financial risks, ensure that progress against plans is monitored, and where appropriate, challenged.

4.12 With the Quality and Oversight Committee identify the need for, and allocate resources where appropriate, to improve performance.

4.13 Provide assurance to the Board and the Audit and Risk Committee of the completeness and accuracy of the financial information provided to the Board.

4.14 Consider and review any external financial monitoring returns and commentary.

4.15 Review, by exception, performance report summaries as required, and consider performance issues in so far as they impact on financial resource.

4.16 Review, scrutinise and recommend business cases (prepared for changes to services and/or expenditure including capital or revenue investments, procurement of services and pathway redesigns) for approval to the Board with an estimated annual cost of £1m and above.

4.17 Review and approve business cases with an estimated annual cost from £500,001 – to £999,999.

4.18 Review, and agree, procurement decisions as appropriate, in accordance with Standing Financial Instructions and the Scheme of Delegation and make recommendation to the Board.

4.19 Recommend to the Board the thresholds above which quotations or formal tenders should be obtained.

4.20 Review tender waivers and tenders from firms not on approved lists and ensure these are reported to the Board and Audit and Risk Committee. Waiver's valued at more than £100,000 must be approved by the Financial and Performance Committee and reported to Audit and Risk Committee, waiver's valued at less than £100,000 must be approved by the Chief Finance Officer and reported to Audit and Risk Committee.

4.21 Work alongside the Audit and Risk Committee to ensure financial probity in the organisation, and that value for money is reviewed and maintained.

4.22 Where appropriate, provide recommendations and actions to the Board.

4.23 Where appropriate, refer issues to other Committees or Sub-Committees of the Board.

4.24 To annually, or periodically as required, review the financial policies of the ICB and make appropriate recommendations to the Board.

4.25 Review and monitor those risks on the ICB's BAF and Corporate Risk Register which relate to finance. Ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner

4.26 Review and agree the termination of leases (under Seal) with an annual rent of more than £100,000.

5. Membership and attendance

Membership

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

5.2 The Committee membership is as follows:

- Finance and Planning Committee Chair (Non-Executive Member)
- SWL ICB Chief Finance Officer
- SWL Chief Operating Officer* (*required for planning and relevant items only)
- Chief Nursing Officer* (*required for planning and relevant clinical-related items only)
- Executive Medical Director* (*required for planning and relevant clinical-related items only)

5.3 The role of Committee Chair will be undertaken by a Non-Executive Member (who cannot be the Audit and Risk Committee Chair).

5.4 Members are required to attend a minimum of 75% of meetings, other than absence due to sickness.

5.5 Members may nominate deputies to represent them in their absence and make decisions on their behalf, subject to the approval of the Chair.

5.6 The Chair of the Board shall not be a member of the Committee.

5.7 Members will possess between them knowledge, skills and experience in the issues pertinent to the Committee's business. When determining the membership of the Committee, active consideration will be made to diversity and equality.

Chair and vice chair

5.8 The Committee will be chaired by a Non-Executive Member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.

5.9 Committee members may appoint a Vice Chair who will be nominated by the Chair of the Committee. If the Committee Chair is absent or is disqualified from participating by a conflict of interest, the Vice Chair, if present, shall preside. If the Chair or Vice Chair are absent from any meeting, a Chair shall be nominated by other members attending that meeting.

5.10 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

Attendees

5.11 The Committee shall have the following non-voting attendees (as and when required):

- Audit and Risk Committee Chair
- Place based finance and planning representatives;
- Collaborative finance and planning representatives;
- Other Directors and/or Managers as appropriate;
- Representatives from other organisations, as required.

5.12 Attendees may present at meetings and contribute to the relevant discussions but are not allowed to participate in any formal vote.

5.13 Attendees may nominate deputies to represent them in their absence, with agreement of the Chair.

5.14 The Committee may call additional experts to attend meetings on a case by case basis to inform discussion.

5.15 The Committee may invite or allow people to attend meetings as observers. Observers may not present at meetings, contribute to any discussion or participate in any formal vote.

5.16 The Chair of the ICB will be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.

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

6. Meeting Frequency, Quoracy and Decisions

6.1 The Committee will usually meet monthly and, at least a minimum of eight times in its first year and at least ten times a year thereafter. Arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

6.2 The Board, Chair or Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

6.3 The Committees may choose to meet physically, at its discretion. However, by default, the Committees will be held virtually. Meetings, unless previously agreed by the Chair, will be held virtually via MS Teams or suitable alternative platform.

Quorum

6.4 For a meeting to be quorate a minimum of three members are required, provided this includes three out of the following:

- Finance and Planning Committee Chair
- the Chief Finance Officer, and
- Chief Operating Officer* (*required for planning and relevant items only).

6.5 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

6.6 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

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

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

6.9 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

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

7. Accountability and reporting

7.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

7.2 The Committee shall make any such recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.

7.3 The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board (in the private session) in accordance with the Standing Orders.

7.4 The Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

7.5 The Committee will report to the Board at least annually on its work in support of the Annual Statement. The Annual Statement should also describe how the Committee has fulfilled its ToR and give details of any significant issues that the Committee considered, and how they were addressed.

8. Conflicts of Interest

8.1 Conflicts of Interest shall be dealt with in accordance with the ICB Conflicts of Interest Policy.

8.2 The Committee will have a Conflicts of Interest Register that will be presented as a standing item on the agenda.

8.3 All members and attendees of the Committee must declare any relevant personal, non-personal, pecuniary or potential interests at the commencement of any meeting. The Committee Chair will determine if there is a conflict of interest such that the member and/or attendee will be required not to participate in a discussion.

9. Behaviours and Conduct

ICB values

9.1 Members will be expected to conduct business in line with the ICB values and objectives.

9.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

9.3 Members must demonstrably consider the equality and diversity implications of decisions they make.

10. Secretariat and Administration

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

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

11. Review

11.1 The Committee will review its effectiveness at least annually and recommend any changes it considers necessary to the Board.

11.2 These ToR will be reviewed at least annually and more frequently if required. Any proposed amendments to the ToR will be submitted to the Board for approval.

11.3 In the first year the committee will review the ToR after 6 months to ensure they are fit for purpose.

Date of approval: 1 July 2022

Date of next review: 31 December 2022

Paper 4 Annex D

NHS South West London
Integrated Care Board

NHS South West London Integrated Care Board

Quality and Oversight Committee

Terms of Reference

Document Management

Revision history

Version	Date	Summary of changes
1.0	07.06.22	ToR presented to GoG

Reviewers

This document must be reviewed by the following:

Reviewer	Title / responsibility	Date	Version
Governance Oversight Group	To oversee the development of the ICB constitutions	n/a	All versions

Approved by

This document must be approved by the following people:

Name	Signature	Title	Date	Version
ICB Board				
Sarah Blow		ICS CEO Designate	07.06.22	1.0
Millie Banerjee		ICS Chair Designate	07.06.22	1.0

Contents

1. Constitution

1.1 The Quality and Oversight Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution, Standing Financial Instructions, Standing Orders and Scheme of Reservation and Delegation).

1.2 These Terms of Reference (ToR) set out the membership, remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the Board. They will be published as part of the Governance Handbook on the ICB's website.

2. Authority

2.1 The Committee is authorised by the Board to:

- Investigate any activity within its ToR;
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these ToR;
- Commission any reports it deems necessary to help fulfil its obligations;
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by the ICB for obtaining legal or professional advice;
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and ToR of any such task and finish sub-groups in accordance with the ICB's Constitution, Standing Orders and SoRD but may not delegate any decisions to such groups.

2.2 For the avoidance of doubt, the Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD, except as outlined in these ToR.

2.3 The Committee has no executive powers, other than those delegated in the SoRD and specified in these ToR.

3. Purpose

3.1 The Committee is established to ensure that the ICB is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Act 2022. This includes reducing inequalities in the quality of care.

3.2 The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high quality care.

3.3 The Committee also ensure that there is system oversight of Performance including at Place and Collaborative level. The remit is to review and escalate key performance risks to the Board.

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

4. Responsibilities of the Committee

4.1 The key duties of the Committee are to:

4.2 Be assured that there are robust processes in place for the effective management of Quality and Performance oversight across the system.

4.3 Scrutinise structures in place to support quality planning, performance oversight, control and improvement, to be assured that the structures operate effectively, and timely action is taken to address areas of concern.

4.4 Agree and put forward the key quality and performance priorities that are included within the ICB strategy / annual plan, including priorities to address variation / inequalities in care.

4.5 Oversee and monitor delivery of the ICB key statutory / mandatory requirements.

4.6 Review and monitor those risks on the BAF and Corporate Risk Register which relate to quality and system performance, and high-risk operational risks which could impact on care. Ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner.

4.7 Oversee and scrutinise the ICB's response to all relevant (as applicable to Quality and Performance oversight) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the DHSC, NHSE/I and other regulatory bodies / external agencies (e.g. CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained.

4.8 Maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation and assure the ICB that these are disseminated and implemented across all sites.

4.9 Oversee and seek assurance on the effective and sustained delivery of the ICB Quality Improvement Programmes and broader improvement plans.

4.10 Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place.

4.11 Receive assurance that the ICB identifies lessons learned from all relevant sources, including, incidents, never events, complaints and claims and ensures that learning is disseminated and embedded.

4.12 Receive assurance that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from death (including coronial inquests and PFD reports).

4.13 To be assured that people drawing on services are systematically and effectively involved as equal partners in quality activities.

4.14 Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children.

4.15 Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for infection prevention and control.

4.16 Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for equality and diversity as it applies to people drawing on services.

4.17 Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety.

4.18 Have oversight of and approve the ToR and work programmes for the groups reporting into the Committee (e.g. System Quality Council, Quality Surveillance Group, Infection Prevention and Control, Safeguarding Boards / Hubs etc).

4.19 Ensure that there is a system of integrated performance oversight reporting, working with the Finance and Planning Committee to ensure that there is the necessary overview of performance risks (including quality, workforce and finance and report these to the ICB when necessary.

4.20 Develop the ICB Performance Oversight Framework and review this framework annually to ensure that is meets the needs of our system to support delivery of our strategic objectives.

4.21 Ensure that there is oversight of NHS System Oversight Framework reviewing mitigations and assessing risk where appropriate.

4.22 Oversee the development and implementation of the system of targeted intervention, ensuring that all issues are considered and review the level and depth of intervention required (including the need for potential external support).

4.23 Oversee the triangulation of performance oversight ensuring that the right balance is struck with workforce, quality, finance and system operational metrics and risks have been fully assessed.

4.24 With the Finance and Planning Committee contribute to the performance oversight elements of the system annual report

4.25 Ensure that there is accurate alignment of the BAF risks and the performance risks.

4.26 With the Finance and Planning Committee consider the implications of systems efficiencies upon quality and performance oversight.

4.27 Review the proposed CQUINS for the system and ensure these are aligned to drive forward system quality and transformation objectives.

5. Membership and attendance

Membership

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

5.2 The Board will appoint no fewer than four members of the Committee including two who are Non-Executive Members of the Board. Other attendees of the Committee need not be members of the Board, but they may be.

5.3 The Committee membership is as follows:

- Non-Executive Member (Chair)
- SWL Chief of Nurse and Executive Director of Quality
- ICB Executive Medical Director
- ICB Chief Operating Officer
- 2 x lay members with lived experience (e.g. Healthwatch, patient safety partners)
- Other representatives* (*required for relevant items only; 1 acute provider representative, 1 primary care representative, 1 local authority lead).

5.4 The role of Committee Chair will be undertaken by a Non-Executive Member (who cannot be the Audit and Risk Committee Chair).

5.5 Members are required to attend a minimum of 75% of meetings, other than absence due to sickness.

5.6 Members may nominate deputies to represent them in their absence and make decisions on their behalf, subject to the approval of the Chair.

5.7 The Chair of the Board shall not be a member of the Committee.

5.8 Members will possess between them knowledge, skills and experience in the issues pertinent to the Committee's business. When determining the membership of the Committee, active consideration will be made to diversity and equality.

Chair and vice chair

5.9 The Committee will be chaired by a Non-Executive Member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.

5.10 Committee members may appoint a Vice Chair who will be nominated by the Chair of the Committee. If the Committee Chair is absent or is disqualified from participating by a conflict of interest, the Vice Chair, if present, shall preside. If the Chair or Vice Chair are absent from any meeting, a Chair shall be nominated by other members attending that meeting.

5.11 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

Attendees

5.12 The Committee shall have the following non-voting attendees (as and when required):

- To be specified, e.g. Other Directors and/or Managers as appropriate;
- To be specified e.g. Representatives from other organisations, as required.

5.13 Attendees may present at meetings and contribute to the relevant discussions but are not allowed to participate in any formal vote.

5.14 Attendees may nominate deputies to represent them in their absence, with agreement of the Chair.

5.15 The Committee may call additional experts to attend meetings on a case by case basis to inform discussion.

5.16 The Committee may invite or allow people to attend meetings as observers. Observers may not present at meetings, contribute to any discussion or participate in any formal vote.

5.17 The Chair of the ICB will be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.

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

6. Meeting Frequency, Quoracy and Decisions

6.1 The Committee shall meet on a bi-monthly basis (to be determined by the ICB). Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

6.2 The Board, Chair or Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

6.3 The Committees may choose to meet physically, at its discretion. However, by default, the Committees will be held virtually. Meetings, unless previously agreed by the Chair, will be held virtually via MS Teams or suitable alternative platform.

Quorum

6.4 For a meeting to be quorate the following will be required:

- Non-Executive Member (Chair)
- SWL Chief of Nurse and Executive Director of Quality, or Executive Medical Director
- one provider representative, and
- one Local Authority representative.

6.5 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

6.6 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

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

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

6.9 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

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

7. Accountability and reporting

7.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

7.2 The Committee shall make any such recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.

7.3 The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board (in the private session) in accordance with the Standing Orders.

7.4 The Chair will provide assurance reports to the Board at each meeting and shall provide a report on assurances received, escalating any concerns where necessary that require disclosure to the Board or require action.

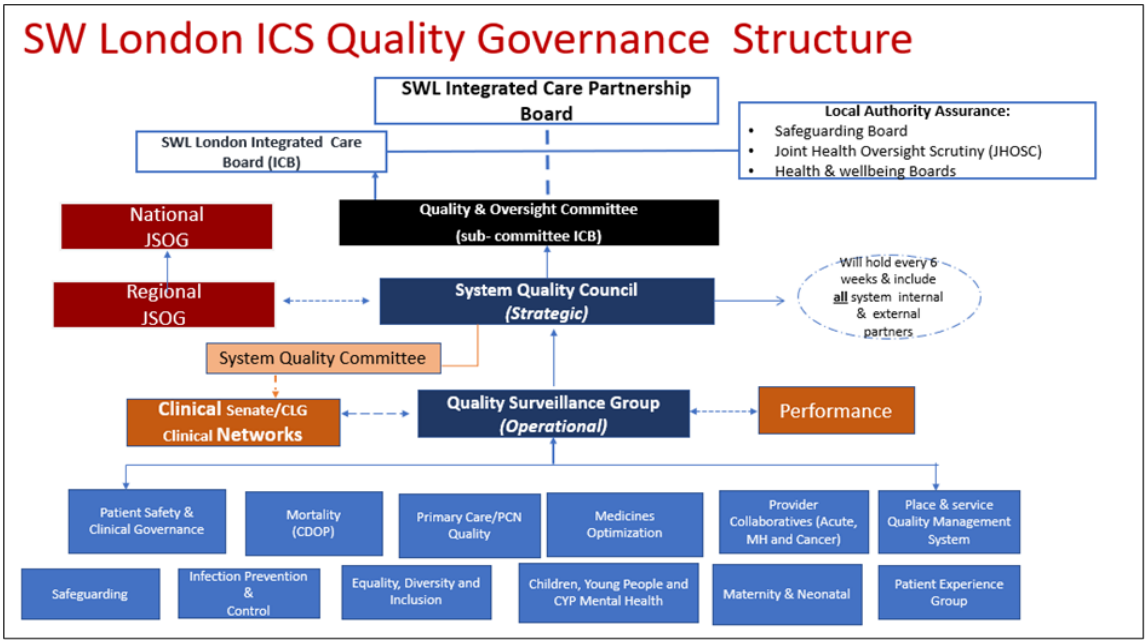
7.5 The Committee will report to the Board at least annually on its work in support of the Annual Statement. The Annual Statement should also describe how the Committee has fulfilled its ToR and give details of any significant issues that the Committee considered, and how they were addressed.

7.6 The Committee will advise the Audit Committee on the adequacy of assurances available and contribute to the Annual Governance Statement.

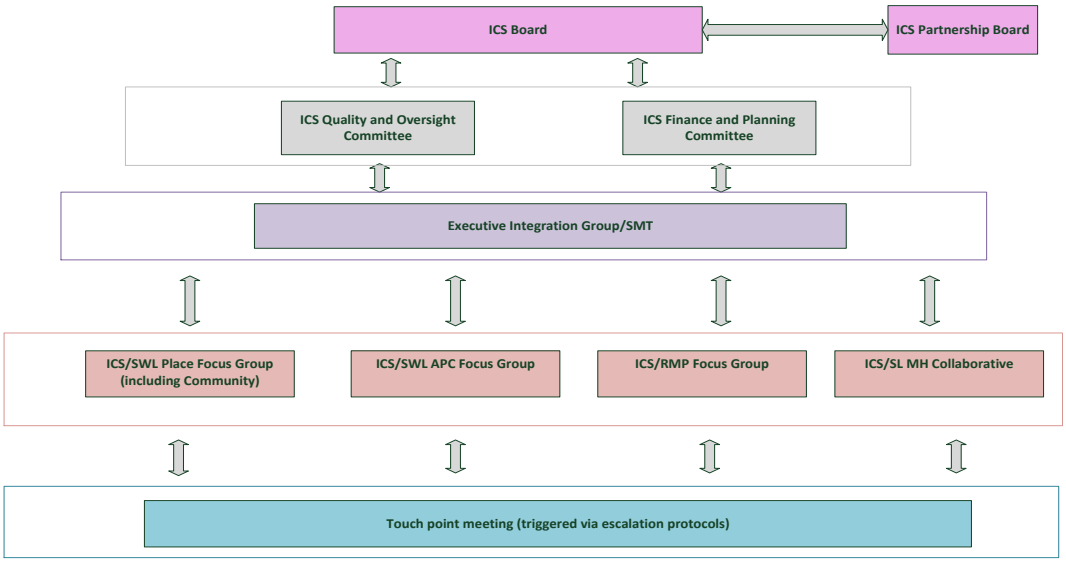
7.7 The Committee will receive scheduled assurance report from its delegated groups (i.e. the System Quality Council). Any delegated groups would need to be agreed by the ICB Board.

7.8 The Committee will also receive the Integrated Performance Report for the system that sets out the areas of good performance and also areas where performance requires improvement.

7.9 Quality reporting governance arrangements to and from the Quality and Oversight Committee is described in the diagram below:



7.10 SWL Performance Oversight arrangements to support delivery of the System Performance Framework (and aligned to both quality, finance, workforce and system tactical performance are set out below:



8. Conflicts of Interest

8.1 Conflicts of Interest shall be dealt with in accordance with the ICB Conflicts of Interest Policy.

8.2 The Committee will have a Conflicts of Interest Register that will be presented as a standing item on the agenda.

8.3 All members and attendees of the Committee must declare any relevant personal, non-personal, pecuniary or potential interests at the commencement of any meeting. The Committee Chair will determine if there is a conflict of interest such that the member and/or attendee will be required not to participate in a discussion.

9. Behaviours and Conduct

ICB values

9.1 Members will be expected to conduct business in line with the ICB values and objectives.

9.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

9.3 Members must demonstrably consider the equality and diversity implications of decisions they make.

10. Secretariat and Administration

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

- The agenda and papers are prepared and distributed in accordance with

the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;

- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
- Good quality minutes are taken in accordance with the Standing Orders and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward between meetings, and progress against those actions is monitored;
- The Chair is supported to prepare and deliver reports to the Board; and
- The Committee is updated on pertinent issues / areas of interest / policy developments.

11. Review

11.1 The Committee will review its effectiveness at least annually and complete an annual report submitted to the Board.

11.2 These ToR will be reviewed at least annually and more frequently if required. Any proposed amendments to the ToR will be submitted to the Board for approval.

11.3 The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Date of approval: 1 July 2022

Date of next review: 30 June 2023

NHS South West London
Integrated Care Board

NHS South West London Integrated Care Board

Place Committee - [insert Place Name]

Terms of Reference

Contents

1. Constitution

1.1 The Integrated Care Board (hereby known as the Board) has established six ICS Place Committees: Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth. These six Places are co-terminus with our six Local Authority boroughs.

1.2 The Place Committee – [insert Place name] (the Committee) is established by the Board as a Committee of the Board in accordance with its Constitution, Standing Financial Instructions, Standing Orders and Scheme of Reservation and Delegation.

1.3 These Terms of Reference (ToR) set out the membership, remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the Board. They will be published as part of the Governance Handbook on the ICB's website.

2. Authority

2.1 The Committee will work under the direction of the Board's strategic direction whilst maintaining a local focus at Place level.

2.2 The Committee is authorised by the Board to:

- Investigate any activity within its terms of reference;
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference;
- Commission any reports it deems necessary to help fulfil its obligations;
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's Constitution, Standing Orders and Scheme of Reservation and Delegation (SoRD) but may delegate any decisions to such groups;
- For the avoidance of doubt, the Committee will comply with, the ICB's Standing Orders, Standing Financial Instructions and the SoRD, except as outlined in these Terms of Reference;
- With the prior agreement of the Board, create sub-committees to support the decision making at the most appropriate local level, and meet the objectives of Place, including the remit outlined in these ToR.

3. Purpose

3.1 The Committee will focus on improving the health and wellbeing outcomes for the local population, assist with the prevention of ill health and addressing health inequalities at Place level.

3.2 The purpose of the Committee is to:

- Support and develop primary care networks (PCNs) which join up primary care and community services, including mental health across local neighbourhoods.

- Create a forum for dialogue between strategic partners to agree priorities and delivery approach.
- Simplify, modernise, and join up health and care (including through technology and by joining up primary and secondary care where appropriate).
- Identify the contribution of the voluntary sector and how this is aligned to health and care to provide a co-ordinated approach across all settings to facilitate independent living and reduce dependency of individuals on statutory organisations.
- Understand and identify its local population and use population health management techniques and other intelligence, to ensure people and families are not at risk of being left behind and are proactively supported.
- Coordinate the local contribution to health, social care, and economic development to prevent future risks to ill health within different population groups.

3.3 An Annual Delivery Plan will be agreed before the start of the financial year; however, this will be flexible to new and emerging priorities and risks.

3.4 The Committee has no executive powers, other than those delegated in the SoRD and specified in these terms of reference.

4. Responsibilities of the Committee

The Committee has the following key responsibilities:

4.1 Lead, plan, coordinate and collaborate to ensure the effective delivery of Health and Care services at Place (Health and Care Plan);

4.2 Review and monitor the effectiveness of the management of services and provide assurance to the Board;

4.3 Improving the health and wellbeing of the population of [insert Place name], in particular tackling health inequalities and reshaping services to promote early intervention and prevention of illness;

4.4 Lead and be responsible for the effective delivery of the system strategic objectives at Place level;

4.5 Work collaboratively, promoting the participation of all key organisations and stakeholders in the development and delivery of local service transformation;

4.6 Provide oversight and scrutiny on the development of the medium and long term local service delivery management plans;

4.7 Oversee and monitor compliance with the Accountability Agreement;

4.8 Maintain oversight of the quality of service provision and any relevant action plans;

4.9 Work with Primary Care Networks and consider how transformation plans and/or newly commissioned services involving and/or impacting on primary care, including community services, will support improving population health, driving quality and safety, and tackling health inequalities; and

4.10 Report progress on delivery of the local Health and Care Plan and Better Care Fund priorities to the Health and Wellbeing Board.

4.11 The Committee is accountable for delivery against existing joint or aligned NHS budgets. Other areas of NHS financial and resource management have been explicitly delegated to the Executive Place Lead. While these accountabilities cannot be delegated further the Executive Place Lead may want to discuss their delivery with the Committee.

5. Membership and attendance

Membership

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

5.2 The Committee membership is as follows; [insert respective roles inclusive of representation below, subject to agreement at Place]

- primary care provider leadership, represented by PCN clinical directors or other relevant primary care leaders.
- providers of acute, community and mental health services, including representatives of provider collaboratives where appropriate.
- people who use care and support services and their representatives including Healthwatch.
- local authorities, including Directors of Adult Social Services and Directors of Public Health and elected members.
- social care providers.
- the voluntary, community and social enterprise sector (VCSE).
- the ICB.

5.3 Members are required to attend a minimum of 75% of meetings, other than absence due to sickness.

5.4 Members may nominate deputies to represent them in their absence and make decisions on their behalf.

5.5 Members will possess between them knowledge, skills and experience in the issues pertinent to the Committee's business. When determining the membership of the Committee, active consideration will be made to diversity and equality.

Convenor

5.6 The Committee will appoint a Convenor on account of their specific knowledge skills and experience making them suitable to convene the Committee.

5.7 In the absence of the nominated Convenor, the Executive Place Lead shall preside.

5.8 The Convenor will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

Attendees

5.9 The Committee shall have the following attendees (as and when required):

5.10 [insert representative]

5.11 [insert representative]

5.12 [insert representative]

5.13 [insert representative]

5.14 Representatives from other organisations, as required.

5.15 Attendees may present at meetings and contribute to the relevant discussions.

5.16 Attendees may nominate deputies to represent them in their absence, with agreement of the Convenor. Deputies need to hold sufficient authority to support effective decision making of the committee.

5.17 The Committee may call additional experts to attend meetings on a case by case basis to inform discussion.

5.18 The Committee may invite or allow people to attend meetings as observers. Observers may not present at meetings or contribute to any discussion.

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

6. Meetings Frequency, Quoracy and Decisions

6.1 The Committee will normally meet [insert frequency based on local determination] and as required to fulfil its duties. Additional meetings may be scheduled at the discretion of the Convenor.

6.2 The Board, Chair or Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

6.3 The Committee may choose to meet physically, at its discretion. However, by default the Committee will be held virtually. Meetings, unless previously agreed by the Convenor, will be held virtually via MS Teams or suitable alternative platform.

Quorum

6.4 For a meeting to be quorate a minimum of one representative from the following roles will be required.

- ICB Executive Place Lead or Convenor.
- Senior (Director / Executive) Local Authority representative.
- Primary Care representative.
- Senior (Director / Executive) Provider representative.
- Senior Voluntary, Community and Social Enterprise (VCSE) representative.

6.5 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

6.6 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making

6.7 Decisions will be taken in according with the Standing Orders. The Committee will reach conclusions by consensus.

6.8 If a decision is needed which cannot wait for the next scheduled meeting, the Convenor may conduct business through the use of email and report the urgent decision to the next scheduled meeting of the Committee.

7. Accountability and reporting

7.1 The Committee is accountable to the Board for the overall delivery of agreed objectives and local outcomes. As set out in the Annual Delivery plan that forms part of the Accountability Agreement.

7.2 The Committee shall provide an assurance report to the Board after each meeting, on how it discharges its responsibilities, set out the matters discussed together with any recommendations to the Board, and provide assurance on the quality of services, performance and any contractual commitments as held by the Board or as otherwise delegated.

7.3 The Place Member of the Board will highlight to the Board any pertinent issues and/or those that require disclosure, escalation, action or approval

7.4 The Committee will work closely with local partners and key stakeholders to enable wide collaboration and engagement in the implementation and development of local services

7.5 The approved minutes will be submitted to the subsequent Board (private session) meeting.

8. Behaviours and Conduct

ICB values

8.1 Members will be expected to conduct business in line with the ICB values and objectives.

8.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

8.3 Members must demonstrably consider the equality and diversity implications of decisions they make.

9. Secretariat and Administration

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

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Convenor with the support of the relevant executive lead.
- Attendance of those invited to each meeting is monitored and highlighting to the Convenor those that do not meet the minimum requirements.
- Good quality minutes are taken in accordance with the Standing Orders and agreed with the Convenor and that a record of matters arising, action points and issues to be carried forward are between meetings and progress against those actions is monitored.
- The minutes of the Committee meetings will be formally recorded, and a draft copy circulated to Committee members together with the action log as soon after the meeting as possible.
- The Place Member of the Board is supported to prepare and deliver reports to the Board.

10. Review

10.1 The Committee will undertake an annual review of its effectiveness and provide a report to the Board of its findings including highlighting areas for improvement.

10.2 These terms of reference will be reviewed at least annually and more frequently if required and will be submitted to the Board for ratification.

Date of approval: 1 July 2022

Date of next review: 1 April 2023

NHS South West London
Integrated Care Board

CCG Close down and ICB Establishment

Supporting Annexes

Paper 5 Annex A SWL CCG AO Due Diligence Assurance Letters

Paper 5 Annex B Due Diligence Assurance letters

Paper 5 Annex C Readiness to Operate Statement

NHS South West London
Clinical Commissioning Group
120 The Broadway
Wimbledon
London SW19 1RH

1 June 2022

Dear Millie,

NHS SWL CCG ICS Transition Programme Due Diligence Assurance

I am writing to you today in my position as the Accountable Officer (AO) for NHS South West London (SWL) Clinical Commissioning Group (CCG). Over the past nine months, in order to prepare the CCG for its close-down and the Integrated Care Board (ICB) for its establishment, we have undertaken a comprehensive programme of due diligence work.

Although we are still a month away from the establishment of the ICB, in line with the guidance issued by NHS England, I am required to provide written assurance to the incoming ICB CEO Designate that a robust and thorough due diligence process has been undertaken to close-down SWL CCG and establish the new SWL ICB. We agreed at the Governance Oversight Group meeting on 23 May 2022 that, as I am both the outgoing AO and the incoming ICB designate CEO, this would not be appropriate for SWL.

I am therefore writing to you, in your position as ICB Designate Chair, to provide the assurance that South West London CCG has followed a robust due diligence process to prepare for closedown and for the safe transfer of staff and property to South West London ICB on 1 July 2022.

In line with the guidance, I confirm that:

- Our preparations have taken account of the NHSEI ICS implementation guidance: *'Due diligence, transfer of people and property from CCGs to ICBs and CCG close down'* and the accompanying due diligence checklist, covering all aspects of current operations, including people, quality, finance and commissioning.
- The CCG(s) has undertaken all the necessary actions prior to close-down. Where there are outstanding matters relating to the CCG which cannot be actioned prior to 1 July (for example, the closure of legacy bank accounts and the finalisation of the

2021/22 annual report and accounts) these have been identified within the due diligence plan for the ICB for action and our ongoing reporting will track the delivery of these items.

- The CCG's risk register will be updated prior to 1 July and shared so that the risks to be taken on by the ICB are clear.
- A staff list has been prepared in line with tab 2.2 of the NHSEI due diligence checklist and has been shared on a strictly 'need to know' basis. It will be kept up to date for 1 July 2022.
- Records of CCG property (tangible and intangible assets (including contracts), rights and liabilities) are in good order, to provide the relevant teams in the ICB with a clear baseline position at 1 July 2022.
- It is understood that the Staff, Property, Rights and Liabilities Transfer Scheme to be made by the NHS Commissioning Board (NHS England) will give legal effect to the transfer of staff and property from the CCG(s) to the ICB on 1 July 2022.

This assurance is based on a comprehensive due diligence process that has been undertaken over the past nine months. Over the past few weeks the delivery of this work has been reviewed by the CCG's relevant Executive Directors, our Internal Auditors, CCG Lay Member representatives and finally by the GoG on Tuesday 31 May. The GoG assured itself at its meeting on the 31st that a robust process had been undertaken and that I could take assurance that the due diligence work has been completed. Where there are still outstanding actions to be delivered over the next month until go live, the GoG also assured itself that robust plans were in place to delivery against these actions.

Should you have any queries regarding the due diligence process, outcomes or assurance provided, please do not hesitate to contact me.

Yours sincerely,

Sarah Blow
Accountable Officer
NHS South West London Clinical Commissioning Group

South West London
Clinical Commissioning Group

NHS South West London
Clinical Commissioning Group
120 The Broadway
Wimbledon
London SW19 1RH

1 June 2022

Dear Andrew,

I am writing to provide assurance that South West London CCG has followed a robust due diligence process to prepare for closedown and for the safe transfer of staff and property (in its widest sense) to South West London ICB on 1 July 2022.

This assurance is based on review of relevant documentation and assurances that I have received from my senior team, internal auditors and South West London ICB Transition Governance Oversight Group.

Our preparations have taken account of the NHSEI ICS implementation guidance: *'Due diligence, transfer of people and property from CCGs to ICBs and CCG close down'* and the accompanying due diligence checklist, covering all aspects of current operations, including people, quality, finance and commissioning.

The CCG(s) has undertaken all the necessary actions prior to closedown. Where there are outstanding matters relating to the CCG which cannot be actioned prior to 1 July (for example, the closure of legacy bank accounts and the finalisation of the 2021/22 annual report and accounts) these have been identified within the Due Diligence plan for the ICB for action and our ongoing reporting will track the delivery of these items

The CCG's risk register will be updated prior to 1 July and shared so that the risks to be taken on by the ICB are clear.

A staff list has been prepared in line with tab 2.2 of the NHSEI due diligence checklist and has been shared on a strictly 'need to know' basis. It will be kept up to date for 1 July 2022.

Records of CCG property (tangible and intangible assets (including contracts), rights and liabilities) are in good order, to provide the relevant teams in the ICB with a clear baseline position at 1 July 2022.

It is understood that the Staff, Property, Rights and Liabilities Transfer Scheme to be made by the NHS Commissioning Board (NHS England) will give legal effect to the transfer of staff and property from the CCG(s) to the ICB on 1 July 2022.

Should you have any queries regarding the due diligence process, outcomes or assurance provided, please do not hesitate to contact me.

Yours sincerely,

Sarah Blow
Accountable Officer
NHS South West London Clinical Commissioning Group

NHS South West London
Clinical Commissioning Group

NHS South West London
Clinical Commissioning Group

CCG Closedown, ICB Establishment – Due Diligence Process

Dear Sarah

I am writing to confirm that the tasks required as part of the due diligence exercise assigned to finance as per the attached have now been completed. Many of these tasks are carried out and evidenced as part of the year end accounts audit so it would be duplicitous to provide standalone evidence. My suggestion is that we place reliance on the External Audit Opinion as evidence that we have complied with the requirements of the due diligence where relevant.

As we move towards the closure of the CCG at the 30 June 2022 many of the tasks carried out at the end of March will need to be rerun. External Audit are not due to do any testing on the evidence for the first quarter of 22/23 until the end of the financial year which they will do concurrently with the ICB audit for the last 3 quarters of 22/23. However given that many of the due diligence tasks are unable to be completed until the end of the CCG we will ensure that all the tasks completed as part of 21/22 are carried out in full and will stand up to scrutiny. However we will be using the year end process as the evidence that we have completed all tasks ahead of the ICB creation on 1 July 2022.

Best Wishes

Name: James Murray

Job Title: Chief Financial Officer

Date: 30 May 2022

South West London
Clinical Commissioning Group

NHS South West London
Clinical Commissioning Group

CCG Closedown, ICB Establishment – Due Diligence Process

Dear Sarah,

I am writing to provide assurance that I have reviewed the evidence in relation to the completion of South West London Due Diligence for the Choose an item. workstream.

I can confirm that the Due Diligence has been completed to my satisfaction, and where it is not possible to complete prior to 1 June I have satisfied myself that there is either a plan in place to complete prior to the transfer on 1 July, or, where there is a requirement to transfer a list (e.g. Complaints, FOIA Requests, Contracts etc) there are current records in place and that those records will be maintained and that they will safely transfer to the new organisation on 1 July 2022

Best Wishes

Name: Charlotte Gawne

Job Title: Executive Director of Communications and Engagement

Date: Wednesday 25 May 2022

NHS South West London
Clinical Commissioning Group

CCG Closedown, ICB Establishment – Due Diligence Process

Dear Sarah,

I am writing to provide assurance that I have reviewed the evidence in relation to the completion of South West London Due Diligence for the Workforce and HR workstream.

I can confirm that the Due Diligence has been completed to my satisfaction, and where it is not possible to complete prior to 1 June I have satisfied myself that there is either a plan in place to complete prior to the transfer on 1 July, or, where there is a requirement to transfer a list (e.g. Complaints, FOIA Requests, Contracts etc) there are current records in place and that those records will be maintained and that they will safely transfer to the new organisation on 1 July 2022

Best Wishes

Name: Karen Broughton

Job Title: Deputy Chief Executive/Director of Transformation and People (Designate)

Date: 31 May 2022

NHS South West London
Clinical Commissioning Group

CCG Closedown, ICB Establishment – Due Diligence Process

Dear Sarah,

I am writing to provide assurance that I have reviewed the evidence in relation to the completion of South West London Due Diligence for the IT workstream.

I can confirm that the Due Diligence has been completed to my satisfaction, and where it is not possible to complete prior to 1 June I have satisfied myself that there is either a plan in place to complete prior to the transfer on 1 July, or, where there is a requirement to transfer a list (e.g. Complaints, FOIA Requests, Contracts etc) there are current records in place and that those records will be maintained and that they will safely transfer to the new organisation on 1 July 2022

Best Wishes

Name: Karen Broughton

Job Title: Deputy Chief Executive/Director of Transformation and People (Designate)

Date: 31 May 2022

South West London
Clinical Commissioning Group

NHS South West London
Clinical Commissioning Group

CCG Closedown, ICB Establishment – Due Diligence Process

Dear Sarah,

I am writing to provide assurance that I have reviewed the evidence in relation to the completion of South West London Due Diligence for the Contracts workstream.

I can confirm that the Due Diligence has been completed to my satisfaction, and where it is not possible to complete prior to 1 June I have satisfied myself that there is either a plan in place to complete prior to the transfer on 1 July, or, where there is a requirement to transfer a list (e.g. Complaints, FOIA Requests, Contracts etc) there are current records in place and that those records will be maintained and that they will safely transfer to the new organisation on 1 July 2022

Best Wishes

Name: Jonathan Bates

Job Title: Chief Operating Officer (Designate)

Date: 27.05.22

NHS South West London
Clinical Commissioning Group

CCG Closedown, ICB Establishment – Due Diligence Process

25th May 2022

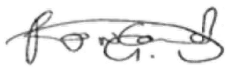
Dear Sarah,

I am writing to provide assurance that I have reviewed the evidence in relation to the completion of South West London Due Diligence for the Quality and Safeguarding workstream.

I can confirm that the Due Diligence has been completed to my satisfaction, and where it is not possible to complete prior to 1 June, I have satisfied myself that there is either a plan in place to complete prior to the transfer on 1 July, or, where there is a requirement to transfer a list (e.g. current CQC investigations, warning notices, open serious incidents, etc) there are current records in place and that those records will be maintained and that they will safely transfer to the new organisation on 1 July 2022

Best Wishes

Name: Dr Gloria Rowland (MBE)



Job Title: SWL Chief Nursing and Allied Health Professional Officer & Director of Patient Outcome

Date: 25/05/2022

South West London Health & Care Partnership

SOUTH WEST LONDON INTEGRATED CARE BOARD
READINESS TO OPERATE STATEMENT

On the basis of a thorough review of the ICB readiness to operate statement checklist (appended) and the supporting evidence, we are satisfied that adequate preparations have been made for the legal establishment of South West London Integrated Care Board with effect from 1 July 2022. The South West London Integrated Care Board will be ready to fulfil its statutory functions from this point. It will develop as a new statutory organisation with ongoing support from NHS England.

The South West London Integrated Care Board will work with its partners to:

- **improve outcomes** in population health and healthcare
- **tackle inequalities** in outcomes, experience and access
- **enhance productivity** and value for money
- help the NHS support broader **social and economic development**.

The preparations to establish the South West London Integrated Care Board and wider integrated care system arrangements have been made through engagement with partner organisations.

We note that the South West London Integrated Care Partnership is also ready to be established between the Integrated Care Board and its partners from 1 July 2022.

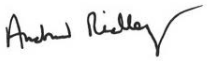
The partner organisations in the Integrated Care Partnership are:

- Our six South West London places: Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth. Each place represents one borough
- Our six Local Authorities: Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth
- Our Acute and Community Providers: Central London Community Healthcare, Croydon Health Services NHS Trust, Epsom and St Helier University Hospitals NHS Trust, Hounslow and Richmond Community Healthcare NHS Trust, Kingston Hospital NHS Foundation Trust, Royal Marsden Foundation Trust and St George's NHS Foundation Trust
- Our two Mental Health Providers: South West London and St George's Mental Health NHS Trust, South London and the Maudsley NHS Foundation Trust
- The GP Federations in each of the six boroughs
- Our 39 Primary Care Networks
- The London Ambulance Service
- Healthwatch (in each borough)
- Representatives from: The Voluntary Sector; local hospices; and patients

ICB Chief Executive *(designate)* signature:

Sarah Blow, 10th June 2022

NHS England and NHS Improvement Regional Director signature:



Date: 17th June 2022