Integrated Care Board
Friday 1st July 2022
Boardroom, Lewis's Building, 2 Renshaw Street, Liverpool, L1 2SA
10:30am to 12:30pm
Agenda

AGENDA NO.	ITEM	LEAD	ACTION / PURPOSE
ICB/22/01 10:30 - 10:40	Welcome, Introductions and Apologies	Chair	Oral
ICB/22/02 10:40 - 10:45	Declarations of Interest	All	Oral
	ICB Appointments		
ICB/22/03 10:45 - 11:00	Report of the Chair: • Details as a matter of public record NHS appointments and the recommendations of the Chair for further appointments to the Board • The Chair and Chief Executive call an extraordinary meeting with the Audit Chair – per the ICB Constitution - to receive the recommendations of the Chair on Appointments to the Board	Chair	Report (page 4-13) For Enorsement / Approval
	ICB Standard Business		
ICB/22/04 11:00 - 11:05	Minutes of the last meeting • To receive minutes of the shadow ICB meeting from June	Chair	Paper (page 14-25) For Approval
	Establishing the ICB		
ICB/22/05 11:05 - 11:25	ICB Constitution • To receive the approved ICB Constitution To consider and adopt a suite of ICB Policies as referenced within the Constitution • Conflicts of Interest – Final • Standards of Business Conduct – Final • Draft Public Engagement/empowerment Framework – Draft • Draft Policy for Public Involvement – Draft	Assistant Chief Executive	Papers (page 26-212) To Note / Adopt To Agree To Agree To Note To Note

ICB/22/06 11:25 - 11:45	Scheme of Reservation and Delegation To receive and approve: • ICB Scheme of Reservation and Delegation • ICB Functions & Decisions Map • ICB Standing Financial Instructions • ICB Operational Limits	Director of Finance	Papers (page 213-260) To Agree
ICB/22/07 11:45 - 12:00	ICB Committees To receive detailed proposals for ICB Committee establishment: • A governance schematic • TOR which describe the coverage and breadth of the ICB committees as referenced within the SORD and ICB Functions and Decision Map • Noting that the first task of ICB Committees upon establishment will be to review and make proposals (to the ICB) on their terms of reference	Assistant Chief Executive & all Directors	Papers (page 261-327) To Agree
ICB/22/08 12:00 - 12:05	ICB Roles To consider proposals for lead ICB roles for named individuals to cover portfolios as set out within section two of report attahced to item ICB/22/03 • Appoint ICB portfolio roles as set out • Designate ICB officer post holders to fulfil certain required functions	Assistant Chief Executive	To Agree
ICB/22/09 12:05 - 12:20	ICB Policies Approach and Governance To consider a report on the ICB's approach to policies, policy development and inherited policies. • To agree the ICB's approach to governing the review and adoption of a new ICB policy framework as required	Assistant Chief Executive	Papers (page 328-39) To Agree
	AOB		
ICB/22/10 12:20 – 12:25	Any Other Business • The Board should note that a meeting of the Shadow ICB Finance Committee took Place on 30 June and it is proposed that the minutes of this meeting go to the first meeting of the ICB's established Finance, Investment and Our Resources Committee	Chair	Oral

ICB/22/11 12:25 – 12:30	Review of the meeting and communications from it	Chair	Oral For Agreement

Date and time of next meeting:

The next meeting of the ICB will take place on 4th August 10-12:30 in St Helens

A Full schedule of meetings, locations and further details on the work fo the ICB can be found here:
www.cheshireandmerseyside.nhs.uk

NHS
Cheshire and Merseyside

NHS C&M ICB
Board Recruitment

Cheshire and Merseyside
Integrated Care Board Meeting

NHS
Cheshire and Merseyside

Date of meeting:	01/07/2022
Agenda Item No:	ICB/22/03
Report title:	NHS C&M ICB Board Recruitment
Report Author & Contact Details:	Ben Vinter / Matthew Cunningham matthew.cunningham@nhs.net
Report approved by:	Raj Jain, ICB Chair

Purpose and any action required	**Decision/ Approve** →	**X**	**Discussion/ Gain feedback** →		**Assurance** →		**Information/ To Note** →	

Committee/Advisory Group previously presented

Recruitment to key positions in the ICB have been progressed through a number of different routes:

- A number of key recruitments have been led nationally or regionally by NHSE
- The ICB has recruited in an open and transparent way to a number of key posts
- Our draft Constitution and regulations have guided our approach to ICB Partner Member Recruitment. These processes have involved the establishment and use of a non executive led ICB Appointments Panel.

Executive Summary and key points for discussion

Named individuals are provided to support their appointment to NHS C&M ICB Board, and additional key roles are detailed.

The Constitution provides a mechanism for the appointment of Board members before or when the Board first meets. This provision requires the Chair and Chief Executive to call an extraordinary meeting with a third Board member. In this case the Audit Chair. Who will together receive the recommendations of the Chair on and for appointments to the Board

This convened group, in the presence of a meeting of the designate Board, is asked to receive and approve the recommendations for appointment.

Cheshire and Merseyside
Integrated Care Board Meeting

Recommendation/ Action needed:	The convened group, in the presence of a meeting of the designate Board is the Chair, Chief Executive and Audit Chair who are asked to: **APPROVE** the appointment of named individuals to the following Ordinary Member roles: • 3 x Executive Members (Medical Director, Director of Finance, Director of Nursing) • 3 x Non-Executive Members • 6 x Partner Members **NOTE** the NHSE appointments to the C&M ICB

Consideration for publication	
Meetings of the Integrated Care Board will be held in public and the associated papers will be published unless there are specific reasons as to why that should not be the case. This paper will therefore be deemed public unless any of the following criteria apply (please insert **'x'** as appropriate:	
The item involves sensitive HR issues	
The item contains commercially confidential issues	
Some other criteria. Please outline below:	

Which purpose(s) of an Integrated Care System does this report align with?	
Please insert **'x'** as appropriate:	
1. Improve population health and healthcare	X
2. Tackle health inequality, improving outcome and access to services	
3. Enhancing quality, productivity and value for money	
4. Helping the NHS to support broader social and economic development	

C&M ICB Priority report aligns with:	
Please insert **'x'** as appropriate:	
1. Delivering today	X
2. Recovery	
3. Getting Upstream	
4. Building systems for integration and collaboration	

Governance and Risk					
Does this report provide assurance against any of the risks identified in the Board Assurance Framework or any other corporate risk? (*please list*) N/A					
What level of assurance does it provide? N/A					
Limited		**Reasonable**		**Significant**	
Any other risks? ~~Yes~~ / No. If yes please identify within the body of the report.					
Is this report required under NHS guidance or for statutory purpose? (*please specify*) Yes – inline with NHS C&M Constitution re: establishment of the Board					

	Any Conflicts of Interest associated with this paper? If Yes please state what they are and any mitigations. N/A
	Any current services or roles that may be affected by issues within this paper? All roles for approval, as listed within the paper.

Document Development	Process Undertaken	Yes	No	N/A	Comments (i.e. date, method, impact e.g. feedback used)
	Financial Assessment/ Evaluation			X	
	Patient / Public Engagement			X	
	Clinical Engagement			X	
	Equality Analysis (EA) - any adverse impacts identified?			X	
	Legal Advice needed?			X	
	Report History – has it been to other groups/ committee input/ oversight (Internal/External)				The consequences of any appointment will be considered by the ICB Remuneration Committee

Next Steps:	Remuneration Committee consideration of matters relevant to the Committee
Responsible Officer to take forward actions:	Chris Samosa, Director of People
Appendices:	N/A

NHS C&M ICB Board Recruitment

1. Executive Summary

The purpose of this paper is to facilitate formal appointment of the membership of the NHS C&M ICB Board subject to Remuneration Committee subsequently determining relevant remuneration.

As per s3.14 of the NHS C&M Constitution; on the day of establishment, the ICB may establish a committee consisting of the Chair, Chief Executive and one other to approve the appointments of the Ordinary Members[1] who are expected to be all individuals who have been identified as designate appointees pre ICB establishment. The Chair and Chief Executive had opted to conduct this business as the first item of the ICB business in conjunction with the Designate Audit Chair.

2. Introduction / Background

2.1 Composition of the NHS C&M Board

As stated at section 2.1.4 of NHS C&M ICB's constitution: "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."

The composition of the board is outlined at section 2.2.3 of the ICB's constitution. The membership is:

a) Chair
b) Chief Executive
c) 2 Partner member(s) NHS Trusts and Foundation Trusts
d) 2 Partner member(s) Primary Medical Services
e) 2 Partner member(s) Local Authorities
f) 4 Non-executive Members
g) Director of Finance
h) Medical Director
i) Director of Nursing (known locally as Director of Nursing and Care)

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.

[1] 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 the procedure set out in the NHS C&M Constitution and NHS C&M Appointments Policy.

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.

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

a) A Director of Public Health
b) An individual bringing knowledge and perspective of Healthwatch
c) An individual bringing knowledge and a perspective of the voluntary, community, faith and social enterprise sector
d) ICB Executives – to be determined when roles and portfolios are agreed: and
e) Place leads, as required, and through rotation.

3. Process of Appointment

Each member of the Board has been through a selection and appointment process to determine that they:

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

Chair
The ICB Chair was appointed by NHS England and Improvement, with the approval of the Secretary of State:

- NHS C&M's appointed Chair is **Raj Jain**

Chief Executive
The Chief Executive was appointed by the Chair[2] of the ICB, with the approval of NHS England and Improvement:

- NHS C&M's Chief Executive is **Graham Urwin**

Ordinary Members
As per section 3.14 of the Constitution, individuals were identified as "designate Ordinary Members" prior to the ICB's establishment on 1st July 2022. All appointment and assessment processes undertaken in advance of establishment identifying the designate Ordinary Members followed, as far as possible, the processes set out in s3.5-3.12 of the NHS C&M Constitution.

[2] Or Interim Chair at the appropriate time of recruitment and selection

Executive Members

Director of Finance
This member was appointed by an ICB appointments panel, and their appointment was approved by the Chair[2]:

- NHS C&M's Director of Finance is **Claire Wilson**

Medical Director
This member was appointed by an ICB appointments panel, and their appointment was approved by the Chair[2]:

- NHS C&M's Medical Director is **Professor Rowan Pritchard-Jones**

Director of Nursing and Care
This member was appointed by an ICB appointments panel, and their appointment was approved by the Chair[2]:

- NHS C&M's Director of Nursing and Care is **Christine Douglas MBE**

With Christine not due to undertake the role until the start of August, an Interim Director of Nursing and Care has been appointed, **Marie Boles**

Non-Executive Members

These members were appointed by an ICB appointments panel, and their appointment approved by the ICB Chair[2]:

- **Neil Large MBE**
- **Tony Foy**
- **Erica Morriss**

In addition, there is a fourth NED vacancy, currently in the process of being recruited to.

Partner Members

NHS Trusts and Foundation Trusts
These Partner Members are considered jointly nominated by the ICB from the constituency of NHS trusts and/or foundation trusts which provide services for the purposes of the health service within the Cheshire & Merseyside area and meet the forward plan condition or (if the forward plan condition is not met) the level of services provided condition. Following the selection and appointment process outlined at s3.5 of the NHS C&M Constitution, the following Partner Members have been appointed to the Board:

- **Ann Marr OBE**
- **Dr Joe Rafferty CBE**

The recommended term for these appointments are to April 2024.

Partner Member(s) - Providers of Primary Medical Services.
These Partner Members are considered jointly nominated by the ICB from the constituency of providers of primary medical services for the purposes of the health service within the Cheshire & Merseyside 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. Following the selection and appointment process outlined at s3.6 of the NHS C&M Constitution, the following Partner Members have been appointed to the board:

- **Dr Raj Kumar**
- **Adam Irvine**

The recommended term for these appointments are to April 2024 and 2025 respectively.

Partner Member(s) - local authorities
These Partner Members are considered jointly nominated by the ICB from the constituency of local authorities whose areas coincide with, or include the whole or any part of, the Cheshire & Merseyside area. Following the selection and appointment process outlined at s3.7 of the NHS C&M Constitution, the following Partner Members have been appointed to the board:

- **Professor Steve Broomhead MBE,** Warrington Borough Council
- **Councillor Paul Cummins,** Sefton Borough Council

The recommended term for these appointments are to April 2024 and April 2025 respectively.

As per the NHS C&M Constitution, the relevant nomination procedures for partner members in advance of establishment are deemed valid as they have been undertaken in accordance with the provisions of s3.5-3.7. This included the use of an Appointments Panel which made recommendations to the Chair made up of, Non-Executives Tony Foy, Neil Large and Erica Morriss held on 21 June 2022.

Wider Directors and Place Directors

ICB Directors:

- Assistant Chief Executive – Clare Watson
- Chief People Officer – Christine Samosa
- Director of Performance & Planning – Anthony Middleton

Place Directors: **Joint appointment with local authority*

1. Cheshire East – Mark Wilkinson
2. Cheshire West – Delyth Curtis*
3. Halton – Anthony Leo
4. Knowsley – Alison Lee
5. Liverpool – Jan Ledward
6. Sefton – Deborah Butcher*

7. St Helens – Mark Palethorpe*
8. Warrington – Carl Marsh
9. Wirral – Simon Banks

Section 2

Additional Key Roles

The following business – termed section two of this report for ease of navigation - maybe considered to be considered as subsequent agenda item following the constitution of the Board.

The ICB is also asked to confirm the appointments to the following key named positions.

Named Individuals (ICB Roles):

- Safeguarding Lead – Erica Morriss, NED
- Children & Young People (CYP) Lead – Raj Jain, Chair
- Special Educational Needs & Disability (SEND) Lead – Tony Foy, NED
- Health & Wellbeing Champion – VACANT 4th NED role
- Conflicts of Interest Guardian – Neil Large, NED
- Mental Health Lead – Joe Rafferty, Trust Partner Member, with MH
- Founding Member of C&M Integrated Care Partnership (ICP) - Raj Jain, Chair

Named Individuals (Officer Roles):

- Senior Information Risk Officer (SIRO) - Christine Douglas, Executive Director of Nursing and Care (Marie Boles in the interim)
- Caldicott Guardian – Rowan Pritchard-Jones, Medical Director
- Data Protection Officer (DPO) – Head of Information Governance
- Local Security Management Standards (LSMS) Lead – Claire Wilson, Executive Director of Finance
- Local Counter Fraud Specialist (LCFS) Lead – Claire Wilson, Executive Director of Finance
- Freedom to Speak Up Guardian/ Raising Concerns Lead – Clare Watson, Assistant Chief Executive
- Whistleblowing Lead – Christine Samosa, Chief People Office
- Accountable Emergency Officer – Anthony Middleton, Director of Performance and Planning

Committee Chairs

Chair of the Remuneration Committee – Tony Foy

Chair of the Audit Committee – Neil Large

4. Recommendations

The convened group, in the presence of a meeting of the Board is the Chair, Chief Executive and Audit Chair who are asked to:

APPROVE the appointment of named individuals to the following Ordinary Member roles:

- 3 x Executive Members (Medical Director, Director of Finance, Director of Nursing)
- 3 x Non-Executive Members
- 6 x Partner Members

NOTE the NHSE appointments to the C&M ICB

SHADOW INTEGRATED CARE BOARD

Thursday 9th June 2022 - 10:00 to 11.30

DRAFT MINUTES

Present:

Raj Jain (RJA)	Designate Chair, ICB
Marie Boles (MBO)	Director of Nursing Advisor, Cheshire and Merseyside Health and Care Partnership
Steven Broomhead (SBR)	Chief Executive, Warrington Borough Council
Dr Simon Constable (SCO)	Medical Director Advisor to SOvB, Chief Executive Warrington and Halton Hospitals NHSFT
Tony Foy (TFO)	Designate Non-Executive Director, ICB
Dr Jonathan Griffiths (JGR)	Primary Care Advisor, Cheshire and Merseyside Health and Care Partnership
Dr Fiona Lemmens (FLE)	Designate ICB Associate Medical Director
Lynn McGill (LMC)	Chair, East Cheshire NHS Trust
Ann Marr (AMA)	Chief Executive at St Helens & Knowsley Teaching Hospitals NHS Trust and Southport and Ormskirk Hospital Trust.
Anthony Middleton (AMI)	Designate ICB Director of Performance and Improvement
Erica Morriss (EMO)	Designate Non-Executive Director, ICB
Neil Large (NLA)	Designate Non-Executive Director, ICB
Chris Samosa (CSA)	Designate ICB Director of People
Jane Tomkinson (JTO)	Interim Chair of Shadow ICB Finance Committee & Chief Executive, Liverpool Heart and Chest Hospital
Graham Urwin (GUR)	Designate Chief Executive, ICB
Clare Watson (CWA)	Accountable Officer, Cheshire CCG and Designate Assistant Chief Executive
Claire Wilson (CWI)	Designate Chief Finance Officer

In attendance:

Jane Cass (JCA)	Locality Director NHSE
Carole Hill (CHI)	Director of Strategy, Communications and Integration, NHS Liverpool CCG
Jonathan Taylor (JTA)	Interim Head of Communications & Empowerment Cheshire and Merseyside Health and Care Partnership
Dylan Murphy	Head of Corporate Governance, Cheshire CCG

Apologies:

Karen Bliss (KBL)	Chair, NHS Bridgewater Community Healthcare NHS FT
Dr Paula Cowan (PCO)	Chair, Wirral CCG
Dwayne Johnson (DJO)	Chief Executive, Sefton Council
Dr Rowan Pritchard Jones (RPJ)	Designate ICB Medical Director
Joe Rafferty (JRA)	Chief Executive, Mersey Care NHS FT

Notes:

Emma Lloyd	Cheshire CCG.

AGENDA NO.	ITEM	ACTION
SOB/22/54	Welcome, Introductions and Apologies: Raj Jain (RJA) as Chair welcomed members noting apologies as listed above.	

AGENDA NO.	ITEM	ACTION
SOB/22/55	Declarations of Interest: No declarations of interest were recorded.	
SOB/22/56	Minutes of the last meeting: The minutes of the previous meeting held on Wednesday 12th May 2022 were agreed as an accurate record.	
SOB/22/57	Designate Chair's Update: There was no Designate Chair's update.	
SOB/22/58	Designate Chief Executive's Update: Graham Urwin (GUR) shared that the final version of the constitution for the ICB was approved by NHS England and has been published in the last week. This is another milestone on the journey towards 1st July and everything is progressing well. Clare Watson will provide an update on the Readiness to Operate and the rest of the approval processes with NHS England later on the agenda. Feedback will be brought back to the Board following two material meetings that are due to take place:- i) The new Improvement Board for Countess of Chester Hospitals; this has been initiated following the recent draft CQC report. The board has been set up using governance resources at regional level and the regional Chief Nurse will take the role of Chair and GUR will be Deputy Chair. After the transition period, the board will be co-chaired by the ICB and the region. ii) The Liverpool University Hospitals were placed into the national recovery programme some time ago and have made some good progress. A national review of progress will be taking place in July and both GUR and RJ will take part in this process. The review will look at the recovery journey and the trajectory for continued improvement. **Outcome:** The Shadow Integrated Care Board noted the Designate Chief Executive's Update.	
	System Delivery	
SOB/22/59	North Mersey Stroke Proposals – Briefing: The Shadow ICB welcomed Carole Hill for this agenda item. Carole Hill (CHI) shared that the purpose of bringing this paper to the meeting is to provide the opportunity for members to ask questions and put any additions into the paper before it is brought to the formal ICB at their meeting on 4th August 2022. Fiona Lemmens (FLE) highlighted that this is not a new piece of work and shared that the passing of these proposals has been delayed due to Covid. FLE also confirmed that the paper brought for formal approval on 4th August will include more detail.	

AGENDA NO.	ITEM	ACTION
	A copy of the report was provided prior to the meeting and FLE highlighted the following: • The report outlines the background information. • There is considerable evidence to support the improvement in outcomes based on the proposed Comprehensive Stroke Centre to serve the populations of Knowsley, Liverpool, Sefton and West Lancashire. • The proposals have been through a clinically led Options Appraisal, the outcome of which was that the Aintree site model is the preferred option with specialist services provided by The Walton Centre. The proposed clinical model is then for patients to be repatriated to a stroke clinic closer to home. • The proposal is in the final stages of the process and has been through a public consultation. Phase 1 of the programme is due to take place in September and Phase 2 in late 2023. • Phase 2 is the completion of the ideal model with a new unit at the front door of Aintree alongside A&E (which will have a separate entrance) and with a diagnostic centre. This is part of a new build and this is reflected in the longer timeline. • Phase 1 needs to happen this September. It is acknowledged that some colleagues in the system feel it should be even sooner as the stroke centre at Southport and Ormskirk is currently being led by a single consultant, however, the plan requires a move of stroke beds into Aintree. This means Ward 35 will be remodelled to become a temporary hyper acute centre and patients will be managed through the A&E department. These moves will be completed by 19th September. A review of the risks linked to an earlier move has taken place and the outcome was that 19th September is the optimum time to make the move. • There are some more elements of the process to complete and the final paper will also be going to boards at West Lancashire and the Lancashire and South Cumbria ICB shortly. There are also further additions to be made to the business case around finance and this will be included in the final paper presented to the ICB. Questions were invited:- Erica Morriss (EMO) noted that the workforce is fragile and asked for FLE's opinion around the impact this proposal will have on retention and attracting staff into the new centre. FLE shared that, from a medical perspective, this will be attractive to new staff as it will be a 'state of the art' hyper acute unit. In addition, given the national shortage of consultants, it makes practical sense to have them centralised. FLE shared that, from a nursing perspective, not all staff are happy to move although the Matron at Aintree is confident that there will be safe staffing levels. EMO noted that the public consultation process was broken up due to Covid and asked whether there has been a true representation from the public in the consultation. CHI confirmed that the consultation commenced during a period of higher levels of Covid, so there were some constraints due to social distancing measures, however, advice was taken and the consultation followed good practice guidance at the time. CHI informed the Shadow ICB that they worked closely with the National Stroke Association who were supportive of the proposals. This provided access to stroke survivors and their families which has given a rich insight.	

AGENDA NO.	ITEM	ACTION
	CHI also shared that they have worked closely with the pre-consultation group and this data has also been used to inform the proposal. CHI shared that they were conscious of the need to address inequalities and therefore the data was reviewed to ensure that it included representation from all areas, areas of deprivation and different cohorts. In addition, they worked with Healthwatch and other voluntary sector organisations. EMO noted the comment made regarding the importance of implementation in line with the key dates and asked whether the August report will include risk and mitigations around this. Both JLE and CHI confirmed that this would be included in the August report. Dr Jonathan Griffiths (JGR) confirmed that he supported the proposals but asked whether this will require a change in pathways for GP referrals and, if so, whether they were aware of this. FLE confirmed that the vast majority of patients will be 999/Category 2 patients and confirmed that they have worked closely with NWAS on this. FLE agreed that comms with GPs is needed to let them know about the changes. Tony Foy (TFO) noted that the principle point of the proposal is to improve outcomes and remove unwarranted variations in service and suggested that it would therefore be useful for the August report to provide an overview of the Cheshire & Merseyside context, to show the variations. FLE noted the request. TFO asked how progress will be monitored and which benchmarks will be set to conclude whether it is successful. JLE confirmed that there is national data to monitor stroke outcomes and this can be included in the paper brought back in August. JTO noted that, in the earlier iterations of the proposal, the main blockers were physical capacity, which has since been addressed, and the financial impact of moving services. JTO asked whether there was confidence that this will not have a negative impact on the overall financial plan. CWI confirmed that the pre-consultation business case cited that the revenue implications were £3m annually plus a one-off capital investment of £4m. CWI informed the Shadow ICB that both provisional figures have been included in the financial plan, subject to more detail when the final business case comes through in August. Jane Tomkinson (JTO) asked whether the Getting It Right First Time (GIRFT) guidelines linked to stroke were included in the report and whether the ICB is on target to meet the deliverables outlined within this. JLE confirmed that the team are fully linked into GIRFT and other national stroke networks. Neil Large (NLA) asked whether someone is leading on the revenue indications and whether these are on track with the figures included in the original plans. CWI confirmed that the current expectation is that the costs will be in line with the original figures. CWI highlighted that the proposals were approved by commissioners prior to the ICB transition and the ICB would look to honour this, subject to the business case and final approval. RJA confirmed that he was pleased to see the paper being presented and agreed that work at pace was needed.	

AGENDA NO.	ITEM	ACTION
	RJA reinforced the request to include data and how improvements will be demonstrated through the data. FLE confirmed that the Sentinel Stroke National Audit Programme (SSNAP) data will be the first step in assessing the stroke outcomes. RJA asked whether the national stroke lead, who is based in the Wirral, had been involved in the process. FLE confirmed that Dr Deborah Lowe is an active member of the C&M Stroke Network. RJA asked what governance structures will be in place to enable a strongly coordinated response in the hyper acute stroke unit. FLE shared that one of the main drives for the Aintree site model is that it is linked to the Thrombectomy unit and there are already strong links between Thrombectomy and all stroke centres. FLE also confirmed that NWAS are engaged in the process. RJA thanked FLE for the update but highlighted the importance of including the governance structures and how issues will be dealt with in the report due in August. RJA asked that the August submission includes a comprehensive report on the impact that the proposal will have on other services to ensure there are no issues likely to arise over time. RJA felt that it would be beneficial to include more detail on the development of place-based rehab in the August report. FLE confirmed that rehab is a main focus of the plan as the current provision does not meet the guidance for after care across C&M. FLE shared that this is another piece of work that commissioners have been taking through the Joint Committee of the CCGs and will be on the ICB paper in due course. Ann Marr (AMA) highlighted the importance of including SSNAP figures in the August report. AMA also stated the importance of looking at data for patients being thrombolysed with a view to ensuring that access to this service is the same for patients across the area. AMA outlined the need to be cognisant of the affect ambulance delays have in terms of the timescales for getting patients into hospital to receive treatment. AMA noted that this is a national issue but suggested that recognition of this should be included in the August report. RJA asked AMA whether she felt provider collaboratives will take a role in monitoring the effectiveness of the involvement of Mid-Mersey and Aintree in thrombectomy. AMA shared that getting access to the same level across the area is a key issue and there is a need to utilise the stroke networks to achieve this. It was agreed that AMA will have an input into the August report around the role of provider collaboratives. GUR stated that, with regard to the SSNAP data, the principal issue to focus on is the avoidable mortality or the avoidable loss of quality of life due to not receiving treatment in a timely manner. GUR shared that, whilst it is accepted that Covid has got in the way of progress and as a result this will be handed over from the CCGs to the ICB,	

AGENDA NO.	ITEM	ACTION
	This is a well orientated piece of work and there is a need to take people back to promises made before Covid and hold them to the fidelity of the business case. GUR confirmed that CWI is working carefully on reviewing the finances linked to this proposal. GUR agreed that the governance arrangements need to be tight and the report in August needs to clearly define the handover of this to the new structure to ensure that patients get to the services quickly and that patients are then moved out of the hyper acute service quickly and appropriately. GUR highlighted the importance of doing this through the lens of the patient and also from a quality and safety-first lens. RJA thanked FLE and CHI for the paper and noted that a list of further work and clarifications has arisen from this discussion to be included in the August submission. **Outcome:** The Shadow Integrated Care Board noted and discussed the North Mersey Stroke Proposals Briefing and noted that a more detailed report for decision will be submitted at the meeting of the ICB on 4th August. **Outcome:** The Shadow Integrated Care Board agreed that Ann Marr would have in input into the August report around the role of provider collaboratives. **Outcome:** The Shadow Integrated Care Board provided additional areas for inclusion in the report submitted in August, along with some areas that required further clarification.	
SOB/22/60	Liverpool Women's Hospital – Case for Change: FLE informed the Shadow ICB that this item has been brought to this meeting for initial review/discussion as decision making responsibility for this will be carried over from the Joint Committee of the CCGs to the ICB. FLE shared that this piece of work has been ongoing for some time, and highlighted the following:- • The Liverpool Women's Hospital Board and its leaders are keen to progress the work. • Significant public interest is expected once this item has been put back onto Board meeting agendas. • The presentation outlines the background information and it remains the very strong view of the clinical advisors and the hospital board, that the proposed changes need to happen. • Three key things have changed since the case for change work commenced:- i. A larger number of complex needs cases are being seen in both maternity and gynaecology. ii. What can be done for patients has changed – more complex surgery is being carried out and more complex maternity issues can be treated.	

AGENDA NO.	ITEM	ACTION
	iii. Training for staff has changed – this is more specialised and midwifes no longer need to be a registered nurse first. This specialisation is a positive when services are co-located but creates risk when they are not. • The Hospital Trust have done an audit of critical care transfers and this shows that a number of cases are unpredictable. • The data also shows that there is unpredictability around which patients become complex cases and there have been a number of instances where the status of healthy women or women with a healthy pregnancy has become critical. • A large amount of risk mitigation has been done already and it is not possible to further mitigate the risks. There has been a delicate balance between understanding and discussing the risks, and ensuring public confidence is maintained. The clinical senate has visited Liverpool Women's Hospital twice. At the first visit they noted the normalisation of risks and at their second visit they made the comment that there are no further mitigations that the staff at Liverpool Women's Hospital can implement as currently configured. Therefore, the clinical view is that we need to be doing something about this soon. • The critical care Operational delivery network (ODN) have been consulted throughout the process and are clear it will not meet the criteria for level three provision whilst it is not co-located. This means that it cannot support women with known complex issues and women who present at A&E may find that there is no surgeon on site to perform the type of surgery required. • FLE highlighted the activity information contained within the papers and emphasised that, behind the headlines, there are patient experience stories which are difficult to capture. FLE shared that she has spoken to a critical care transfer patient and spent time discussing their experience which included a lack of dignity and the pain of the separation from their baby. • FLE shared that the data shows that men who suffer the same post operation issues have quite different experiences of service to women. • The counterfactual case has been considered previously and this is now a much more significant piece of work. Full details of this can be shared. The conclusion is that Liverpool Women's have reached the limit of mitigations available to them and staff sometimes understate the risks that they have learned to live with. • There is public and political interest in this case for change and there is a reputational risk and a risk around public confidence. It is therefore important to ensure there is a meticulous and robust process in place. • During the Options Appraisal, a decision was made not to look at Crown Street enhancements, however, the position is now different and the Crown Street site is being used by other parts of the system. The focus is now on looking at this as a system problem rather than one provider. • FLE shared that the timescales included in the papers are indicative timescales and there is still a lot of work to do before finalising the timescales. • FLE highlighted that the reason progress was held back last time was around there being no route for capital being identified. FLE confirmed that they will not be able to continue with the proposal without capital investment and work is still needed to address this.	

AGENDA NO.	ITEM	ACTION
	Questions were invited:- JGR noted that the clinical case for change is strong but felt that the public perception is that this is linked to the need to make cost savings. JGR asked what steps will be taken to counteract this view. FLE confirmed that there is a financial driver in that Liverpool Women's Trust have been in a deficit position for some time and they are not in a position to rectify this. FLE highlighted that this is not the primary reason but agreed that there is a need for a careful public engagement process before it goes out to consultation. JTO referenced the lack of access to capital and noted that, even if the finances became available, a new build would not be in place for 5-6 years. JTO asked, given the clinical view is that no more mitigations are possible, how this will be managed. FLE shared that the paper does outline the mitigations and how risks will be managed in the interim and confirmed that a blood bank is being established on the Women's site which still requires staffing but will be open this year. FLE shared that there is a partnership board with LUFT to support joint appointments, particularly with regard to anesthetic teams which has seen an improvement in recruitment. FLE stated that continuous discussions will be needed to look at ongoing improvements where possible, whilst accepting that the situation cannot be completely fixed. JTO asked how the situation is managed in Birmingham which also has a separate women's hospital. FLE confirmed that Birmingham is different in that the Women's hospital is in a separate building but is on the same site as the adult services. AMA noted that there is a similar situation in Ormskirk, albeit on a smaller scale, and highlighted that it is possible for an emergency situation to arise anywhere. AMA therefore asked whether, given the extent of the risk and lack of further mitigations, any thought had been given to the misalignment of services in the right places. AMA felt that there was an option to take a pragmatic approach and improve the current situation by moving staff around sites or swapping services over using existing sites. JLE confirmed that these options are all included in the new Optional Appraisal. JLE informed the board that consideration had been given to splitting Obstetrics and Gynaecology and assessing the risks associated with this. JLE confirmed that it was agreed that this would need to be done as part of a bigger review of maternity and gynaecology services across Cheshire and Merseyside. NLA noted concern around raising expectations given the financial situation. NLA felt that there was a need to assess all the funding streams available and then put together a strategic framework to look at all capital opportunities under an overarching strategy. This will ensure that funding is not allocated on a first come first served basis but is prioritised in line with the broader strategy. Marie Boles (MBO) shared that maternity services are being discussed across several organisations around Cheshire and Merseyside and on the back of these, as well as the outcomes in the Ockendon Review, an event has been organised by the LMS on 7th July to discuss current services.	

AGENDA NO.	ITEM	ACTION
	Dr Simon Constable (SCO) shared his view that, by going down a route that is not affordable, there is a risk of letting down another group of patients. SCO therefore shared his support for a wider, more strategic approach to capital investment across C&M, particularly given that some buildings on university campuses are further away from each other than the Crown Street site is from The Royal Liverpool Hospital. CWI agreed that there is a strong clinical case for change and shared that the only really credible source of funding is the new hospital programme. CWI noted that, even if another source were found, capital would still be required. CWI confirmed that her team will look at every option available to them but felt that there is a need to manage expectations. CWI also noted that the new hospital programme has a long pipeline and there will be other projects higher up the list for receipt of this funding. CWI accepted that new site is the most clinically advantageous option but felt that the Optional Appraisal should be used to look carefully at the other options. CWI agreed with the recommendation that an overarching strategy is needed to look at maternity in a holistic way and CWI will ensure that a capital strategy and supporting estates strategy were developed. Lynn McGill (LMC) agreed that the clinical case is powerful but requested that the August report also considers neo-natal provision. JLE noted the request. GUR highlighted that ICB workplan outlines the commitment to developing a 5-year strategy before March 2023. GUR shared that this will be for the whole of the ICB and will be driven by the clinical, estates and financial strategy. GUR highlighted that the 5-year strategy will be built based on the biggest risks we collectively deal with. GUR also highlighted that, whilst the risks presented today are real and cannot be ignored, the ICB is also required to maintain confidence in the NHS so that the public are confident to use services. It is therefore important not to overstate risks to gain support for funding because this could also diminish public confidence. With regard to the issue of risk mitigation, GUR noted that the blood bank has been discussed for some time and the fact that it is still not in place shows there is an issue with the risk mitigation process. Boards must be held to account for patient safety and the ICB must ask for clear updates with regard to risk mitigation plans which may require support from neighbouring organisations. FLE confirmed that she will bring risk mitigation plans to the Board in August. GUR highlighted that the issue is not just about the quality of care that mums and babies receive this year or in the coming years; any change will be fundamental to retaining the future workforce and training them for the C&M footprint and beyond. Therefore, it is important that the right decisions are made. GUR shared that it is important to acknowledge there will be ideal solutions to some issues which are not possible to implement and therefore the ICB need to find the best compromises available to them, whilst keeping a focus on the ideal solution at a point in the future.	

AGENDA NO.	ITEM	ACTION
	Steven Broomhead (SBR) highlighted the need for a clear statement to outline the situation as the likely outcomes may not reflect current expectation. RJA agreed that a statement is needed to manage public expectations. RJA summarised the key points to be covered within the submission to the ICB in August:- 1) There needs to be a strong statement about how this is a system issue and how it will be managed as a system. It must also outline that any actions taken by Liverpool Women's Hospital Trust must be aligned with this system working. 2) It needs to bring absolute clarity to the capital question. We are not expecting a new hospital in the next six years and this needs to be stated. A statement that outlines the required capital and the likelihood of receiving it should be prepared. 3) The ICB will be concentrating on the point made by GUR about being clear on the mitigations. The next report should provide detail on this. 4) Data points should be included and focus on what is the avoidable mortality and morbidity of the current model. The personal stories are important, but the Board needs to understand data points to articulate the clinical case. 5) The ICB would like to see the plan around how the system will work together around the risk mitigation strategy; this will include how to go about implementing the solutions for the additional mitigations that may be possible. 6) The position around the fragility of obstetric and gynaecology services in C&M overall needs to be understood, and the timelines for a strategic review should be stated. **Outcome:** The Shadow Integrated Care Board noted and discussed the Liverpool Women's Hospital – Case for Change and noted that a more detailed report for decision will be submitted at the meeting of the ICB on 4th August. **Outcome:** The Shadow Integrated Care Board provided additional areas for inclusion in the report submitted in August, along with some areas that required further clarification.	
	ICB Development	
SOB/22/61	ICB Readiness to Operate Statement (ROS): Clare Watson (CWA) shared that the purpose of this verbal report was to provide assurance on progress since the previous report. CWA confirmed that:- • The ROS will be submitted today (9th June 2022). This will include 37 items coded blue (no further action), 2 coded green and 1 not applicable. CWA confirmed that this is a good position to be in. CWA informed the Board that a peer review session has taken place this week to ensure that a consistent approach was taken around the processes and procedure and also shared that Mersey Internal Audit Agency have been commissioned to review the evidence.	

AGENDA NO.	ITEM	ACTION
	CWA confirmed that she is confident the two items coded green will move to blue very quickly, by early July at the latest. • Alongside the ROS, a delegation agreement for primary care (Section 4) will be submitted. CWA confirmed that this consists of 200 lines and 100% of these have been coded blue. Questions were invited:- Anthony Middleton (AMI) noted that the green items on the ROS are linked to the EPRR training for staff which is ongoing until the end of June. RAJ requested that the Board receives a briefing on this before 1st July, so their role is clearly outlined. **Outcome:** The Shadow Integrated Care Board noted the Readiness to Operate (ROS) update.	
	Reporting	
SOB/22/62	ICB Shadow Finance Committee: Jane Tomkinson (JTO) shared that a number of issues are being worked on and will come back to the finance committee for discussion. This includes:- • Systemwide cash management. • A deficit deep dive and understanding how different boards have made decisions. • The longer-term finance strategy. • Capital risk management Feedback on all these items will come to the Shadow ICB via the committee minutes. No comments or questions were raised. **Outcome:** The Shadow Integrated Care Board noted the ICB Shadow Finance Committee update.	
SOB/22/63	Any Other Business: SBR requested that there is a future agenda item to discuss the integration of health and social care, including the issues being faced around real integration, the importance of intermediate care and hospital discharges etc. RJA confirmed that the Partnership Board – the ICP – would be the key forum for discussion those issues but the ICB will need to be aware of the issues and actions to address them. it was agreed that RJA would consider when the most appropriate time to discuss this will be and update the forward planner accordingly. GUR confirmed that the costs of social care has been discussed at internal meetings and meetings with provider collaboratives and confirmed that this issue is anchored within a number of areas in the governance structures. RJA also confirmed that the agenda for the Shadow ICB has been quite limited and the agendas for the ICB going forward will become more holistic. **Action: RJA to incorporate a future agenda item around the integration of health and social care onto the ICB forward planner.**	Raj Jain

AGENDA NO.	ITEM	ACTION
	Outcome: The ICB forward planner to be updated to include an item on the integration of health and social care. RJA to determine the most suitable meeting for this item.	
SOB/22/64	Review of the meeting and communications from it: RJA thanked members for their contributions to the two main topics: North Mersey Stroke Proposals and the Liverpool Women's Hospital Case for Change. RJA noted that there was some good news about future stroke services and some comms is required in due time to share this new. RJA highlighted the need to keep the item about the Liverpool Women's Hospital Case for Change confidential. There is no further meeting of the Shadow ICB. The next meeting will be the first formal meeting of the ICB on Friday 1st July 2022 at 10.00 am.	

End of meeting

NHS C&M ICB Adoption of Constitution

Cheshire and Merseyside
Integrated Care Board Meeting

NHS
Cheshire and Merseyside

Date of meeting:	01/07/2022
Agenda Item No:	ICB/22/05
Report title:	**Adoption of NHS C&M ICB Constitution and associated key policies**
Report Author & Contact Details:	Ben Vinter / Matthew Cunningham matthew.cunningham@nhs.net
Report approved by:	Clare Watson, Assistant Chief Executive

Purpose and any action required	**Decision/ Approve →**	**X**	**Discussion/ Gain feedback →**		**Assurance →**		**Information/ To Note →**	

Committee/Advisory Group previously presented
The Constitution was developed following engagement with stakeholders and was shared widely for comment. This has included dedicated engagement sessions with partners but also CCG audit lay members and designate members of the ICB. The development of this documentation has also been subject to extensive engagement with NHSE at both a regional and national level who ultimately have had responsibility to sign-off and approve the ICB Constitution

Executive Summary and key points for discussion
The ICB Constitution describes how the ICB is governed, where and how decisions are made and where more information on its work can be found. The Constitution was developed following engagement with stakeholders and was shared widely for comment.

Recommendation/ Action needed:	The Board is asked to: • **NOTE** and **ADOPT** the ICB Constitution, as approved by NHS England and Improvement • **AGREE** the ICB Policy for Standards of Business Conduct • **AGREE** the ICB Policy for Conflicts of Interest • **RECEIVE** and **NOTE** the draft positions on: o Public Engagement Framework o Public Involvement Policy

Cheshire and Merseyside
Integrated Care Board Meeting

Consideration for publication	
Meetings of the Integrated Care Board will be held in public and the associated papers will be published unless there are specific reasons as to why that should not be the case. This paper will therefore be deemed public unless any of the following criteria apply (please insert **'x'** as appropriate:	
The item involves sensitive HR issues	
The item contains commercially confidential issues	
Some other criteria. Please outline below:	

Which purpose(s) of an Integrated Care System does this report align with?	
Please insert **'x'** as appropriate:	
1. Improve population health and healthcare	X
2. Tackle health inequality, improving outcome and access to services	
3. Enhancing quality, productivity and value for money	
4. Helping the NHS to support broader social and economic development	

C&M ICB Priority report aligns with:	
Please insert **'x'** as appropriate:	
1. Delivering today	X
2. Recovery	
3. Getting Upstream	
4. Building systems for integration and collaboration	

Governance and Risk					
Does this report provide assurance against any of the risks identified in the Board Assurance Framework or any other corporate risk? (*please list*) N/A					
What level of assurance does it provide? N/A					
Limited		**Reasonable**		**Significant**	
Any other risks? ~~Yes~~ / No. If yes please identify within the body of the report.					
Is this report required under NHS guidance or for statutory purpose? (*please specify*) Statutory document required for establishment of Integrated Care Boards					
Any Conflicts of Interest associated with this paper? If Yes please state what they are and any mitigations. N/A					
Any current services or roles that may be affected by issues within this paper? N/A					

Document Development	Process Undertaken	Yes	No	N/A	Comments (i.e. date, method, impact e.g. feedback used)
	Financial Assessment/ Evaluation			X	
	Patient / Public Engagement			X	
	Clinical Engagement			X	
	Equality Analysis (EA) - any adverse impacts identified?			X	

	Legal Advice needed?			X	
	Report History – has it been to other groups/ committee input/ oversight (Internal/External)				NHSE/I template, supported by NHSEI support through workshops and webinars.

Next Steps:	NHS C&M Constitution and supporting documents to be uploaded to public website, and form foundation documents of NHS C&M.
Responsible Officer to take forward actions:	Clare Watson, Assistant Chief Executive
Appendices:	1. NHS Cheshire and Merseyside Constitution v1 2. ICB Policy for Standards of Business Conduct 3. ICB Policy for Conflicts of Interest 4. Draft Public Engagement Framework 5. Draft Public Involvement Policy

Adoption of NHS C&M ICB Constitution and associated key policies

1. Executive Summary

The ICB Constitution describes how the ICB is governed, where and how decisions are made and where more information on its work can be found. The Constitution sets out:

- The membership of the ICB
- The procedures for appointing Members to the board
- The principles of good governance to be observed by the ICB
- The ICB's authority to act and ability to delegate authority to act on its behalf
- The ICB's procedures for making decisions
- The ICB's arrangements for managing conflicts of interest and its standards of business conduct
- The ICB's arrangements for ensuring accountability and transparency
- The ICB's arrangements for determining the terms and conditions of employees and
- The ICB's arrangements for ensuring public involvement.

2. Introduction / Background

The NHS C&M ICB Constitution was developed following engagement with stakeholders and was shared widely for comment. The outputs of these exercises have been recorded and influenced the final published version of the C&M ICB Constitution. The process and timescales for these engagements can be summarised as follows:

- C&M engaged with Partners on the size and composition of the Board which needed to be proposed during November
- Continued dialogue with partners on the wider content of the Constitution, specifically, the process for nominations and appointments to the Board and key aspects of the Standing Orders through December and January
- Key contacts and stakeholders were accessed by both the Health and Care Partnership and CCGs.

The initial Constitution was agreed by NHS England and Improvement and came into effect on 1 July 2022. Once approved by NHSE&I, 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).

The **Constitution** is supported by a number of documents which provide further details on how governance arrangements in the ICB will operate:

- **Standing orders** – which set out the arrangements and procedures to be used for meetings and the processes to appoint the ICB committees. An annex to the Constitution
- The **ICB Governance Handbook** – which brings together the ICB's key governance documents, including: the Scheme of Reservation and Delegation (SORD); a Functions and Decisions Map; the Standing Financial Instructions (SFIs); committee terms of reference; any delegation agreements the ICB has entered into (to be published on the ICB website following the Board meeting); and
- **Key policy documents** – which will include the ICB's: standards of business conduct policy; policy and procedures relating to the management of conflicts of interest; and policy for public involvement and engagement/empowerment framework*. Included within this agenda item.

> ** As per Readiness to Operate requirements, a draft strategy for working with people and communities was submitted to NHS England on 27 May for national review, moderation and feedback. Written feedback is expected in July 2022 and will be reviewed and responded to alongside the output of national public consultation on statutory guidance for working with people and communities (also July 2022).*
>
> *A further programme of engagement with partners, people and communities is planned, in order to ensure system-wide sign-up to the principles and approaches outlined in the Cheshire and Merseyside Public Engagement Framework. Further presentation will then be made to both the Integrated Care Board and Integrated Care Partnership.*

Attached to this report and following the Constitution are:

- the C&M Standard for Business Conduct Policy – for agreement
- the C&M Conflict of Interest Policy – for agreement
- C&M policies related to Communications and Engagement which are shared in draft and for noting as they are subject to wider system engagement prior to their envisaged adoption by the ICB in due course
  - A Strategy for Working with People and Communities – Our "Public Engagement Framework" - to note
  - Public Involvement Policy - to note

3. Recommendations

The Board is asked to:

- **NOTE** and **ADOPT** the ICB Constitution, as approved by NHS England and Improvement
- **AGREE** the ICB Policy for Standards of Business Conduct
- **AGREE** the ICB Policy for Conflicts of Interest
- **RECEIVE** and **NOTE** the draft positions on:
  - Draft Public Engagement Framework
  - Draft Public Involvement Policy

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board

CONSTITUTION

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

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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:

- 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.

1.1.3 This Constitution describes how we are governed, where and how decisions are made and where more information can be found on our work.

We want everyone in Cheshire and Merseyside to have a great start in life and get the support they need to stay healthy and live longer. Through NHS Cheshire and Merseyside Integrated Care Board's (ICB) work with our Health and Care Partnership, we are committed to tackling health inequalities and improving the lives of our poorest fastest. We believe we can do this best by working together to realise our shared ambitions to reduce health inequalities and improve the health of the 2.7 million people who live in our area and improving the quality of their health and care services.

To create the conditions for this to happen we must support and enable integrated working within our places and through our wider partnership. Sometimes we will be required to work across places or at system-level. When we work at a bigger scale than place we must be clear on our rationale for doing so.

Place is where our residents live their lives and receive the majority of their care, meaning it is where we, and partners, need to operate primarily and by default. Therefore, our approach to collaboration begins in our local communities, with our primary care networks in which GP practices work together, with community and social care services, to offer integrated health and care services to local people.

Our focus must be to move away from simply treating ill health to preventing it, to reducing health inequalities, and tackling the wider determinants of health. We want to work with the widest range of partners to achieve our ambitions. Not only statutory organisations but also the voluntary, community, faith and social enterprise sector.

NHS Cheshire and Merseyside is a statutory body charged with specific legal duties and functions. Our work is underpinned by the duty for NHS bodies and local authorities to co-operate, and it supports the triple aim - requiring NHS bodies to consider the effects of their decisions on the health and wellbeing of people and communities, the quality of services and the sustainable and efficient use of resources.

NHS Cheshire and Merseyside has been established to:

- Develop a plan to meet the health and care needs of the population
- Allocate resources to deliver the plan across the system
- Ensure value for money, manage incidents and delegations from NHS England and Improvement
- Deliver the NHS Constitution

We are leaders of our organisation, our places and of our system, Cheshire and Merseyside.

1.2 Name

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

1.3 Area covered by the Integrated Care Board

1.3.1 The area covered by the ICB is co-terminous with the Borough of Cheshire East, Borough of Cheshire West and Chester, Borough of Halton, Borough of Knowsley, City of Liverpool, Borough of Sefton, Borough of St Helens, Borough of Warrington, and Borough of Wirral.

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.cheshireandmerseyside.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 1989 and section 14Z32 of the 2009 Act);
b) Exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act);
c) Duties in relation to children including safeguarding, promoting welfare etc (including the Children Acts 1989 and 2004, and the Children and Families Act 2014);
d) Adult safeguarding and carers (the Care Act 2014);
e) Equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35); and
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 inequalities),
c) section 14Z38 (obtaining appropriate advice),

d) section 14Z40 (duty in respect of research),
e) section 14Z43 (duty to have regard to effect of decisions)
f) section 14Z44 (public involvement and consultation),
g) sections 223GB to 223N (financial duties), and
h) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

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

1.5 Status of this Constitution

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

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

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

1.6 Variation of this Constitution

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

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

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

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

a) The Chief Executive or Chair may periodically propose amendments to the constitution.
b) The Chief Executive, in consultation with the Chair, will present all proposed amendments to the ICB so board members can consider whether engagement with the ICP is required in accordance with 1.6.2c).

c) The ICB shall engage its partners, via the Integrated Care Partnership (ICP), to discuss any proposed amendments that any board member believes may materially affect:
   i) the operation of the ICB or
   ii) its relationship with partners.

d) The proposed amendments shall be considered and approved by the ICB before an application is submitted to NHS England. In considering the proposed amendments, board Members are expected to apply knowledge of and a perspective from their sectors.

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

1.7 Related documents

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

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

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

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

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

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

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

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

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

e) **Key policy documents** 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 Integrated Care Board. Further information about the criteria for the roles and how they are appointed is in section 3.

2.1.2 Further information about the individuals who fulfil these roles can be found on our website at www.cheshireandmerseyside.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:
- Director of Finance
- Medical Director
- Director of Nursing

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:

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

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

2.2 Board membership

2.2.1 This ICB has 6 Partner Members:

a) 2 from section 2.1.6a - providing the ICB with access to a perspective and experience from acute or specialist and mental health care settings

b) 2 from section 2.1.6b - providing the ICB with access to a perspective and experience from primary care and general practice (as prescribed)

c) 2 from section 2.1.6c - providing the ICB with access to a perspective and experience from local authorities drawing upon the range of context, circumstance and communities that make up C&M

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

a) 2 additional Non-executive Members

2.2.3 The board is therefore composed of the following members:

a) Chair
b) Chief Executive
c) 2 Partner member(s) NHS Trusts and Foundation Trusts
d) 2 Partner member(s) Primary Medical Services
e) 2 Partner member(s) Local Authorities
f) 4 Non-executive Members
g) Director of Finance
h) Medical Director
i) Director of Nursing (known locally as Director of Nursing and Care)

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

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

2.2.6 Through its recruitment, nomination and appointment processes the board will be mindful of the benefit that a range of perspectives and breadth of geographical insights and experiences will secure and bring to its work and discussions. The ICB is committed to securing the broadest range of perspectives through its recruitment ensuring that the board is as representative of the communities it serves as practical and possible.

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 advance 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. Named and equal participants will include:

a) A Director of Public Health;
b) An individual bringing knowledge and perspective of Healthwatch;
c) An individual bringing knowledge and a perspective of the voluntary, community, faith and social enterprise sector;
d) ICB Executives – to be determined when roles and portfolios are agreed; and
e) Place leads as required and through rotation.

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

2.3.4 Participants and / or observers may be asked to leave the meeting or part of a meeting by the Chair in the event that the board passes a resolution to exclude the public (including representatives of the press) in accordance with the Public Bodies (Admission to Meetings) Act 1960 as per the Standing Orders.

3 Appointments process for the board

3.1 Eligibility criteria for board membership:

3.1.1 Each member of the ICB must:

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

3.2 Disqualification criteria for board membership

3.2.1 A Member of Parliament.

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

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

a) in the United Kingdom of any offence; or

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

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

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

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

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

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

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

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

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

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

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

3.2.8 A person who is subject to:
a) a disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002; or
b) an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

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

3.2.10 A person who has at any time been removed, or is suspended, from the management or control of any body under:
a) section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities); or
b) section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).

3.3 Chair

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

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

3.3.3 Individuals will not be eligible if:
a) They hold a role in another health and care organisation within the ICB area.

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

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

3.3.5 In the first instance, at the time of ICB establishment, the Chair will be appointed for four years.

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 the approval of NHS England in accordance with any procedure published by NHS England

3.4.3 In addition to criteria specified at 3.1, 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 18(4)(b) of Schedule 1B to the 2006 Act.

3.4.4 Individuals will not be eligible if:

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

3.5 Partner Member(s) - NHS Trusts and Foundation Trusts

3.5.1 These Partner Members are jointly nominated by the NHS trusts and/or 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. Those Trusts and Foundation Trusts are:

a) Alder Hey Children's NHS Foundation Trust;
b) Bridgewater Community Healthcare NHS Foundation Trust;
c) Cheshire and Wirral Partnership NHS Foundation Trust;
d) The Clatterbridge Cancer Centre NHS Foundation Trust;
e) Countess of Chester NHS Foundation Trust;
f) East Cheshire NHS Trust;
g) Liverpool Heart and Chest Hospital NHS Foundation Trust;
h) Liverpool University Hospitals NHS Foundation Trust;
i) Liverpool Women's Hospital NHS Foundation Trust;
j) Mersey Care NHS Foundation Trust;
k) Mid Cheshire Hospital NHS Foundation Trust;
l) North West Ambulance Service NHS Foundation Trust

m) St Helens and Knowsley Teaching Hospitals NHS Trust;
n) Southport and Ormskirk Hospital NHS Trust;
o) The Walton Centre NHS Foundation Trust;
p) Wirral University Teaching Hospital NHS Foundation Trust;
q) Wirral Community NHS Foundation Trust; and
r) Warrington and Halton Hospitals 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 an Executive Director of one of the NHS Trusts or FTs within the ICB's area.
b) One shall have specific knowledge, skills and experience of the provision of acute or specialist services
c) One shall have specific knowledge, skills and experience of the provision of mental health services such that the ICB complies with clause 2.2.4 of this constitution.
d) Any other criteria as may be set out in any NHS England guidance.
e) Any other criteria as may be agreed 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) Any other criteria as may be set out in any NHS England guidance apply.
c) Any locally determined exclusion criteria agreed by the ICB apply including:
    i. Compliance with the ICB Member Appointments Policy

3.5.4 These members will be appointed by an ICB appointments panel subject to the approval of the Chair. Membership of the appointments panel should be determined by the Chair and Chief Executive but must include at least one non-executive board Member and be supported by an HR professional.

3.5.5 The appointment process will be as follows:

a) The ICB will produce a role description and person specification for the roles. This will establish the requirement that the individual(s) must:
    i) bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the board but they are not to act as delegates of those sectors; and
    ii) have the skills, knowledge, experience and attributes required to fulfil the role of board Member
b) The ICB will issue the role description and person specification to the Partner Members listed at section 3.5.1 and establish a timeline for a selection and appointment process.
c) Joint nomination:

- When a vacancy arises, each eligible organisation listed at 3.5.1.a will be invited to make two nominations.
- The nomination of an individual must be seconded by one other eligible organisation.
- Eligible organisations may nominate individuals from their own organisation or another organisation
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within seven working days being deemed to constitute agreement. If they do agree, the list will be put forward to step d) below. If they do not, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

d) Assessment, selection, and appointment subject to approval of the Chair under e)

- 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.

e) Chair's approval

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

3.5.6 The term of office for these Partner Members will be three years. There is no limit on the number of terms an individual may serve but there is no automatic reappointment and an appointment process will be undertaken at the end of each term.

3.5.7 Initial appointments, on the creation of the ICB, may be for a shorter period than the usual three years. This will allow future appointments to be staggered and support continuity of membership on the board.

3.5.8 The appointment/reappointment process will be initiated by the Chair who will engage with the individual on their continuing availability before the process set out in 3.5.4 - 3.5.5 is commenced.

3.6 Partner Member(s) - Providers of Primary Medical Services.

3.6.1 These Partner Members are 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 These members must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Any other criteria as may be set out in any NHS England guidance

b) Any other criteria as may be agreed by the ICB, including a requirement that:

i. At least one of the C&M Primary Medical Services members will meet the criteria of the Primary Medical Services Partner Member as a General Practitioner and:

a) Hold a license to practice as a GP (on the GMC GP register) and be registered on the Performers List for England

b) Be a current provider of such services (practicing in C&M and for a period of not less than the preceding 24 months); and

c) In accordance with b) work at least two sessions per week

ii. One of the C&M Primary Medical Services members may be a practising primary care clinician or care professional[1] and:

a) Be a current provider of services (practicing in C&M and for a period of not less than the preceding 24 months).

3.6.4 Individuals will not be eligible if:

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

b) Any other criteria as may be set out in any NHS England guidance apply.

c) Any locally determined exclusion criteria agreed by the ICB apply, including:

i. Compliance with the ICB Member Appointments Policy

3.6.5 This member will be appointed by an ICB appointments panel subject to the approval of the Chair. Membership of the appointments panel should be determined by the Chair and Chief Executive but must include at least one non-executive board Member and be supported by an HR professional.

3.6.6 The appointment process will be as follows:

[1] Pharmacist, Physiotherapist, Dentist, Optometrist, Allied Health Professional, Social Care or other registered care professional

a) The ICB will produce a role description and person specification for the roles. This will establish the requirement that the individual(s) must:
   i) bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the board but they are not to act as delegates of those sectors; and
   ii) have the skills, knowledge, experience and attributes required to fulfil the role of board Member

b) The ICB will issue the role description and person specification to the Partner Members listed at section 3.6.1 and establish a timeline for a selection and appointment process.

c) 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 two nominations.
   - The nomination of an individual must be seconded by one other eligible organisation.
   - Eligible organisations may nominate individuals from their own organisation or another organisation.
   - All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within seven working days being deemed to constitute agreement. If they do agree, the list will be put forward to step d) below. If they do not, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

d) Assessment, selection, and appointment subject to approval of the Chair under e)
   - 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.

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

3.6.7 The term of office for this Partner Member will be three years. There is no limit on the number of terms an individual may serve but there is no automatic reappointment and an appointment process will be undertaken at the end of each term.

3.6.8 Initial appointments, on the creation of the ICB, may be for a shorter period than the usual three years. This will allow future appointments to be staggered and support continuity of membership on the board.

3.6.9 The appointment / reappointment process will be initiated by the Chair who will engage with the individual on their continuing availability before the process set out in 3.6.4 - 3.6.5 is commenced.

3.7 Partner Member(s) - local authorities

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

a) Borough of Cheshire East
b) Borough of Cheshire West and Chester
c) Borough of Halton
d) Borough of Knowsley
e) City of Liverpool
f) Borough of Sefton
g) Borough of St Helens
h) Borough of Warrington
i) Borough of Wirral

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

a) Be the Chief Executive or hold a relevant Executive level role of one of the bodies listed at 3.7.1.
b) Any other criteria as may be set out in any NHS England guidance.
c) Any other criteria as may be agreed 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) Any other criteria as may be set out in any NHS England guidance apply.
c) Any locally determined exclusion criteria agreed by the ICB apply including:
    i. Compliance with the ICB Member Appointments Policy

3.7.4 This member will be appointed by an ICB appointments panel subject to the approval of the Chair. Membership of the appointments panel should be determined by the Chair and Chief Executive but must include at least one non-executive board Member and be supported by an HR professional.

3.7.5 The appointment process will be as follows:

a) The ICB will produce a role description and person specification for the roles. This will establish the requirement that the individual(s) must:
   i) bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the board but they are not to act as delegates of those sectors; and
   ii) have the skills, knowledge, experience and attributes required to fulfil the role of board member

b) The ICB will issue the role description and person specification to the Partner Members listed at section 3.7.1 and establish a timeline for a selection and appointment process.

c) Joint Nomination:
- When a vacancy arises, each eligible organisation listed at 3.7.1. will be invited to make two nominations.
- The nomination of an individual must be seconded by one other eligible organisation.
- Eligible organisations may nominate individuals from their own organisation or another organisation
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within seven working days being deemed to constitute agreement. If they do agree, the list will be put forward to step d) below. If they do not, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

d) Assessment, selection, and appointment subject to approval of the Chair under e)
- 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.

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

3.7.6 The term of office for this Partner Member will be three years. There is no limit on the number of terms an individual may serve but there is no automatic reappointment and an appointment process will be undertaken at the end of each term.

3.7.7 Initial appointments, on the creation of the ICB, may be for a shorter period than the usual three years. This will allow future appointments to be staggered and support continuity of membership on the board.

3.7.8 The appointment / reappointment process will be initiated by the Chair who will engage with the individual on their continuing availability before the process set out in 3.7.4 - 3.7.5 is commenced.

3.8 Medical Director

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

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.
b) Be a registered Medical Practitioner.
c) Any other criteria as may be set out in any NHS England guidance.
d) Any other criteria as may be agreed by the ICB, including:
    i. Be a member of a recognised professional body.

3.8.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.
b) Any other criteria as may be set out in any NHS England guidance apply.
c) Any locally determined exclusion criteria agreed by the ICB apply including:
    i. Compliance with the ICB Member Appointments Policy

3.8.3 This member will be appointed by an ICB appointments panel subject to the approval of the Chair. Membership of the appointments panel should be determined by the Chair and Chief Executive but must include at least one non-executive board Member and be supported by an HR professional.

3.9 Director of Nursing and Care

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

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.
b) Be a registered Nurse
c) Any other criteria as may be set out in any NHS England guidance.
d) Any other criteria as may be agreed by the ICB, including:
    i. Be a member of a recognised professional body.

3.9.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.
b) Any locally determined exclusion criteria agreed by the ICB apply including:

i. Compliance with the ICB Member Appointments Policy

c) Any other criteria as may be set out in any NHS England guidance apply.

3.9.3 This member will be appointed by an ICB appointments panel subject to the approval of the Chair. Membership of the appointments panel should be determined by the Chair and Chief Executive but must include at least one non-executive board Member and be supported by an HR professional.

3.10 Director of Finance

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

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

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

c) Any other criteria as may be agreed by the ICB, including:

i. Be a member of a recognised professional body.

3.10.2 Individuals will not be eligible if:

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

b) Any locally determined exclusion criteria agreed by the ICB apply including:

i. Compliance with the ICB Member Appointments Policy

c) Any other criteria as may be set out in any NHS England guidance apply.

3.10.3 This member will be appointed by an ICB appointments panel subject to the approval of the Chair. Membership of the appointments panel should be determined by the Chair and Chief Executive but must include at least one non-executive board Member and be supported by an HR professional.

3.11 Four Non-executive Members

3.11.1 The ICB will appoint four Non-executive Members.

3.11.2 These members will be appointed by an ICB appointments panel subject to the approval of the Chair. Membership of the appointments panel should be determined by the Chair and Chief Executive but must include at least one non-executive board member and be supported by an HR professional.

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) Meet the requirements as set out in the Non-Executive Director Person Specification
f) Any other criteria as may be set out in any NHS England guidance.
g) Any other criteria as may be agreed by the ICB.

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) Any locally determined exclusion criteria agreed by the ICB apply including:
   i. Compliance with the ICB Member Appointments Policy
d) Any other criteria as may be set out in any NHS England guidance apply.

3.11.5 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 (up to a total of nine years).

3.11.6 Initial appointments, on the creation of the ICB, may be for a shorter period than the usual three years. This will allow future appointments to be staggered and support continuity of membership on the board.

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

3.12 Board members: removal from office.

3.12.1 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. In accordance with 3.12.3, the Chief Executive may suspend the membership of any board member other than the Chair if they believe any of the criteria outlined at 3.12.3 apply. If any of these criteria apply to the Chair, the Chief Executive shall inform NHSE which shall determine the necessary steps to suspend the Chair and undertake any necessary investigation.

3.12.2 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 50% of the meetings to which they are invited over a six-month period unless agreed with the Chair in extenuating circumstances
c) If they are deemed to not meet the expected standards of performance at their annual appraisal
d) If they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the ICB and is likely to bring the ICB into disrepute. This includes but it is not limited to dishonesty; misrepresentation (either knowingly or fraudulently); defamation of any member of the ICB (being slander or libel); abuse of position; non-declaration of a known conflict of interest; seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise
e) If they are deemed to have failed to uphold the Nolan Principles of Public Life
f) If they are subject to disciplinary action by a regulator or professional body

3.12.3 Members may be suspended pending the outcome of an investigation into whether any of the matters in 3.12.2 apply. Such investigations will be undertaken by a Panel convened by the Chief Executive and Chair, the membership of which must include an HR professional. The outcome of any such investigation will be reported to the ICB for approval.

3.12.4 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.

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

3.12.6 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:

3.13.6.1 terminate the appointment of the ICB's chief executive; and

3.13.6.2 direct the chair of the ICB as to which individual to appoint as a replacement and on what terms.

3.13 Terms of appointment of board members

3.13.1 With the exception of the Chair, arrangements for remuneration and any allowances will be agreed by the Remuneration Committee in line with the ICB remuneration policy and any other relevant policies published at www.cheshireandmerseyside.nhs.uk and any guidance issued by NHS England or other relevant body. Remuneration for Chairs will be set by NHS England. Remuneration for Non-executive Members will be set by Remuneration Committee members other than Non-executive Members of the ICB

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

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

3.14 Specific arrangements for appointment of Ordinary Members made at establishment

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

3.14.2 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

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

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

3.14.5 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 Nolan Principles of Public Life and any governance guidance issued by NHS England.

4.1.2 The ICB has agreed standards of business conduct which set out the expected behaviours that members of the board and its committees will uphold whilst undertaking ICB business. It also includes a set of principles that will guide decision making in the ICB. The ICB Standards of Business Conduct Policy 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 at www.cheshireandmerseyside.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; and
c) those functions delegated to another body or to be exercised jointly with another body, under section 65Z5 and 65Z6 of the 2006 Act

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

4.5 Functions and Decision Map

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

4.5.2 The Functions and Decision Map is published at www.cheshireandmerseyside.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; and
d) functions delegated to the ICB (for example, from NHS England).

4.6 Committees and sub-committees

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

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

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

4.6.4 The board remains accountable for all functions, including those that it has delegated to committees and subcommittees and therefore, appropriate reporting and assurance arrangements are in place and documented in terms of reference. All committees and sub committees that fulfil delegated functions of the ICB, will be required to:
a) Submit regular reports of their business to the ICB.
b) Make minutes of their meetings available to the ICB.
c) Prepare an annual report outlining how it has delivered its responsibilities and submit this to the ICB.

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 SFIs and any other relevant ICB policy.

4.6.8 The following committees will be maintained:

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

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

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

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

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

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

4.7 Delegations made under section 65Z5 of the 2006 Act

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

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

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

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

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

5 Procedures for making decisions

5.1 Standing Orders

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

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

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

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

5.2 Standing Financial Instructions (SFIs)

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

5.2.2 A copy of the SFIs is published at www.cheshireandmerseyside.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 website at www.cheshireandmerseyside.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 one of its Non-executive Members to be the Conflicts of Interest Guardian. In collaboration with the ICB's governance lead, their role is to:

a) Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest;

b) Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest;

c) Support the rigorous application of conflict of interest principles and policies;

d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation; 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. All NHS C&M staff and members will:

a) Comply with the requirements of the NHS Constitution and NHS C&M Constitution and be aware of the responsibilities outlined within them;

b) Act in good faith and in the interests of the C&M ICS – including NHS C&M and place-based partnerships;

c) Adhere to the 'Seven Principles of Public Life (the Nolan Principles), and the NHS Code of Conduct and Code of Accountability (2004)2, maintaining strict ethical standards; and

d) Comply with NHS C&M policies on Business Conduct and managing Conflicts of Interest.

6.3 Declaring and registering interests

6.3.1 The ICB maintains registers of the interests of:

a) Members of the ICB.

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

c) Its employees.

6.3.2 In accordance with section 14Z30(2) of the 2006 Act registers of interest are published at www.cheshireandmerseyside.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); and
c) comply with the ICB Standards of Business Conduct Policy, and any requirements set out in the policy for managing conflicts of interest.

6.4.2 Board Members are expected to commit to:

a) The values of the NHS Constitution.
b) Promoting equality, diversity, inclusion
c) Promoting human rights in the treatment of patients and service users, their families and carers, the community, colleagues and staff, and in the design and delivery of services for which they are responsible.
d) Acting strategically while being informed by operational context.
e) Being open to challenge and when challenging delivering this in a supportive way.
f) Acting in a supportive and empowering way.
g) Being approachable and open.

6.4.3 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

7.2.1 The ICB will:

- Publish its intentions and operating procedures for involving people and communities.
- Involve people and communities in commissioning services for NHS patients, in accordance with our duties under section 14Z2 of the 2006 Act, and as set out in more detail in the ICB's Engagement and Communications strategy.
- Undertake and oversee public consultation in line with legal duties.

7.3 Meetings and publications

7.3.1 Board and committee meetings 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.

7.3.2 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:

- Standards of Business Conduct Policy
- Conflicts of interest policy and procedures
- Registers of interests
- Scheme of Reservation and Delegation
- Key policies

7.3.8 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:

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

And

- proposed steps to implement the Cheshire West and Chester; Cheshire East; Halton; Knowsley; Liverpool City; Sefton; St Helens; Warrington and Wirral joint local health and wellbeing strategies

7.4 Scrutiny and decision-making

7.4.1 Five Non-executive Members 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.

7.4.2 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 once it is introduced, and will comply with existing procurement rules until the Provider Selection Regime comes into effect including:

a) Following NHS policy
b) Promoting the NHS and its statutory partners.
c) Achieving best value.
d) Delivering for Cheshire and Merseyside while utilising and drawing upon the expertise within the ICS and securing the best possible outcomes for residents.

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 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 Committee 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. Committee members must never consider their own remuneration or allowances so the committee membership must be sufficiently broad to enable it to operate while effectively managing such conflicts of interest. 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) ICS HR team or their suppliers.
b) Independent HR advisers being in attendance to support the 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 at www.cheshireandmerseyside.nhs.uk

8.1.6 The duties of the Remuneration Committee 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) Evaluation and appraisal of the Executive Directors;
f) Consideration and approval of any severance payments on termination of office;
g) Ensuring compliance with the requirements for disclosure of directors' remuneration in the annual report and accounts; and
h) 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 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) Engagement with local Healthwatch.
b) Engagement with the Voluntary, Community and Faith Sector.
c) Public engagement via Place-based communications and engagement networks.
d) Engagement with Health and Wellbeing Boards and Local Authority Health Scrutiny Committees.

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

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

b) Start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions.

c) Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.

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

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

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

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

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

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

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

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

9.1.5 These arrangements, include collaborating with ICS system partners to develop appropriate mechanisms for the involvement of people and communities such as:

- ICS and Place-Based Citizens' Panels;
- Experts-by-Experience and Patient Leadership roles;
- Health Champions' networks;
- Engagement forums; and
- Co-production groups

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
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.
Director of Nursing and Care	The ICB role that satisfies the requirement for a "Director of Nursing" as stated at section 2.1.5
Health Service Body	Health service body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.
ICB board	Members of the ICB
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.
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.
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.
Partner Member	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are and appointed in accordance with the procedures set out in Section 3 having been nominated by the following: • NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description

	• the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description • the local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.
Sub-Committee	A committee created and appointed by and reporting to a committee.

Appendix 2: Standing Orders

1. Introduction

1.1. These Standing Orders have been drawn up to regulate the proceedings of NHS Cheshire and Merseyside 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 section 1.6 of the ICB's 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 governance lead, will provide a settled view which shall be final.

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

3.6. If, for any reason, these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal

meeting of the board for action or ratification and the Audit Committee for review.

4. Meetings of the Integrated Care Board

4.1. Calling board meetings

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

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

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

b) A majority 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 a non-executive member of the ICB board other than the Audit Committee Chair will take on the role and responsibility of chairing the

board meeting or agenda item in question. The non-executive member will not be expected to undertake the other duties of the ICB Chair when deputising in this way.

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

4.3. Agenda, supporting papers and business to be transacted

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

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

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

4.4. Petitions

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

4.5. Nominated deputies

4.5.1 With the permission of the person presiding over the meeting, the Executive Director Members may nominate a deputy to attend a meeting of the board that they are unable to attend. Executive Director Members should inform the Chair of their intention to nominate a deputy and should ensure that any such deputy is suitably briefed and qualified to act in that capacity. The deputy may speak and vote on their behalf.

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

4.6. Virtual attendance at meetings

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

4.7. Quorum

4.7.1 The quorum for meetings of the board will be a majority of members (eight), including:

a) The Chair and Chief Executive or their designated deputies;
b) At least one Executive Director (in addition to the Chief Executive or their nominated deputy);
c) At least one Non-Executive member;
d) At least one Partner Member; and
e) At least one member who has a clinical background or qualification.

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 (or the figure required to achieve a majority in accordance with 4.9.2, should that be required).

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:

- The Chair, in agreement with at least one non-executive board member, may nominate a suitably qualified / experienced person to cover a vacant position on the board until a full selection and appointment process can be undertaken.
- Any such nomination shall be subject to endorsement by the board.
- Should there be a vacancy in the Chair position, the ICB shall seek approval from NHSE to appoint a suitably qualified / experienced

person to cover the position on the board until a full selection and appointment process can be undertaken.

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 and are not precluded from taking part in a decision by reason of a conflict of interest will be eligible to cast one vote each.

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

c) For the sake of clarity, any additional participants and observers (as detailed within paragraph 5.6. of the Constitution) will not have voting rights.

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

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

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

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, having consulted the lead non-executive member in the case of committees) subject to every effort having made to consult with as many members as possible in the given circumstances.

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

4.10. Minutes

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

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

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

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

4.11. Admission of public and the press

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

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

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

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

5.1.1 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 2 other members.

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

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

6. Use of seal and authorisation of documents.

6.1.1 The ICB may have a seal for executing documents where necessary. The following individuals or officers are authorised to authenticate its use by their signature:

- the Chief Executive;
- the ICB Chair; and
- the Director of Finance

6.1.2 The Governance Lead shall keep a register of every sealing made and numbered consecutively in a book for that purpose. A report of all sealings shall be made to the ICB at least bi-annually.

NHS
Cheshire and Merseyside

Conflicts of Interest Policy & Procedure

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1. Organisational Context

1.1 NHS Cheshire and Merseyside Integrated Care Board (referred to in the policy as "NHS C&M") was established as a statutory body on 1 July 2022. NHS C&M operates in the 9 geographical areas of Cheshire, Halton, Knowsley, Liverpool, Sefton, St Helens, Southport & Formby, Warrington, and Wirral (referred to in the policy as "Places").

1.2 NHS C&M is a member of the C&M Integrated Care Partnership ("C&M ICP") alongside representatives from the local authorities, NHS providers, Healthwatch, and the voluntary and community sector across Cheshire and Merseyside.

1.3 All employees and members operate in accordance with agreed policies and the principles relating to business conduct which can be found in NHS C&M Standards of Business Conduct Policy (LINK).

2. Introduction

2.1 The guiding principle for this policy is to ensure that decisions are made in the public interest by avoiding any undue influence.

2.2 Effective handling of conflicts of interest is crucial to give confidence to patients, taxpayers, healthcare providers and parliament that NHS C&M decisions are robust, fair and transparent and offer value for money. It is essential in order to protect healthcare professionals and maintain public trust in the NHS. Failure to manage conflicts of interest could lead to legal challenge and even criminal action in the event of fraud, bribery and corruption.

2.3 NHS C&M acknowledges that conflicts of interest will be inevitable, and it is how they are managed that matters. The Health and Social Care Act 2022 ("the Act") sets out the minimum requirements of what both NHS England and NHS C&M must do in terms of managing conflicts of interest.

2.4 This policy adheres to the NHS-wide guidance, **Managing conflicts of interest in the NHS: Guidance for staff and organisations**[1], and principles as set out in **Guidance…on preparing integrated care board constitutions**[2]**.**

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

2.6 All individuals within NHS C&M must abide by the Seven Principles of Public Life as set out by the Committee on Standards in Public Life (attached at Appendix 1).

[1] NHS England » Managing Conflicts of Interest in the NHS: Guidance for staff and organisations

[2] www.england.nhs.uk/wp-content/uploads/2021/06/B1551--Guidance-to-Clinical-Commissioning-Groups-on-the-preparation-of-Integrated-Care-Board-constitutions.pdf

3. Scope

3.1 Who does the policy apply to?

Some staff/ post-holders are more likely than others to have an influence on the use of taxpayers' money, because of the requirements of their role. For the purposes of this policy these people are referred to as "decision-makers".

Though the training requirements may differ, dependent on individuals' roles, this policy applies to all individuals involved with the business or decision-making of NHS C&M. This includes:

3.1.1 **All NHS C&M staff members**, including:

- All full and part time staff
- Any staff on sessional or fixed/ short term contracts
- Any students and trainees (including apprentices)
- Agency staff; and
- Seconded staff

3.1.2 In addition, any self-employed consultants or other individuals working for NHS C&M under a contract for services should make a declaration of interest in accordance with this guidance, as if they were NHS C&M staff members.

3.1.3 **Members of the Board and members of NHS C&M committees and sub-committees.** All members of NHS C&M's committees, sub-committees/sub-groups, including:

- Co-opted members
- Appointed deputies; and
- Any members of committees/ groups from other organisations.

3.2 Where NHS C&M is participating in a joint committee alongside other organisations, any interests which are declared by the committee members should be recorded on the register(s) of interest of each participating organisation.

3.3 It is recognised that individuals, with a role within NHS C&M, may also have distinct or separate roles as providers of services or roles, responsibilities or accountabilities to another statutory organisation. High standards of probity and transparency are required when fulfilling both roles, however activities undertaken as providers of services are regulated and governed by the appropriate professional and regulatory bodies. While this policy relates to activities undertaken in relation to fulfilling NHS C&M responsibilities, in practice it may be difficult to draw a distinction between the two roles – see 4.2 below for further guidance.

4. Principles

4.1 The principles of collaboration, transparency and subsidiarity should be at the centre of all decision making. Decision-making will be geared towards meeting the statutory duties of ICBs at all times, including the triple aim[3]. Any individual involved in decisions relating to ICB functions will 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.

[3] The triple aim is a common duty for NHS bodies that plan and commission services (NHS England and ICBs) and that provide services (trusts and foundation trusts). It will oblige these bodies 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.

4.2 **Separation of Functions**

ICBs enable trusts/foundation trusts, local authorities, and primary medical services (general practice) provider nominees to have a role in decision-making. It is expected these individuals will act in accordance with the first principle (their role on the ICB), and while it should not be assumed that they are personally or professionally conflicted just by virtue of being an employee, director, partner or otherwise holding a position with one of these organisations, the possibility of actual and perceived conflicts of interests arising remains, and will be both **acknowledged and managed** by NHS C&M – with consideration given as to whether an individual's role in another organisation could result in actual or perceived conflicts of interest and whether or not these outweigh the value of the knowledge they bring to the process.

Using the separation of functions basis - a conflict would only arise if the individual or their organisation would benefit **specifically and directly** to the exclusion of some other organisations and as such would need appropriate controls in the event of a decision being made.

4.3 The personal and professional interests of all ICB board members, ICB committee members and ICB staff who are involved in decision-taking need to be declared, recorded and managed appropriately. A Declaration of Interests Register will be held by the ICB detailing all conflicts of interest declared; decision making roles will be included on a published version of the register available on the public website. See section 10.1 for further information.

4.4 NHS C&M will consider the composition of decision-making forums and clearly distinguish between those individuals who should be involved in formal decision-taking and those whose input informs decisions.

4.5 Actions to mitigate conflicts of interest will be proportionate and seek to preserve the spirit of collective decision-making wherever possible. Mitigation will take account of a range of factors including the perception of any conflicts and how a decision may be received if an individual with a perceived conflict is involved.

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

5. Definitions

5.1 What do we mean by "an interest"?

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

5.2 Four categories of interest can be defined:

Financial interests

Where an individual may get *direct financial benefits* from the consequences of a decision. For example, this could include being:

- A director, including a non-executive director, or senior employee in a company (public or private) or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations

- A shareholder (or similar ownership interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations
- A management consultant for a provider
- In secondary employment (see section 9)
- In receipt of secondary income from a provider
- In receipt of a grant from a provider
- In receipt of any payments (for example honoraria, one-off payments, day allowances or travel or subsistence) from a provider
- In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and
- Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).

Non-financial professional interests
Where an individual may obtain a non- financial professional benefit from the consequences of a decision, such as increasing their *professional reputation or status* or promoting their professional career. For example, including situations where the individual is:

- An advocate for a particular group of patients
- A provider with special interests e.g., in dermatology, acupuncture etc.
- A member of a particular specialist professional body (excluding routine memberships – RCGP, BMA or a medical defence organisation)
- An advisor for the Care Quality Commission (CQC) or the National Institute for Health and Care Excellence (NICE)
- A medical researcher

All members of the ICB or committees of NHS C&M, should declare details of their roles and responsibilities held within other organisations. These may be financial or non-financial in nature.

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. For example, where the individual is:

- A voluntary sector champion for a provider
- A volunteer for a provider
- A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation
- Suffering from a particular condition requiring individually funded treatment
- A member of a lobby or pressure group with an interest in health

Indirect interests
Where an individual has a close association with someone who has a financial interest, a non-financial professional interest or a non-financial personal interest in a decision (as those categories are described above) for example, a:

- Spouse/ partner
- Close relative e.g., parent, grandparent, child, grandchild or sibling
- Close friend
- Business partner.

Whether an interest held by another person gives rise to a conflict of interests will depend upon the nature of the relationship between that person and the individual, and the role of the individual within NHS C&M. Further guidance can be sought from the Conflicts of Interest Guardian, or Governance Team.

5.3 A conflict of interest may be:

- **Potential** – i.e. there is the possibility of a material conflict between one or more interests in the future;
- **Actual** - i.e. there is a material conflict between one or more interests; or
- **Perceived** – i.e. an observer could reasonably suspect there to be a conflict of interest regardless of whether there is one or not.

5.4 Further guidance on what might constitute a conflict of interest and example case studies can be found on the NHS England website:
https://www.england.nhs.uk/commissioning/pc-co-%20comms/coi/
https://www.england.nhs.uk/publication/managing-conflicts-of-interest-ccg-case-studies/
and within the NHS C&M ICB COI Awareness Training Slides – LINK

6. Roles and Responsibilities

This section outlines the roles and responsibilities of key individuals and significant groups with responsibility for managing conflicts of interest.

6.1 All staff and members

All staff and members should ensure they are aware of the principles and procedures outlined in this and other NHS C&M policies and take responsibility for ensuring they are familiar with the contents and the relevance to their role. They must comply with the requirements to declare interests; manage potential conflicts of interests; declare gifts, hospitality and sponsorship; and abide by all other requirements set out in the policy.

Staff and members will need to complete conflicts of interest training to raise awareness of the risks of conflicts of interest and to support them in managing conflicts of interest. See Section 17 for further information.

6.2 Chief Executive

The Chief Executive has overall accountability for NHS C&M's management of conflicts of interest. Operational responsibility for the management of conflicts of interest, declarations of interest and Hospitality register sits within NHS C&M's governance team led by the Assistant Chief Executive.

6.3 The Conflicts of Interest Guardian

The Conflicts of Interest Guardian role is to be undertaken by NHS C&M's Audit Committee Chair, provided they have no significant material provider interests, as this role already has a key role in conflicts of interest management. They are supported in this role by NHS C&M's Associate Director Corporate Affairs & Governance. The Conflicts of Interest Guardian shall:

- act as a conduit for all staff, members of the public and healthcare professionals who have any concerns with regards to conflicts of interest
- be a safe point of contact for staff or workers of NHS C&M to raise any concerns in relation to this policy
- support the rigorous application of conflict-of-interest principles and policies
- provide independent advice and judgment where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation
- provide advice on minimising the risks of conflicts of interest
- attest annually that NHS C&M has had due regard to the statutory guidance on managing conflicts of interest

6.4 Associate Director Corporate Affairs & Governance

The Associate Director Corporate Affairs & Governance responsibilities include being the designated governance lead for NHS C&M; responsible for the development and delivery of operational procedures to deliver the requirements of this policy. They are also responsible for keeping the Conflicts of Interest Guardian well briefed on conflicts of interest matters and supporting them deliver their role.

6.5 Non-Executive Board Members

Non-Executive Board members play a critical role in providing scrutiny, challenge and an independent voice in support of robust and transparent decision-making and management of conflicts of interest. Individual non-executive members play particular roles in chairing the Audit Committee and acting as the conflicts of interest guardian.

6.6 The Audit Committee

The Audit Committee has oversight of the arrangements in place to manage conflicts of interest.

7. Declaring Interests

7.1 **Written Declarations –** All persons referred to in section 3.1 must declare any interests they hold which are relevant to the work of NHS C&M. Declarations should be made as soon as reasonably practicable and, in any event, within 28 days after the interest arises (this could include an interest an individual is pursuing). Interests should be declared using the form attached at Appendix 2.

7.2 Declarations should be submitted to the Governance Team for review and sign off by the Associate Director Corporate Affairs & Governance; prior to being input on to the NHS C&M Register of Interests, and any necessary mitigations agreed.

7.3 Formal declarations should be submitted:

On appointment

Applicants for any appointment to NHS C&M or its Board or any committees should be asked to declare any relevant interests prior to undertaking the role. When an appointment is made, a formal written declaration of interests should again be made and recorded.

Annually

Formal, written declarations of interest should be submitted by all relevant individuals every year. Where there are no interests or changes to declare, a "nil return" should be made.

On changing role, responsibility or circumstances

Whenever an individual's role, responsibility or circumstances change in a way that affects the individual's interests (e.g., where an individual takes on a new role outside NHS C&M or enters into a new business or relationship), a further formal, written declaration should be made to reflect the change in circumstances as soon as possible, and in any event *within 28 days*.

7.4 Where an interest has been declared, the declarer will ensure that before participating in any activity connected with NHS C&M's exercise of its commissioning or other functions, they have received confirmation of and understand the arrangements to manage the conflict of interest or potential conflict of interest from the Associate Director Corporate Affairs & Governance and/ or COI Guardian (as described below). In cases of doubt or where the declarer is yet to receive details of the arrangements to mitigate the conflict, the declarer should withdraw from any such activity until the arrangements have been clarified.

7.5 Verbal Declarations

In addition to the written declarations described above, relevant verbal declarations must be made at meetings, as appropriate. All attendees are required to declare their interests as a standing agenda item for every Board, committee, sub-committee or working group meeting, before the business is discussed. Even if an interest has been recorded in the register of interests, it should still be declared in meetings *where matters relating to that interest are discussed*. Declarations of interest should be recorded in minutes of meetings.

8. Gifts, Hospitality and Sponsorship

8.1 Gifts

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

8.1.2 All **gifts offered** to individuals within the scope of this policy **by current or prospective suppliers or contractors** linked to NHS C&M's business should be declined and the offer should be declared. The only exceptions to the presumption to decline such gifts relates to items of low financial value (i.e., less than £6) such as diaries, calendars, stationery and other gifts acquired from meetings, events or conferences.

8.1.3 Such gifts may be accepted and do not need to be declared.

8.1.4 **Gifts offered from other sources** (i.e. not from suppliers/contractors or potential suppliers/contractors) should also be declined if accepting them might give rise to perceptions of bias or favouritism, and a common sense approach should be adopted as to whether or not this is the case. The general rules around the acceptance of such gifts are:

a) Modest gifts under a value of £50 may be accepted and do not need to be declared;
b) Gifts valued at over £50 should be treated with caution and only be accepted on behalf of an organisation, not in a personal capacity. Such gifts should be declared.
c) 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.

8.1.5 **Any personal gift of cash or cash equivalents** (e.g. vouchers, tokens, offers of remuneration to attend meetings whilst in a capacity working for or representing NHS C&M) must always be declined, whatever their value and whatever their source. The offer which has been declined must be declared to the governance lead for inclusion on the register of gifts and hospitality.

8.1.6 **Bequests from patients**

Where a clinician who is subject to this policy due to their role/relationship with NHS C&M is the beneficiary of the estate of a patient who was under their care (due to their clinical role as a provider of services), they should comply with the relevant professional and regulatory guidance issued by bodies including the British Medical Association and General Medical Council. Such instances should be declared to NHS C&M where they are relevant to that individuals' role with NHS C&M and could be considered to represent a conflict of interest in carrying out that role.

8.1.7 **Donations to the organisation**
Staff members must check with the Associate Director of Corporate Affairs & Governance before making any requests for donations 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.

8.1.8 **Donations/ Gifts from individuals, charities, companies** (as long as they are not associated with known health-damaging products) – often related to individual pieces of equipment or items – provide additional benefits to patients but may have resource implications for NHS C&M. Further guidance regarding charitable funds and gifts and donations can be requested from the Executive Director of Finance.

8.1.9 Any gifts to the organisation should be receipted, through the finance team and a letter of thanks should be sent.

8.2 Hospitality

8.2.1 A blanket ban on accepting or providing hospitality is neither practical nor desirable from a business point of view. However, individuals should be able to demonstrate that the acceptance or provision of hospitality would benefit the NHS or NHS C&M.

8.2.2 Modest hospitality provided in normal and reasonable circumstances may be acceptable, although it should be on a similar scale to that which NHS C&M might offer in similar circumstances (e.g. tea, coffee, light refreshments at meetings). A common sense approach should be adopted as to whether hospitality offered is modest or not. "Modest" hospitality may be considered hospitality with an estimated value under £25. Hospitality of this nature does not generally need to be declared to the governance lead.

8.2.3 Exceptions to this include, when offers of modest hospitality should be declared and recorded on the register, are where:

- Such hospitality is offered by current or prospective suppliers or contractors linked to NHS C&M's business (whether or not such an offer is accepted). Offers of this nature can be accepted if they are modest and reasonable but advice should be sought from a senior member of NHS C&M (e.g. a Director or ICB Chair) as there may be particular sensitivities, for example if a contract re-tender is imminent.
- Several such offers from the same or a closely related source amounting to an estimated value above £100 in a 12 month period.

8.2.4 Offers of meals and refreshments valued at between £25 and £75 may be accepted and must be declared for inclusion on the register.

8.2.5 There is a presumption that the following should be politely refused:

- offers of hospitality which go beyond a value of £75 (for meals and refreshments); or
- offers of travel or accommodation that go beyond a type that NHS C&M itself might offer, such as business or first class travel and accommodation and offers of foreign travel and accommodation.

8.2.6 There may be some limited and exceptional circumstances where accepting such hospitality may be contemplated. **Express prior approval should be sought from a senior manager or officer of NHS C&M (e.g. a Director or the ICB Chair)** before accepting such offers, and the reasons for acceptance should be recorded in NHS C&M's register of gifts and hospitality. Hospitality of this nature should be declared to the governance lead and recorded on the register, whether accepted or not.

8.2.7 The acceptance of such hospitality may be perceived as a potential conflict of interest. In these circumstances, a written declaration of interests return should also be made.

8.3 Sponsorship

8.3.1 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" (November 2000). 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 NHS C&M and for NHS C&M 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 sponsor and the NHS.

8.4 Sponsored Posts

8.4.1 Staff who are considering entering into an agreement regarding the external sponsorship of a post within NHS C&M or a place-based partnership must seek formal approval from the Chief Executive. Staff will be required to demonstrate acceptance of a sponsored post is transparent and does not stifle competition.

8.4.2 There should be written confirmation that the sponsorship arrangements will have no effect on any commissioning or other management decisions over the duration of the sponsorship and auditing arrangements should be established to ensure that this is the case. These written arrangements should set out the circumstances under which sponsorship arrangements can be exited if conflicts of interest arise which cannot be mitigated.

8.4.3 Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and confirm the appropriateness of the arrangements continuing.

8.4.4 Holders of sponsored posts must not promote or favour the sponsor's specific products or organisation and information about alternative suppliers must be provided. Sponsors must not have any influence over the duties of the post or have any preferential access to services, materials or intellectual property related to or developed in connection with the sponsored post.

8.4.5 **All such arrangements, including offers of sponsorship from external parties that are subsequently declined – must be declared to NHS C&M's governance lead so they can be included on NHS C&M's register of gifts, hospitality and sponsorship.**

8.5 Sponsored events

8.5.1 Sponsorship of events, including courses, conferences and meetings, by external bodies should only be approved if it can be demonstrated that the event will result in clear benefits for NHS C&M and the wider NHS. Sponsorship should not in any way compromise any of NHS C&M's decisions or be dependent on the purchase or supply of goods or services. Sponsors should not have any influence over the content of an event, meeting, seminar, publication or training event – NHS C&M is not to appear to endorse individual companies or their products or services because of the sponsorship.

8.5.2 During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection (or other) legislation. As a rule, information which is not in the public domain should not be supplied and no information should be supplied to a company for its commercial gain.

8.5.3 At the discretion of NHS C&M, sponsors or their representatives may attend or take part in the event, but they should not have a dominant influence over the content or the main purpose of the event. The involvement of a sponsor in an event should always be clearly identified in the interests of transparency.

8.5.4 NHS C&M staff should discuss any proposals/ offers of sponsorship of events with the relevant Director. The Director, or staff member following approval from the relevant Director, should consult with the governance lead on the appropriateness of accepting any such sponsorship before approving any such arrangement. The governance lead may consult the Conflicts of Interest Guardian when considering the proposal.

8.5.5 ICB / committee members should discuss any proposals / offers of sponsorship of events with the ICB Chair. The Chair, or ICB / committee member with explicit approval from the Chair, should consult with the governance lead on the appropriateness of accepting any such sponsorship before approving any such arrangement. The governance lead may consult the Conflicts of Interest Guardian when considering the proposal.

8.5.6 **All such arrangements – including offers of sponsorship from external parties that are subsequently declined - must be declared to NHS C&M's governance lead so they can be included on NHS C&M's register of gifts, hospitality and sponsorship.**

8.6 Sponsored research

8.6.1 Funding sources for research purposes must be transparent.

8.6.2 There must be a written protocol and written contract between NHS C&M and the institute 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. Where the contract includes provision of people this, and accompanying arrangements, must be clearly articulated.

8.6.3 The study must not constitute an inducement to commission any service.

8.6.4 NHS C&M staff should discuss any proposals / offers of sponsored research with the relevant Director. The relevant Director, or staff member with explicit approval from their Director, should consult with the governance lead on the appropriateness of accepting any such sponsorship before approving any such arrangement. The governance lead may consult the Conflicts of Interest Guardian when considering the proposal.

8.6.5 ICB / committee members should discuss any proposals / offers of sponsored research with the ICB Chair. The Chair, or ICB/committee member with explicit approval from the Chair, should consult with the governance lead on the appropriateness of accepting any such sponsorship before approving any such arrangement. The governance lead may consult the Conflicts of Interest Guardian when considering the proposal.

8.6.6 **All such arrangements – including offers of sponsorship from external parties that are subsequently declined - must be declared to NHS C&M's governance lead so they can be included on NHS C&M's register of gifts, hospitality and sponsorship.**

8.7 Joint Working with the Pharmaceutical Industry (PI)

8.7.1 Joint working between NHS C&M and the PI must be for the benefit of patients or the NHS and preserve patient care, the main beneficiary being the patient. Joint working arrangements must be entered into at a corporate level and not with any individual member of staff or ICB member. All pharmaceutical companies entering into sponsorship agreements must comply with the Code of Practice for the Pharmaceutical Industry.

8.7.2 NHS C&M staff member considering entering discussion with the PI about joint working (referred to subsequently as "the designated lead") should:

- First discuss the outline proposal with their line manager and relevant clinical leads.
- If that proposal is supported by the line manager / clinical leads, the designated lead should consult the Director of Nursing and governance lead on the appropriateness of pursuing any such arrangement.

- If that proposal is supported by the Director of Nursing and governance lead, the designated lead should provide an outline proposal for the arrangements in accordance with **NHS C&M's Standards of Business Conduct Policy Appendix 3: Working with the Pharmaceutical Industry Policy** and submit a summary to the Audit Committee for consideration and formal approval.

8.7.3 **All such arrangements must be declared to NHS C&M's governance lead so they can be included on NHS C&M's register of gifts, hospitality and sponsorship.**

8.8 Rewards for Initiative

8.8.1 NHS C&M will identify potential intellectual property rights (IPR), as and when they arise, so that they can protect and exploit them properly, and thereby ensure that they receive any rewards or benefits (such as royalties), in respect of work commissioned from third parties, or work carried out by individuals in the course of their NHS duties. Most IPR are protected by statute; e.g. patents are protected under the Patents Act 1977 and copyright (which includes software programmes) under the Copyright Designs and Patents Act 1988. To achieve this, NHS organisations and employers should build appropriate specifications and provisions into the contractual arrangements which they enter into before the work is commissioned, or begins. They should always seek legal advice if in any doubt, in specific cases.

8.8.2 With regard to patents and inventions, in certain defined circumstances the Patents Act gives staff or individuals in the course of their duties a right to obtain some reward for their efforts, and NHS C&M will see that this is affected. Other rewards may be given voluntarily to staff or other individuals who, within the course of their employment or duties, have produced innovative work of outstanding benefit to the NHS.

8.8.3 In the case of collaborative research and evaluative exercises with manufacturers, NHS C&M will obtain a fair reward for the input they provide. If such an exercise involves additional work for an NHS C&M employee or individual outside that paid for by NHS C&M under his or her contract of employment, or sessional arrangements, arrangements may be made for some share of any rewards or benefits to be passed on to the employee(s) or individuals concerned from the collaborating parties. Care will, however, be taken that involvement in this type of arrangement with a manufacturer does not influence the purchase of other supplies from that manufacturer.

9. Secondary Employment

9.1 For the purposes of this section, "secondary employment" includes part-time, temporary and fixed term contract work as well as "one-off" payments for advice or services provided and ad hoc/ occasional sessional cover within another organisation e.g. locum work.

9.2 Individuals must obtain prior permission to engage in secondary employment, and NHS C&M reserve the right to refuse permission where it believes a conflict will arise which cannot be effectively managed.

9.3 In particular, it is unacceptable for pharmacy advisers or other advisers, staff or consultants to NHS C&M on matters of procurement to themselves be in receipt of payments from the pharmaceutical or devices sector.

9.4 Staff members should not engage in outside employment during any periods of sickness absence from NHS C&M. 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 NHS C&M's Anti-Fraud Policy.

9.5 **Additional Employment/ Consultancy Work**
All individuals identified at Section 3.1, are required to inform NHS C&M if they are employed or engaged in, or wish to be employed or engage in, any employment or consultancy work in addition to their work with NHS C&M. The purpose of this is to enable the appropriate check on any potential conflict of interest related to secondary/ additional employment. Examples of work which might conflict with the business of NHS C&M include:

- Employment with another NHS body
- Employment with another organisation which might be in a position to supply goods/services to NHS C&M
- Employment within a Provider Collaborative
- Directorship of a Primary Care Network/ Alliance or Federation; and
- Self-employment, including private practice, in a capacity which might conflict with the work of NHS C&M or which might be in a position to supply goods/services to NHS C&M.

9.6 All individuals declaring secondary or additional employment, as above, should clearly state the agreed or approximate hours expected to be worked each week, and details of the value e.g. income (hourly rate or one of payment). Such details may not be published in the register of interests, but will be used to assess the level of risk and ensuing mitigations applied.

9.7 **Payment for speaking at a meeting/conference**
Staff acting on behalf of NHS C&M, who are asked to speak at an event relating to NHS C&M business for which a payment is offered must have agreement in advance from their line manager, and any payment should be credited to NHS C&M.

9.8 When considering such offers, consideration must be given to the general principles outlined in this policy around the appropriateness of accepting any such offer (either to speak or to accept payment).

10. Maintaining Registers of Interest and Gifts and Hospitality

10.1 NHS C&M will maintain one or more registers of interest and one or more registers of gifts and hospitality. Register(s) of interest shall be maintained for each of the groups identified at section 4. NHS C&M will publish the register(s) of interest of the following groups in a prominent place on NHS C&M's websites:

- Members of the Board
- Members of NHS C&M committees and sub-committees; and
- Other senior NHS C&M staff members / decision-makers.

10.2 An interest shall remain on the public register for a minimum of 6 months after the interest is deemed to have expired. In addition, NHS C&M will retain a private record of historic interests for a minimum of 6 years after the date on which they are deemed to have expired. NHS C&M's published register of interests shall state that historic interests are retained by NHS C&M for the specified timeframe, with details of whom to contact to submit a request for this information.

10.3 In exceptional circumstances, where the public disclosure of information could give rise to a real risk of harm or is prohibited by law, an individual's name and/or other information may be redacted from the publicly available register(s).Where an individual believes that substantial damage or distress may be caused, to him/herself or somebody else by the publication of information about them, they are entitled to request that the information is not published. Such requests must be made in writing.

Decisions not to publish information must be made by the Conflicts of Interest Guardian who should seek appropriate legal advice where required, and NHS C&M should retain a confidential un-redacted version of the register(s).

10.4 The Audit Committee will review the registers at least annually.

11. Appointments

11.1 Candidates for Appointment

11.1.1 Candidates for any appointment with NHS C&M must disclose in writing if they are related to or in a significant relationship with (e.g. spouse or partner to) any Board member or employee of NHS C&M. The NHS Jobs application form requests this information and therefore must be disclosed before submission.

11.1.2 A member of an appointment panel which is to consider the employment of a person to whom he/she is related must not take part in the interview process.

11.1.3 Candidates for any appointment with NHS C&M 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 NHS C&M.

11.2 Canvassing for Appointment

11.2.1 It is acknowledged that informal discussions concerning an advertised post can be part of the recruitment process. Canvassing or lobbying of NHS C&M's staff members, 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 and not through any such canvassing or lobbying.

11.3 Appointing Board or committee members and senior staff members

11.3.1 On appointing Board, committee or sub-committee members and senior staff, NHS C&M will consider whether conflicts of interest should exclude individuals from being appointed to the relevant role. This will be considered on a case-by-case basis.

11.3.2 NHS C&M will assess the materiality of the interest, in particular whether the individual (or any person with whom they have a close association) could benefit (whether financially or otherwise) from any decision NHS C&M might make. This will be particularly relevant for Board, committee and sub-committee appointments, but will also be considered for all staff and especially those operating at senior level.

11.3.3 NHS C&M will also determine the extent of the interest and the nature of the appointee's proposed role within NHS C&M. If the interest is related to an area of business significant enough that the individual would be unable to operate effectively and make a full and proper contribution in the proposed role, then that individual should not be appointed to the role.

11.3.4 Any individual who has a material interest in an organisation which provides, or is likely to provide, substantial services to a NHS C&M (whether as a provider of healthcare or support services, or otherwise) should recognise the inherent conflict of interest risk that may arise and should not be a member of the Board or of a committee or sub-

committee of NHS C&M, in particular if the nature and extent of their interest and the nature of their proposed role is such that they are likely to need to exclude themselves from decision-making on so regular a basis that it significantly limits their ability to effectively perform that role.

12. Primary Care Commissioning

12.1 Arrangements for managing conflicts of interest in the commissioning of primary medical care services will accord with any requirements set out in the Delegation Agreement with NHS England.

13. Making Declarations at Meetings

13.1 NHS C&M uses a variety of different groups to make key strategic decisions about things such as:

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

13.2 Conflicts of interest could potentially arise at various stages of the development, review and approval process. The interests of those involved in this process and the associated groups involved in development/ decision-making should be well known so they can be managed effectively. Meetings of any such groups should operate in accordance with the principles detailed in this policy.

13.3 **Formal Declarations at Meetings**

13.3.1 Each Board, committee and sub-committee agenda will include an item for the Declaration of Interests. It is the responsibility of individuals to declare any interest they have which may represent a conflict of interest in the business of any such meeting they attend.

13.3.2 Wherever possible, potential conflicts of interests should be brought to the attention of the meeting chair in advance of the meeting. At the very least, they must be declared at the beginning of the meeting and the individual must comply with the agreed treatment of the potential conflict at the appropriate point in the meeting.

a) Where an individual declares an interest relating to the scheduled or likely business of the meeting **which they have previously declared in writing**, the individual concerned will bring this to the attention of the chair of the meeting, together with details of arrangements which have been confirmed for the management of the conflict of interests or potential conflict of interests.

The chair of the meeting will then determine how this should be managed and inform the member of their decision, taking into account any such arrangements already confirmed for the management of the conflict of interests or potential conflict of interests. The chair of the meeting may require the individual to withdraw from the meeting or part of it and/or may direct that such an individual will not be able to vote on the issue. The chair's decision will be final in the matter and the individual will then comply with these arrangements, which must be recorded in the minutes of the meeting.

b) Where an individual declares an interest relating to the scheduled or likely business of the meeting **which they have not previously declared in writing**, the individual concerned will bring this to the attention of the chair of the meeting.

The chair of the meeting will then determine how this should be managed and inform the member of their decision. The chair of the meeting may require the individual to withdraw from the meeting or part of it and/or may direct that such an individual will not be able to vote on the issue. The Chair's decision will be final in the matter and the individual will then comply with these arrangements, which must be recorded in the minutes of the meeting.

13.3.3 Where the chair of a meeting has a potential conflict of interest, whether previously declared or otherwise, in relation to the scheduled or likely business of the meeting, they must make a declaration and the deputy chair will act as chair for the relevant part of the meeting. Where there is no deputy chair, or the deputy chair also has a potential conflict of interest, the members of the meeting will select another individual to act as chair.

13.3.4 Any verbal declarations of interests not previously declared in writing must be followed by the submission of a written declaration (using the declarations of interest form attached at Appendix 2), and signed off by the Associate Director Corporate Affairs & Governance; including any mitigations agreed by the Committee Chair.

13.4 Declarations and issues with Quorum

13.4.1 Where more than 50% of the members of a meeting are required to withdraw from a meeting or part of it, owing to the arrangements agreed for the management of conflicts of interests or potential conflicts of interests, the chair (or deputy) will determine whether or not the discussion can proceed.

13.4.2 In making this decision the chair will consider whether the meeting is quorate, in accordance with the number and balance of membership set out in NHS C&M standing orders. Where the meeting is not quorate, owing to the absence of certain members, the discussion will be deferred until such time as a quorum can be convened. Where a quorum cannot be convened from the membership of the meeting, owing to the arrangements for managing conflicts of interest or potential conflicts of interests, the chair of the meeting shall consult with the Associate Director Corporate Affairs and Governance and/ or Chief Executive on the action to be taken.

13.4.3 This action may include requiring another of the groups' committees or sub-committees, Board or its committees or sub-committees (as appropriate) which can be quorate to progress the item of business or inviting another individual (who is permitted to be a member of the committee, sub-committee or Board as appropriate) to attend on a temporary basis to progress the item of business. These arrangements must be recorded in the minutes.

13.4.4 Where appropriate, the Chief Executive will also put into place any further arrangements as a result of application of this Policy, in order to ensure that decisions and the business of NHS C&M may continue. Such steps may involve co-opting individuals onto the Board (e.g. from another NHS C&M or the Health and Wellbeing Board) or asking them to review the proposal.

13.5 Minute Taking

13.5.1 If any conflicts of interest are declared or otherwise arise in a meeting, the chair must ensure the following information is recorded in the minutes:

- who has the interest
- the nature of the interest and why it gives rise to a conflict, including the magnitude of any interest

- the items on the agenda to which the interest relates
- how the conflict was agreed to be managed; and
- evidence that the conflict was managed as intended (for example recording the points during the meeting when particular individuals left or returned to the meeting).

13.6 Register of procurement decisions

13.6.1 NHS C&M needs to be able to identify and manage any conflicts or potential conflicts of interest that may arise in relation to the procurement of any services, or the administration of grants. "Procurement" relates to the purchase of goods, services and works, and the term "procurement decision" should be understood in a wide sense to ensure transparency of decision making on spending of public funds. It should include:

- Entering into a new contract
- Extending an existing contract or
- Materially altering the terms of an existing contract

13.6.2 The ICB will put in place a register of procurement decisions, which will include information on:

- the details of the decision
- who was involved in making the decision (i.e. Board or committee members and others with decision-making responsibility); and
- a summary of any conflicts of interest in relation to the decision and how this was managed by the ICB

13.6.3 The procurement decision register will be updated whenever a procurement decision is taken; and an updated version uploaded to the public website each quarter. The register will also be available upon request for inspection.

13.6.4 Whenever interests are declared during the procurement process, they will be reported to the Associate Director Corporate Affairs & Governance who will then ensure the Declarations of Interest is updated accordingly.

14. Raising Concerns

14.1.1 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.

14.1.2 Individuals who have concerns regarding conflict of interest or ethical misconduct either in respect of themselves or colleagues should raise it in the first instance with their manager. If the concern relates to any suspected fraudulent practice, staff should follow the advice given in section below on Fraud/Theft.

14.2 Confidentiality

14.2.1 Staff, NHS C&M members, members of the Board, or a member of a committee or a sub-committee of NHS C&M are bound by the Data Protection Act 1998 NHS C&M's policies relating to confidential information and (as applicable) professional and ethical rules, guidelines and codes of conduct on confidentiality.

14.2.2 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, professional and/or criminal action.

14.3 Fraud/Theft/Bribery

14.3.1 If you suspect theft, fraud, or other untoward events (including bribery) taking place at work you should:

- Make a note of your concerns; and
- In the case of theft contact your Local Security Management Specialist;
- In the case of suspected fraud and/or bribery contact the Local Counter Fraud Specialist on 0151 285 4500
- You can also report to the national NHS Fraud and Corruption Reporting Line on 0800 028 40 60 or www.reportnhsfraud.nhs.uk.
- You should not investigate the issue yourself.

14.3.2 NHS England's *Tackling Fraud, Bribery & Corruption: Policy & Corporate Procedures* document defines fraud as "the dishonest intent to obtain a financial gain from, or cause a financial loss to, a person or party through false representation, failing to disclose information or abuse of position". Examples of fraud include:

- For staff - Use of false qualification certificates and references in order to gain employment; Claiming for hours not worked; Working whilst off sick; Claiming for travel and other expenses not incurred; Managers obtaining goods and services for personal use; Creation of ghost employees. This list is not exhaustive.
- For contractors – GPs: creating ghost patients; claiming for services provided to ghost employees including production of false prescriptions; claiming for services not provided (enhanced services); raising false prescriptions for self-medicating; Accepting bribes to register overseas visitors/ Pharmacists: claiming for medication not dispensed; claiming for services not provided; failure to declare prescription charges collected; creation of claims for ghost patients/ Dentists and opticians: claiming for higher number of Units of Dental Activity than provided; Optician claiming NHS allowances for individuals who are not entitled. This list is not exhaustive.

14.3.3 The Guidance to the Bribery Act 2010 offers the following definition of bribery: "Very generally, this is defined as giving someone a financial or other advantage to encourage that person to perform their functions or activities improperly or to reward that person for having already done so. So this could cover seeking to influence a decision-maker by giving some kind of extra benefit to that decision maker rather than by what can legitimately be offered as part of a tender process". The Act also introduces a corporate offence of failing to prevent bribery by an organisation not having adequate preventative procedures in place. NHS C&M's Anti-Bribery Strategy makes clear that NHS C&M "do not, and will not, pay bribes or offer improper inducements to anyone for any purpose; nor do we, or will we, accept bribes or improper inducements. This approach applies to everyone who works for us, or with us. To use a third party as a conduit to channel bribes to others is a criminal offence. We do not, and will not, engage indirectly in, or otherwise encourage, bribery."

14.4 Concerns regarding conflicts of interest

14.4.1 It is the duty of every NHS C&M employee, Board member, committee or sub-committee member and GP practice member to speak up about genuine concerns in relation to the administration of NHS C&M's policy on conflicts of interest management, and to report these concerns. These individuals should not ignore their suspicions or undertake investigations themselves but should generally speak to NHS C&M's designated Conflicts of Interest Guardian to raise any concerns in the first instance.

14.4.2 Non-compliance with NHS C&M's conflicts of interest policy should be reported in accordance with this policy, NHS C&M's whistleblowing policy (where the breach is being reported by an employee or worker of NHS C&M) or the whistleblowing policy of

the relevant employer organisation (where the breach is being reported by an employee or worker of another organisation).

14.4.3 All such notifications will be treated with appropriate confidentiality at all times in accordance with NHS C&M's policies and applicable laws, and the person making such disclosures should expect an appropriate explanation of any decisions taken as a result of any investigation.

14.4.4 Anonymised details of breaches will be published on NHS C&M's website for the purpose of learning and development.

15. Breach of the Policy

15.1 In accordance with NHS C&M's Constitution, NHS C&M will uphold "the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business".

15.2 Compliance with all NHS C&M policies, procedures, protocols, guidelines, guidance and standards is a condition of employment. Breach of policy may result in disciplinary action. Failure to comply with this Policy, including failure to notify NHS C&M of a conflict of interest, additional employment or business may lead to disciplinary or regulatory action against the individual and/or criminal action (including prosecution) under the relevant legislation.

15.3 Individuals who fail to disclose any relevant interests or who otherwise breach NHS C&M's rules and policies relating to the management of conflicts of interest are subject to investigation and, where appropriate, to disciplinary action or referral to the relevant regulatory body.

15.4 It is the duty of every staff member, Board/ Committee member, or sub-committee member to speak up about genuine concerns in relation to the administration of the ICB's policy on conflicts of interest management, and to report these concerns to the Associate Director: Corporate Affairs & Governance, or the Conflict of Interest Guardian.

15.4 The Conflicts of Interest Guardian, with support from Associate Director Corporate Affairs & Governance, will undertake an initial investigation of the alleged breach. In doing so, they will maintain an appropriate record of the potential breach and the subsequent investigation; establishing:

- If a breach has actually occurred
- The nature of that breach
- The impact of the breach
- The arrangements in place at that time that could have prevented the breach
- The learning as a consequence
- What remedial action is required
- What other policies may need to be engaged to address the breach e.g., but not limited to, Anti-Fraud, Bribery and Corruption Policy, HR related policies or the Whistleblowing (Freedom to Speak Up) Policy.

15.5 If necessary, support will be sought from Human Resources and a referral will be made to the local counter fraud team to undertake further investigation. Anonymised reports on any alleged breaches will be submitted to the Audit Committee. Anonymised reports

on breaches of the policy will be published and reported to NHS England as appropriate (in accordance with national guidance).

15.6 All breaches will be published on the ICB website as part of an annual publication in April each year.

15.6 Open source audit checks by NHS C&M and/ or a Local Counter Fraud Specialist will take place on a regular basis.

16. Monitoring and Reporting

16.1 Compliance with this policy will be reviewed by the Audit Committee.

17. Training and Awareness

17.1 Mandatory training on managing conflicts of interest will be given to all new starters at the corporate induction – copies of the COI Awareness Training slides can be found at LINK.

17.2 NHS C&M's governance team will co-ordinate the delivery of additional conflicts of interest training for Board members and other key staff / attendees of NHS C&M Committees and sub-committees as required. This training will provide opportunity for attendees to discuss and work through potential scenarios for conflicts of interest pertinent to local systems.

18. Dissemination and Implementation

18.1 This policy will be disseminated throughout C&M via the regular communication channels and will be available on both the intranet and public website.

18.2 Generic responsibilities in relation to standards of business conduct are included in individuals' job / role descriptions. Specific responsibilities in relation to managing conflicts of interest will be outlined in job / role descriptions of relevant members of staff.

19. Review

19.1 This policy will be reviewed in 3 years, or earlier if there are changes to national guidance or there are significant changes to the structure or operation of NHS C&M which impact on this policy.

Appendix 1: The Committee on Standards in Public Life's Seven Principles of Public Life (known as the Nolan Principles)

- **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 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 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.

Appendix 2: Declaration of interests' form

Name:			
Position within, or relationship with, NHS C&M:			
Are you a Voting member of an ICB Committee – if YES please specify	COMMITTEE(s):	VOTING MEMBER:	NON VOTING MEMBER:
Are you a Voting member of a Place-based Committee – if YES please specify	COMMITTEE(s):	VOTING MEMBER:	NON VOTING MEMBER:

Type of Interest* *See attachment for details *(If Indirect, please explain your relationship with the person that holds the interest)*	***Description of the Interest, including:*** • ***Name and details of the organisation (or subject);*** • ***The nature of the role / relationship with it which constitutes an interest.*** *(Please include positions within any provider organisation or GP practice; directorships; ownership / part-ownership of companies; shareholdings in companies in the field of health & social care; positions of authority in any organisation linked with health & social care; any research or funding grants received;* ***any other role or relationship which could be perceived to influence your judgement when acting for NHS C&M)*** *For secondary employment please state time & value impact of role(s).*	**The dates the interest remains valid** *(e.g. the length of tenure in a particular position)* **From:**	**To:**	**Actions to be taken to mitigate the conflict of interest** *(If already agreed with Associate Director Corporate Affairs/ Chief Executive or COI Guardian)*

The information submitted will be held by NHS C&M for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that NHS C&M holds.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to NHS C&M as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, or internal disciplinary action may result.

I **do / do not [delete as applicable]** give my consent for this information to published on registers that NHS C&M holds. If consent is NOT given please give reasons:

Signed: …… **Date**: ……..
(Individual)

Please return completed, approved form to **ICB Governance Team** **EMAIL**

Reviewed & Added to Register – Mitigation agreed where relevant

Signed: …….. **Date:** ……..
(Associate Director Corporate Affairs & Governance)

Appendix 3: Definition of types of interest

Type of Interest	Description
Financial Interests See following sections in the policy for further information: **Section 8** (8.1.5 & 8.8) **Section 9** (9.6 & 9.7)	This is where an individual may get direct financial benefits from the consequences of a decision. This could, for example, include being: • A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations • A shareholder (or similar owner interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations. • A management consultant for a provider • In secondary employment: **details of secondary/ additional employment must include value (hourly rate or one-off payment) & time commitment in that role** • In receipt of income from a provider • In receipt of a grant from a provider • In receipt of any payments (for example honoraria, one off payments, day allowances or travel or subsistence) from a provider • In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and • Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).
Non-Financial Professional Interests	This is where an individual may obtain a non-financial professional benefit from the consequences of a decision, such as increasing their professional reputation or status or promoting their professional career. This may, for example, include situations where the individual is: • An advocate for a particular group of patients • A provider with special interests e.g., in dermatology, acupuncture etc. • A member of a particular specialist professional body (although routine GP membership of the RCGP, BMA or a medical defence organisation would not usually by itself amount to an interest which needed to be declared); • An advisor for Care Quality Commission (CQC) or National Institute for Health and Care Excellence (NICE) • A medical researcher.
Non-Financial Personal Interests	This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is: • A voluntary sector champion for a provider • A volunteer for a provider • A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation • Suffering from a particular condition requiring individually funded treatmen • A member of a lobby or pressure groups with an interest in health.
Indirect Interests	This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a decision (as those categories are described above). For example, this should include: • Spouse/ partner • Close relative e.g., parent, grandparent, child, grandchild or sibling • Close friend • Business partner.

Appendix 4: Register of declared interests

				Type of Interest (Y/N)				Date interest is relevant		
Name	Role/ Position within/ relationship with NHS C&M	Committees Membership Note VOTING or NON VOTING member	Description of the Interest, including the name and details of the organisation (or subject) and the nature of the role / relationship with it that constitutes an interest.	Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Direct (D) or Indirect (I) Interest	From:	To:	Action Taken to mitigate potential conflicts of interest

Appendix 5: Guidance on standard treatment of potential conflicts of interest

Where it may be perceived that your interests could adversely influence your ability to act in an open and transparent manner:

In all cases:

- You should alert the chair of any meeting you are scheduled to attend where the business of that meeting relates to the interests you hold. You should do this in advance of the meeting whenever possible. In doing so, you should confirm the agreed treatment of the potential conflict of interest with the chair (with reference to the guidance set out below);
- You should declare the interest at any such meeting.
- You should alert the appropriate NHS C&M lead on any working group, project work or other activity you are involved in, or are invited to be involved in, of any interests you hold which may constitute a potential conflict of interest while undertaking that role.

If you have an interest which represents a direct financial interest either to you, or someone you are closely associated with (i.e. where you as an individual, or someone you have a close relationship with, may benefit financially from a decision. This includes potential financial benefits received as a partner, member or shareholder in an organisation):

- You should participate in general discussion on related topics at the discretion of the chair. If it is considered that you should not participating in the discussion the chair may direct that you leave the meeting for the duration of any such discussion;
- You should withdraw from discussion(s) on the awarding of contracts, or the making of recommendations on the awarding of contracts, which relate to the interests you hold; You should do this by not participating in the discussion / leaving the meeting for the duration of any such discussion (as directed by the chair of the meeting);
- You should withdraw from the making of decisions on the awarding of contracts which relate to the interests you hold; You should do this by not participating in the decision / leaving the meeting for the duration of any such discussion (as directed by the chair of the meeting).
- You should participate in working groups, project work or other activity undertaken on behalf of NHS C&M which relate to the interest you hold, as directed by NHS C&M. If you have not received directions from NHS C&M and become aware of a potential conflict of interest you should withdraw from any such activity.

If you have an interest which represents a non-financial professional interest to you, or someone you are closely associated with (i.e. where you, or they, may obtain a non-financial professional benefit from the consequences of a decision):

- You should participate in discussion relating to the interests you hold at the discretion of the chair of the meeting;
- You should withdraw from discussion(s) on the awarding of contracts, or the making of recommendations on the awarding of contracts, which relate to the interests you hold; You should do this by not participating in the discussion / leaving the meeting for the duration of any such discussion (as directed by the chair of the meeting);
- You should withdraw from the making of decisions on the awarding of contracts which relate to the interests you hold; You should do this by not participating in the decision / leaving the meeting for the duration of any such discussion (as directed by the chair of the meeting).

- You should participate in working groups, project work or other activity undertaken on behalf of NHS C&M which relate to the interest you hold, as directed by NHS C&M. If you have not received directions from NHS C&M and become aware of a potential conflict of interest you should withdraw from any such activity.

If you have an interest which represents a non-financial personal interest to you, or someone you are closely associated with (e.g. where you, or they, may benefit personally in ways which are not directly linked to your role in /relationship with NHS C&M and which do not give rise to direct financial benefits):

- You should participate in discussion relating to the interests you hold at the discretion of the chair of the meeting
- You should withdraw from discussions and decisions on the awarding of contracts which relate to the interests you hold; You should do this by not participating in the discussion / leaving the meeting for the duration of any such discussion (as directed by the chair of the meeting).

If you may receive some other benefit which could be perceived as a conflict of interest (e.g. where you may derive some qualitative, non-monetary benefit from the consequences of a decision which does not obviously fit in one of the categories described above but you feel should be declared):

- You should participate in the discussion and any associated decisions at the discretion of the chair of the meeting.
- You should participate in working groups, project work or other activity undertaken on behalf of NHS C&M which relate to the interest you hold, as directed by NHS C&M.

Should your circumstances change, please remember to inform your line manager and NHS C&M governance lead in accordance with the conflicts of interest policy.

Appendix 6: Gifts, hospitality and sponsorship form

Name:	
Position within, or relationship with, NHS C&M:	

Date of Offer	Details of gift / hospitality / sponsorship, including estimated value	Supplier / Offeror Name and Nature of Business	Was the offer accepted or declined? If accepted, Include date of receipt.	Reasons for Acceptance	If accepted, who approved the acceptance?	Other Comments	Details of Previous Offers or Acceptance by this Offeror/ Supplier

The information submitted will be held by NHS C&M for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that NHS C&M holds.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to NHS C&M as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, professional regulatory or internal disciplinary action may result.

I **do / do not (delete as applicable)** give my consent for this information to published on registers that NHS C&M holds. If consent is NOT given please give reasons:

Signed: …… **Date**: ……..
(Individual Staff Member)

Signed: …….. **Date:** ……..
(Line Manager or senior NHS C&M manager)

Please return completed, approved form to **ICB Governance Team** EMAIL

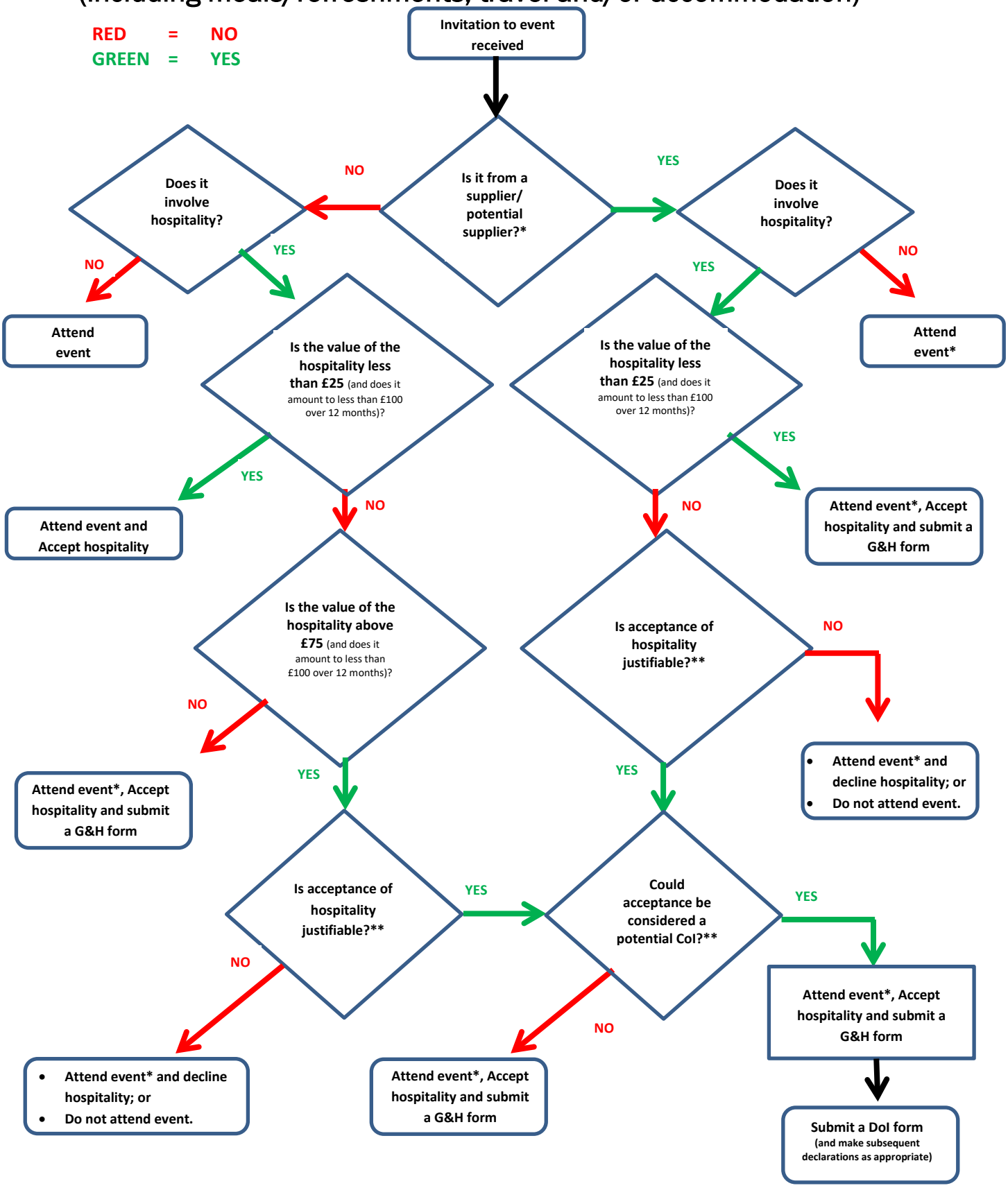
Reviewed & Added to Register
Signed: …….. **Date:** ……..
(Associate Director Corporate Affairs & Governance)

Appendix 7: Gifts, hospitality and sponsorship register

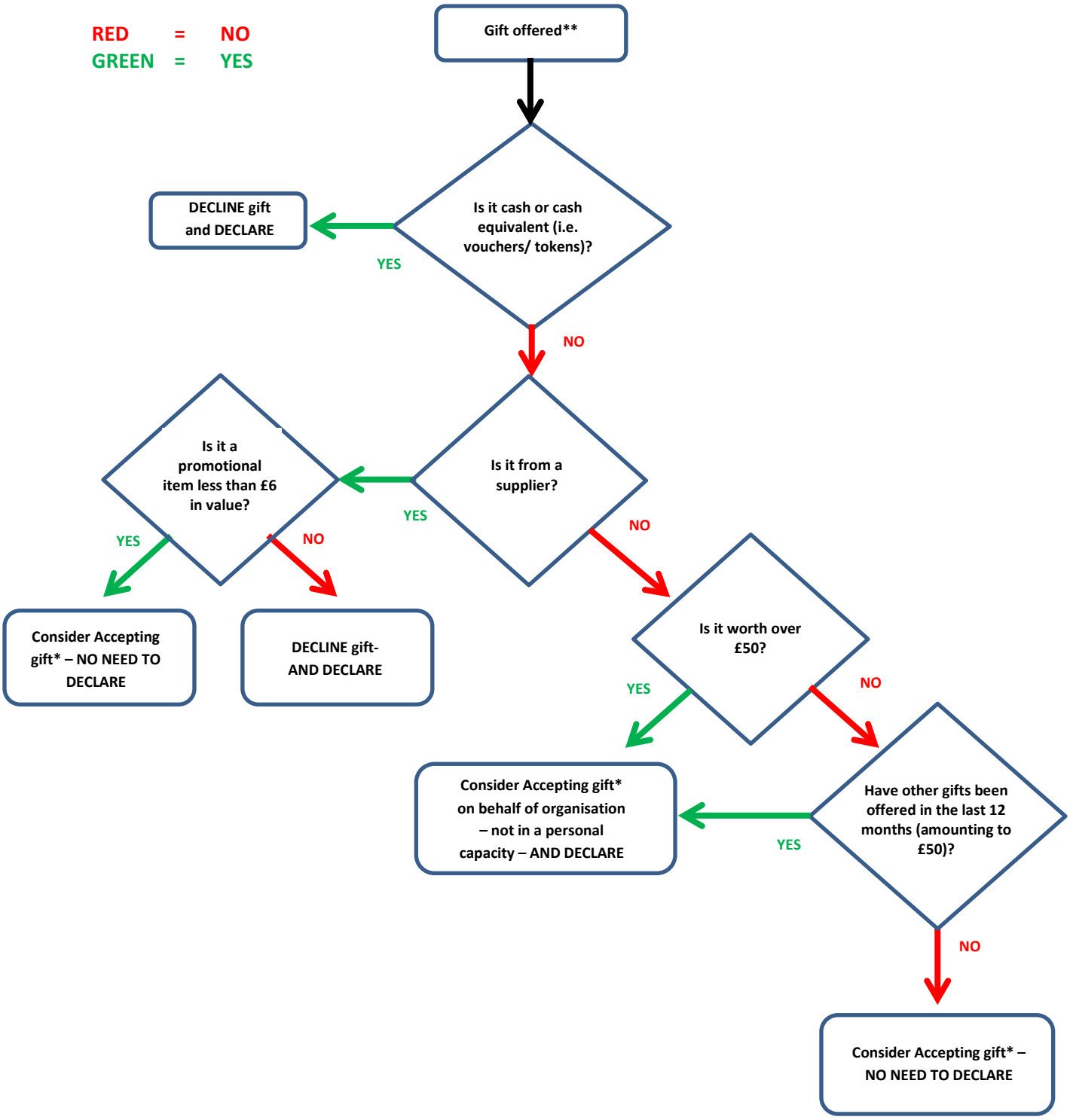
REGISTER OF GIFTS, HOSPITALITY & SPONSORSHIP: 1st April XX – 31st March XX

Name	Position/ Role	Date of Offer	Date of Receipt/ Date of Event	Details of Gift / Hospitality	Estimated Value	Supplier / Offeror (Name & Nature of Business)	Details of Previous GAHR Accepted from Supplier	Declined or Accepted?	Reason for Accepting or Declining	Authorised By (NAME/ ROLE)	Date Authorised

Appendix 8: Guidance on considering acceptance of hospitality (including meals/refreshments; travel and/or accommodation)



* Consideration should be given to the appropriateness of attending any event run by a supplier or potential supplier whether or not hospitality is provided.
**Discussion required with senior member of NHS C&M (i.e. Director or ICB Chair) who may wish to consult the Conflicts of Interest Guardian or NHS C&M governance lead.



* Consideration should always be given to the appropriateness of accepting any gifts. Acceptance should be agreed with a Line Manager or Senior NHS C&M Manager.

**For bequests and donations to the organisation (of equipment etc.) please consult the relevant sections of the Policy

NHS
Cheshire and Merseyside

Standards of Business Conduct Policy

Including Working with the Pharmaceutical Industry Policy & Procedure

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Document Owner:	Approval date:	First published:
	Next review date:	Version:

1. Organisational Context

1.1 NHS Cheshire and Merseyside Integrated Care Board (referred to in the policy as "NHS C&M") was established as a statutory body on 1 July 2022. NHS C&M operates in the 9 geographical areas of Cheshire, Halton, Knowsley, Liverpool, Sefton, St Helens, Southport & Formby, Warrington, and Wirral (referred to in the policy as "Places").

2. Introduction

2.1 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 staff working for NHS C&M are expected to follow. See Section 2 for further information on those in scope of this policy.

2.2 As a publicly funded organisation, NHS C&M have a duty to set and maintain the highest standards of conduct and integrity. NHS C&M expects the highest standards of corporate behaviour and responsibility from all directly employed staff and those working across the C&M Integrated Care System (ICS); the NHS Constitution[1] sets out key responsibilities of all NHS staff. In addition, all officers, regardless of their role, are expected to act in the spirit set out in the seven principles of public life, or commonly referred to as the 'Nolan Principles' (Appendix A).

2.3 The Code of Conduct and Code of Accountability in the NHS (2004)[2] sets out three public service values which are central to the on-going work and sustainability of both the ICS and NHS C&M:

- **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, officers, members and suppliers and in the use of information acquired during the course of their NHS duties, and
- **Openness** – there should be sufficient transparency about NHS activities to promote confidence between each ICS, Integrated Care Body (e.g. NHS C&M) and staff, partners, patients and public.

[1] https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england
[2] https://www.nhsbsa.nhs.uk/sites/default/files/2017-02/Sect_1_-_D_-_Codes_of_Conduct_Acc.pdf

3. Scope

3.1 All staff working within the Cheshire & Merseyside Integrated Care System (ICS), including within place-based partnerships and hosted organisations, without exception, are within the scope of this policy, including and without limitation:

- All employees of the NHS C&M -
  - Integrated Care Board (ICB) members (including in attendance and non-voting members)
  - Members of all NHS C&M committees and sub-committees
  - Agency, locum and other temporary staff engaged by NHS C&M
  - Students (including those on work experience), trainees and apprentices
- Independent members of the ICB & Committees (not directly employed by NHS C&M)
- Member practices across the ICS (any individuals directly involved with the business of NHS C&M, including at place level)
- Third parties acting on behalf of the ICS/ NHS C&M (including Commissioning Support Units and shared services)

3.2 Collectively, and for the purpose of this policy the above will simply be referred to as 'staff' throughout the document.

3.3 Throughout this policy, reference is made to NHS C&M policies and management structures. In applying the policy, other in- scope organisations to whom the policy applies are expected to do so in accordance with their own HR and other related policies and structures.

4. Policy Principles

4.1 Expectations of staff

Staff are expected at all times to:

- Comply with the requirements of the NHS[1] & NHS C&M[3] Constitutions and be aware of the responsibilities outlined within them
- Act in good faith and in the interests of the C&M ICS – including NHS C&M and place-based partnerships
- Adherence to the 'Seven Principles of Public Life (the Nolan Principles), and the NHS Code of Conduct and Code of Accountability (2004)[2], maintaining strict ethical standards.

[3] ICB Constitution web page https://www.england.nhs.uk/publication/the-constitutions-of-integrated-care-boards/

4.2 Failure to comply with the Standards of Business Conduct Policy

4.2.1 Failure by an employee to comply with the requirements set out in this policy may result in action being taken in accordance with the relevant organisational disciplinary procedure; such disciplinary action may include termination of employment (where applicable).

4.2.2 Where the failure to comply relates to an officer that is not a direct employee of NHS C&M, this may result in action being taken in accordance with the relevant engagement procedures (e.g., termination of a secondment agreement).

4.2.3 Any financial or other irregularities or impropriety which involve evidence or suspicion of fraud, bribery or corruption by any officer, will be reported to NHS Counter Fraud Authority in accordance with the **NHS C&M Anti-Fraud, Bribery & Corruption Policy** and the **NHS C&M Standing Financial Instructions**, with a view to an appropriate investigation being conducted and potential prosecution being sought.

4.3 Standing Orders (SOs), Prime Financial Policies (PFPS) and Scheme of Reservation & Delegation (SoRD)

4.3.1 All staff are required to carry out their duties in accordance with SOs, PFPs and the SoRD as these key documents set out the statutory and governance framework in which NHS C&M operates. There is considerable overlap with this policy and the provisions set out in these documents so staff must ensure that they refer to and act in accordance with them to ensure that correct, up to date processes are followed. In the event of doubt, staff should seek advice from their relevant line manager. The provisions of the SOs, PFPs and SoRD will always take primacy in the event of any conflicts arising with the content of this policy.

4.4 Management of Conflicts of Interest

4.4.1 A conflict of interest occurs where an individual's ability to exercise judgement or act in one role is, or could be, impaired or otherwise influenced, by his or her involvement in another role or relationship.

4.4.2 A conflict of interest may be:

- **Actual** – there is a relevant and material conflict between one or moreinterests now
- **Potential** – there is the possibility of a material conflict between one or more interests in the future.
- **Perceived** – i.e. an observer could reasonably suspect there to be a conflict of interest regardless of whether there is one or not.

4.4.3 An individual does not need to exploit his or her position or obtain an actual benefit, financial or otherwise – the potential for competing interests and/or a perception of impaired judgement or undue influence can also be a conflict of interest.

4.4.4 Staff should not allow their judgement or integrity to be compromised and should always be and seen to be honest and objective in the exercise of their duties in line

with their terms of employment, duties and responsibilities. All staff must declare any interests outside of their role, either on appointment or when the interest is acquired (which may directly or indirectly give rise to an actual or potential conflict of interest or duty).

4.4.5 Interests can be broadly defined as:

1. **Financial Interests** - where an individual may get direct financial benefits from the consequences of a commissioning decision.
2. **Non-Financial Professional Interests** - where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career.
3. **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 e.g. voluntary sector champion or a volunteer for a provider, or a member of a voluntary sector board etc.
4. **Indirect Interests** - where an individual may have a close association with someone who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision (as those categories are described above) e.g. spouse or partner, close relative or friend etc

4.4.6 NHS C&M has clear principles and robust processes for minimising, managing and registering real or perceived conflicts of interest which could be deemed or assumed to affect the integrity of decisions made by staff in awarding contracts, procurement, policy development, employment and other commissioning decisions. Further information can be found in the **NHS C&M Conflicts of Interest Policy**[4] and the NHS England website.[5]

4.4.7 Where a situation falls outside of the above categories, for any avoidance of doubt as to whether it represents a conflict of interest staff should always seek advice from the Associate Director of Corporate Affairs & Governance or Conflicts of Interest Guardian.

4.4.8 **Declaring Interests**

Written Declarations

All persons referred to in section 2.1, above, must declare any interests they hold which are relevant to the work of the ICS/ NHS C&M. Declarations should be made as soon as reasonably practicable and by law within 28 days after the interest arises (this could include an interest an individual is pursuing). Interests should be declared using the appropriate form within the NHS C&M Conflicts of Interest Policy[4].

On appointment

Applicants for any appointment to the NHS C&M's ICB or any committees/ subcommittees should be asked to declare any relevant interests. When an

[4] LINK to COI Policy web page
[5] https://www.england.nhs.uk/commissioning/pc-co- comms/coi/

appointment is made, a formal written declaration of interests should again be made and recorded.

Annually
Formal, written declarations of interest should be submitted by all relevant individuals every year. Where there are no interests or changes to declare, a "nil return" should be made.

On changing role, responsibility or circumstances
Whenever an individual's role, responsibility or circumstances change in a way that affects the individual's interests (e.g., where an individual takes on a new role outside NHS C&M or enters into a new business arrangement or relationship), a further formal, written declaration should be made to reflect the change in circumstances as soon as possible, and in any event within 28 days.

Verbal Declarations
All attendees are required to declare their interests as a standing agenda item for every Board, committee, sub-committee or working group meeting, before the business is discussed. Even if an interest has been recorded in the register of interests, it should still be declared in meetings where matters relating to that interest are discussed. All declarations of interest should be recorded in meeting minutes.

4.4.9 Where an interest has been declared, the declarer will ensure that before participating in any activity connected with NHS C&M's exercise of its commissioning or other functions, they have received confirmation of and understand the arrangements to manage the conflict of interest or potential conflict of interest from the Accountable Officer or relevant Committee Chair. In cases of doubt or where the declarer is yet to receive details of the management arrangements, the declarer should withdraw from any such activity until these have been clarified – further advice can be sought from the Governance Lead and/ or COI Guardian as at section 3.4.7 above.

4.4.10 **Secondary Employment**
Employees, Board members, committee members, contractors and others engaged under contract with NHS C&M are required to inform the Accountable Officer & Governance Lead if they are employed or engaged in, or wish to be employed or engaged in, any employment or consultancy work in addition to their work with NHS C&M. The purpose of this is to ensure that NHS C&M is aware of any potential conflict of interest. For the avoidance of doubt, "secondary employment" includes part-time, temporary and fixed term contract work as well as "one-off" payments for advice or services provided.

Examples of work which might conflict with the business of NHS C&M include:

- Employment with another NHS body
- Employment with another organisation which might be in a position to supply goods/services to NHS C&M or within the C&M Integrated Care System area
- Directorship of a Primary Care Network; and
- Self-employment, including private practice, in a capacity which might conflict with the work of NHS C&M, or which might be in a position to supply goods/services to NHS C&M.

Individuals must obtain prior permission to engage in secondary employment, and NHS C&M reserve the right to refuse permission where it believes a conflict will arise which cannot be effectively managed.

Employees should not engage in outside employment during any periods of sickness absence from NHS C&M. 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 NHS C&M's Anti-Fraud, Bribery & Corruption Policy.

4.5 Gifts, Hospitality & Sponsorship

For the purpose of this policy, a gift is defined as 'any item of goods and/or cash or any service which is provided for personal benefit, free of charge or at less than its commercial value'.

4.5.1 Gifts

All **gifts offered** to individuals **by current or prospective suppliers or contractors** linked to the business of NHS C&M should be declined and the offer should be declared. The only exception relates to items of low financial value (i.e., less than £6) such as diaries, calendars, stationery, and other gifts acquired from meetings, events or conferences. Such gifts may be accepted and do not need to be declared.

Gifts offered from other sources (i.e. not from suppliers/contractors or potential suppliers/contractors) should also be declined if accepting them might give rise to perceptions of bias or favouritism, and a common sense approach should be adopted as to whether or not this is the case. The general rules around the acceptance of such gifts are below - any gifts accepted should be receipted and a letter of thanks sent:

a) Modest gifts under a value of £50 may be accepted and do not need to be declared
b) Gifts valued at over £50 should be treated with caution and only be accepted on behalf of an organisation, not in a personal capacity - such gifts should be declared
c) 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

Personal gift of cash or cash equivalents (e.g. vouchers, tokens, offers of remuneration to attend meetings whilst in a capacity working for or representing the ICS or NHS C&M) must always be declined, whatever their value and whatever their source. The offer which has been declined must be declared to the Governance Lead for inclusion on the register of gifts and hospitality.

Bequests from patients

Clinicians (under the scope of this policy) should comply with the relevant professional and regulatory guidance issued by bodies including the British Medical Association and General Medical Council. Such instances should be declared to the NHS C&M Governance Lead where they are relevant to that individuals' role with the ICS/ NHS C&M and could be considered to represent a conflict of interest in carrying out that role.

Donations to the organisation

Employees must check with their line manager or director before accepting a donation, to clarify appropriateness and/or financial or contractual consequences of acquisition. Donations of equipment or services should not be accepted without the express permission of the Accountable Officer. Further guidance regarding charitable funds, gifts and donations can be requested from the Governance Lead.

4.5.2 **Hospitality**

A blanket ban on accepting or providing hospitality is neither practical nor desirable from a business point of view. However, individuals should be able to demonstrate that the acceptance or provision of hospitality would directly benefit the NHS or NHS C&M.

Modest hospitality provided in normal and reasonable circumstances may be acceptable, although it should be on a similar scale to that which NHS C&M might offer in similar circumstances (e.g. tea, coffee, light refreshments at meetings). A common sense approach should be adopted as to whether hospitality offered is modest or not - "modest" hospitality may be considered hospitality with an estimated value under £25. Hospitality of this nature does not generally need to be declared.

Exceptions to this - when offers of modest hospitality should be declared and recorded on the register – include where:

- Such hospitality is offered by **current or prospective suppliers or contractors** linked to the business of NHS C&M (whether or not such an offer is accepted). Offers of this nature can be accepted if they are modest and reasonable but advice should be sought from the Accountable Officer and/ or Governance Lead.
- Several such offers from the same or a closely related source amounting to an estimated value above £100 in a 12-month period.

Offers of meals and refreshments valued at between £25 and £75 may be accepted but must be declared for inclusion on the register.

There is a presumption that the following should be politely refused:

- offers of hospitality beyond a value of £75 (for meals and refreshments); or
- offers of travel or accommodation that go beyond a type that NHS C&M itself might offer, such as business or first-class travel and accommodation and offers of foreign travel and accommodation.

There may be some limited and exceptional circumstances where accepting such hospitality may be contemplated – further guidance can be found in the NHS C&M Conflicts of Interest Policy[4].

4.5.3 **Sponsorship**

Sponsored Posts

Staff who are considering entering into an agreement regarding the external sponsorship of a post within the ICS/ NHS C&M or a place-based partnership must seek formal approval from the Accountable Officer for final approval. Staff will be required to demonstrate acceptance of a sponsored post is transparent and does not stifle competition.

There should be written confirmation that the sponsorship arrangements will have no effect on any commissioning or other management decisions over the duration of the sponsorship and auditing arrangements should be established to ensure that this is the case. These written arrangements should set out the circumstances under which sponsorship arrangements can be exited if conflicts of interest arise which cannot be mitigated.

Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and confirm the appropriateness of the arrangements continuing.

Holders of sponsored posts must not promote or favour the sponsor's specific products or organisation and information about alternative suppliers must be provided. Sponsors must not have any influence over the duties of the post or have any preferential access to services, materials or intellectual property related to or developed in connection with the sponsored post.

Sponsored events

Sponsorship of events, including courses, conferences and meetings, by external bodies should only be approved if it can be demonstrated that the event will result in clear benefits for NHS C&M and the wider NHS. Any event sponsorship would require the approval of the Governance Lead in advance. Sponsorship should not in any way compromise any of NHS C&M's decisions or be dependent on the purchase or supply of goods or services. Sponsors should not have any influence over the content of an event, meeting, seminar, publication or training event – NHS C&M is not to appear to endorse individual companies or their products or services because of the sponsorship.

During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection (or other) legislation. As a rule, information which is not in the public domain should not be supplied and no information should be supplied to a company for its commercial gain.

At the discretion of NHS C&M, sponsors or their representatives may attend or take part in the event, but they should not have a dominant influence over the content or the main purpose of the event. The involvement of a sponsor in an event should always be clearly identified in the interests of transparency.

Sponsored research

Funding sources for research purposes must be transparent. Any proposed research must go through the relevant approvals process.

There must be a written protocol and written contract between NHS C&M and the institute 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. Where the contract includes provision of people this, and accompanying arrangements, must be clearly articulated.

The study must not constitute an inducement to commission any service.

Declaring sponsorship

As per NHS C&M Conflicts of Interest Policy[4] all sponsorship must be declared on the public register[6]

All pharmaceutical companies entering into sponsorship agreements must comply with the Code of Practice for the Pharmaceutical Industry. Further information can be found in NHS C&M's Joint Working with the Pharmaceutical Industry Policy Appendix 3.

A common-sense approach should be applied to valuing the sponsorship if there is not a contractual value specified, for example a room and refreshments being provided for an event.

All officers must declare any sponsorship secured through, contracted by, paid directly to, or managed through a 3rd party, such as exhibitors at our events sold through a 3rd party or a sponsor paying for catering directly to an event venue.

4.5.4 Joint Working with the Pharmaceutical Industry (PI)

See Appendix 3 for further information.

4.6 Personal Conduct

NHS C&M places the utmost importance upon the honesty, integrity and moral behaviour of its staff. It is the responsibility of all staff, irrespective of position or pay band to ensure they are not placed in a position which risks or appears to risk the reputation of the organisation, or the wider ICS, through actions which may be considered as an abuse of official position or by placing personal interests ahead of those of NHS C&M during the course of their duties. The following principles for personal conduct should be applied consistently by all staff:

4.6.1 Corporate Responsibility

All staff have a responsibility to respect and promote the corporate or collective decision of NHS C&M, even though this may conflict with their personal views. This applies particularly if NHS C&M are yet to decide on an issue or has decided in a way with which they personally disagree. Directors and officers may comment as they wish as individuals however, if they decide to do so, they should make it clear that they are expressing their personal view and not the view of NHS C&M, or the wider ICS.

When speaking as a member of NHS C&M, whether to the media, in a public forum or in a private or informal discussion, all staff should ensure that they reflect the current policies or view of the organisation. For any public forum or media interview, approval should be sought in advance:

- in the case of members of the Integrated Care Board (ICB), approval from the Chair and/or Accountable Officer or their nominated deputies, and the Communications Team
- in the case of all other staff, approval from the Communications Team

[6] LINK to web page where published.

When this is not practicable, they should report their action to the Chair or Accountable Officer, or their nominated deputies, as soon as possible.

All staff must ensure their comments are well considered, sensible, well informed, made in good faith, in the public interest and without malice and that they enhance the reputation and status of NHS C&M and the wider ICS. All staff must follow the guidance for communication with the media; disciplinary action may be taken if this is not followed.

4.6.2 **Social Media**

NHS C&M staff should ensure that their personal use of social media does not include disclosure of confidential information in relation to NHS C&M, display material or express views or opinions which could be linked with NHS C&M, and harmful to its reputation. Staff should be aware that social networking websites are public forums andshould not assume that their entries will remain private.

4.6.3 **Political Activities**

Conferences or functions run by a party-political organisation should not be attended by NHS C&M staff in an official NHS C&M capacity except where prior permission has been granted by the Accountable Officer. Staff should ensure that any political activity they undertake outside of their role does not identify them individually as an employee of NHS C&M.

4.6.4 **Lending and borrowing of money**

Staff should refrain from the lending or borrowing of money between colleagues and peers, whether informally or as a business and particularly where the amounts are significant sums of money. It is a particularly serious breach of discipline for any staff member to use their position to place pressure on colleagues, business contact or member of the public to loan them money.

4.6.5 **Charitable collections**

Individual – whilst NHS C&M supports staff who wish to undertake charitable collections amongst immediate colleagues, no reference or implication should be drawn to suggest that NHS C&M, or the wider ICS, is supporting the charity. Permission is not required for informal collections amongst immediate colleagues on an occasion like retirement, marriage, birthday, or a new job.

Organisational – Charitable collections which reference NHS C&M must be authorised and documented by a relevant Director in advance and reported to the Governance Lead, who will ensure a central record of collections is maintained.

4.6.6 **Individual Voluntary Arrangements, County Court Judgment (CCJ),Bankruptcy/ Insolvency**

Any staff member 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. Staff who are declared bankrupt or insolvent cannot be employed, or otherwise engaged, in posts that involve duties which might permit the misappropriation of public funds or involvethe approval of orders or handling of money.

4.6.7 **Arrest or Conviction**

Any staff member who is arrested, subject to continuing criminal proceedings, or convicted of any criminal offence must inform their line manager and the HR Department as soon as is practicably possible.

4.6.8 **Gambling**

No member of staff may bet or gamble whilst on duty or on NHS C&M premises. The only exceptions to this are small lottery syndicates or sweepstakes relating to national/world sporting events such as the Grand National or World Cup, which are confined to immediate colleagues; where no profitsare 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 (see section 3.6.5 above).

4.6.9 **Trading on NHS C&M premises**

Trading on NHS C&M premises is strictly prohibited, whether for personal gain or on behalf of others; this includes flyers advertising services/ products or catalogues in common areas. This also applies to canvassing within offices by, on behalf of, external bodies or companies (including non-NHS C&M interests of staff or their relatives). This provision excludes refreshment arrangements conducted solely by staff (e.g. tea and coffee funds).

4.6.10 **Confidentiality**

All staff 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 patientinformation; personal information relating to officers; commercial information. This duty of confidence remains after a staff member (however employed) leaves NHS C&M.

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 NHS C&M Information Governance and Corporate Information Technology policies[7] for detailed information.

4.6.11 **Initiatives**

Any patents or designs, trademarks or copyright resulting from the work (e.g. research) of an individual employee of NHS C&M carried out as part of their terms of employment shall remain the Intellectual Property of NHS C&M.

Approval from the appropriate line manager/head of service should be sought before entering into any obligation to undertake external work connected with the business of NHS C&M (e.g. writing articles for publication, speaking at conferences or events).

Where the undertaking of external work (including gaining patent, copyright or the involvement of innovative work) benefits or enhances NHS C&M's reputation or results in a financial gain for the organisation, consideration will be given to rewarding

[7] LINK to where policies are saved

employees subject to any relevant guidance for the management of Intellectual Property in the NHS issued by the Department of Health.

4.6.12 **Contractors & Suppliers of Services**

NHS C&M will ensure that all services are procured in a manner that is open, transparent, non-discriminatory and fair to all potential providers and has in place a robust Procurement Policy[8].

Staff who are in contact with suppliers and contractors (including external consultants) and particularly those who are authorised to sign purchase orders or enter into contracts for goods and services are expected to adhere to professional standards in line with those set out in the Codes of Ethics of the Chartered Institute of Purchasing and Supply (Appendix 2).

Staff involved in the awarding of contracts and tender processes must take no part in a selection process if a personal interest or conflict of interest is known. Such an interest must be declared in accordance with the NHS C&M Conflicts of Interest Policy[4] as soon as it becomes apparent.

Details of all contracts, including the value of the contract will be published on the public-facing website[9] as soon as contracts are agreed. Where NHS C&M decides to commission a service(s) via an Any Qualified Provider (AQP) arrangement, the type of service and agreed price for each service commissioned will be published on the website and will also be included in the Annual Report.

4.7 Fraud, Bribery & Corruption

Staff must be aware of and act in accordance with the NHS C&M Anti-Fraud, Bribery & Corruption Policy[10], and understand that in certain circumstances a breach of this policy could potentially result in criminal proceedings being brought against individuals, the organisation, and other linked organisations. Policy breaches could also result in civil legal challenge.

NHS C&M will not tolerate acts of fraud, bribery or corruption committed against it or in the wider NHS. The **Fraud Act 2006** created a criminal offence of fraud and defines three ways of committing it:

- Fraud by false representation
- Fraud by failing to disclose information and
- Fraud by abuse of position.

In simple terms fraud can be defined as **theft by deception**. An offender's conduct must be dishonest, and their intention must be to make a gain, or a cause a loss (or the risk of a loss) to another; the offence includes where the fraudster fails to get what they intended through their fraud, the focus being on the dishonest intention. In law, whether someone's behaviour is 'dishonest' is determined by the objective standards of

[8] LINK to where policies are saved
[9] LINK to Procurement List webpage
[10] LINK to Fraud Policy

ordinary decent people. It is not a defence for the individual to claim that they did not realise their behaviour was dishonest by those standards.

The **Bribery Act 2010** makes it easier to tackle this offence in public and private sectors. A bribe is a financial or other advantage intended to induce or reward the 'improper performance' of a person's official public functions or work activities. Generally, this means offering or receiving something of value to influence a transaction that someone shouldn't do (although offences include offering, promising, giving, requesting, accepting, or agreeing to accept). Bribery can be committed by a body corporate. Commercial organisations, including NHS bodies, will be exposed to criminal liability, punishable by an unlimited fine, for failing to prevent bribery unless they can prove that they had in place adequate proportionate procedures designed to prevent bribery occurring on its behalf.

Fraud and Bribery are criminal offences and carry maximum sentences of 10 years imprisonment and/or unlimited fines.

Corruption is where the integrity or honesty of a person, government, company, or organisation is manipulated for personal gain. It is an umbrella term covering several different offences, including bribery.

All NHS staff have a right and duty to raise legitimate concerns in the public interest about malpractice or wrongdoing at work; this includes criminal offences. **NHS C&M expects that staff do not ignore their suspicions, but report them as soon as possible through the correct channels. Staff should not initiate their own investigations or discuss with others as this could jeopardise any formal investigation.** There are a number of ways to report reasonable suspicions of fraud, bribery or corruption; you do not need solid proof or evidence to raise concerns, and you can remain anonymous if you wish.

Internal channels:
Anti-Fraud Specialist (AFS), Ruth Barker, tel: 07584 774 763 or 0151 285 4500, email: ruth.barker@miaa.nhs.uk
Chief Finance Officer, Claire Wilson, tel: 07736 446 410, email: c.wilson7@nhs.net

Further information can be found in the NHS C&M Raising Concerns (Freedom to Speak Up) Policy - this includes options to raise concerns externally in certain situations.

External channels:
NHS Counter Fraud Authority (NHSCFA) National Fraud and Corruption Reporting Line: 0800 020 4060 (freephone 24/7 powered by Crimestoppers)

Online reporting form at https://cfa.nhs.uk/reportfraud. This is a national service independent to the rest of the NHS. User rights are protected, and information is treated confidentially. Users can update their referral at a later date if they wish to.

5. Related Documents

Legislation and statutory requirements

Fraud Act 2006
Bribery Act 2010
Data Protection Act 2018/ General Data Protection Regulations (GDPR) 2018

Other related policy documents

NHS C&M Conflicts of Interest Policy
NHS C&M Working with the Pharmaceutical Industry Policy
NHS C&M Anti-Fraud, Bribery & Corruption Policy
NHS C&M Freedom to Speak Up(Raising Concerns) Policy

Best practice recommendations

NHS Code of Conduct and Code of Accountability (2004)
Records Management: NHS Code of Practice 2016

6. Monitoring and Reporting

Compliance with this policy will be reviewed by the Audit Committee

7. Training and Awareness

It has been determined that there are no specific training requirements associated with this policy.

8. Dissemination and Implementation

This policy will be available to all NHS C&M staff, via the staff Intranet[11]. All managers are responsible for ensuring that relevant staff within the organisation have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

This policy should be read in conjunction with the policies listed at section 4 above.

9. Review

This policy will be reviewed on an annual basis or earlier if there are changes in legislation, relevant case law decisions, significant incidents and/or changes to the organisational infrastructure of NHS C&M.

[11] LINK to intranet

Appendix 1: The Seven Principles of Public Life (Nolan Principles)

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 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 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

Appendix 2: The Chartered Institute of Purchasing and Supply (CIPS) Code of Ethics)

Use of the code

Members of CIPS are required to uphold this code and to seek commitment to it by all those with whom they engage in their professional practice. Members are expected to encourage their organisation to adopt an ethical purchasing policy based on the principles of this code and to raise any matter of concern relating to business ethics at an appropriate level. The Institute's Royal Charter sets out a disciplinary procedure which enables the CIPS Board of Trustees to investigate complaints against any of our members and, if it is found that they have breached the code to take appropriate action. Advice on any aspect of the code is available from CIPS. This code was approved by the CIPS Council on 11 March 2009.

As a member of The Chartered Institute of Purchasing & Supply, I will:

- Maintain the highest standard of integrity in all my business relationships
- Reject any business practice which might reasonably be deemed improper
- Never use my authority or position for my own personal gain
- Enhance the proficiency and stature of the profession by acquiring and applying knowledge in the most appropriate way
- Foster the highest standards of professional competence amongst those for whom I am responsible
- Optimise the use of resources which I have influence over for the benefit of my organisation
- Comply with both the letter and the intent of:
  - The law of countries in which I practice
  - Agreed contractual obligations
  - CIPS guidance on professional practice
- Declare any personal interest that might affect, or be seen by others to affect, my impartiality or decision making
- Ensure that the information I give in the course of my work is accurate
- Respect the confidentiality of information I receive and never use it for personal gain
- Strive for genuine, fair and transparent competition
- Not accept inducements or gifts, other than items of small value such as business diaries or calendars
- Always to declare the offer or acceptance of hospitality and never allow hospitality to influence a business decision
- Remain impartial in all business dealing and not be influenced by those with vested interests

Advice on any aspect of the code of ethics is available from CIPS.

Appendix 3: Working with the Pharmaceutical Industry (PI) Policy

1.1 JOINT WORKING WITH PHARMACEUTICAL COMPANIES

Joint working between NHS C&M and the PI must be for the benefit of patients or the NHS and preserve patient care; the main beneficiary being the patient. Joint working arrangements must be entered into at a corporate level and not with any individual member of staff or ICB member.

For the purpose of this policy joint working is defined as situations where, for the benefit of patients, NHS C&M and one or more pharmaceutical companies' pool skills, experience and/or resources for the joint development and implementation of patient centered projects and share a commitment to successful delivery. Joint working agreements and management arrangements are conducted in an open and transparent manner. Joint working differs from sponsorship, where pharmaceutical companies simply provide funds for a specific event or work programme.

Any tentative discussion about entering into joint working which staff may have and consider worth pursuing should first be discussed with their line manager and relevant clinical leads as appropriate; formal discussion must be had with the Director of Nursing and Governance Lead – if the proposal is deemed suitable to explore further the designated lead should provide initial details on the joint working outline proposal using the quality standards checklist (Appendix 3c) for considering commercial partnerships and a summary should then be submitted to the Finance Committee for consideration and formal approval.

The length of the arrangement, the potential implications for patients and the NHS, together with the perceived benefits for all parties, should be clearly outlined before entering into any joint working. When entering into an agreement for joint working, NHS C&M will also consider the impact once the arrangements are concluded. An effective exit strategy must be in place at the outset of a given project detailing the responsibilities of each party.

A formal written agreement must be in place and an executive summary of the joint working agreement must be made publicly available (on the Procurement Decisions Register) before arrangements are implemented.

All aspects of confidentiality with regard to patient information must be observed and how this will be achieved clearly stated in the Joint Working Agreement, through a Data Privacy Impact Assessment (DPIA). Confidentiality of information received in the course of duty should be respected and should never be used outside the scope of the specific exercise.

Arrangements for monitoring the operation of the agreement and assessing clinical and financial outcomes should be agreed and clearly stated within the Joint Working Agreement. All assessments of the joint working programme should be made readily available to other NHS organisations and the public.

1.2 DISCLOSURES OF TRANSFERS OF VALUE BY PHARMACEUTICAL COMPANIES

From June 2016 the Association of the British Pharmaceutical Industry (ABPI) began publishing a public database declaring benefits that UK pharmaceutical companies give in cash or in kind to healthcare organisations, individual healthcare professionals and any relevant decision makers within a healthcare organisation. These benefits are termed 'transfers of value'. For individual Healthcare Professionals, transfers of value activities cover:

- Events – registration fees
- Events – Travel and accommodation
- Consultancy Services – fees
- Consultancy Services – expenses

For Healthcare Organisations, requirements cover:

- Activities covered by contract under which organisations provide any type of service on behalf of companies
- NHS joint-working projects
- Donations, grants and benefits in kind
- Contribution towards the cost of meetings
- Provision of medical and educational goods and services

As per section 4.5 in the Standards of Business Conduct above, NHS C&M maintains a register of all gifts, hospitality and sponsorship offered to the organisation and/or individual members of staff – to ensure this is kept up to date and matches the public ABPI database it is important that staff adhere to the NHS C&M Conflicts of Interest Policy and Standards of Business Conduct Policy regarding recording all transfers of value offered in the course of ICB business.

1.3 ATTENDANCE AT SPONSORED CLINICAL TRAINING OR EDUCATION MEETINGS/ EVENTS

NHS C&M employees must ensure there is an entry made on the Gifts, Hospitality and Sponsorship register regarding any attendance at clinical training or education provided by or sponsored by a pharmaceutical company. This should include details of company name, drugs discussed at meetings, and hospitality or other sponsorship provided.

1.4 MEETINGS WITH PHARMACEUTICAL COMPANY REPRESENTATIVES

NHS C&M does not approve any 'cold calling' to staff or ICB members from PI representatives. All requests for meetings and contacts by PI representatives to staff or members should be done via the dedicated proforma (Appendix 3a). All contact should then be via email to the generic communications email address INSERT until such a decision has been made that a meeting or direct contact will take place.

In considering requests for meetings with representatives of the PI, consideration should be given to whether this will represent best use of NHS C&M staff or board member's time and therefore not all requests can be granted. All approval decisions to be made by the ICB Head

of Medicines Management. All proformas will be logged centrally by the Medicines Management Team and held for 12 months for reference purposes.

GPs and any other clinician members of NHS C&M who PI representatives may contact in their capacity as prescribers or related health professionals should follow good practice and ensure inclusion in their own registers.

1.5 SPONSORSHIP OF MEETINGS/ EVENTS BY PHARMACEUTICAL INDUSTRY REPRESENTATIVES

Please refer to the NHS C&M Conflicts of Interest Policy, section 7.3 for sponsorship by *non-pharmaceutical representatives*. Sponsorship of meetings is not permitted for routine internal meetings of NHS C&M; only for educational or special events.

The ABPI Code states that meetings must be held in appropriate venues conducive to the main purpose of the event. Hospitality must be strictly limited to the main purpose of the event and must be secondary to the purpose of the meeting i.e., subsistence only. The level of subsistence offered must be appropriate and not out of proportion to the occasion. The costs involved must not exceed that level which the recipients would normally adopt when paying for themselves. It must not extend beyond members of the health professions or appropriate administrative staff.

For sponsored meetings/ events being organised by NHS C&M staff or board members, a form for proposed sponsorship of meeting must be completed and forwarded to the ICB Head of Medicines Management for approval, see Appendix 3b. A copy of the approved form should be sent to the Governance Lead, for inclusion on the Gifts, Hospitality & Sponsorship Register, to provide a central overview of all events being sponsored.

When seeking sponsorship for a meeting, use of a company with products directly related to the topic under consideration should be avoided as far as possible. Please contact the Director of Nursing for advice if you are unsure. Products that are not approved by NHS C&M and on the NHS C&M formulary should not be promoted.

If meetings are sponsored by pharmaceutical companies, that fact must be disclosed in all of the papers relating to the meetings and in any published proceedings. The declaration of sponsorship must be sufficiently prominent to ensure that readers are aware of it at the outset. Details of the sponsorship should also be highlighted to attendees at the beginning of the meeting.

For PI sponsored meetings, the level of access to clinicians or associated staff for the promotion of specific drugs or services by the pharmaceutical company (before the primary purpose of the meeting commences) must be agreed in advance, (as stated on sponsorship request form). For a sponsored sandwich lunch for example the representative could have a stand with promotional materials and attend the stand to engage with attendees during lunch and before the meeting starts.

Representative/s of the pharmaceutical company sponsoring the meeting should be thanked for the sponsorship ahead of the commencement of the primary purpose of the meeting and then must not remain in attendance at the meeting unless it is a public meeting.

Meetings of the Integrated Care Board (ICB)
NHS C&M holds meetings of its ICB in public and is required to do so both by statute and its Constitution. Where a PI representative chooses to attend, they do so in their capacity as a member of the public and have no special privileges. They should receive no greater or lesser opportunity to participate in the meeting or engage with individual members of the ICB than would any other member of the public.

Where a member of the ICB may be approached by representatives who seek to engage with them for the purpose of promoting their particular products or canvassing support for products or projects; it is recommended that they politely but firmly decline to engage with pharmaceutical representatives in these circumstances and ask them to contact NHS C&M directly via the general communications route.

Appendix 3a Appointment Request Form

For Pharmaceutical Industry Representatives
All sections must be completed prior to consideration of an appointment
Please email to INSERT

Request Date	
Name of Representative	
Name of Company	
Email/Mobile No.	(We may offer teleconference appointments)
Category of topic(s) you wish to discuss	**Please mark the relevant category/categories**

Commissioning pathways and service development	
Prescribing – please complete additional table below	
Proposed joint working	

ALL requests relating to prescribing please complete (highlight all relevant)	**Please mark the relevant category/categories**

New Medicine		Formulary		Sharing Resources	
Clinical data (efficacy, safety etc)		**Licence extension**		**Medicines optimisation collaborative initiative**	
Budget impact document		**New formulation of existing medicine**		**Other collaborative initiative**	
Pre-licence advanced planning notification		**Efficiency saving**			

Outline what you wish to discuss and attach relevant pre-reading material	
What is the outcome you hope to achieve from the meeting?	
How long do you anticipate the meeting lasting?	

Office Use Only

Date of last appointment			
To be given an appointment	**Yes** ☐ **No** ☐	**Urgent** ☐ **Routine** ☐	**Time required** ……

Reason if no appointment given	
Details of appointment if applicable	

Appendix 3b Request Proforma (ICB internal) for sponsorship of a meeting/ event by a pharmaceutical company

Date of sponsorship offer:		
ICB Lead or member of staff organising the meeting/ processing sponsorship offer:		
Title and details of Meeting/ Event:		
Target audience:		
Venue:	Proposed date of offer (e.g. date of event):	
Proposed Pharmaceutical Sponsor(s) details: Include name, address & nature of business		
Representative name(s) and contact details (please list all):		
Details of sponsorship requested. Please include details of whether invoices are to be raised for each sponsor – details to be confirmed with each sponsor.		
Approximate value of sponsorship	Overall Value £……..	Per Sponsor £…….
Details of direct marketing contact at meeting: e.g. whether representative will attend the meeting, have a marketing stand showing product information; which products and or services will be marketed.		
Please confirm that any products or services to be marketed are included on the C&M formulary and/or have been approved for use locally by NHS C&M. If unsure please seek advice from medicines management before proceeding.		Please Tick to confirm ☐
Reviewed & Approved by Assistant Director: Medicines Management Signed:		Date approved:
Please forward the completed form to CONTACT ***prior*** to the event taking place		

Appendix 3c Quality Standards Checklist for Joint Working with a commercial company or the pharmaceutical industry

Quality Standards Checklist for considering Joint Working with a commercial company or the pharmaceutical industry		
	Yes	**No**
Does the scheme have clear aims and objectives?		
Does the sponsorship offer any benefits to the following aspects of health care?		
• Diagnostics and referral? Include details:		
• Investigations and measurements? Include details:		
• Informing and educating patients?		
o Will the material be checked by NHS C&M before it is distributed to ensure it is non-promotional and culturally appropriate		
• Informing and educating health professionals?		
o Will the material be checked by the NHS C&M before it is distributed to ensure it is valid, non-promotional and in line with national and local formulary and guidance?		
Is the sponsorship directly related to patient treatment?		
• Have alternative treatments been considered and evaluated?		
• Has an assessment of the costs and benefits of the package in relation to alternative options been investigated?		
• Has monitoring of the patients been considered as part of the treatment?		
• Has a criteria for success of the project been established?		
• Has patient perceptions been included as part of the criteria?		
• Has a health care professional been designated clinically responsible for the patient at each stage of the package?		
• Has an assessment been made as to how the package fits with existing systems of primary and secondary care?		
• Is the treatment on the current formulary or is approved by NHS C&M?		

Appendix 11: Register of procurement decisions

Information and Data considerations		
• Is the sponsorship related to the collection of data?		
• Who will own the data? Please state:		
• Will the sponsor have access to the data?		
• Have the provisions of the Data Protection Act & GDPR been taken into consideration?		
• Who will evaluate the data? Please state:		
Is the sponsorship related to any of the following?		
• Provision of clinical products?		
o Will this encourage the use of a particular product in the future?		
o Is the product included in the local formulary or is approved by NHS C&M?		
o Will the use of the product limit patient choice?		
o Is this project intended to increase the market share for a particular product or company?		
o Will this limit clinical freedom of a prescriber to select the most appropriate product?		
o Has evidence been provided to support use of this product and has this been independently reviewed?		
• Provision of equipment?		
o Is the equipment linked to the use of one particular brand of consumables?		
o Has an assessment been undertaken to establish that it is the best for purpose?		
o Has the equipment been approved for use locally?		
o Is there any guidance locally or nationally regarding use of this type of product?		
• Provision of free stationery?		
o Does the stationery include commercial advertising?		
o Does NHS C&M have control over the content of the advertising?		
Are there any recurring costs for the scheme?		
Who will be responsible for recurring costs? Please state:		
How does the use of a product impact on other providers in the future e.g. costs, supply, FP10 availability, very specialist etc.		
Further Information		

Cheshire and Merseyside
Health and Care Partnership

NHS
Cheshire and Merseyside

Draft Public Engagement Framework

Our Strategy for Empowering People and Communities in C&M

July 2022

Cheshire and Merseyside
Health and Care Partnership

NHS
Cheshire and Merseyside

Overview

- Co-produced with commissioned partners from Healthwatch, the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector, and system engagement practitioners.
- Development overseen by a multi-disciplinary task and finish group from 1 April – 30 June, with engagement of Place engagement forums led by task and finish group members.
- Draft framework submitted to NHS England on 27 May 2022 (in line with national readiness to operate requirements).
- Draft Framework currently being reviewed and moderated by national transformation and participation teams, with written feedback expected at the end of July.
- Further draft will then be developed based on that feedback, and the outcome of national public consultation on statutory guidance for working with people and communities (also expected at the end of July).
- Further programme of engagement with partners, people and communities will follow, along with the development of an action plan and new engagement mechanisms for NHS Cheshire and Merseyside.

Cheshire and Merseyside
Health and Care Partnership

NHS
Cheshire and Merseyside

10 Principles

1. Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.	6. Provide clear and accessible public information about vision, plans and progress, to build understanding and trust.
2. Start engagement early when developing plans and feed back to people and communities how their engagement has influenced activities and decisions.	7. Use community development approaches that empower people and communities, making connections to social action.
3. Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.	8. Use co-production, insight and engagement to achieve accountable health and care services.
4. Build relationships with excluded groups, especially those affected by inequalities.	9. Co-produce and redesign services and tackle system priorities in partnership with people and communities.
5. Work with Healthwatch and the voluntary, community and social enterprise (VCSE) sector as key partners.	10. Learn from what works and build on the assets of all ICS partners - networks, relationships, activity in local places.

Cheshire and Merseyside
Health and Care Partnership

Key success factors

NHS
Cheshire and Merseyside

- Draft framework is co-produced with Healthwatch, VCFSE and system engagement experts.
- Ongoing engagement with key audiences to develop the framework, an action plan for delivery, and engagement mechanisms.
- Utilise the feedback and insights from workshops delivered by Healthwatch and the VCFSE sector
- Transition what has worked well from legacy CCGs into new arrangements.
- Recognise and build on the approaches, strengths and assets already rooted in the system and at Place.
- Further engagement in strategic Place partnership forums to enable collective “sign-up” to the principles and ways of working.

Cheshire and Merseyside
Health and Care Partnership

NHS
Cheshire and Merseyside

Next steps

- Draft public engagement framework will be presented to the public Board meetings of both NHS Cheshire and Merseyside and Cheshire and Merseyside Health and Care Partnership.
- The framework will be adopted in draft with ongoing further work to make it meaningful to system partners and Places.
- A shorter-form, designed document, that is jargon-free will be published and used to support engagement with people and communities.
- An engagement reference will be set up to use the public engagement framework to respond to the feedback gathered through engagement activity led by Healthwatch and VCFSE partners.
- Specific mechanisms designed and implemented to deliver effective involvement opportunities at system and in Place.

Cheshire and Merseyside
Health and Care Partnership

NHS
Cheshire and Merseyside

Public Engagement Framework

Our strategy for involving people and communities in Cheshire and Merseyside

2022 – 2023

NHS Confederation 2022

Champs Public Health Collaborative

VSNW

healthwatch

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Foreword

Cheshire and Merseyside Integrated Care System (ICS) is committed to involving people and communities to identify what will help to improve their health and wellbeing and to work with us to shape services.

We are therefore pleased to present our public engagement framework as the first step in delivering on that commitment. We will be using the framework to look at what resources are available locally to help people improve their health and care, use their skills, and tell us what they want and need.

We are proud that this framework has been co-produced with Healthwatch and local Voluntary Community, Faith and Social Enterprise (VCFSE) sector partners.

We want to continue that relationship and have a conversation with the public to seek their views on this framework and help further shape our approach at Cheshire and Merseyside system-level, in our nine borough-Places, and in our neighbourhoods.

Healthwatch, the VCFSE sector, our councils, hospitals and other partners already have well-established ways of engaging with people and communities, and we need to build on these strengths and assets. We want our approach to be one of evolution, not revolution.

If we are to help reduce inequalities and continuously improve health and care outcomes for all, we must engage and communicate well and listen to the views and experiences of people and communities in relation to their health and wellbeing.

The publication of this engagement framework should act as a springboard for our work to develop new engagement mechanisms for our ICS. Looking ahead, it will be integrated with strategies for communications, equality, diversity, and inclusion, and will be underpinned by detailed action plans at Cheshire and Merseyside system-level, at Place and in our neighbourhoods.

Designate Chair Raj Jain

Designate Chief Executive Graham Urwin

1. Context and Introduction

1.1 Purpose

The purpose of our public engagement framework is to describe Cheshire and Merseyside's ambition to empower people and communities. It also outlines how our engagement will help us to further tackle the inequalities in our area.

The framework has been coproduced with Healthwatch, local Voluntary, Community, Faith and Social Enterprise (VCFSE) sector organisations and engagement leads across Cheshire and Merseyside.

Public engagement will be undertaken to further design our approach, specific engagement mechanisms, and an action plan, following the national consultation and publication of statutory guidance in July 2022.

1.2 Language

In this framework we talk about 'involving' and 'empowering' people and communities. We use these phrases to cover a variety of approaches such as engagement, participation, co-production, and consultation. These terms often overlap, mean different things to different people, and sometimes have a technical or legal definition too.

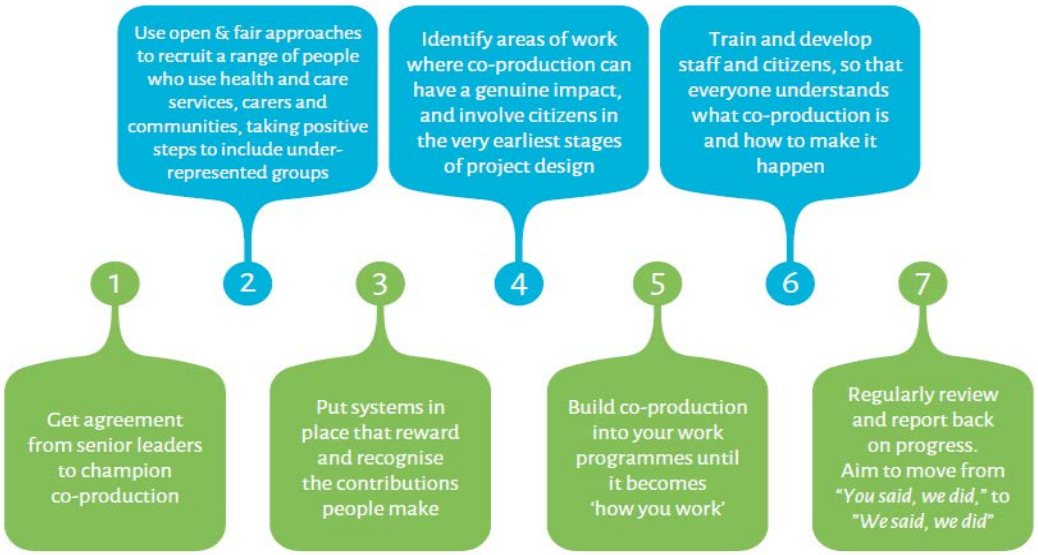
By 'people' we mean everyone of all ages, their representatives, relatives, and unpaid carers. This is inclusive of whether they use or access health and care services and support. 'Communities' are groups of people that are interconnected, by where they live, how they identify or their shared interests.

'Community-centred approaches' recognise that many of the factors that create health and wellbeing are at community level, including social connections, having a voice in local decisions, and addressing health inequalities.

'Co-production' is a way to involve people by sharing power with them. The Coalition for Personalised Care defines co-production as:

'a way of working that involves people who use health and care services, carers and communities in equal partnership; and which engages groups of people at the earliest stages of service design, development and evaluation.'

The guiding principle is that people with 'specific lived experience' are often best placed to advise on what support and services will make a positive difference to their lives. When done well, co-production helps to ensure discussions are honest, reflective, and that they maintain a person-centred perspective.



1.3- Our Integrated Care System (ICS)

The Cheshire and Merseyside ICS embodies a new way of working which brings together all the health and care organisations in our area, so they can work more collaboratively and empower people and communities who live and work here.

Our health and care organisations have already been successfully working in this integrated way, particularly through the Covid pandemic, and this is the next step in recognising this success.

Our ICS is responsible for looking after and delivering all the health and care services in the area we cover. We are made up of an Integrated Care Board and an Integrated Care Partnership, working together.

What is our Integrated Care Board (ICB)?

NHS Cheshire and Merseyside Integrated Care Board (ICB) holds responsibility for planning NHS services, including those previously planned by clinical commissioning groups (CCGs). As well as our chair and chief executive, membership of the board includes 'partner' members drawn from local authorities, NHS trusts and general practice.

The ICB will ensure that services are in Place to deliver the integrated care strategy developed by the Integrated Care Partnership (ICP). NHS Cheshire and Merseyside ICB will be created as a statutory organisation from July 2022

What is our Integrated Care Partnership (ICP)?

Cheshire and Merseyside Health and Care Partnership (the ICP) will operate as a statutory committee made up of partners from across the local area, including Healthwatch, VCFSE sector organisations and independent healthcare providers, as well as representatives from the ICB.

One of the key roles of the partnership is to assess the health, public health and social care needs of people living and working in Cheshire and Merseyside and to produce a strategy to address them. This, in turn, will direct the ICB's planning of health services and local authorities' planning of social care services.

Our ICP will be established from July 2022, supported by our staff but not employing them as an organisation (as is the case with the ICB).

We will work in partnership with CHAMPS Public Health Collaborative and the nine Directors of Public Health to develop strategies that improve public health, reduce health inequalities and ensure the health and care system across Cheshire and Merseyside is sustainable.

We have a responsibility to improve the health and wellbeing of our population. We will do this by:

- Coordinating plans to make sure our services continue to meet everyone's needs
- Joining up services to provide better care, closer to home
- Ensuring all our partners across Cheshire and Merseyside focus on addressing the causes of poor health, as well as improving diagnosis and treatment

Members of the integrated care board and partnership will be required to hear directly from, gather and represent the views of the people and communities we serve. This framework is just the start of a conversation about how we connect with our population and the different needs within it.

Local Healthwatch and VCFSE sector organisations are our key partners. They have used their expertise in representing the voice, and advocating on behalf of people and communities, to co-produce this framework.

We will continue to work together to develop the best arrangements for people to share their views and get involved in decisions that affect their wellbeing, health, and care.

Provider collaboratives

There are two Provider Collaboratives for Cheshire and Merseyside:

- The Cheshire and Merseyside Acute and Specialist Trusts (CMAST)
- Mental Health, Community, Learning Disability collaborative (MHLDSC)

Both will agree specific objectives with the ICB to contribute to the delivery of Cheshire and Merseyside's strategic priorities and are committed to working together to support the delivery of benefits of scale and mutual aid across multiple Places or systems.

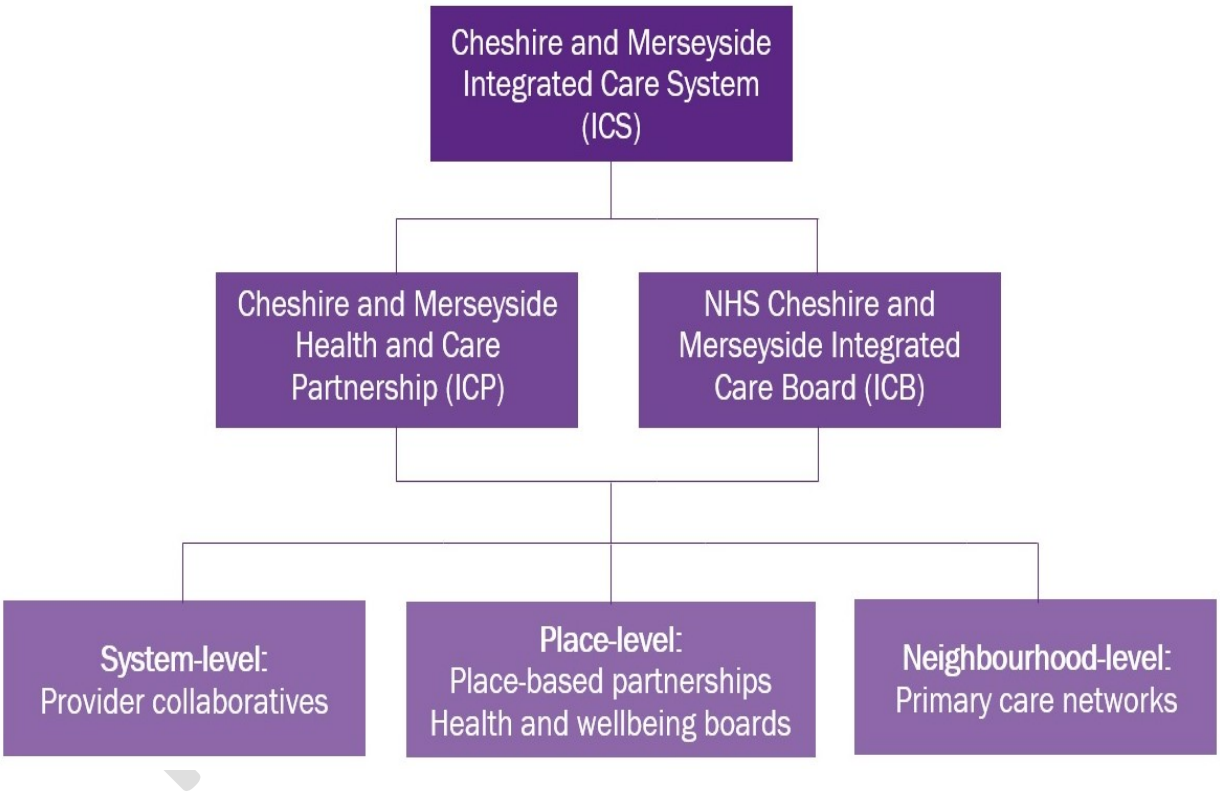
Place-based Partnerships

Our Integrated Care Board will arrange for some of its functions to be delivered, and decisions about NHS funding to be made in the region's nine borough Places – through wider Place-Based Partnerships.

The ICB will remain accountable for NHS resources deployed at borough Place-level. The ICB will set out the role of designated Place Directors within its governance arrangements.

Health and Wellbeing Boards (HWBs) will continue to develop the joint strategic needs assessment and joint health and wellbeing strategy, which both the ICP and ICB will give due regard.

Our new integrated care structure



1.4 – About our population

Cheshire and Merseyside is home to 2.7 million people across our nine 'Places'. Halton is smallest Place in Cheshire and Merseyside with a population of 129,000, compared with Liverpool which has a population of c500,000

Compared to the England average, the region currently has higher rates of premature cancer, cardiovascular disease (CVD) and respiratory deaths.

33% of our population live in the most deprived 20% of neighbourhoods in England. 1 in 4 People in Liverpool and Knowsley Live in poverty. Even within the wealthier areas in the region, there is substantial deprivation and associated poor health – while 31 percent of neighbourhoods in Cheshire West and Chester are in the top two income deciles, compared to an England average of 20 percent, 16 percent of neighbourhoods in Cheshire West and Chester are in the lowest income deciles

Whilst levels of deprivation are not as high in Cheshire, there are stark pockets of deprivation and health outcomes for some long-term conditions, while alcohol misuse and self-harm are worse than the England average.

Demand for health and care services across the region is high and growing, and with demand outstripping available resources, we must work together – placing even greater emphasis on prevention and the promotion of positive health and wellbeing

All system partners are fully committed to advancing equality, diversity and inclusion across the region. To help us do that and build on census data and the Joint Strategic Needs Assessments (JSNAs) produced by our councils, we will be working with people and communities to develop detailed 'Place profiles'. The development of these profiles will be an early focus of our engagement and help us to better understand and respond to the needs and aspirations of our population.

2. Key Principles

2.1 – The 10 Principles

There are 10 key principles that will guide how we work with people and communities in Cheshire and Merseyside. These principles have been developed through national consultation, but we want to make sure they resonate with local people as part of a wider conversation about our engagement framework.

Alongside our partners from local Healthwatch and VCFSE sector organisations, we will continue to test these principles with people and communities in Cheshire and Merseyside and adapt them for local use, based on the feedback we receive.

Cheshire and Merseyside is a very large and complex system and there can be no 'one size fits all' approach within our system, Places and neighbourhoods. These principles will help our health and care organisations develop ways of working with people and communities, depending on local circumstances and population health needs. They should be applied throughout Cheshire and Merseyside, whether activity takes place within neighbourhoods, in Places, or at system-level.

1. Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.	6. Provide clear and accessible public information about vision, plans and progress, to build understanding and trust.
2. Start engagement early when developing plans and feed back to people and communities how their engagement has influenced activities and decisions.	7. Use community development approaches that empower people and communities, making connections to social action.
3. Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.	8. Use co-production, insight and engagement to achieve accountable health and care services.
4. Build relationships with excluded groups, especially those affected by inequalities.	9. Co-produce and redesign services and tackle system priorities in partnership with people and communities.
5. Work with Healthwatch and the voluntary, community and social enterprise (VCSE) sector as key partners.	10. Learn from what works and build on the assets of all ICS partners - networks, relationships, activity in local places.

2.2 - Turning the principles into action

Our public engagement framework should be used by Cheshire and Merseyside system partners to develop plans in 2022/23 that turn the principles into action.

1. Ensure people and communities have an active role in decision-making and governance

- Build the voices of people and communities into governance structures so that people are part of decision-making processes
- Recognise the collective responsibility at board level for upholding legal duties, bringing in lay perspectives but avoiding creating isolated, independent voices.
- Make sure that boards and communities are assured that appropriate involvement with relevant groups has taken place (including those facing the worst health inequalities); and that this has an impact on decisions
- Ensure that effective involvement is taking place at the appropriate level, including system, Place and neighbourhood, and that there is a consistency and coordination of approaches
- Support people with the skills, knowledge and confidence to contribute effectively to decision-making and governance
- Make sure that senior leaders role model inclusive and collaborative ways of working.

2. Involve people and communities at every stage and feed back to them about how it has influenced activities and decisions

- Take time to plan and budget for participation and start involving people as early as possible so that it informs options for change and subsequent decision-making
- Involve people and communities on a continual basis, embed relationships, rather than taking a stop-start approach when decisions are required. As a result, there will be much greater, ongoing awareness of the issues, barriers, assets and opportunities
- Be clear about the opportunity to influence decisions; what taking part can achieve; and what is out of scope
- Vary the voices, record and celebrate people's contributions and give feedback on the results of involvement, including changes, decisions made and what has not changed and why
- Keep people informed of changes that take place sometime after their involvement and maintain two-way dialogue so people are kept updated and can continue to contribute
- Take time to understand what works and what could be improved.

3. **Understand your community's needs, experiences, ideas and aspirations for health and care, using engagement to find out if change is working**

    - Use data about the experiences and aspirations of people who use (and do not use) health services, care and support and have clear approaches to using this information and insight to inform decision-making and quality governance
    - Work with what is already known by partner organisations, from national and local data sources, and from previous engagement activities including those related to the wider determinants of health
    - Share data with communities and seek their insight about what lies behind the trends and findings. Their narrative can help inform about the solutions to the problems that the data identifies
    - Understand what other engagement might be taking place on a related topic and take partnership approaches where possible, benefiting from your combined assets and avoiding 'consultation fatigue' amongst communities by working together in an ongoing dialogue that is not limited by organisation boundaries
    - Build on existing networks, forums and community activities to reach out to people rather than expecting them to come to us. Be curious and eager to listen; don't assume we know what people will say or what matters to them.

4. **Build relationships based on trust, especially with marginalised groups and those affected by inequalities**

    - Proactively seek participation from people who experience health inequalities and poor health outcomes, connecting with trusted community leaders, organisations and networks to support this
    - Consider how to include people who do not use services, whether because they do not meet their needs or are inaccessible, and reach out to build trust and conversations about what really matters to them
    - Work with people and communities from the outset, taking time to build trust, listen and understand what their priorities are being realistic about what is in scope and where they can set the agenda for change
    - Tailor our approach to engagement to include people in accessible and inclusive ways so we include those who have not taken part before. This includes recognising that some communities will not feel comfortable discussing their issues and needs within wider meetings, so may need separate, targeted activities. They may need additional support to take part including reimbursements for their time
    - When reporting on engagement activity, explain the needs and solutions for different communities rather than simply aggregating all data and feedback together.

5. **Work with Healthwatch and the voluntary, community, faith and social enterprise sector as key partners**

    - Continue to strengthen our partnership with Healthwatch and the VCFSE sector to bring their knowledge and reach into local communities. Work with them to facilitate involvement from different groups and develop engagement activities.
    - Understand the various types of VCFSE sector organisations in our area, their different features and how the ICS can connect with them
    - Give due consideration to who is commissioned, and;
    - When we commission other organisations to work with communities, ensure that our decision-makers remain personally involved and hear directly what people have to say.

6. **Provide clear and accessible public information**

    - Develop information about plans that is easy to understand, recognising that everyone has different needs and testing information where possible. Where accessible formats such as easy read are used, these should be ready at the same time as other materials
    - Providers of NHS care must meet their requirements under the Accessible Information Standard for the information and communication needs of people in their own care. The same principles should be applied for public information so that is clear and easy to understand
    - Be open and transparent in the way we work, being clear about where decisions are made and the evidence base that informs them, along with resource limitations and other relevant constraints. Where information must be kept confidential, explain why
    - Make sure we describe how communities' priorities can influence decision-making, how people's views are considered, and that we regularly feedback to those who shared their views and others about the impact this has made
    - Provide feedback in an inclusive and accessible way that suits how people want or are able to receive it
    - Make sure information on opportunities to get involved is clear and accessible and encourage a wide range of people to take part.

7. **Use community-centred approaches that involve people and communities, making connections to what works already**

    - Support and build on existing community assets, such as activities and venues which already bring people together such as faith communities, schools, community centres, employers and local businesses, public spaces and community-centred services like link workers, community champions and peer support volunteers

- Build trust and meaningful relationships in a way that people feel comfortable sharing ideas about opportunities, solutions and barriers. Design, deliver and evaluate solutions together that are built around existing community infrastructure
- Recognise existing volunteering and social action that supports health and wellbeing and create the sustainable conditions for them to grow

8. **Use co-production, insight and engagement methods so that people and communities have actively participate in health and care services**

- Choose a method of working with people and communities that is appropriate to specific circumstances, ensuring it is relevant, fair and proportionate. The most extensive method possible should be used that suitable for the situation. Use blended methods where appropriate
- Design engagement activities to take place at a time and in a way that encourages participation, and consider the support people may need to take part, including reimbursements for their time
- Recognise that people are busy and have other priorities such as work and caring responsibilities and ensure that there are different ways to get involved with varying levels of commitment.
- Include approaches such as co-production where professionals share power and have an equal partnership with people to plan, design and evaluate together
- Where decisions are genuinely co-produced, then people with specific lived experience work as equal partners alongside health and care professionals (those with learnt experience), and jointly agree issues and develop solutions.

9. **Tackle system priorities and service reconfiguration in partnership with people and communities**

- People who use health and care services have knowledge and experience that can be used to help make services better. They can put forward cost-effective and sustainable ideas that clinicians and managers have not thought of, leading to changes that better meet the needs of the local population.
- Communities often have longer memories than our staff who may change roles and move. Understanding the local history of change that communities have experienced helps to learn and build trust with people
- When people better understand the need for change, and have been involved in developing the options, they are more likely to advocate the positive outcomes and involve others in the process.

10. Learn from what works and build on the assets of all health and care partners

- Collaborate with partners across our system to build on their skills, knowledge, connections and networks
- Reduce duplication by understanding what is already known and what has already been asked, before designing the approach to engagement
- Learn from approaches taken elsewhere in the country and how they can be adapted and applied locally
- Plan together across systems so that partnership work with people and communities is co-ordinated, making the most of partners' skills, experiences and networks.

3. Priorities for 2022-23

3.1- System priorities

All ICSs have four core purposes. In Cheshire and Merseyside we have also set out our shorter-term priorities.

Improve population health and healthcare

- Reduce deaths from cardiovascular disease, suicide and domestic abuse
- Reduce levels of obesity
- Reduce harm from alcohol
- Provide high quality, safe services
- Provide support to all those experiencing 'long covid'
- Provide integrated, high quality, mental health and wellbeing services for all people requiring support from low levels of intervention to crisis management and inpatient care.

- Underpin improvements in health and healthcare with Research and Innovation by supporting collaboration between Cheshire and Merseyside academic partners, and making them a key part of our Health and Care Partnership (ICP).

Tackling unequal outcomes and access

- Reduce the life expectancy gap in the most deprived communities, in children and those with mental health conditions and help people live extra years in good health.
- Improve early diagnosis, treatment and outcome rates for cancer
- Improve waiting times for children and adult mental health services
- Target those with chronic diseases so they access services especially those in our most deprived areas.
- Reduce the impact of poor health and deprivation on educational achievement.

Enhancing productivity and value for money

- Prioritise making greater resources available to prevention and well-being services
- Plan, design and deliver services at scale (where appropriate) to drive better quality, improved effectiveness and efficiency
- Maximise opportunities to reduce costs by procuring and collaborating on corporate functions at scale
- Develop whole system plans to address workforce shortages and maximise collaborative workforce opportunities
- Secure value for money
- Develop a whole system Estates Strategy.

Support broader social and economic development

- Embed a commitment to social value in all our partner organisations
- Establish the 'Anchor Institution' in Cheshire and Merseyside, offering significant employment opportunities for local people
- ICS will be involved in regional initiatives to develop economy and support communities in Cheshire and Merseyside
- Develop a programme in schools to support mental wellbeing of young people and inspire a career in health and social care
- Work with Local Economic Partnerships to connect ICS partners with business and enterprise.

3.2 – Our programmes

There are several system-wide programmes that will help us to meet our priorities. The involvement of people and communities in our programmes is essential to help us improve wellbeing, provide better services and design smoother care pathways.

Programme	Summary
Ageing Well	Urgent community response, enhanced health in care homes and helping people with complex needs stay healthy.
Beyond Programme (children and young people)	Healthy weight, emotional wellbeing, respiratory health, and care for people with a learning disability and autism.
Cardiac Board	Initiatives focussed on prevention and early intervention, population health and creating stable services.
Diagnostics	Includes all diagnostic tests including, pathology, imaging, endoscopy, screening programmes, cardio & respiratory, neurophysiology and more.
Digital	Tackling digital exclusion, driving integration of care records and population health management, systems to support transformation including; remote monitoring, digital primary care and digital social care, cyber security and service recovery plans to improve treatment times.
Elective Recovery	Reducing waiting lists, restoring services to pre-covid levels, and embedding sustainable services.
Medicines and Pharmacy	Reducing unwanted variation and creating equitable service provision across Cheshire and Merseyside.
Mental Health	Community mental health, crisis care, psychological therapies, maternal and perinatal mental health, support for our workforce.
Neuroscience	Building on new clinical pathways and increasing the range of services to improve population health.
Population Health	Improving population health and healthcare, tackling health inequalities, and improving outcomes and access to services.
Women's Health and Maternity	Transforming and improving support for women's health, improving wellbeing, life chances and outcomes for women and babies.
Diabetes	Improving treatment targets, multi-disciplinary footcare teams in all Places, specialist nursing and flash glucose monitoring,
Palliative and End of Life Care	For adults, children and young people to live well, before dying in peace and with dignity, in the Place they would like to die, supported by the people important to them.

Respiratory	Quality assured diagnostic spirometry, pulmonary rehab and psychological support to manage respiratory disease.
Stroke	Reducing the number of strokes in Cheshire and Merseyside by focusing on prevention, reducing health inequalities, improving access and community rehabilitation.

Case Study – Involvement in the Digital Programme

The Cheshire and Merseyside Health and Care Partnership's Digital Programme is working on updating its Digital Strategy 2018-23, with a digital and data strategy that better supports recent policy context (For example, as set out in What Good Looks Like and Data Saves Lives), and the massive acceleration of digital transformation that's been brought on by COVID-19.

As part of this piece of work, several engagement exercises are being undertaken with members of the public and health and care professionals living and working in Cheshire and Merseyside. To ensure that the strategy is inspired by and helps to; digitally empower the diverse population we serve to take control of their own health and wellbeing, and to digitally enable our health and care workforce to deliver safer, more effective, and efficient care to their patients.

To help illustrate the breadth and depth of this engagement work we've included two case studies below that highlight exercises we've started, and how they'll shape our work moving forward.

Digital Inclusion Heatmap and Insight Project

The COVID-19 pandemic has exacerbated inequalities within society, including the digital divide. At a time when having full access to computers and the internet could not be more important, in allowing people to use online health and care services.

What's more, digitally excluded people (such as older people, financially disadvantaged people, and disabled people), who may be unable to get online due to factors such as access, confidence, motivation, and skills, are some of the heaviest users of health and care services.

To enable better targeting of interventions to support digitally excluded people across Cheshire and Merseyside, our Digital Inclusion programme, has commissioned the development of a "Digital Inclusion Heatmap for Cheshire and Merseyside".

The heatmap is a tool that uses data sets supplied by primary care, social care, and local authority partners, to provide an up-to-date snapshot (that can be updated over time) of digital inclusion initiatives and resources available across the nine local authority areas or "Places" in Cheshire and Merseyside.

A focused piece of insight is being undertaken to gather attitudes of digitally excluded people and the barriers and issues that they face when it comes to accessing health and care online, with a specific focus on the NHS App.

Multiple methods are being used, including focus groups, in-depth surveys, community outreach, and local businesses engagement, to ensure that the views of a wide range of people both living and working in Cheshire and Merseyside are captured.

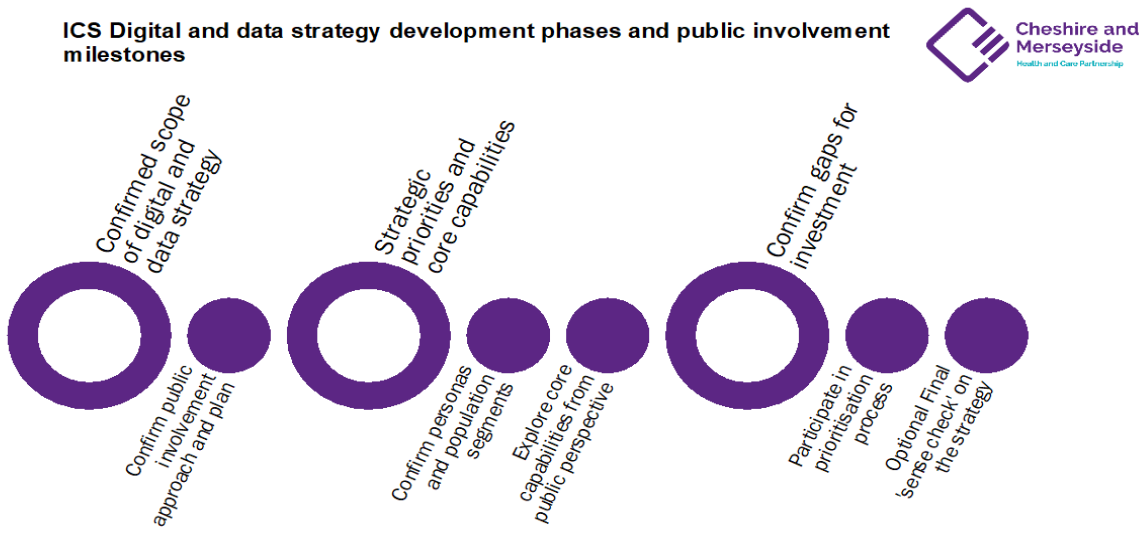
It is hoped that the heatmapping tool and insight work will provide us with a broader understanding of the barriers faced by digitally excluded people in our area, and in a variety of settings, when trying to access digital equipment, data, and skills.

Our aim is to ensure that everyone who is unable to access and engage digitally in Cheshire and Merseyside, has the opportunity (as far as possible) to do so, or is provided with an alternative solution, so they're not left behind as we move towards a 'digital first' culture.

Public involvement panels

To create a digital programme that is people-centred we are co-producing our strategy development work. We have identified several 'touchpoints' where public involvement is helping to test our proposals for digital architecture and systems that span Cheshire and Merseyside.

These touchpoints are shown below as solid circles in the strategy development timeline;



The deliberative method we are using incudes 'on-line' group work involving adults from the Public Advisers from the National Institute for Health and Care Research (NIHR) and Applied Research Collaboration (ARC) Northwest Coast. Advisers are drawn from across Cheshire and Merseyside and represent diverse communities from our area. They have received training and support from the ARC in participating in this activity.

For children and young people we are partnering with Youth Federation to involve young people in on-line events. We have also run an on-line session with Alder Hey Hospital Children and Young People's Form.

These initial events were focussed on testing the population segments or 'personas' which we have created, which are key to the structure and focus of the strategy. Our next events will focus on the core capabilities to be commissioned by ICS digital to ensure these meet the aspirations of the personas.

3.3 Tackling health inequalities

Health inequalities are the unjust and avoidable differences in people's health across the population and between specific population groups. Tackling the causes and consequences of health inequalities is a central priority for the Cheshire and Merseyside ICS.

One of the key priorities of our public engagement framework is to build relationships with excluded groups, especially those who are affected by inequalities, so that we can understand and meet their needs and aspirations for wellbeing, health, and care

People and Communities Panel

There are some excellent examples of Healthwatch and Local Authority partners gathering insights from people and communities in Cheshire and Merseyside.

We want to join-up, and build on this work at system level, with a particular emphasis on people and communities who are most affected by heath inequalities in our cities, towns and villages.

We will work with Healthwatch, VCFSE sector and Local Authority partners to support the development of a 'people and communities panel', which will seek to better understand the barriers faced by ethnic communities and people affected by poverty, unemployment and housing issues, in order to capture a holistic picture of inequalities and work with people and communities on joined up solutions.

The social determinants of health (such as local neighbourhoods, access to greenspace, opportunities for being more active and access to healthy food) as well as physical and mental wellbeing are key. As a listening organisation, we want to develop an ongoing discussion with panellists about

- health and care services
- health and wellbeing issues and their ideas to resolve them
- aspirations for better services and care pathways

The response to COVID-19 has seen people in Cheshire and Merseyside support family, friends and neighbours including those self-isolating and encouraging vaccine take-up. The learning from this should be transferred to help us meet other challenges that health and care services face by listening to people and working with them to decide what will work best locally.

.Health inequalities can be reduced by identifying solutions that are developed in partnership with people using community-centred approaches. Understanding the experiences and perspectives of those who face barriers to care and support, and have different outcomes, will help to develop opportunities for improvement and investment. By building trust and mutual

understanding of the full range of our marginalised communities, then we will start to address unequal access to services and health outcomes.

3.4 Equality, Diversity and Inclusion

It is important that we listen, respond to, and make every effort to involve individuals from all protected characteristic groups for example young people, older people, and lesbian, gay, bisexual, transgender, and questioning (LGBTQ) groups. In Cheshire and Merseyside, we celebrate the diversity of our communities.

It is also important that we listen to other underserved groups such as people with specific health conditions, homeless people, refugees and asylum seekers or people living in deprivation and/or rural communities to make sure we reach a diverse range of people to give them the opportunity to share their views.

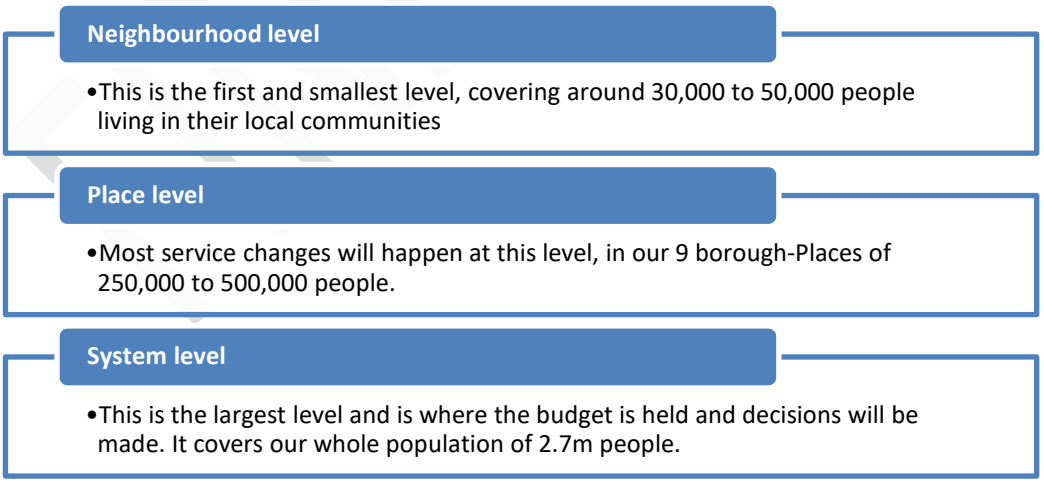
We will use equality impact assessments to help us understand which groups may need to be specifically targeted for a programme of work. We will be informed by public health and their needs assessments and evidence on health inequalities.

Healthwatch is developing a checklist for assessing the quality of Equality Impact Assessments which can be used to provide the checks and balances to hold the system to account.

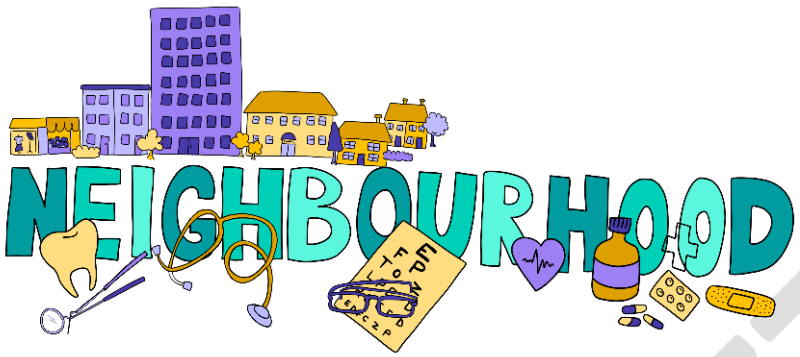
4. Involving people and communities

4.1 Levels of engagement

Our Cheshire and Merseyside public engagement framework will support us to work with people and communities at different levels.



Neighbourhood



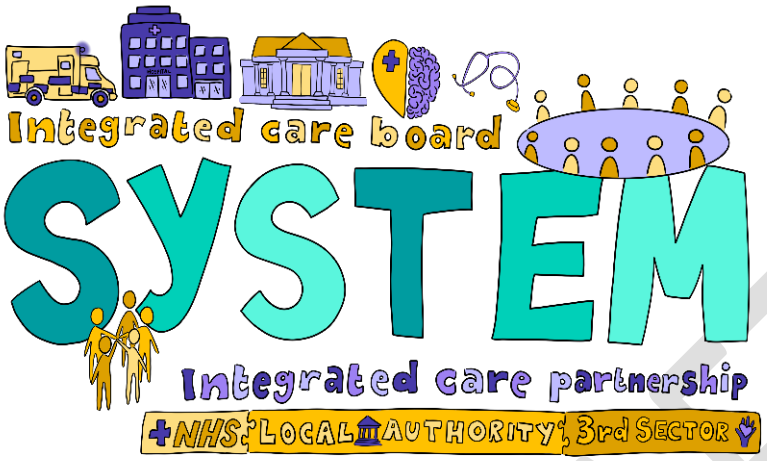
At neighbourhood level, our GPs, opticians, dentists and community pharmacists are working together to deliver 'Primary Care', which is care that takes Place outside of a hospital setting. They work together in your local area, to form a Primary Care Network (or PCN). All doctors and primary care professionals are part of one of these networks now, so they can work with people and communities to shape and improve local services

Nine borough-Places

Our Places are the areas covered by our nine local authorities and include several neighbourhoods. This is where most health and care services are delivered, including hospital care.

There are Place-based partnerships, where local hospitals, care providers, local councils, doctors, Healthwatch and the VCFSE sector are coming together to discuss key health and care issues with local people and communities.

Cheshire and Merseyside 'System'



Our Cheshire and Merseyside Integrated Care System, which is responsible for running health and care services, is made up of two key bodies:

Integrated Care Partnership (ICP)
Links in with all the wider partners – including Healthwatch the VCFSE sector, employment, health – at Place level. Through discussion with people and communities, the partnership will use the information about the local population to create a strategy for helping everyone who lives and works in the system area to live healthily.

Integrated Care Board (ICB)

The ICB oversees the NHS budget and makes sure the services are in place to make the strategy become a reality on the ground.

4.2 Using the Framework

This strategic framework is not a finished product, it reflects a moment in time, providing our early blueprint for working with people and communities. The longer-term strategy and delivery plan for Cheshire and Merseyside must be co-produced with residents, partners, staff and stakeholders.

Developing our engagement framework will require us to test approaches, learn and evolve over time. We must challenge ourselves, be flexible and collaborate with people and communities to meet longer term goals.

Core priorities include developing a culture of co-production and embedding the residents' voice in the way we plan, develop and deliver services.

People and communities have the experience, skills and insight to transform how health and care is designed and delivered. The ambition is for the Cheshire and

Merseyside ICS is to build positive and enduring relationships with communities to improve services, support and outcomes for people.

This means

- listening more and broadcasting less
- being flexible and responsive
- ongoing involvement and engagement of people and communities that is iterative and not only done in isolation, when proposing to change services
- focussing on what matters to communities, including people from marginalised groups and those who experience the worst health inequalities
- supporting approaches around existing networks, community groups and other Places where people come together
- developing plans and strategies that are fully informed by people and communities
- providing clear feedback about how people's views will lead to improvement, impact and change
- Involving communities to develop their own solutions to improving the health of all.

Working in this way will enable better decisions with people about service changes, and improve operational effectiveness, CQC inspection outcomes, safety, quality, experience and performance.

It is vital, whether working at system, in one of our Places or local neighbourhoods, that engagement is carefully planned and designed to ensure that partners, people and communities get the best out of our work together.

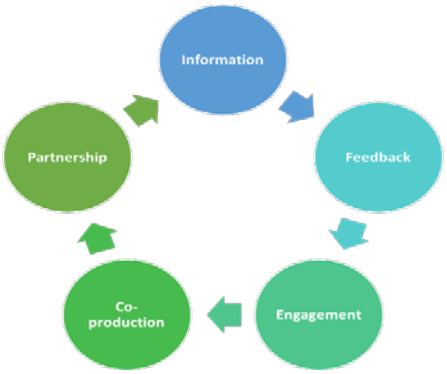
4.3 – People's voice

We recognise how important it is for us to be open and transparent about how the feedback we receive informs our planning and decision making. The diagram below simply illustrates the feedback loop that we will use to keep people informed.

To plan, develop and deliver wellbeing, health and care services and support that the people of Cheshire and Merseyside need, we will constantly evaluate feedback from a wide range of sources. We will use the feedback we gather, alongside the quantitative data we collect, to develop a repository of intelligence that we will use to identify actionable insights and ensure people's voice is at the centre of our decision-making.

During the year we will bring that information together to produce 'Insight and Intelligence' reports at system and in Place, that can be used by our teams to shape programme plans and service change activity.

These reports will be published to show what we have captured, and we'll also publish details of how feedback's been used and the impact it's had.



4.4 Our approach

1. Reach out to people and ask them how they want to be involved.

2. Promote equality and inclusion and encourage and respect different beliefs and opinions.

3. Proactively seek the involvement of people who are underserved and who experience health inequalities and poorer health outcomes.

4. Value people's specific lived experience and use all the strengths and talents that people bring to the table.

5. Provide clear and easy-to-understand information and recognise that everyone has different needs.

6. Take time to plan with and involve people as early as possible.

7. Be open, honest, and transparent in the way we work; explain decisions, be clear about resource limitations and constraints. Where information must be kept confidential, explain why.

8. Invest in partnerships, ongoing dialogue and provide information, support, and training to enable leadership from those with specific lived experience.

9. Review people's experiences and learn from them to continuously improve how people are involved.

10. Recognise, record, and celebrate people's contributions and give feedback on the results of involvement and engagement.

5 Collaboration and partnership working

Collaboration and partnership working is about building relationships with organisations and local communities in a way that treats partners equitably, and that recognises the contribution that can be made to improving the health and care system.

Working collaboratively and in partnership, gives us a far greater opportunity to ensure that our services meet people's needs and that experiences and outcomes can be improved. People and communities have the knowledge, skills, experience and connections to support and improve health and wellbeing.

We want to identify and deliver 'shared outcomes' that meet the needs of communities. This is particularly relevant in the context of population health management and reducing health inequalities. Our health and wellbeing is affected by many things – housing, unemployment, financial stress, domestic abuse, poverty and lifestyle choices.

Within our partnership Healthwatch, the VCFSE sector, and our local authorities bring vital strengths in working with people and communities - and vast experience of working with people to design and deliver services that meet local needs and build community assets.

In Cheshire and Merseyside, we have very well-established partnerships at a local level, and have had for many years. Our partners work together to improve the health and wellbeing of local people and communities through policies and plans for housing, early years, growth, skills and employment.

Our Integrated Care System puts us in an even better position to respond to these challenges in Cheshire and Merseyside, alongside our local authroities, Healthwatch and the VCFSE sector.

5.1 Working with Healthwatch & the VCFSE sector

In co-producing our public engagement framework, we have identified a set of principles that will enable us to strengthen our partnership with Healthwatch and the VCFSE sector.

Healthwatch

What will good look like?

The strength and value of the independent, statutory role of Healthwatch is recognised as fundamental to the planning and delivery of health, care and wellbeing services throughout Cheshire and Merseyside.

What good will look like, includes:

- strong relationships with the local Healthwatch network being built upon and strengthened, to help ensure that services are shaped around the needs of people and communities
- partners respecting, valuing and supporting the core duty of Healthwatch to engage with people and communities across all health and care services and the whole 'life-course'
- acknowledging and benefitting from the unique position Healthwatch holds both outside and inside the wider system, as a voice for people and communities, including those not regularly heard, and as constructive critical friend with statutory powers
- working in partnership with Healthwatch to ensure people and communities are able to share their experiences and be involved in service design, planning and delivery, knowing that their input is respected, heard and responded to.
- ensuring the statutory functions, activities and duties of Healthwatch are maximised to plan, design and deliver quality services
- insight and intelligence from Healthwatch reports, and Enter and View programmes of work, regularly being used and referred to for quality planning and assurance of services
- early inclusion of Healthwatch in designing, planning and delivering engagement activities, ensuring resources and mechanisms are in place to deliver.
- recognising the co-location of local Healthwatch within each of the Cheshire and Merseyside Places; their commitment to working collaboratively, and the ability to carry out their role at a Neighbourhood/Care Community, Place, System and National levels.

The VCFSE sector

The VCFSE sector has always provided a wide range of support to health, care and wellbeing services including helping community voices to be heard. Working with Cheshire and Merseyside VCFSE infrastructure provides access to a network of over 15,000 VCFSE organisations, ensuring a stronger collective voice across our diverse communities.

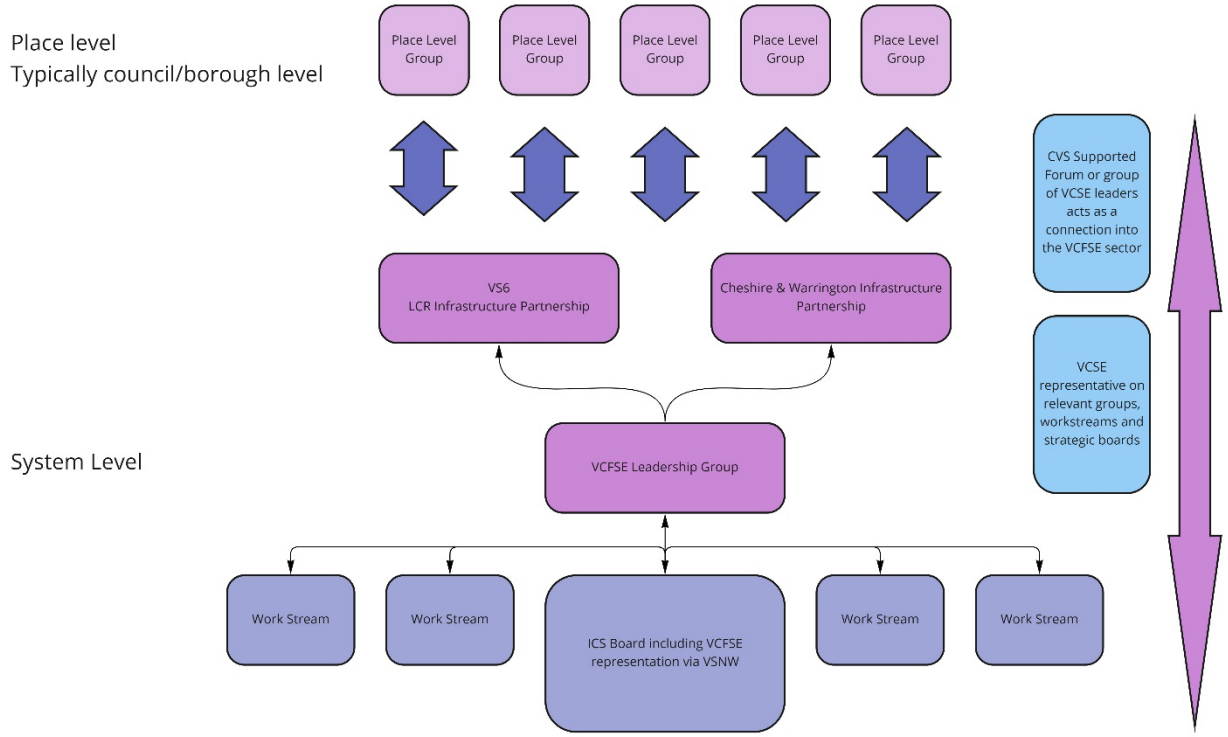
What good will look like includes:

- Recognition that the VCFSE has a rich source of insight and data, that reflects local community need which is used to inform planning and delivery.
- Increased opportunities for community engagement, designed and led by the VCFSE sector, delivering meaningful engagement to provide up-stream solutions with opportunities to co-design, to help influence and shape service provision.
- Leaders and advocates across the VCFSE sector are fully engaged on decision-making programmes and project boards at system, place and in neighbourhood level.

- Increased engagement though the extensive VCFSE reach within our diverse and seldom heard communities to share views and experiences to shape and influence service re-design and encourage coproduction.
- Resources and investment to ensure the VCFSE has the capacity to engage as an equal partner across local and regional systems.
- Utilising local infrastructure and established relationships across the Cheshire and Merseyside strategic ecosystem of boards, forums and groups, ensuring credibility and assurance when representing the views of the sector.

VCFSE infrastructure organisations are recognised and used as a key channel for two-way communications with NHS Cheshire and Merseyside, providing a consistent approach to engagement.

Local model for strategic VCFSE engagement



5.2 The benefits

Accountability and transparency:

Our organisations should be able to explain to people how decisions are made in relation to any proposal – and how their views have been taken onboard. Transparent decision-making, with people and communities involved in governance, will help make our ICS accountable to communities.

Participating for health

Being involved can reduce isolation, increase confidence and improve motivation towards wellbeing. Individuals' involvement in their own care can lead to involvement at a service level and to more formal volunteering roles and employment in health and care sectors. It is well recognised that doing something for others and having a meaningful role in your local community supports wellbeing. Getting involved, being part of a community and being in control is good for our health.

Better decision-making

We view the world through our own lens and that brings its own judgements and biases. Business cases and decision-making are improved when insight from local people is used alongside financial and clinical information to inform the case for change. People's insight can add practical weight and context to statistical data, and fill gaps through local intelligence and knowledge.

Improved quality

Partnership approaches mean that services can be designed and delivered more appropriately, because they are personalised to meet the needs and preferences of local people. Without insight from people who use, or may not use, services, it is impossible to raise the overall quality of services. It also improves safety, by ensuring people have a voice to raise problems which can be addressed early and consistently.

Value for money

Services that are designed with people and therefore effectively meet their needs are a better use of public sector resources. They improve health outcomes and reduce the need for further, additional care or treatment because a service did not meet people's needs first time.

Meeting legal duties

Failure to meet the relevant legal duties risks legal challenge, with the substantial costs and delays that entails, and damage to relationships and trust and confidence between organisations, people and communities.

5.3 - Culture and Leadership

Our communities and staff will look to system leaders to role model a culture of partnership, to demonstrate that their views are taken seriously, and that power is shared so they can play a genuine part in decision-making. Leadership can be a joint endeavour, with leaders from our system and from within communities working together.

Collaborative and inclusive leadership means seeing involvement as everybody's business (not just a handful of people with a relevant job title) and is fundamental to meeting shared objectives. It means making sure that professionals and communities can work, learn, and improve together.

Senior leaders must:

- Promote involvement and co-production through culture and behaviour
- Identify areas of work where co-production can have a genuine impact and involving people at the earliest stages
- Invest in training and development so that people with specific lived experience and people working in the system know what co-production is and how to make it happen.
- Hold the system, Places and neighbourhoods to account by seeking assurance that involvement and co-production is happening

5.4 – Our workforce

WE ARE ONE

We Are One is the term we use to create a 'one team' ethos for our ICS workforce. We must support and give our staff permission to innovate and collaborate in new ways and give them the permission and autonomy to try things out, to learn and to celebrate success.

Our staff are our most valuable resource, and we must invest in training and development opportunities to support them and the effective delivery of our public engagement framework. In Cheshire and Merseyside, we believe involvement is everyone's business not just a handful of people with relevant job titles.

This requires a commitment for the resources, training and support to do so effectively, and allowing people time to build trust and relationships. One way of doing this effectively is using community-centred approaches that enable staff to work with diverse communities to develop their skills, in a way that supports people and communities to take more control of their health. This will help realise the potential of both groups.

Our Chair, Chief Executive and Board members are all committed to creating the right conditions to ensure that our workforce collaborates to involve people and communities in Cheshire and Merseyside.

5.5 Progress and next steps

We have already made lots of progress in working with people, communities and health and care staff, but there is much work to do to build on this in 2022/23.

Progress

- Ongoing engagement with elected members, hospital governors and non-executive directors in developing our ICS
- Work with the Institute for Health Equity to co-produce interventions and actions with communities, including nine Place-based health inequalities workshops
- Work with the Cheshire and Merseyside public health collaborative (CHAMPS) and Population Health Board to develop
    - Combined Intelligence for Population Health Action (CIPHA)
    - Community alcohol licencing plans
- The national award winning Getting Under the Skin research campaign, to understand and respond to the impact of COVID-19 on ethnic communities in in Cheshire and Merseyside
- The Kind to your mind campaign – development of dedicated telephone and website for support for mental wellbeing, advice and signposting
- Cheshire and Merseyside Opening Doors programme - aimed at improving the health of people in social housing and offering opportunities for residents to develop the skills to work in social care.
- Work with people with a learning disability and autism via the Cheshire and Merseyside Transforming Care Partnership
- Council-led Community Champion and inspirers initiatives to influence the policy agenda

Next steps

The draft public engagement framework will be presented to the public Board meetings of both NHS Cheshire and Merseyside (the ICB) and Cheshire and Merseyside Health and Care Partnership (the ICP) following their establishment on 1 July 2022.

The framework will be adopted following the publication of national statutory guidance, and a shorter-form, designed document, that is jargon-free will be published and used to support engagement with people and communities.

An engagement reference group has been set up to use the public engagement framework to respond to the feedback gathered through engagement activity led by Healthwatch and VCFSE partners, and design specific mechanisms to deliver effective involvement opportunities at system, Place and neighbourhood levels, that ensure;

- clear and transparent mechanisms for developing integrated health plans with people and communities
- clear and accessible public information about its vision, plans and progress
- annual reporting on the involvement of people and communities at ICS and in Place
- collaboration with Healthwatch and the VSFSE Sector as key engagement partners

- involvement with people and communities representing equality protected groups and people affected by inequalities
- that involvement is monitored and audited
- that people and communities are represented in priority setting and decision-making forums
- that the participation of people and communities is supported by ensuring there is a training and development offer that equips people to contribute to governance arrangements.
- that the experiences and aspirations of people and communities are gathered, reviewed, and responded to
- that these experiences and aspirations are used to produce insight and intelligence reports to inform decision-making and quality governance.

The role of this group will be to develop and publish detailed action plans at both system and Place-levels.

5.6 - Meeting legal duties

Statutory guidance for working with people and communities will be published in July 2022 following national public consultation. The System Partnerships team at NHS England and Improvement (NHSEI) has also recently published (February 2022) a Major Service Change: An Interactive Handbook.

ICS partners must give regard to this guidance, and meet other legal duties, such as;

- *Equalities:* The Public Sector Equality Duty (PSED), section 149 of the Equality Act 2010
- *Health inequalities: The* Health and Social Care Act 2012
- *Triple aim duty*: The Health and Care Bill 2021
- *Social value:* Public Services (Social Value) Act 2012.

National statutory guidance and our Cheshire and Merseyside public engagement framework are relevant to the entire health and care system:

- Our **Integrated Care Board** carries the legal duties that will be discharged through the adherence to statutory guidance and adoption of our Cheshire and Merseyside Framework
- Our **Integrated Care Partnership** can use them to inform the development of its strategy
- Our **Place-based partnerships** can use them to guide how they involve people in decision-making processes and engage them on plans for change
- Our **provider collaboratives and programmes** can use them to support working with people on improving care pathways across multiple Places
- Our **Primary Care Networks** can use them to work with their local communities to understand local needs and reduce health inequalities.

6 Monitoring and Evaluation

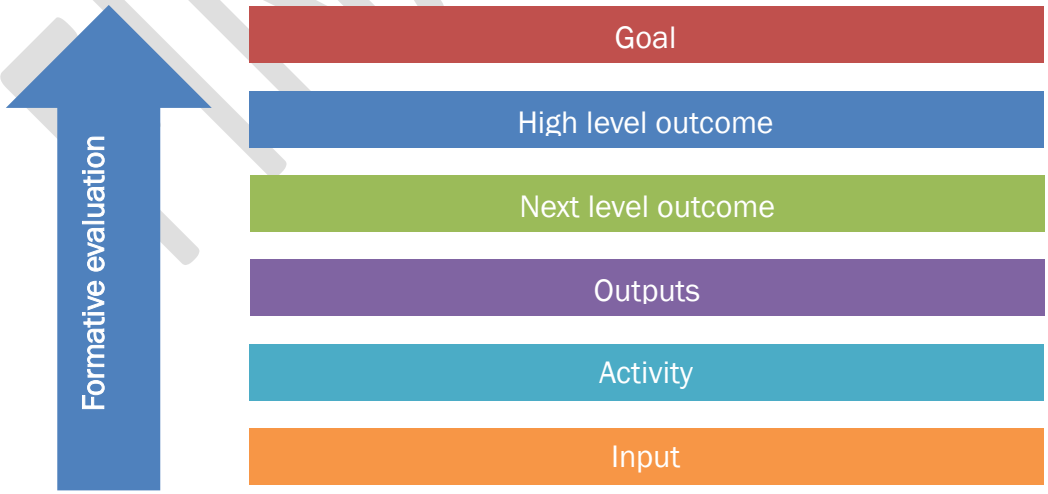
The Cheshire and Merseyside ICS is working with NHS England and NHS Improvement and other systems to develop a formative approach to the evaluation of our engagement with people and communities. This will be further informed by a new oversight framework.

Our aim is to develop an evaluation approach (using a basic theory of change model) that meets our specific ICS priorities, whilst being aligned to national oversight and quality assurance measures.

By working in this way, we can

- Demonstrate the impact of working with people and communities
- Learn as we develop
- Be held accountable to people, communities, regulators, and our partners

Approach	Benefits
1. Co-produce a 'people and communities' theory of change through workshops with other ICSs	Share good practice and inform national quality assurance framework
2. Develop a shared evaluation toolkit	Practical tools that system partners can use to meet national standards
3. Develop a local evaluation framework	Robust local mechanisms to assure people, communities, regulators and our partners



7 Appendix

7.1 How the framework was developed

Cheshire and Merseyside's public engagement framework was developed by a multidisciplinary task and finish group which drew its membership from our Health and Care Partnership.

Task and finish group have held fortnightly meetings and members have undertaken extensive engagement with forums at system, Place and neighbourhood levels over a period of three months from 1 April to 30 June 2022.

The framework has been developed in line with ICS implementation guidance for working with people and communities and following the national content guide provided by NHS England and NHS Improvement.

Oversight of strategy development has been provided by the following ICS forums

- The Cheshire and Merseyside Partnership Assembly
- The Cheshire and Merseyside ICS Development Advisory Group
- The Cheshire and Merseyside Transition Programme Board

The framework has been co-produced with Healthwatch and the VCFSE sector who have undertaken the engagement activity set out below, to inform its development. The feedback and insights from this activity will be taken forward by the engagement reference group mentioned in section 5.5 (pg.29 above).

7.2 Healthwatch engagement activity

Healthwatch	Who	How feedback was collected
Liverpool	Community engagement board (made up of representatives of organisations working with local communities especially often ignored communities). Staff and volunteer team.	Online focus groups
Wirral	Survey sent through community networks	Survey
Sefton	Focus groups with staff team, board, and volunteers	Focus groups
Knowsley	Focus groups with Knowsley residents, and Healthwatch Knowsley board	Focus groups
St Helens	Meetings, web form and survey for staff team, board, volunteers and local community groups	Webform/survey, visits to groups, team meetings.
Cheshire East and Cheshire West	Staff team, volunteers, Board members Supported conversations on engagement activities	Using a mixture of: Comments on full draft Feedback collected verbally at meetings and recorded based on 10 Principles Survey of small cohort of people, to include members of HWC's Citizen's Focus Panel
Halton	Staff team Advisory board focus group Small group of volunteers Survey to virtual peoples panel	Focus group with staff, board and volunteers
Warrington	Staff, board members and volunteers and volunteers, People Panel, Virtual Voices panel , small focus groups.	Survey feedback

7.3 VCFSE engagement activity

VCFSE	Who	How feedback was collected
VS6	VS6 is the Liverpool City Region network of CEO's leading infrastructure support its membership includes: • Together Liverpool (Faith) • Sefton CVS • One Knowsley • VCAW • Halton and St Helens VCA • Liverpool CVS • Network for Europe • Community Foundation Merseyside • Merseyside Youth Association • It is Chaired independently by Rev Canon Dr Ellen Loudon, Director of Social Justice & Canon Chancellor, Diocese of Liverpool	Online facilitated focus group
CWIP	CWIP is the Cheshire and Warrington network of CEO's leading infrastructure support its membership includes: • Warrington VA • Cheshire East CVS • Cheshire West VCA	Online facilitated focus group

CVS	Who	How feedback was collected
Liverpool	Health and Wellbeing Network	Online facilitated focus group
Wirral	Wirral CVS VCFSE Board and established network of VCFSE leaders	Online facilitated focus group
Sefton	Health and Wellbeing Network	Online facilitated focus group
Knowsley	Health and Wellbeing network, VCFSE Leaders network	Online facilitated focus group
St Helens	VCFSE forum	Online facilitated focus group
Halton	VCFSE Forum	Online facilitated focus group
Warrington	VCFSE Health and Wellbeing Alliance VCFSE Health Engagement Event	Face to face focus group
Cheshire East and Cheshire West	Sector Leadership Group from the Membership of CWVA.	Facilitated conversation by Michelle Whitaker, Health & Wellbeing Programme Lead office for Health Improvement & Disparities, Northwest Region

7.4 Emerging Place priorities

Place-based partnerships are starting to identify and develop priorities, in collaboration with Health and Wellbeing Boards, that will be further tested through engagement with people and communities in 2022/23.

Place	Key Priorities
Cheshire East	
Cheshire West	To identify Cheshire West population health needs now and in the future, proactively detecting and preventing ill health, whilst promoting wellbeing and self-care to our residents. To reduce health inequalities by continuing to develop our approach to population health management (PHM), using data and analytics to prevent ill-health, address health inequalities, and identify those residents who are at higher risk of their health deteriorating, enabling us to deliver preventive interventions. Improving the quality of services that are delivered within Cheshire West, expanding on efficiencies, and delivering safe and effective care.
Halton	
Knowsley	A targeted approach to population health and reducing health inequalities starting with Northwood (our most deprived area) A single front door to health information, guidance and advice as part of the Knowsley Offer A reduction in avoidable attendances and admissions to hospital Improving access to general practice
St Helens	The St Helens People's Plan covers three priorities to improve the health and wellbeing outcomes of residents in the borough. The priorities are resilient communities, mental health and healthy weight. These are underpinned by the crosscutting theme of tackling health inequalities. **Resilient communities:** The objectives and scope for this project is to support people to live independently, reduce social isolation and loneliness, embed multi-sector/disciplinary team working in our four localities/networks and to develop a health innovation hub.

	Mental wellbeing: St Helens partners are currently working towards preventing and reducing self-harm and suicide, expanding the voluntary and community service capacity to support mental health and wellbeing, and improving the wellbeing of children and young people. An action plan is being developed using the OHID prevention concordat for better mental health. **Healthy weight:** The objectives for the workstream are to support healthy eating choices in the borough, encouraging residents to lead a more active life and there is a focus diabetes prevention. The Active Lives strategy and action plan has been developed and the group are working with Food Active on a health weight declaration.
Liverpool	
Sefton	
Warrington	
Wirral	Recovering from the COVID-19 pandemic and transforming our Place by implementing the Wirral Plan 2021-2026. Refreshing, refocusing and strengthening partnerships and collaboration in Wirral to support delivery of our plans, including co-production. Improving population outcomes and tackling health inequalities by addressing the needs of our population in a more targeted way.

NHS
Cheshire and Merseyside

Public Involvement Policy

Draft 001

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Impact Assessed	To follow

Further information

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Introduction

NHS Cheshire and Merseyside is committed to involving people and communities to identify what will help to improve their health and wellbeing and to work with us to shape services.

If we are to help reduce inequalities and continuously improve health and care outcomes for all, we must engage and communicate well and listen to the views and experiences of people and communities in relation to their health and wellbeing.

Aims of the Policy

This policy has been established to ensure public involvement with NHS Cheshire and Merseyside is fair, transparent and managed in a way that protects people, communities and our staff.

NHS Cheshire and Merseyside recognises that public representatives who share their time, experience and skills with the organisation should receive fulfilment from their role, development opportunities, and respect for the contribution they make. In turn, NHS Cheshire and Merseyside should receive added value to its work, for people who use services, and contribution that helps improve health and care services.

In the context of this policy the term 'public representative' encompasses patients, carers, volunteers, and people and community representatives who are involved in the work of NHS Cheshire and Merseyside.

Code of Conduct (Appendix A)

A Code of Conduct has been established which public representatives will be expected to sign up to. All public representatives, through the Code of Conduct, will adhere to the following:

- Nolan Principles of Public Life
- Grievance Guidance
- Disciplinary Guidance
- Conflict of Interest policy
- Expense Policy
- Public Charter

The Code of Conduct sets out what is expected from NHS Cheshire and Merseyside and what is expected of an NHS Cheshire and Merseyside public representative. Compliance to this Code of Conduct is a condition of involvement.

Role Descriptions (Appendix B)

Generic role descriptions, including person specifications, have been developed, which include a brief overview why we need public representatives, and the responsibilities and commitments of the roles.

At this stage, the two opportunities are public representatives at NHS Cheshire and Merseyside committee meetings and 'lay readers' to give a public view of documents and resources produced by NHS Cheshire and Merseyside. Additional opportunities will be identified in future. Generic person specifications have been developed; however more specific information will be included for people undertaking the roles.

There will be other opportunities to be involved in the work of NHS Cheshire and Merseyside for those whom public representation is not appropriate.

Recruitment

Recruitment of public representatives will be co-ordinated by the engagement team, with the involvement of other NHS Cheshire and Merseyside staff as appropriate.

If necessary, a Disclosure and Barring Service (DBS) check will be undertaken. For most roles, a DBS check is unlikely to be required.

Induction and Training

Prior to attending any meetings, events or networks all public representatives will receive an induction and induction pack.

This will include:

- Introduction to NHS Cheshire and Merseyside
- Information about what being a public-representative entails, and how to feel confident in the role
- The difference between speaking as an individual and speaking on behalf of others, how to prepare and participate in meetings, how to manage conflicts of interest, how to influence others and how to support others to have a voice
- Explanation and copy of Patient Engagement Framework
- Agreement to sign up to policies and Code of Conduct

When specific opportunities have been agreed the public representative will receive an introduction to appropriate NHS Cheshire and Merseyside staff (those staff who Chair or facilitate the meetings/committees they will be involved in).

Any training will be provided both in-house and externally via induction sessions, individual supervision sessions and team meetings. The meetings will be conducted both face to face and via Microsoft Team.

Where required, patient representatives will receive training and support to navigate this platform. If the representative does not have access to digital platforms, alternative arrangements will be made.

Depending on roles other mandatory and voluntary training courses may be required

Support and Supervision

NHS Cheshire and Merseyside's engagement team will be responsible for the coordination of public representatives. The engagement team can be contacted for information or advice.

Supervision sessions will be held to support public representatives, review performance, and implement any changes or improvements. Suggestions will be sought from public representatives to improve the experience and relationship with NHS Cheshire and Merseyside. There will be several methods of support and supervision. The supervision sessions will be agreed on an individual basis; however, the minimum requirement will be to attend a quarterly group session.

The choices are listed below:

Individual Supervision
Individual supervision sessions will be held when required, to take a broader look at progress and the aspirations of the public representative. This will also be offered for those individuals who undertake more frequent activity to discuss progress, issues or concerns. These will be organised as appropriate.

Team Meetings:
Public representatives will be invited to attend team meetings to discuss progress, issues or concerns and seek guidance about any elements of their role.

Feedback will be encouraged to improve NHS Cheshire and Merseyside public representative activities, and to share good practice.

Record-keeping, Monitoring and Review

The following records will be kept in order to monitor and support effective involvement:

- Supervision notes
- Training records
- Records of meetings/events
- Details of skills, experiences and interests
- Any other activities undertaken

Records will be kept confidential. Access will be limited to the engagement team and senior managers, as appropriate.

Representatives can also expect to receive notes, minutes and associated presentations for the meetings which they attended. These resources are sent via email by default. However, should individuals wish to receive paper copies, this can be arranged (with seven days notice) via the engagement team who will send them via post. Making this request within seven days of a meeting may result in papers not being received in time.

To support this policy, each public representative will have a portfolio that will capture**:**

- Contact Details
- Background and skills
- Specific areas of interest and expertise
- Specific public representative role with NHS Cheshire and Merseyside
- DBS undertaken and review date (if appropriate)
- Hours of activity
- Date of supervision
- Details and dates of relevant training

The involvement of public representatives will be monitored and reviewed annually and reported through the NHS Cheshire and Merseyside committee structure. This will include monitoring information on public representatives' recruitment, roles and performance; training, support and supervision mechanisms.

All information will be kept and stored in accordance with the Data Protection Act.

Expenses **(Appendix C)**

Expenses are any reasonable costs that allow public representatives to carry out their duties and can be classed as legitimate expenses. An Expenses Policy has been included at Appendix C.

Absence

NHS Cheshire and Merseyside aims to maximise the attendance of all public representatives. However, it recognises that a certain level of absence due to sickness etc. is unavoidable.

As public representatives give their time freely to NHS Cheshire and Merseyside, and are not given set working patterns, it is expected through mutual trust that if a public representative has said that they will be undertaking a certain activity, but are unable to do so, they should let a member of the engagement team know in good time, so that a replacement can be arranged.

If a public representative decides to leave their role, an exit interview will be arranged to evaluate the experience and for feedback to be given and received.

Grievance Guidance (Appendix D)

NHS Cheshire and Merseyside recognises the importance of a fair and appropriate system through which public representatives and staff can express any grievance relating to their roles. The aim of this guidance is to help public representatives and staff, by giving practical guidance on how to deal with grievance issues.

Disciplinary Guidance (Appendix E)

The purpose of the disciplinary guidance is to ensure that NHS Cheshire and Merseyside behaves fairly and consistently towards all public representatives in investigating and dealing with alleged instances of unacceptable conduct or performance. There may be times when the performance or conduct of a public representative falls below what is expected. Having a clear and established disciplinary process in place will prevent misunderstandings and seek to protect the public representative and NHS Cheshire and Merseyside.

Conflict of Interest (Appendix F)

All public representatives will be asked to complete a Conflict-of-Interest Form, this will ensure that no public representative role is undermined by the possibility of a clash between the person's self-*interest*, professional *interest* or public *interest*.

Expectation of NHS Cheshire and Merseyside

NHS Cheshire and Merseyside's engagement team will be responsible for supporting public representatives.

This will include:

- commitment to providing timely and clear information on each activity (including hard copy information as requested)
- help and support to carry out activities
- provision of appropriate materials to carry out activities
- advice and support in dealing with any difficulties and providing guidance for situations that are new
- provision of correct and up to date information, sent in an agreed way and format (such as email or post)
- timely feedback
- parity of esteem
- accessible meetings
- appropriate ID, training and DBS Checks if appropriate
- Reimbursement of Travel Expenses in a timely manner

NHS Cheshire and Merseyside will consider practical issues relating to meetings that public representatives attend, these will include that:

- everyone should introduce themselves at each meeting
- public representatives should not be asked to sit through lengthy meetings without a break
- avoidance of jargon that might exclude public representatives from playing a full part
- Staff be mindful that public representatives cannot be expected to be fully conversant with subject matter (as a member of staff might)

Appreciation

NHS Cheshire and Merseyside recognises and values the important work public representatives. During national Volunteer Week NHS Cheshire and Merseyside will show its appreciation by highlighting the work of our public representatives.

Public Charter (Appendix G)

A Public Charter has been developed. This charter will be further shaped by public representatives and NHS Cheshire and Merseyside's committee structure.

Appendix A

NHS Cheshire and Merseyside Public representatives Application and Code of Conduct

Name		
Contact Details		
Interests	Public Representation	Lay Reader Panel
Interested in (please select all that apply)		
Children, Young People and Families		
Mental Health for children		
Mental Health for adults		
Acute Care		
Primary Care		
Finance		
Quality		
Community Care		
Medicines Management		
Long Term Conditions		
Others please specify		
Please briefly write any background information and relevant skills that you feel is relevant to this role		
Please state any additional needs that NHS Cheshire and Merseyside needs to be aware of to support you in this role		

The Code of Conduct sets out what is expected from NHS Cheshire and Merseyside and what is expected of a public representative. Compliance to this Code of Conduct is a condition of involvement in NHS Cheshire and Merseyside's public representative scheme.

All public representatives should, as a minimum requirement, adhere to the **Seven Nolan Principles of Public Life**, which are set out below.

Selflessness
Holders of public office should take decisions 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 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 they should 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 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.

It is likely that representatives may want to be involved in different ways at different times in the work of NHS Cheshire and Merseyside. The following provides a general code of conduct which may be applicable, dependent on public representation activities.

- commit to playing an active role in NHS Cheshire and Merseyside
- act and conduct myself in a reasonable and responsible way, to any staff, public representatives or members of the public I work with, or meet through my role
- never disclose confidential or sensitive information unless there is a legal duty to do so - for example in the interests of public safety
- declare any conflict of interest, or anything that might be seen by other people as a conflict of interest, as soon as it arises. A register of interests will be kept by NHS Cheshire and Merseyside
- not accept gifts or hospitality which could be seen as trying to influence the decisions, independence or activities of NHS Cheshire and Merseyside
- comply with relevant legislation including equal opportunities, discrimination, human rights, data protection and freedom of information
- treat all people with respect and act in a way which does not discriminate against or exclude anyone
- to inform NHS Cheshire and Merseyside staff if you are unable to attend or undertake agreed activity in good time
- to undertake mandatory training
- to attend regular supervision sessions as appropriate

NHS Cheshire and Merseyside's engagement team will be responsible for supporting public representatives. This will include:

- commitment to providing timely and clear information on each activity (including hard copy information as requested)
- help and support to carry out activities
- provision of appropriate materials to carry out activities
- advice and support in dealing with any difficulties and providing guidance for situations that are new
- provision of correct and up to date information, sent in an agreed way and format (such as email or post)
- timely feedback
- parity of esteem
- accessible meetings
- appropriate ID, training and DBS Checks if appropriate
- Reimbursement of Travel Expenses in a timely manner

I have read and agreed to the Patient Representation Policy

Signed by public representative Date

Signed by NHS Cheshire and Merseyside Date

Appendix B
Public representative Role descriptions

It is likely that you will want to be involved in different ways at different times. There are differing opportunities to be involved these include:

- Patient Representation at meetings/ committees
- Lay Readers

For each opportunity role descriptions have been produced.

Role Title	**Lay Readers**
What/why:	As part of NHS Cheshire and Merseyside's public involvement work, resources and promotional materials are produced. It is essential that these resources are user-friendly and contain the most appropriate information. Therefore Lay Readers are essential.
Commitment:	Lay Reader activities will vary but it would be unusual for you to undertake activities more than once a month.
Responsibilities	Information/draft resources will usually be shared via email, unless otherwise agreed. Feedback must be given within 10 days. NHS Cheshire and Merseyside will share final versions of materials with the lay readers.

Role Title	**Representation**
Why we want you:	It is important that people and communities are represented at every level NHS Cheshire and Merseyside's work. Public representatives will be required to be involved in meetings, committee structures and engagement forums.
Commitment:	Opportunities and their frequency will vary. Considering varying commitments, a deputy can be appointed to attend on behalf of the nominated public representative.

Responsibilities	Champion that the views, experiences and aspirations of people and communities are met through any proposals made by NHS Cheshire and Merseyside. Consider the impact of proposals on diverse populations within Cheshire and Merseyside. Act as a constructive critical friend. Advise on how to raise the awareness of proposals with people and communities Act and behave in a reasonable and responsible way, through adherence to the Nolan Principles of Public Life Not accept gifts or hospitality which could be seen as trying to influence the decisions, independence or activities of NHS Cheshire and Merseyside Comply with relevant legislation including equal opportunities, discrimination, human rights, data protection and freedom of information To inform NHS Cheshire and Merseyside staff if you are unable to attend or undertaken agreed activity in good time To undertake any relevant training and a DBS check if appropriate
Person specification	Ability to contribute confidently to high-level discussions and ensure the voice of people and communities is heard, acting as a constructive critical friend, as appropriate. Ability to display sound judgment and to be objective Awareness of, and commitment to, equality and diversity Understanding of the need for confidentiality when required Sufficient time and (if relevant) management support from NHS Cheshire and Merseyside to be able to effectively participate (including reading material in preparation for meetings)
NHS Cheshire and Merseyside responsibilities	Commitment to provide timely and clear information Help and support to carry out activities

	Provide appropriate materials to carry out your activities Advice and support in dealing with any difficulties you are having and provide guidance with situations that are new to you Provide correct and up to date information, sent in an agreed way and format (such as email or post) Provide appropriate ID, training and DBS Checks (if appropriate) Reimbursement of any associated expenses in a timely manner To consider whether the public representative is able to use/receive information electronically or require paper copies To consider whether public representatives are required to and/or are able to transport themselves or need assistance. To consider whether public representatives are able to write their own notes or need assistance/support.

Appendix C Expense Policy

Introduction

NHS Cheshire and Merseyside recognises the importance of involving people and communities. A public representative scheme has been developed to involve people and communities.

NHS Cheshire and Merseyside values this contribution and we want to ensure that there are no barriers to involvement. Out of pocket expenses incurred in the course of scheme activity will be reimbursed. In order to claim expenses, an expense form must be completed and handed into the engagement team.

Scope

This policy is relevant to NHS Cheshire and Merseyside public representatives only.

Activity covered by the policy

Any activity that has been agreed by the engagement team.

What expenses will be paid for?

- Travel to include bus, train or car (car mileage will be paid at the standard NHS rate)
- Taxis will only be paid for if agreed in advance by NHS Cheshire and Merseyside
- Receipted travel-related costs e.g. parking costs
- Any other reasonable costs (to be discussed and agreed with NHS Cheshire and Merseyside)

NHS Cheshire and Merseyside encourages the following to save costs:

- Use of car sharing
- Use of public transport

Expenses incurred through working-from-home procedures.

NHS Cheshire and Merseyside will pay expenses to contribute towards the following

- At-home printing costs
- Increased utility costs

This list is not exhaustive, and any other reasonable associated costs can be discussed with the engagement team.

Make a claim

When a public representative wishes to make a claim they need to fill in an expenses form (available on request) within 30 days of attending an activity, and submit it to the engagement team. Relevant receipts will be required.

When an expenses form has been completed and authorised, a payment will then be made by bank transfer (where bank details and permission have been given).

Fraudulent expense claims
Fraudulent expense claims will be considered as theft. Any public representatives found to be making fraudulent claims will be removed from being a public representative and may be reported to the police.

Claiming Expenses P2P Form

Full Name	**Mr / Miss / Mrs / Ms / Dr**
Address	
Contact Number	
Email	
Bank Details	**Name on Card :**
	Account Number (8 digits)
	Sort Code (6 digits)
Signature	_____
Date	

Appendix D

Grievance Guidance
NHS Cheshire and Merseyside recognises the importance of a fair and appropriate system through which public representatives can express any grievance related to their role.

The aim of this policy is to help staff and public representatives by giving practical guidance on how to deal with grievance issues.

Any public representatives, may at some time, experience problems or concerns about their tasks or relationships with colleagues or staff that they wish to talk about. The grievance needs to be addressed, and if possible, resolved before it develops into major difficulties for all concerned.

Process
Informal Grievance
All public representatives should approach the engagement team in the first instance to discuss the matter informally.

Where the grievance is against a member of staff and the public representative feels unable to approach him/her, the public representative should approach the Associate Director of Communications and Empowerment who will have an informal discussion with the public representative.

Formal Grievance
If the public representative feels the matter has not been resolved through informal discussion, or if the matter is serious, they should then provide staff with full details of the grievance in writing. The engagement team will arrange a meeting with the public representative(s) concerned to discuss the grievance.

A third-party representative can be involved to support the public representative

Where the grievance is against a member of staff and the public representative feels unable to approach him/her, the public representatives should write to the NHS Cheshire and Merseyside's Associate Director of Communications and Empowerment.

The appropriate nominated person will call a meeting with the public representative(s) to discuss the grievance.

The nominated person may need to carry out further investigations to establish the facts of the case before reaching a decision which may delay the decision.

After the meeting, a decision in writing will be sent to the public representative(s).

Mediation
NHS Cheshire and Merseyside may in some cases ask the individuals involved in a dispute to participate in mediation if it is felt that this may be beneficial to resolving the dispute. This is voluntary and public representatives may choose to decline to participate in mediation.

A third party representative can be involved to support the public representative

Appendix E
Disciplinary Guidance
The purpose of disciplinary guidance is to ensure that NHS Cheshire and Merseyside behaves fairly and consistently towards all public representatives in investigating and dealing with alleged instances of unacceptable conduct or performance.

The aims of this guidance are:

- To encourage public representatives to achieve and maintain standards of behaviour
- To be fair to all public representatives at all levels of the organisation
- To allow for careful investigation of any allegations
- To deal rapidly and effectively with misconduct issues
- Aim to correct behaviour where possible

This guidance is applicable to all NHS Cheshire and Merseyside public representatives. Any public representatives can have their role terminated at any time.

Informal Stage
In some instances, staff may consider that it is sufficient to guide and support a public representative where conduct or capability is considered unsatisfactory. In most cases, supervision sessions will attempt to address any issues.

Examples of General Misconduct (These will normally be discussed and dealt with the informal stage)

- Minor breaches of Code of Conduct and procedures
- Minor safety violations
- Lack of co-operation
- Unsatisfactory standards
- Lack of application

Formal Stage
If matters have not been settled through the informal stage, a meeting will be held. If a public representative continues to be unavailable to attend a meeting, NHS Cheshire and Merseyside may conclude that a decision will be made on the evidence available and will inform the public representative of this prior to reaching a decision.

A third party representative can be involved to support the public representative

Examples of Serious Misconduct (These will normally be discussed and dealt with the formal stage)

- Serious breaches of Code of Conduct and procedures
- Persistent minor breaches of Code of Conduct and procedures
- Offensive, abusive or objectionable behaviour
- Posting or distributing unauthorised literature
- Serious neglect
- Misuse of NHS Cheshire and Merseyside property

- Persistent examples of general misconduct

These lists are for the purpose of illustration and are not exhaustive

Public representatives may be suspended from their role pending the conclusion of the investigation and/or meeting, without prejudice.

Gross Misconduct
No public representative will have their role terminated for unsatisfactory standards, except for instances of gross misconduct.

In cases requiring investigation, the public representatives may be suspended. Such a suspension will be for as short a period as possible. The consequence for gross misconduct may be immediate termination.

Examples of Gross Misconduct

- Falsification of records, or documents.
- Fighting or acts of violence or intimidation against any public representative, NHS Cheshire and Merseyside employee or visitor.
- Persistent refusal to obey reasonable instructions given by staff
- Wilfully endangering others.
- Serious misrepresentation on the public representative's application.
- Unauthorised possession of NHS Cheshire and Merseyside property or property of third parties.
- Serious negligence which causes unacceptable loss, damage or injury.
- Conduct which could bring NHS Cheshire and Merseyside into disrepute.
- Theft, attempted theft or wilful damage to NHS Cheshire and Merseyside property, or property belonging to any public representative, employee or visitor.
- Being drunk and disorderly, or under the influence of alcohol on NHS Cheshire and Merseyside premises or conducting organisational activities
- Being in possession of illegal substances whilst on NHS Cheshire and Merseyside premises or conducting organisational activities
- Unauthorised disclosure of any NHS Cheshire and Merseyside information.
- Serious and/or persistent harassment or discrimination or bullying whether sexual, racial or otherwise.
- Serious act of insubordination or insulting, abusive or indecent behaviour.
- Convictions for any offence affecting staff or external relations which amount to a breach of trust.
- The abuse or misuse of NHS Cheshire and Merseyside IT systems.
- Serious breach of the Code of Conduct
- Serious breach of the Confidentiality of Information Policy
- Gross negligence
- Gross insubordination
- Persistent examples of Serious Misconduct

This list is for purpose of illustration and is not exhaustive.

The public representative will have the right to appeal which will be outlined to them should this arise.

Appendix F

Declaration of interests for NHS Cheshire and Merseyside Public Representatives

Name:	
Position within, or relationship with, NHS Cheshire and Merseyside or it's partners	

Detail of interests held (complete all that are applicable):

Type of Interest* *See reverse of form for details	Description of Interest (including for indirect Interests, details of the relationship with the person who has the interest)	Date interest relates From & To		Actions to be taken to mitigate risk (to be agreed with NHS Cheshire and Merseyside)

The information submitted will be held by NHS Cheshire and Merseyside for HR or other reasons specified on this form, and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act. Information may be disclosed to third parties in accordance with the Freedom of Information Act and published in registers that NHS Cheshire and Merseyside holds.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to NHS Cheshire and Merseyside as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, or internal disciplinary action may result.

I **do / do not [delete as applicable]** give my consent for this information to published on registers that NHS Cheshire and Merseyside holds. If consent is NOT given please give reasons:

Signed: **Date**:

Signed: **Position:** **Date:**

Please return to commuications@cheshireandmerseyside.nhs.uk

Types of interest

Type of Interest	Description
Financial Interests	This is where an individual may get direct financial benefits from the consequences of a commissioning decision. This could, for example, include being: • A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations; • A shareholder (or similar owner interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations. • A management consultant for a provider; • In secondary employment (see paragraph 56 to 57); • In receipt of secondary income from a provider; • In receipt of a grant from a provider; • In receipt of any payments (for example honoraria, one off payments, day allowances or travel or subsistence) from a provider • In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and • Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).
Non-Financial Professional Interests	This is where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career. This may, for example, include situations where the individual is: • An advocate for a particular group of patients; • A GP with special interests e.g., in dermatology, acupuncture etc. • A member of a particular specialist professional body (although routine GP membership of the RCGP, BMA or a medical defence organisation would not usually by itself amount to an interest which needed to be declared); • An advisor for Care Quality Commission (CQC) or National Institute for Health and Care Excellence (NICE); • A medical researcher.
Non-Financial Personal Interests	This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is: • A voluntary sector champion for a provider; • A volunteer for a provider; • A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation; • Suffering from a particular condition requiring individually funded treatment; • A member of a lobby or pressure groups with an interest in health.
Indirect Interests	This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision (as those categories are described above). For example, this should include: • Spouse / partner; • Close relative e.g., parent, grandparent, child, grandchild or sibling; • Close friend; • Business partner.

Appendix G

Public Charter

An NHS Cheshire and Merseyside public representative will be trustworthy, display good time keeping, be honest, adhere to confidentiality, conduct themselves in a professional manner and will undertake the role to the best of their ability.
Public representatives will:

1. Take responsibility for their actions
2. Be accessible and communicate effectively with each other, and NHS Cheshire and Merseyside
3. Take no personal agenda into any meetings/committees
4. Commit to the role and be honest with the level of commitment that can be offered
5. Be there to listen as well as to be heard

NHS Cheshire and Merseyside will value and support the contribution of the public representatives and will provide timely and effective information and communication to the public representatives.
NHS Cheshire and Merseyside will:

1. *Continuously update public representatives on local, regional and national issues*
2. *Review public representative activities to ensure best quality outcomes*
3. *Be flexible and adaptable in supporting the public representatives*
4. *Be mindful of any extra expenses that might be incurred and support public representatives to ensure they are not out of pocket*
5. *Consider the individual circumstances of public representatives*

NHS
Cheshire and Merseyside

NHS C&M ICB Scheme of Reservation and Delegation and Standing Financial Instructions and Associated Documents

Cheshire and Merseyside
Integrated Care Board Meeting

NHS
Cheshire and Merseyside

Date of meeting:	01/07/2022
Agenda Item No:	ICB/22/06
Report title:	**NHS C&M ICB Scheme of Reservation and Delegation and Standing Financial Instructions**
Report Author & Contact Details:	Ben Vinter / Mark Bakewell mark.bakewell1@nhs.net
Report approved by:	Claire Wilson, Executive Director of Finance

Purpose and any action required	**Decision/ Approve** →	**X**	**Discussion/ Gain feedback** →		**Assurance** →		**Information/ To Note** →	

Committee/Advisory Group previously presented

The Scheme of Reservation and Delegation (SoRD) and associated documents have been developed in a coordinated way between the designate ICB's governance and finance functions in line with NHSE guidance and actively reviewed by a task and finish group including Place Directors, ICB Directors and subject matter experts. The documentation has also been circulated and initially reviewed by wider members if the designate ICB.

Executive Summary and key points for discussion

The **Scheme of Reservation and Delegation** 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; supported by the Operational Scheme of Delegation (OSORD) and a set of **Standing Financial Instructions (SFIs)** which form 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.

The ICB is also required to publish a Function and Decision Map which seek to summarise where responsibilities sit and interactions take place across the Integrated Care System.

These key documents are needed for Day 1 ICB Establishment but are also noted as key enablers in the ICB's function and development and will therefore necessarily change and develop as the ICB's approach is defined.

Cheshire and Merseyside
Integrated Care Board Meeting

NHS Cheshire and Merseyside

Recommendation/ Action needed:	The Board is asked to: • **APPROVE** the NHS Cheshire and Merseyside ICB Scheme of Reservation and Delegation • **APPROVE** the NHS Cheshire and Merseyside ICB Functions and Decisions Map • **APPROVE** the NHS Cheshire and Merseyside ICB Standing Financial Instructions • **APPROVE** the NHS Cheshire and Merseyside ICB Scheme of Reservation and Delegation – Operational Limits

Consideration for publication	
Meetings of the Integrated Care Board will be held in public and the associated papers will be published unless there are specific reasons as to why that should not be the case. This paper will therefore be deemed public unless any of the following criteria apply (please insert **'x'** as appropriate:	
The item involves sensitive HR issues	
The item contains commercially confidential issues	
Some other criteria. Please outline below:	

Which purpose(s) of an Integrated Care System does this report align with?	
Please insert **'x'** as appropriate:	
1. Improve population health and healthcare	X
2. Tackle health inequality, improving outcome and access to services	
3. Enhancing quality, productivity and value for money	
4. Helping the NHS to support broader social and economic development	

C&M ICB Priority report aligns with:	
Please insert **'x'** as appropriate:	
1. Delivering today	X
2. Recovery	
3. Getting Upstream	
4. Building systems for integration and collaboration	

Governance and Risk					
	Does this report provide assurance against any of the risks identified in the Board Assurance Framework or any other corporate risk? (*please list*) N/A				
	What level of assurance does it provide? N/A				
	Limited		**Reasonable**		**Significant**
	Any other risks? ~~Yes~~ / No. If yes please identify within the body of the report.				
	Is this report required under NHS guidance or for statutory purpose? (*please specify*) Statutory document required for establishment of Integrated Care Boards				

Cheshire and Merseyside
Integrated Care Board Meeting

	Any Conflicts of Interest associated with this paper? If Yes please state what they are and any mitigations. N/A
	Any current services or roles that may be affected by issues within this paper? N/A

Document Development	Process Undertaken	Yes	No	N/A	Comments (i.e. date, method, impact e.g. feedback used)
	Financial Assessment/ Evaluation			X	
	Patient / Public Engagement			X	
	Clinical Engagement			X	
	Equality Analysis (EA) - any adverse impacts identified?			X	
	Legal Advice needed?			X	
	Report History – has it been to other groups/ committee input/ oversight (Internal/External)				NHSE/I template, supported by NHSEI support through workshops and webinars.

Next Steps:	NHS C&M Constitution and supporting documents to be uploaded to public website, and form foundation documents of NHS C&M.
Responsible Officer to take forward actions:	Claire Wilson, Executive Director of Finance
Appendices:	1. NHS Cheshire and Merseyside ICB Scheme of Reservation and Delegation 2. NHS Cheshire and Merseyside ICB "Functions and Decisions Map" 3. NHS Cheshire and Merseyside ICB Standing Financial Instructions 4. NHS Cheshire and Merseyside ICB Scheme of Reservation and Delegation – Operational Limits

Approval of NHS Cheshire and Merseyside ICB Scheme of Reservation and Delegation (SoRD) and Standing Financial Instructions (SFIs)

1. Executive Summary

As described at section 1.7.3a) of the ICB's Constitution:
*The **Scheme of Reservation and Delegation** 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.*

2. NHS C&M SoRD and SFIs

As set out in section 4.4 of the ICB Constitution:

4.4.1 The ICB has agreed a scheme of reservation and delegation (SoRD) which is published in full at www.cheshireandmerseyside.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 and*
- 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.

The SORD is a key supporting document to the Constitution of the ICB and is published within the ICB's Corporate Governance Handbook.

The SORD's development was coordinated between the ICB's governance and finance functions and actively reviewed by a task and finish group including Place Directors, ICB Directors and subject matter experts. The documentation has also been circulated and initially reviewed by the ICB's non executives.

The SORD is supported by the ICB's **Scheme of Reservation and Delegation - Operational Limits** (known as the operational scheme of delegation, or "OSORD") and a set of **Standing Financial Instructions (SFIs).**

The SFIs and OSORD 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.

The OSORD sets the delegated financial authority of the board, its committees and officers.

The 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 and help the Chief Executive and Executive Director of Finance to effectively perform their responsibilities.

The governance arrangements for the ICB are summarised in a "**Functions and Decisions Map**".

3. Recommendations

The Board is asked to:

- **APPROVE** the NHS Cheshire and Merseyside ICB Scheme of Reservation and Delegation
- **APPROVE** the NHS Cheshire and Merseyside ICB Functions and Decisions Map
- **APPROVE** the NHS Cheshire and Merseyside ICB Standing Financial Instructions
- **APPROVE** the NHS Cheshire and Merseyside ICB Scheme of Reservation and Delegation – Operational Limits

Cheshire and Merseyside Integrated Care Board – draft Scheme of Reservation and Delegation (SoRD) 27th May 2022

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
1. Regulation, control, constitution & governance						
1.1	Determine the arrangements by which the ICB approves those decisions that are reserved for the Boardwhere they have not been delegated	Board				Assistant Chief Executive
1.2	Consider and approve applications to NHS England on changes tothe Constitution	Board			ICB Executive (the executive committee meeting)	Assistant Chief Executive
1.3	Prepare the ICB scheme of reservationand delegation (SORD), which sets out those decisions that are in statute theresponsibility of the ICB and are reservedto the ICB Board, andthose delegated to • committees andsub-committees, employees	Board			ICB Executive	Director of Finance

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
1.4	Approval of the ICB scheme of reservation and delegation, which sets out those decisions that are the statutory responsibilityof the Board and thosedelegated to the • Board • committees, sub-committees, or advisory panelsof the ICB or • employees	Board			ICB Executive	Director of Finance
1.5	Promote the governance arrangements of the ICB to employees andto people working on behalf of the ICB			ICB Executive		Assistant Chief Executive
1.6	Disclosure of non- compliance with the group's constitution (incorporating its standing orders, primefinancial policies and scheme of reservationand delegation)	Board			Audit Committee Finance, Investment and Our Resources Committee	Assistant Chief Executive
1.7	Review of suspensionof standing orders		Audit Committee			Assistant Chief Executive

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
1.8	Suspension of standing orders	Board				Assistant Chief Executive
1.9	Preparation of the operational scheme of delegation (incl. financial limits) that underpins the group's overarching scheme ofreservation and delegation		Finance, Investment and Our Resources Committee		Finance, Investment and Our Resources Committee	Director of Finance
1.10	Approval of the operational scheme of delegation (incl. financial limits) that underpins the ICB's overarching scheme ofreservation and delegation	Board			Finance, Investment and Our Resources Committee	Director of Finance
1.11	Approve the ICB's prime financial policies financial governance	Board			Finance, Investment and Our Resources Committee	Director of Finance
1.12	Set out who can execute a documentby signature / use ofthe seal	Board			ICB Executive	

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
1.13	Approve the arrangements for discharging the ICB's statutory duties and functions	Board			ICB Executive	Assistant Chief Executive
1.14	Establish governance arrangements to support collective accountability betweenpartner organisations for whole system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations	Board			Quality and Performance Committee Finance, Investment and Our Resources Committee	Assistant Chief Executive
	2. Strategy & Planning					
2.1	Approve the values and planning in accordance with strategic direction of the ICP	Board			Finance, Investment and Our Resources Committee	Director of Finance
2.2	Approve the ICB operating structure		ICB Executive	Chief Executive		

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
2.4	Approve the ICB arrangements for engaging the public and key stakeholdersin the ICB's planning and commissioning arrangements	Board			Transformation Committee	Assistant Chief Executive
2.5	Approve the ICB budgets that meet thefinancial duties of the ICB	Board			Finance, Investment and Our Resources Committee	
2.6	Agree a plan to meetthe health and healthcare needs of the Cheshire & Merseyside population, within the context of the NHS national strategy, the C&M ICP Partnership integrated care strategy and place health and wellbeing strategies	Board			Transformation Committee	Assistant Chief Executive

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
2.8	Allocate resources to deliver the plan across the system, determining what resources should be available to meet population need across C&M and in eachplace, and setting principles for how they should be allocated across services and providers (both revenue and capital)	Board			Finance, Investment and Our Resources Committee	Transformation Committee Place Directors through Place-Based Partnership Boards
2.9	Allocate resources to deliver the plan at place, determining what resources as delegated by the Board should be available to meet population need in place and setting principles for how theyshould be allocated across services and providers (both revenue and capital)	Board			Finance, Investment and Our Resources Committee	Transformation Committee Place Directors through Based Partnership Boards

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
2.10	Approve decisions on the review, planning and procurement of primary medical care services (to reflect the terms of the delegationagreement with NHS England)		System Primary Care Committee		Place Primary Care Committee	Assistant Chief Executive
2.11	Approve the operating structure in each place		Executive Team			Place Directors
2.12	Agree system-wide action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the center of their care		Transformation Committee		Executive Team	

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
2.13	Agree place action on data and digital: working with partners across the NHS and with local authorities toput in place smart digital and data foundations to connecthealth and care services to put the citizen at the center of their care		Transformation Committee		Place Based Partnership Board	Place Directors
2.14	Agree C&M joint work on estates, procurement, supply chain and commercial strategies to maximisevalue for money across the system andsupport wider goals of development and sustainability		Finance, Investment and Our Resources Committee		Transformation Committee Place Based Partnerships	Director of Finance
2.15	Agree place action onestates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability		Finance, Investment and Our Resources Committee		Transformation Committee Place Based Partnerships	Director of Finance

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
2.16	Agree arrangements for planning, responding to and leading recovery from incidents (EPRR), to ensure NHS and partner organisationsare joined up at timesof greatest need, including taking on incident coordination responsibilities as delegated by NHSE/I	Board				Director of Performance
3. Annual Reports and Accounts						
3.1	Approval of the ICBannual report and annual accounts	Board			Audit Committee	Director of Finance
4. Partnership Working						
4.1	Agree joint working arrangements with partners that embedcollaboration as the basis for delivery within the ICB plan	Board			Transformation Committee Place Based Partnerships	Assistant Chief Executive

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
4.2	Develop joint working arrangements with partners in place that embed collaboration as the basis for delivery within the ICBplan	Board			Transformation Committee Place Based Partnerships	Assistant Chief Executive
4.3	Approve arrangementsfor coordinating the commissioning of services with other ICBs or with local authorities, where appropriate	Board			Transformation Committee Place Based Partnerships	Assistant Chief Executive
4.4	Approve arrangementsfor risk sharing and /or risk pooling with other organisations (for example arrangementsfor pooled funds with other ICBs or pooled budget arrangements under section 75 of the NHSAct 2006)	Board			Finance, Investment and Our Resources Committee	Director of Finance

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
5. Employment, Remuneration, Workforce & OD						
5.1	Agree system implementation of people priorities including delivery of the People Plan and People Promise by aligning partners across the ICS to develop and support 'one workforce', including through closer collaboration across the health andcare sector, with localgovernment, the voluntary and community sector andvolunteers	Board			People Board	Director of People
5.2	Agree implementationin Locality of People Priorities		Place Partnership Board		People Board	Director of People

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
5.3	Accountability for theICB's responsibilitiesas an employer including adopting a Code of Conduct for staff	Board			Audit Committee	Director of People
5.4	Approve the terms and conditions, remuneration and travelling or other allowances for Board members, including pensions and gratuities		Renumeration Committee		Finance, Investment and Our Resources Committee	Director of People
5.5	Approve the terms and conditions of employment for non- AFC employees including pensions, remuneration, fees andtravelling or other allowances for employees of the ICB and to other persons providing services to the ICB		Renumeration Committee		People Board	Director of People
5.6	Approve any other terms and conditions of services for the ICB's AFC employees		Finance, Investment and Our Resources		ICB Executive	Director of People

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
5.7i	Approve disciplinary arrangements for employees, excluding the accountable officer(where he/she is an employee of the ICB) and for other persons working on behalf of the ICB		Finance, Investment and Our Resources		ICB Executive	Director of People
5.7ii	Approve disciplinary arrangements for employees, including the accountable officer(where he/she is an employee of the ICB)		Remuneration Committee	Chair		Director of People
5.8	Approve disciplinary arrangements where the ICB has joint appointments with another group and the individuals are employees of thatgroup			Shared Chief Executive discussion		Director of People
5.9	Approval of the arrangements for discharging the ICB's statutory duties as an employer	Board	Finance, Investment and Our Resources		Finance, Investment and Our Resources ICB Executive	Director of People

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
5.10	Approve human resources policies for ICB employees and forother persons working on behalf of the ICB		Finance, Investment and Our Resources		ICB Executive	Director of People
5.11	Approve arrangementsfor staff appointments (excluding matters detailed within the constitution)		Finance, Investment and Our Resources		ICB Executive	Director of People
5.11a	Appointment of ICBChief Exec	Board			Remuneration Committee	Director of People
5.11b	Appointment of allother roles		Remuneration Committee (non AfC levels only)	ICB Executive		Chief Exec or other responsible Executive
5.12	Approve the ICB organisational development plans		Finance, Investment and Our Resources			
6. Quality and Safety						
6.1	Establish clinical governance arrangements to support collective accountability betweenpartner organisations	Board			Quality and Performance Committee	Director of Nursing through System Quality Surveillance Group

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
6.2	Approve arrangementsto ensure duties are discharged effectively and foster the development of policies, processes and initiatives to minimise clinical risk, maximise patient safety, and promote equality to secure the continuous improvement in qualityand patient outcomes	Board			Quality and Performance Committee	Director of Nursing
6.3	Approve the ICB arrangements for handling complaints		Quality and Performance Committee	ICB Executive		Director of Nursing
6.4	Approve the ICB arrangements for safeguarding childrenand vulnerable adults		Quality and Performance Committee	ICB Executive		Director of Nursing
6.5	Approve the ICB arrangements for engaging patients andtheir carers in decisions concerning their healthcare		Quality and Performance Committee	ICB Executive		Director of Nursing

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
6.6	Approve arrangementsfor supporting the NHSin discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services		Quality and Performance Committee	ICB Executive		Director of Nursing
6.7	Approve the arrangements for the quality oversight, assurance and improvement systemswithin the ICS.		Quality and Performance Committee	ICB Executive		Director of Nursing
6.8	Approve the arrangements for delivering the NHS Patient Safety Strategyto achieve its vision to continuously improve patient safety and to develop and implement the patient safety initiatives that the strategy introduced.		Quality and Performance Committee	ICB Executive		Director of Nursing
6.9	Agree the Strategy forQuality and Patient Safety inclusive of thealigned quality priorities for the system		Quality and Performance Committee	ICB Executive		Director of Nursing

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
6.10	Agree the ICB arrangements for responding to and learning from patient safety events		Quality and Performance Committee	ICB Executive		Director of Nursing
6.11	Approve the operating structure for the monitoring, oversight and reporting on Quality and Safety in each place		Quality and Performance Committee	ICB Executive		Director of Nursing
7. Business operation and Risk Management						
7.1	Approve the ICB counter fraud and security managementarrangements		Audit Committee			Director of Finance
7.2	Approval of the ICBrisk management arrangements	Board			ICB Executive	Director of Finance
7.3	Approve ICB operational policies (i.e. excluding thosedefined as clinical or finance)				ICB Executive	Assistant Chief Executive

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
7.4	Approve ICB financialpolicies		Finance, Investment and Our Resources Committee			Director of Finance
7.5	Approve ICB clinical policies and clinical pathways		Quality and Performance Committee	ICB Executive		Director of Nursing
7.6	Approve system-level arrangements to minimise clinical risk,maximise patient safety and to secure continuous improvement in qualityand patient outcomes		Quality and Performance Committee	ICB Executive		Director of Nursing
7.7	Approve arrangementsfor managing conflicts of interest	Board			Audit Committee	Assistant Chief Executive
7.8	Approve arrangementsfor complying with the NHS Provider Selection Regime	Board			Finance, Investment and Our Resources Committee	Director of Finance
7.9	Report and provide assurance to the Board on the effectiveness of ICB governance arrangements		Audit Committee			Assistant Chief Executive

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
7.10	Receive the annual governance letter fromthe External Auditor and advise the Board of proposed action		Audit Committee			Director of Finance
7.11	Approve the internal audit, external audit and counter-fraud plans and any changesto the provision or delivery of related services (other than the appointment or removal of the externalauditor where authority is reserved to theBoard)		Audit Committee			Director of Finance
8. Information Governance						
8.1	Approve the arrangements for ensuring appropriate and safekeeping and confidentiality of records and for the storage, managementand transfer of information and data		Audit Committee			Advised and supportedby IG & Data Security groups
8.2	Approve information sharing protocols withother organisations		ICB Executive			SIRO

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
8.2	Approve arrangements for handling Freedom of Information requests		ICB Executive			Assistant Chief Executive
8.3	Approve arrangementsfor handling Freedom of Information requests		ICB Executive			Assistant Chief Executive
9. Partnership, joint or collaborative working						
9.1	Approve the arrangements governing joint or collaborative arrangements betweenthe ICB and another statutory body(ies), where those arrangements incorporate decision making responsibilities	Board			Transformation Committee	Assistant Chief Executive
9.2	Approve the delegated decision-making responsibilities of individual employees of the ICB who represent the ICB in joint or collaborative arrangements with another statutory body(ies)	Board			Finance, Investment and Our Resources Committee	Chief Executive
9.3	Receive the minutes of meetings of, or reportsfrom, joint or collaborative arrangements betweenthe ICB and another statutory body(ies)	Board				Assistant Chief Executive

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
10.	**Communications**					
10.1	Approval of ICB communications plan	Board			Transformation Committee	Assistant Chief Executive
11.	**Arrangements for Patient & Public Involvement**					
11.1	Approve arrangementsfor the involvement of and consultation with patients and the publicin ICB decision making	Board			Transformation Committee	Assistant Chief Executive

Cheshire & Merseyside Integrated Care System (ICS)

Integrated Care Partnership:
- Setting System Integrated Strategy
- Wide engagement & alignment
- Liaison with Local HWBB

Strategy

Integrated Care Board:
- Implements strategy & sets priorities
- Resource deployment, commissioning
- Assurance on delivery/ delegations & programmes

Strategy

Accountability: Delegation

Assurance: Delegation

Partners
- Partner decision making including oversight
- Assurance and oversight
- Implements Plan
- Local strategy setting
- e.g., Trust Boards, HWBB
- Subject to scrutiny OSC

Place Based Partnerships
- Place decision-making
- Delivery
- Local alignment with HWBB
- Subject to scrutiny
- 9 areas of Cheshire & Merseyside

Place
- Delivery
- Standardisation & reducing unwarranted variation
- Pathway development and localisation
- Breaking down silos

System
Provider Collaboratives
- Delivery
- Standardisation and reducing unwarranted variation
- Clinical strategy & network development
- System view & no silos

ICB Committees:
Decisions / Policy
- System alignment (Place, Direct Commissioning and PvCv)
- Prioritisation recommendations to ICB
- Business Case Development & review
- Alignment & resolution

ICB Committees:
Assurance
- Quality
- Performance
- Audit & Finance
- Remuneration
- Delegations

Clinical & Strategic Networks: Appling evidence based practice to improve patient care and outcomes; Focus on priority NHS areas improving quality and equity of care and outcomes for our population

Locality & MDT working / delivery: PCN networks, neighbourhood delivery, locally attuned service redesign, delivery and policy connections with and through Primary Care Forum.

Strategies: ICP, HWBB, JSNAs, Workforce, Clinical, Quality, System Delivery Plans as detailed through enablers

C&M system wide programmes / Enabling Programmes : Digital, BI, ICT, Estates, Diagnostics, Procurement, Staff passports

C&M wide engagement & comms: Communicating often, and well, with all stakeholders, sharing best practice. Reducing inequality and increasing accessibility. Being open, honest, clear and accurate. Minimising duplication. Listening and acting on feedback

C&M ICS: Board & Committee Framework

Integrated Care Partnership (ICP)

A statutory committee, established jointly by the ICB and relevant local authorities. Bringing together a range of local partners with the common purpose of meeting population health and social care needs.

Integrated Care Board (ICB)

The principal NHS decision making vehicle in Cheshire & Merseyside, providing a forum for collective and collaborative action, within the Cheshire & Merseyside Integrated Care System.

Health & Wellbeing Boards

Agree Health & Wellbeing Strategy for each of the nine places

Place Based Partnerships

Delivery of the ICB strategy at place level, includes place decision making around H&WB Strategy & priorities.

Audit Committee	**Chaired by an Independent Non-Executive Director. Provide ICB with oversight and assurance on the adequacy of governance, risk management and internal control.**
Remuneration Committee	Chaired by an Independent Non-Executive Director. Responsible for confirming the ICB Pay Policy including adoption of any pay frameworks for all employees including board members, senior managers/directors and Non-Executive Directors excluding the Chair. Also, responsibility for elements of the appointments process for Board members and oversight of executive board member performance and Board OD
Quality & Performance Committee	With oversight of the overall level of quality and safety within the system, based on aggregated intelligence across the nine places of C&M. The Committee will seek to promote a 'system' environment around quality and safety risks, inequalities, and variation (including equity of care), and improving patient experiences of the services provided across C&M.
Finance, Investment and Our Resources Committee	A forum for the oversight, scrutiny and exploration of finance and performance issues within the C&M ICS. The committee will support development of financial strategy, overseeing financial development, management and deployment within the ICS and the establishment of a whole system approach and culture to financial management and planning. Delegated Primary Care Functions:
Primary Care Committees	Primary Care & Pharmacy. System has oversight and delegation regulated policy functions. Place considers discretionary local activities
Transformation Committee	Collaboration, partnerships, system alignment - provider collaboratives and Place: Co-ordination of delegated functions (inc Specialised Commissioning), Commissioning at Scale (CaS), Transformation Programme Board and alignment of system wide initiatives including population health board, sustainability and personalisation, PPI, public affairs, non clinical research.
ICB Executive	Exercising and discharging executive functions in line with delegated limits and/or working up proposals for consideration by ICB decision making structures
Place Committees TBC	Delegations intially through Place Directors

Standing Financial Instructions

1 General

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.

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

SFIs define the purpose, responsibilities, legal framework and operating environment of the ICB. They enable sound administration, lessen the risk of irregularities and support commissioning and delivery of effective, efficient and economical services and help the Chief Executive and Executive Director of Finance to effectively perform their responsibilities.

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

In support of these prime financial policies, the Board has prepared more detailed operating policies and procedures, also approved by the Executive Director of Finance.

These prime financial policies identify the financial responsibilities which apply to everyone working for the Integrated Care Board, they do not provide detailed procedural advice and should be read in conjunction with the detailed financial policies.

A list of the Integrated Care Board's prime financial policies will be published and maintained on the ICB website at www.cheshireandmerseyside.nhs.uk
Or upon request by
• Post – Regatta Place, Brunswick Business Park, Summers Lane, Liverpool, L3 4BL.
• Email – enquiries@cheshireandmerseyside.nhs.uk

They should be used in conjunction with the scheme of reservation and delegation found in section 1.

The user of these prime financial policies should also be familiar with and comply with the provisions of the Board's constitution, standing orders and scheme of reservation and delegation.

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.

If for any reason these prime financial policies 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 ICB Audit Committee for referring action or ratification.

All the Board's members and employees have a duty to disclose any non-compliance with these prime financial policies to the Executive Director of Finance as soon as possible.

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

To ensure that these prime financial policies remain up-to-date and relevant, the Executive Director of Finance will review them at least annually.

Following consultation with the Chief Executive and scrutiny by the ICB Audit Committee, the Executive Director of Finance will recommend amendments, as fitting, to the board for approval.

As these prime financial policies are an integral part of the Boards constitution, any amendment will not come into force until the Board applies to NHS England and that application is granted, however detailed financial procedures may be changed by the Integrated Care Board locally.

Scope, Roles and Responsibilities

2 Staff

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

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

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

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

All ICB Officers are separately 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; an
- conforming to the requirements of these SFIs

2.1 Accountable Officer

The ICB constitution provides for the appointment of the Chief Executive by the ICB chair. The Chief Executive is the accountable officer for the ICB and is personally accountable to NHS England for the stewardship of ICB allocated resources.

The Executive Director of Finance reports directly to the ICB Chief Executive officer and is professionally accountable to the NHS England regional finance director

The Chief Executive will delegate to the Executive Director of Finance 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 5)
- meets the financial targets set for it by NHS England;
- use of incidental powers such as management of ICB assets, entering commercial agreements;
- the Governance statement and annual accounts & reports are signed;
- planned budgets are approved by the relevant Board; developing the funding strategy for the ICB to support the board in achieving ICB objectives, including consideration of place-based budgets;
- making use of benchmarking to make sure that funds are deployed as effectively as possible;
- executive members (partner members and non-executive members) and other officers are notified of and understand their responsibilities within the SFIs;
- specific responsibilities and delegation of authority to specific job titles are confirmed;
- financial leadership and financial performance of the ICB;
- identification of key financial risks and issues relating to robust financial performance and leadership and working with relevant providers and partners to enable solutions; and
- the Executive Director of Finance 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.

2.2 Audit Committee

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

3 Strategy, Budgetary Control and Monitoring

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

The Executive Director of Finance has financial leadership responsibility for the following statutory duties:

- the financial performance of the ICB , in conjunction with its partner NHS trusts and NHS foundation trusts, to exercise its 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;
  - local revenue resource use does not exceed the limit specified in a direction by NHS England;
  - the duty of the ICB to perform its functions, as to secure 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.

3.1 Expenditure Control

The Chief Executive has overall executive responsibility for ensuring that the group complies with certain of its statutory obligations, including its financial and accounting obligations, and that it exercises its functions effectively, efficiently and economically and in a way which provides good value for money.

The Executive Director of Finance will:

a) provide reports in the form required by NHS England;
b) ensure money drawn from NHS England is required for approved expenditure only and is drawn down only at the time of need and follows best practice;
c) be responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the board to fulfil its statutory responsibility not to exceed its expenditure limits, as set by direction of NHS England, delivered through implementation of effective financial management arrangements.
d) will prior to the start of the financial year, submit a plan to the board for approval, ensuring it discharges its financial duties, duly considering financial targets as appropriate compared to available resource allocations

e) monitor financial performance against agreed budgets and planned levels, and report to the Board, including relevant explanations for any variances with any material departures from agreed financial plans or budgets.
e) develop longer term financial plans to support delivery of ICB objectives

The Executive Director of Finance will delegate the budgetary control responsibilities to budget holders through a formal documented process.

3.2 Resource Allocation

The Executive Director of Finance will:
a) periodically review the basis and assumptions used by NHS England for distributing allocation and ensure that these are reasonable and realistic and secure the Boards entitlement to funds;
b) prior to the start of each financial year submit to the Board for approval, a report showing the total allocations received and their proposed distribution including any sums to be held in reserve; and
c) regularly update the Board on significant changes to the initial allocation and the uses of such funds.
d) delegate the budgetary control responsibilities to budget holders through a formal documented process

3.3 Other Controls

The Executive Director of Finance will also 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);
- that budget holders are accountable for obtaining the necessary approvals and oversight of all expenditure incurred on the cost centres they are responsible for;
- improved financial literacy of budget holders with the appropriate level of expertise and systems training;
- that 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.

The Executive Director of Finance and any senior officer responsible for finance within the ICB will promote a culture where budget holders and decision makers consult their finance business partners in key strategic decisions that carry a financial impact.

4 Income, banking arrangements and debt recovery

4.1 Income

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

The Executive Director of Finance is responsible for ensuring that:

- 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;

4.2 Banking

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

The Executive Director of Finance will ensure that:

- the ICB holds the minimum number of bank accounts required to run the organisation effectively and through the government banking services contract; and
- the ICB has effective cash management policies and procedures in place.

4.3 Debt management

The Executive Director of Finance is responsible for the ICB debt management strategy, including

- 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.

5 Financial systems and processes

5.1 Provision of finance systems

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

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

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

The Executive Director of Finance 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.

6 Procurement and purchasing

6.1 Principles

The Executive Director of Finance will take a lead role on behalf of the ICB to ensure that there are appropriate and effective financial, contracting, monitoring and performance arrangements in place to ensure the delivery of effective health services.

The ICB will ensure that any procurement activity is performed in accordance with the Public Contracts Regulations 2015 (PCR) and associated statutory requirements whilst securing value for money and sustainability.

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

The ICB will ensure it has a Procurement Policy which complies with all legislative requirements.

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

All officers must ensure that any conflicts of interest are identified, declared and appropriately mitigated or resolved in accordance with the ICB standards of business conduct policy.

Budget holders are accountable for obtaining the necessary approvals and oversight of all expenditure incurred on the cost centres they are responsible for. This includes obtaining the necessary internal and external approvals which vary based on the type of spend, prior to procuring the goods, services or works

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

Retrospective expenditure approval will 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 committee.

7 Staff costs and staff related non pay expenditure

7.1 Chief People Officer

The Chief People Officer will lead the development and delivery of the long-term people strategy of the ICB ensuring this reflects and integrates the strategies of all relevant partner organisations within the ICS

Operationally the Chief People Officer will be responsible for;

- defining and delivering the organisation's overall human resources strategy and objectives; and
- overseeing delivery of human resource services to ICB employees.

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

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

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

8 Annual reporting and Accounts

8.1 Principles

The Executive Director of Finance 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
- the ICB, in each financial year, prepares a report on how it has discharged its functions in the previous financial year;

An annual report will include information relating to

- how the ICB has discharged its duties in relating to improving quality of services, reducing inequalities, the triple aim and public involvement;
- reviewed 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
- reviewed any steps that the board has taken to implement any joint local health and wellbeing strategy.

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

The ICB will give a copy of its annual report to NHS England by the date specified by NHS England and publish the report.

8.2 Internal audit

The Chief Executive, as the accountable officer, is responsible for ensuring there is appropriate internal audit provision in the ICB. For operational purposes, this responsibility is delegated to the Executive Director of Finance to ensure that:

- all internal audit services provided under arrangements proposed by the Executive Director of Finance are approved by the Audit 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 committee and board;
- the head of the internal audit provision 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 provision will be required attend audit committee meetings and have a right of access to all audit committee members, the Chair and Chief Executive of the ICB.

- 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.

8.3 External Audit

The Executive Director of Finance 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
- 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.

9 Losses and special payments

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

The Executive Director of Finance will support a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and process are in place to minimise risks from losses and special payments.

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

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

All losses and special payments (including special severance payments) must be reported to the ICB Audit Committee and managed in line with the relevant losses and special payments operational guidance – see section 1C in Scheme of Reservations and Delegations

10 Fraud, bribery and corruption (Economic crime)

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

The ICB Executive Director of Finance is responsible for ensuring appropriate arrangements are in place to provide adequate counter fraud provision which will

include reporting requirements to the board and audit committee, and defined roles and accountabilities for those involved as part of the process of providing assurance to the board.

The ICB Executive Director of Finance will ensure that arrangements comply with relevant requirements as issued by NHS Counter Fraud Authority and any guidance issued by NHS England / Improvement.

11 Capital Investments & security of assets

The Executive Director of Finance 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 Executive Director of Finance is responsible for ensuring there are processes in place to ensure that a business case is produced.

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

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

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

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

The ICB will establish a defined and established property governance and management framework, which

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

Decisions regarding the disposal of surplus assets will be made in accordance with published guidance and supported by a business case which will be required to 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 Grants

The Executive Director of Finance is responsible for providing robust management, governance and assurance to the ICB with regards to the use of specific powers under which it can make capital or revenue grants available to;

- any of its partner NHS trusts or NHS foundation trusts; and
- to a voluntary organisation, by way of a grant or loan.

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

13 Legal and insurance

The ICB will ensure that is has relevant 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.

The ICB will not buy commercial insurance to protect against risk unless it is part of a risk management strategy that is approved by the accountable officer.

NHS Cheshire & Merseyside Integrated Care Board (ICB) Scheme of Reservation & Delegation Operational Limits

Version: 0.9

1. Operational Delegated Limits

Section	Description	Reserved by	Delegated to									
		Integrated Care Board (ICB)	Finance, Investment & Resources Committee	Primary Care Committee	'Place' Committee's	ICB Chief Executive	ICB Executive Director of Finance	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	'Place' Directors	Other named ICB Officer (or as per ICB authorised signatory list)
A	**ACCEPTANCE OF GIFTS, HOSPITALITY & SPONSORSHIP** (Governance Lead to maintain a register of declared gifts and hospitality received)					Gifts over £50	Gifts over £50		Gifts over £50	Gifts up to £50	Gifts up to £50	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
B	**LITIGATION CLAIM PAYMENTS** Medical negligence and other litigation payments made on the advice of NHSLA	Over £1,000,000				£50,001 - £1,000,000	Up to £50,000					
C	**LOSSES & SPECIAL PAYMENTS** (CFO to maintain a register of losses and special payments (including bad debts to be written off). All payments to be reported to the Audit Committee.	Over £100,000				£50,001 - £100,000	£5,001 - £50,000	Up to £5,000				
D	**PETTY CASH FLOAT**											
D1	Authorisation to set up float					Over £300	Over £300	Up to £300 float				
D2	Replenish petty cash float											Head of Financial Services (or equivalent role) Up to maximum float
D3	Issue petty cash						Up to £50	Up to £50				Assistant Director of Finance (Place) Up to £50
E	**CREDIT CARD**											
E1	Account signatories (who can make changes to the account, authorise additional card holders, amend card limit)											
E2	Authorise single transaction (single transaction limit £2,500)											
F	**REQUISTIONING GOODS & SERVICES: NON-HEALTHCARE**											

Section	Description	Reserved by	Delegated to									
		Integrated Care Board (ICB)	Finance, Investment & Resources Committee	Primary Care Committee	'Place' Committee's	ICB Chief Executive	ICB Executive Director of Finance	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	'Place' Directors	Other named ICB Officer (or as per ICB authorised signatory list)
F1	Utilisation of External Agency Staff (based on total expected cost as per below notes) *Supporting Notes* *a) Prior approval from NHSE must be sought for:* • *Any appointments over £600 per day; or* • *Any appointments for over a 6 month period, or* • *Any appointment with significant influence (e.g. ICB roles)* *b) prior to recruitment HR must conduct and sign off with relevant Director acknowledgement of IR35 compliance and/or status confirmation*	Over £500,000	Over £150,000			Up to £75,000	Up to £50,000	Up to £25,000	Up to £25,000	Up to £25,000	Up to £25,000 (within place based structure)	Up to £25,000
F2	Utilisation of Consultancy (based on total expected cost as per below notes). *Supporting Notes* *a) Prior approval from NHSE must be sought for:* • *Any appointments over £600 per day; or* • *Any appointments for over a 6 month period, or* • *Any appointment with significant influence (e.g. ICB roles)* *b) prior to recruitment HR must conduct and sign off with relevant Director acknowledgement of IR35 compliance and/or status confirmation*	Over £150,000	Over £150,000			Up to £75,000	Up to £50,000		Up to £25,000 (within approved budget)	Up to £25,000 (within approved budget	Up to £25,000 (within approved budget)	
F3	Services including IT, maintenance, and support services (over lifetime of contract) were not included within agreed annual budgets	Over £1,000,000	Over £500,00 and Up to £1,000,000			Up to £500,000	Up to £250,000		Up to £100,000	Up to £100,000		As delegated by Chief Executive/ CFO at the limits outlined within

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												the Authorised Signatory List
F4	Recharges from other public sector bodies not included within agreed annual budgets					Up to £500,000	Up to £250,000	Up to £100,000	Up to £100,000	Up to £100,000	Up to £100,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
F5	Approval of non-healthcare expenditure within agreed budget *With appropriate consideration of procurement requirements	Over £1,000,000	Over £500,000	Over £500,000		Up to £500,000	Up to £250,000	Up to £100,000	Up to £100,000	Up to £100,000	Up to £100,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
F6	Approval of all other non-healthcare requisitions *With appropriate consideration of procurement requirements	Over £500,000				Up to £250,000	Up to £100,000	Up to £50,000	*Up to £50,000	Up to £50,000	Up to £50,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
G	**RELOCATION EXPENSES** In line with Policy approved by ICB Remuneration Committee					Over £8,500	Up to £8,500					
H	**DECISION TO APPROVE HEALTHCARE INVESTMENT BUSINESS CASES**											
H1	Where covered in the Annual Plan (Annual Contract Value)	Over £1,000,000	Up to £1,000,000	Up to £1,000,000 *Primary Care Related		Up to £1,000,000	Up to £1,000,000	Up to £100,000 (within approved budget)	Up to £250,000 (within approved budget)	Up to £250,000 (within approved budget)	Up to £250,000 (within approved budget)	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
H2	Where **not** covered in detail in the Annual Plan (Annual Contract Value)	Over £500,000	Up to £500,000	Up to £500,000 *Primary Care Related		Up to £250,000	Up to £100,000		Up to £100,000	Up to £100,000	Up to £100,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
I	**HEALTHCARE CONTRACTS**											
I1	**Signing of Healthcare Contracts** (Annual Contract Value)					Over £150,000,000	Up to £150,000,000	Up to £50,000,000				

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I2	**Approval of Healthcare Contract Payments** All healthcare contract payments must be supported by signed contract (see I1).					As per agreed plan / budget value	As per agreed plan / budget value)	As per agreed plan / budget value)		As per agreed plan / budget value	As per agreed plan / budget value	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
I3	**Procurement Route Decision Whether to put Healthcare Service Out to Tender** Committee to review and make risk-based decisions as appropriate on case by case basis	All – as required										
J	**APPROVAL OF OTHER HEALTHCARE PAYMENTS WITHIN BUDGET** See authorised signatory list for approval limits for other officers.	Over £1,000,000	Up to £1,000,000	Up to £1,000,000 *Primary Care Related		Up to £1,000,000	Up to £1,000,000	Up to £100,000 (within approved budget)	Up to £250,000 (within approved budget)	Up to £250,000 (within approved budget)	Up to £250,000 (within approved budget)	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
K	**QUOTATIONS AND TENDERS HEALTHCARE / NON-HEALTHCARE**											
K1	**Quotation Waiver Approval** (Total Contract Value – see detailed financial policy on tendering when permissible)		From £20k to delegated limit for additional expenditure within budget									
K2	**ii) Tender Waiver Approval**	Above Tender Limit for Healthcare / Non-Healthcare	Nil – N.B. Reporting of all Tender Waiver Approval to Audit Committee									
K3	**Approval to issue a Formal Tender** In compliance with 'Public Contract Regulations 2015 and amendments'.		All - Threshold and above approved by ICB Board Threshold is £213,477 (including VAT) unless light touch regime applies for healthcare services (see I3)									
K4	**Approval to seek 3 quotes (up to identified tender limit)** In compliance with 'Public Contract Regulations 2015 and amendments'.		Up to delegated limit for additional expenditure within budget £20,000 to Threshold Minimum of three written quotes required									
K5	Non Healthcare -Expenditure below quite threshold (quotes still recommended to secure VFM)		Up to £19,999									

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K5	**Opening of Tender Documentation** (where not received electronically) (at least 2 people from list)					X	X	X	X			
L	**VIREMENT** In accordance with the virement policy, a virement form must be completed and signed by both parties.	Over £10,000,000				Up to £1,000,000	Up to £1,000,000	Up to £250,000		Up to £250,000	Up to £250,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
M	**DISPOSALS AND CONDEMNATION** All assets disposed at market value.	Over £50,000				Up to £50,000	Up to £10,000	Up to £5,000				
N	**CHARITABLE FUNDS** (Not applicable to ICB)											
O	**HUMAN RESOURCES**											
O1	**Approve HR Decisions Not Covered By CCG HR Policies or Is Exceptional To Policies** (e.g. additional compassionate leave or exceptional carry forward of leave days)					X	X	X	X	X	X	
O2	**Decisions As Set Out Within HR Policies** (where there is some management discretion e.g. study leave authorisation)					X	X		X	X	X	
O3	**Approval of Operational Structure** (re staffing and departments), and in accordance with organisation change policy					X						
O4	**Approval of Appointment to Posts Below Executive Directors**						X	X	X	X	X	X
P	**EXTERNAL COMMUNICATIONS & REPORTING**											
P1	**Approve Complaints Responses** and Letters to **Politicians and Media Responses**					X				X (Assistant Chief Executive)		
P2	**Approve Public Consultation Material**					X				X (Assistant		

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										Chief Executive)		
P3	**Approve Public & Staff Engagement Material** inc Website					X				X (Assistant Chief Executive)		
P4	**Approve FOI Responses**									X (Assistant Chief Executive)		X* Corporate Affairs / Governance Lead
Q5	**Approve Annual Engagement & Communication Plan**	X								X (Assistant Chief Executive)		

NHS
Cheshire and Merseyside

NHS C&M ICB Committee Structure

Cheshire and Merseyside
Integrated Care Board Meeting

NHS
Cheshire and Merseyside

Date of meeting:	01/07/2022
Agenda Item No:	ICB/22/07
Report title:	NHS C&M ICB Committees
Report Author & Contact Details:	Ben Vinter / Matthew Cunningham matthew.cunngham@nhs.net
Report approved by:	Clare Watson, Assistant Chief Executive

Purpose and any action required	**Decision/ Approve** →	**X**	**Discussion/ Gain feedback** →		**Assurance** →		**Information/ To Note** →	

Committee/Advisory Group previously presented
Proposals have been developed following engagement with designate non executives and ICB executives. The ICB has been formally established only on 1st July.

Executive Summary and key points for discussion
To receive detailed proposals for ICB Committee establishment: • A governance schematic • ICB Committee terms of reference fulfilling what is described within the SORD and ICB Functions and Decision Map • Noting that the first task of ICB Committees upon establishment will be to review and make proposals (to the ICB) on their terms of references • The ICB Committees proposed for establishment are: o Audit Committee o Remuneration Committee o Finance, Investment and Our Resources Committee o Quality and Performance Committee o ICB Executive o Primary Care Committees o Transformation Committee

Cheshire and Merseyside
Integrated Care Board Meeting

Recommendation/ Action needed:	The Board is asked to: • **APPROVE** the core governance structure for NHS Cheshire and Merseyside ICB • **APPROVE** the terms of reference of the ICB's committees • **NOTE** the proposed approach to the development of Place Primary Care Committee structures which will be subject to further reporting to the Board • **NOTE** the receipt of Place based s75 agreements which govern defined relationships with and between specified local authorities and the ICB in each Place.

Consideration for publication	
Meetings of the Integrated Care Board will be held in public and the associated papers will be published unless there are specific reasons as to why that should not be the case. This paper will therefore be deemed public unless any of the following criteria apply (please insert **'x'** as appropriate:	
The item involves sensitive HR issues	
The item contains commercially confidential issues	
Some other criteria. Please outline below:	

Which purpose(s) of an Integrated Care System does this report align with?	
Please insert **'x'** as appropriate:	
1. Improve population health and healthcare	X
2. Tackle health inequality, improving outcome and access to services	
3. Enhancing quality, productivity and value for money	
4. Helping the NHS to support broader social and economic development	

C&M ICB Priority report aligns with:	
Please insert **'x'** as appropriate:	
1. Delivering today	X
2. Recovery	
3. Getting Upstream	
4. Building systems for integration and collaboration	

Governance and Risk					
Does this report provide assurance against any of the risks identified in the Board Assurance Framework or any other corporate risk? (*please list*) N/A					
What level of assurance does it provide? N/A					
Limited		**Reasonable**		**Significant**	
Any other risks? ~~Yes~~ / No. If yes please identify within the body of the report.					
Is this report required under NHS guidance or for statutory purpose? (*please specify*) Statutory document required for establishment of Integrated Care Boards					

	Any Conflicts of Interest associated with this paper? If Yes please state what they are and any mitigations. N/A
	Any current services or roles that may be affected by issues within this paper? N/A

Document Development	Process Undertaken	Yes	No	N/A	Comments (i.e. date, method, impact e.g. feedback used)
	Financial Assessment/ Evaluation			X	
	Patient / Public Engagement			X	
	Clinical Engagement			X	
	Equality Analysis (EA) - any adverse impacts identified?			X	
	Legal Advice needed?			X	
	Report History – has it been to other groups/ committee input/ oversight (Internal/External)				NHSE/I guidance and good practice guidance

Next Steps:	NHS C&M Constitution and supporting documents to be uploaded to public website, and form foundation documents of NHS C&M.
Responsible Officer to take forward actions:	Clare Watson – Assistant Chief Executive
Appendices:	A. NHS Cheshire and Merseyside ICB Governance schematic B. Audit Committee Terms of Reference C. Remuneration Committee Terms of Reference D. Finance, Investment and Our Resources Committee E. Quality and Performance Committee Terms of Reference F. ICB Executive Terms of Reference G. System Primary Care Committee Terms of Reference H. Transformation Committee Terms of Reference

NHS Cheshire and Merseyside

NHS C&M ICB Committees

1. Executive Summary

The ICB has a number of statutory duties under the National Health Service Act 2006, including the following:

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).

The Integrated Care Board (ICB) will meet every month in the first year of the ICB's operation. The ICB shall engage its partners via an Integrated Care Partnership (ICP). The Cheshire and Merseyside Integrated Care Partnership (ICP) – known as the C&M Health and Care Partnership (HCP) – shall meet every other month. The ICB recognises its obligations and the status of this forum within its governance and of the wider integrated care system.

2. NHS C&M Committees

In order to fulfil its statutory duties, the ICB will also establish a number of committees:

- Audit Committee Terms of Reference (Audit)
- Remuneration Committee Terms of Reference (Rem)
- Finance, Investment and Our Resources Committee (FIR)
- Quality and Performance Committee Terms of Reference (Q&P)
- ICB Executive Terms of Reference (Exec)
- System Primary Care Committee Terms of Reference (PCC)
- Transformation Committee Terms of Reference (TRC)

For the purposes of this paper, these committees, the board, and the HCP will be referred to as the "core" corporate ICB meetings. This structure presents a proposal for the first year of the ICB's operation. The frequency of meetings and/or the remit of the committees may change over time.

Each committee will consider and adopt its own terms of reference at its inaugural meeting. Any proposed changes will need to be submitted to the Board for approval. Terms of reference will be published and made available via the ICB'S Governance Handbook.

The ICB expects to establish 9 Place focused Primary Care Committees. These continue to be developed and it is proposed that the ICB delegate oversight of their establishment to the System Primary Care Committee which will in turn report on progress to the Board.

There will also be a number of advisory / consultative groups supporting the "core" corporate ICB meetings:

- People Board (PEB)
- Clinical and Care Professional Advisory Council (CCPAC)
- System Quality Surveillance Group
- ICB and Providers' "System Assembly" (SA)

In addition, the ICB will establish task and finish groups as required to progress particular pieces of work.

The ICB acknowledges that its committees and forums will develop over time. Relationships within the ICS and between ICS and the ICB will evolve and could cover Provider Collaboration and Place based structures as developments occur.

The ICB receives and is bound by a number of current s75 agreements with each of the local authorities within its boundaries as defined and set out within our Constitution. These agreements have established governance, covering defined scope and activities. Operational responsibility for these agreements' rests with the ICB Place Directors and will be subject to review during 2022/3.

There will also be an array of partnership groups / meetings at a Place, ICS, or wider level, that the ICB will be a member of. These are not captured in this paper. Programme structures and Boards will also exist or be established and the ICB recognises that a number of wider partnership forums and Boards which may either connect or be governed by the already detailed committee structure or the HCP are in place. Our integral Population Health Board being just one example.

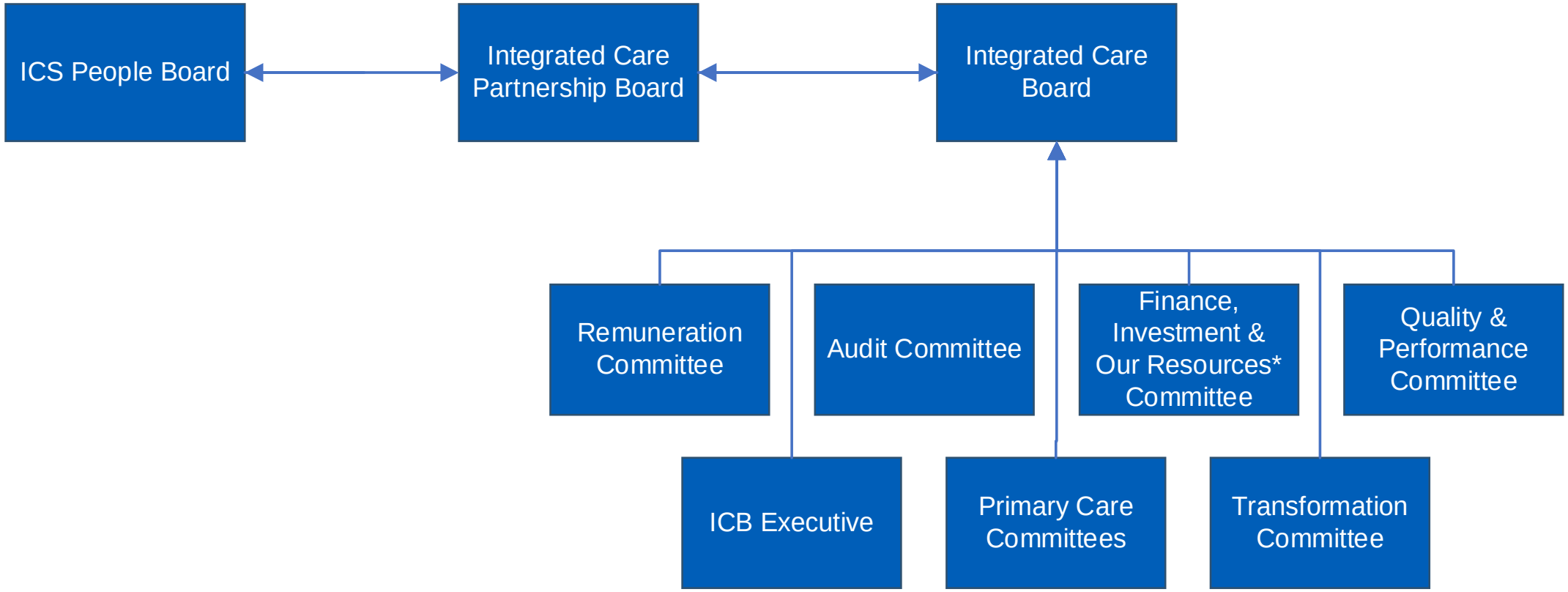
3. Recommendations

The Board is asked to:

- **APPROVE** the core governance structure for NHS Cheshire and Merseyside ICB
- **APPROVE** the terms of reference of the ICB's committees
- **NOTE** the proposed approach to the development of Place Primary Care Committee structures which will be subject to further reporting to the Board
- **NOTE** the receipt of Place based s75 agreements which govern defined relationships with and between specified local authorities and the ICB in each Place.

ICS Governance Schematic

NHS
Cheshire and Merseyside



* Our resources reflects the importance of the ICB's people, its workforce, to the ICB

NHS
Cheshire and Merseyside

C&M ICB

Audit Committee

Terms of Reference

Document revision history

Date	Version	Revision	Comment	Author / Editor
XX	1.0	Initial ToRs		Ben Vinter

Review due
Xxx xxx 2022/3

1. Introduction

The Audit Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. Role & Purpose

To contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.

The duties of the Committee will be driven by the organisation's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year; however this will be flexible to new and emerging priorities and risks.

The Audit Committee has no executive powers, other than those delegated in the SoRD and specified in these terms of reference.

The Committee's duties for and on behalf of the ICB and its functions can be categorised as follows (where Board is referenced this refers to the Integrated Care Board):

<u>Integrated governance, risk management and internal control</u>

- To review the adequacy and effectiveness of the ICB and inform its view of the system's integrated governance, risk management and internal control. Focused specifically on the ICB's activities, contributions or controls which support the achievement of its objectives, and to highlight any areas of weakness to the Board
- To ensure that ICB financial systems and governance are established which facilitate compliance with DHSC's Group Accounting Manual
- To review the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of the ICB's objectives, the effectiveness of the management of principal risks
- To have oversight of system risks where they relate to the achievement of the ICB's objectives
- To ensure consistency that the ICB acts consistently with the principles and guidance established in HMT's Managing Public Money
- To seek reports and assurance from directors and managers as appropriate, concentrating on the systems of integrated governance, risk management and internal control, together with indicators of their effectiveness
- To identify opportunities to improve governance, risk management and internal control processes across the ICB.

Internal audit

To ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved
- Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework
- Considering the major findings of internal audit work, including the Head of Internal Audit Opinion, (and management's response), and ensure coordination between the internal and external auditors to optimise the use of audit resources
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation and
- Monitoring the effectiveness of internal audit and carrying out an annual review.

External audit

To review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan
- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee and
- Reviewing all external audit reports, including to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

Other assurance functions

To review the findings of assurance functions in the ICB, and to consider the implications for the governance of the ICB.

To review the work of other committees in the ICB, whose work can provide relevant assurance to the Audit Committee's own areas of responsibility.

To review the assurance processes in place in relation to financial performance of the ICB including the completeness and accuracy of information provided and where appropriate to advise the ICB of any assurance considerations for wider system working.

To review the findings of external bodies and consider the implications for governance of the ICB. These will include, but will not be limited to:

- Reviews and reports issued by arm's length bodies or regulators and inspectors: e.g. National Audit Office, Select Committees, NHS Resolution, CQC; and

- Reviews and reports issued by professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges and accreditation bodies).

Counter fraud

To assure itself that the ICB has adequate arrangements in place for counter fraud, bribery and corruption (including cyber security) that meet NHS Counter Fraud Authority's (NHSCFA) standards and shall review the outcomes of work in these areas.

To review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans, provide direct access and liaison with those responsible for counter fraud, review annual reports on counter fraud, and discuss NHSCFA quality assessment reports.

To ensure that the counter fraud service provides appropriate progress reports and that these are scrutinised and challenged where appropriate.

To be responsible for ensuring that the counter fraud service submits an Annual Report and Self-Review Assessment, outlining key work undertaken during each financial year to meet the NHS Standards for Commissioners; Fraud, Bribery and Corruption.

To report concerns of suspected fraud, bribery and corruption to the NHSCFA.

Freedom to Speak Up

To review the adequacy and security of the ICB's arrangements for its employees, contractors and external parties to raise concerns, in confidence, in relation to financial, clinical management, or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.

Information Governance (IG)

To receive regular updates on IG compliance (including uptake & completion of data security training), data breaches and any related issues and risks.

To review the annual Senior Information Risk Owner (SIRO) report, the submission for the Data Security & Protection Toolkit and relevant reports and action plans.

To receive reports on audits to assess information and IT security arrangements, including the annual Data Security & Protection Toolkit audit.

To provide assurance to the Board that there is an effective framework in place for the management of risks associated with information governance.

Financial reporting

To monitor the integrity of the financial statements of the ICB and any formal announcements relating to its financial performance.

To ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

To review the annual report and financial statements (including accounting policies) before submission to the Board focusing particularly on:

- The wording in the Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- Changes in accounting policies, practices and estimation techniques
- Unadjusted misstatements 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

The chair of the Audit Committee will be the nominated Conflicts of Interest Guardian.

The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

Management

To request and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the ICB as they may be appropriate to the overall arrangements.

To receive reports of breaches of policy and normal procedure or proceedings, including such as suspensions of the ICB's standing orders, in order provide assurance in relation to the appropriateness of decisions and to derive future learning.

Communication

To co-ordinate and manage communications on governance, risk management and internal control with stakeholders internally and externally.

To develop an approach with other committees, including supporting the ICB with the Integrated Care Partnership, to ensure the relationship between them is understood.

3. Authority

The Audit Committee is authorised by the Board to:

- Investigate any activity within its terms of reference
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference
- Commission any reports it deems necessary to help fulfil its obligations
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In

doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice

- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation (SoRD) but may/ not delegate any decisions to such groups.

For the avoidance of doubt, the Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD,

4. Membership & Attendance

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint no fewer than four members of the Committee including at least two who are Non-Executive Members of the Board. Other members of the Committee need not be members of the Board, but they may be.

As a minimum the membership of the Audit Committee will therefore be:

- the ICB non executive members
- An ICB Partner Member
- The Committee may choose to seek up to two system lay members

Neither the Chair of the Board, nor employees of the ICB will be members of the Committee.

Members will possess between them knowledge, skills and experience in: accounting, risk management, internal, external audit; and technical or specialist issues pertinent to the ICB's business. When determining the membership of the Committee, active consideration will be made to diversity and equality.

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

- Director of Finance or their nominated deputy;
- Representatives of both internal and external audit;
- Individuals who lead on risk management and counter fraud matters;

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

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

The Chief Executive should be invited to attend the meeting at least annually.

The Chair of the ICB may also be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.

Attendance
Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

Access
Regardless of attendance, External Audit, Internal Audit, Local Counter Fraud and Security Management providers will have full and unrestricted rights of access to the Audit Committee.

5. Meetings

5.1 Leadership

In accordance with the constitution, the Committee will be chaired by an Independent Non-Executive Member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.

The Chair of the Committee shall be independent and therefore may not chair any other committees. They will be mindful of their role should they participate in any other committee.

Committee members may appoint a Vice Chair.

The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

5.2 Quorum

For a meeting to be quorate a minimum of two independent Non-Executive Members of the Board are required, including the Chair or Vice Chair of the Committee.

If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

5.3 Decision-making and voting

Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

5.4 Frequency

The Audit Committee will meet at least four times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

The Board, Chair or Chief Executive may ask the Audit Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

Papers for the meeting will be issued ideally one week in advance of the date the meeting is due to take place and no later than 4 working days.

5.5 Administrative Support

The Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept
- The Chair is supported to prepare and deliver reports to the Board
- The Committee is updated on pertinent issues/ areas of interest/ policy developments
- Action points are taken forward between meetings and progress against those actions is monitored.

5.6 Accountability and Reporting Arrangements

The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board in accordance with the Standing Orders.

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.

The Audit 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.

6. Behaviours and Conduct

ICB values
Members will be expected to conduct business in line with the ICB values and objectives.

Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity
Members must demonstrably consider the equality and diversity implications of decisions they make.

7. Review

The Committee will review its effectiveness at least annually

These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

NHS
Cheshire and Merseyside

C&M ICB Remuneration Committee

Terms of Reference

Document revision history

Date	Version	Revision	Comment	Author / Editor
XX	1.0	Initial ToRs		Ben Vinter

Review due
Xxx xxx 2022/3

1. Introduction

NHS C&M has been established 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

2. Purpose

The Remuneration 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.

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.

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 senior managers/directors (including board members) and non-executive directors.

The Board has also delegated the following functions to the Committee:

- Salary, including any performance-related pay or bonus
- Provisions for other benefits, including for example pensions and cars and
- Allowances.

The Committee will:

- Adhere to all relevant laws, regulations and company policy in all respects, including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate Executive Directors whilst remaining cost effective
- Advise upon and oversee contractual arrangements for Executive Directors, including but not limited to termination payments.

3. Responsibilities / duties

The Committee's duties are as follows:

For the Chief Executive, Directors and other Very Senior Managers:

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

For all staff:

- Determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change)
- Oversee contractual arrangements

- Determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate.

For NEDs:

- Determine the ICB remuneration policy (including the adoption of pay frameworks)
- Oversee contractual arrangements.

Additional functions that ICBs has chosen to include in the scope of the committee include:

- Functions in relation to nomination and appointment of (some or all) Board members through convening an ICB Appointments Panel
- Functions in relation to performance review/ oversight for directors/senior managers
- Succession planning for the Board
- Assurance in relation to ICB statutory duties relating to people such as compliance with employment legislation including such as Fit and proper person regulation (FPPR)
- Board development which maybe progressed through a discreet working group

4. Authority

The Remuneration Committee is authorised by the Board to:

- Investigate any activity within its terms of reference
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the committee) within its remit as outlined in these terms of reference
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by the ICB for obtaining legal or professional advice
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and SoRD but may /not delegate any decisions to such groups.

For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference other than the committee being permitted to meet in private.

5. Membership & Attendance

Membership

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint no fewer than three members of the Committee including at least two independent members of the Board. Other members of the Committee need not be members of the board, but they may be.

When determining the membership of the Committee, active consideration will be made to diversity and equality.

The Committee Membership will be composed of:

- Chair of Remuneration Committee
- All NED members of the ICB may be members of the committee recognising that there may be times when the audit chair needs to abstain
- At least two independent members of the committee drawn from the wider ICS system
  - An independent member with expertise in remuneration of audit
  - An independent system partner member (Lay or NED member of the ICS) ideally fulfilling a remuneration capacity at present
- The ICB Chair will receive a standing invitation to attend and will sit as a member when there is a need to maintain quoracy or when a decision involving non-Executive members is to be made.

Attendees

Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

Meetings of the Committee may also be attended by the following individuals who are not members of the Committee for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote:

- The ICB's most senior HR Advisor or their nominated deputy
- Director of Finance or their nominated deputy
- Chief Executive or their nominated deputy

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

<u>Management of Conflicts of Interest</u>

No individual should be present during any discussion relating to:

- Any aspect of their own pay
- Any aspect of the pay of others when it has an impact on them.

6. Meetings

6.1 Leadership

Committee members may appoint a Vice Chair from amongst the members.

In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number Chair the meeting recognising that this may not be the ICB Chair or Audit Chair.

The Chair of the Board may be a member of the Committee but may not be appointed as the Chair.

The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

6.2 Quorum

For a meeting to be quorate a minimum of two of the non-executive members[1] is required, including the Chair or Vice Chair.

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.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

6.3 Decision-making and voting

Decisions will be guided by national NHS policy and best practice to ensure that staff are fairly motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency.

Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

6.4 Frequency

The Committee will meet in private.

The Committee will meet at least twice each year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

The Board, Chair or Chief Executive may ask the Remuneration Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

6.5 Administrative Support

The Committee shall be supported with a secretariat function. Which will include ensuring that:

[1] Other than where specified in the constitution to assess NED remuneration where two committee members will also represent the quorum.

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept
- The Chair is supported to prepare and deliver reports to the Board
- The Committee is updated on pertinent issues/ areas of interest/ policy developments; and
- Action points are taken forward between meetings.

6.6 Accountability and Reporting Arrangements

The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

A summary of key issues discussed and concluded shall be produced and formally submitted to the Board. Reporting will be appropriately sensitive to personal circumstances and contain no personally sensitive or personally identifiable information.

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.

7. Behaviours and Conduct

Benchmarking and guidance
The Committee will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

ICB values
Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

Members of, and those attending, the Committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality diversity and inclusion
Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

8. Review

The Committee will review its effectiveness at least annually

These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

NHS
Cheshire and Merseyside

C&M ICB

Finance, Investment & Resources Committee

Terms of Reference

Document revision history

Date	Version	Revision	Comment	Author / Editor
XX	1.0	Initial ToRs		Ben Vinter

Review due
Xxx xxx 2022/3

1. Introduction

NHS C&M has been established 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

2. Purpose

High functioning Boards traditionally focus on a number of key responsibilities: setting strategy; delivery; assurance and culture and establish a number of supporting committees. This committee will provide the ICB with a vehicle to support assurance, risk management, system engagement, delivery and collaborative resolution in finance and investment (including capital and resources (for the ICB as an employer).

The Committee will support development and delivery of the ICS' financial strategy, oversee financial delivery and provide assurance on the arrangements in place for financial control and value for money across the system.,

The committee will also take a system view on use of resources and deployment but also provide a forum where ICB directors and ICB members can consider, govern and assure ICB actions as an employer.

3. Responsibilities / duties

The Committee will fulfil its purpose by:

- Defining principles for financial operations and management within the ICS and making recommendations for financial priorities including:
  - Delivery of long-term system financial sustainability and year on year system balance
  - Risk and gain share
  - Capital, investment and digital investment priorities
  - Strategic estates considerations
  - Resource distribution and funds flow arrangements

- Securing assurance, oversight and any action to ensure delivery of the financial plan

- Enabling development of a financial strategy in support of the wider system clinical strategy including:
  - Aligning financial performance to quality and activity and workforce standards
  - Reviewing the allocation of resources to organizations taking into account the strategic objective of reducing health inequalities, improving health outcomes and supporting financial sustainability.
  - Considering the road map for resource distribution across the system to support both place and provider collaboration design over the medium term

- Provide a forum to convene ICB members and directors to consider ICB employment matters (consideration if such matters will be reserved to ICB members of directors)

4. Delegated Powers and Authority

The committee will act with the authority of the C&M Integrated Care Board covering the scope of its remit through regular reporting, discussions, investigation and action.

5. Membership & Attendance

5.1 Members

- ICS Finance Director (Chair)
- At least one ICB NED
- A Partner NED from at least one of each of the C&M provider collaboratives
- A Partner CEO from at least one of each of the C&M provider collaboratives
- ICB Director of Nursing
- ICB Director of Performance and Planning
- ICB Director of HR
- A minimum of one Place finance representative
- A Primary Care Representative – nominee from the Primary Care Leadership Forum
- ICS or Partner representatives supporting any conversation
- A number of additional attendees may be invited

Consideration has been given to the role and connection of Provider NEDs on this committee and collaboratives. Close connection with the ICS finance community and DOF level and finance conversations, dialogue and work will be critical to the success of delivery against this agenda but supporting decision making and assurance through this Committee and to the ICB.

Notified, named deputies to support attendance and participation is encouraged.

5.2 In attendance

The group may invite representatives from the wider system, ICB, ICS, NHSE/I region or supporting staff such as secretariat, governance, performance, direct commissioning, local authority or transformation colleagues as required to support discussions.

6. Meetings

6.1 Leadership

The Committee is Chaired by an ICB NED.

6.2 Quorum

For a meeting to be quorate at least 50% of the membership must be present. Not less than two ICB executives and two partner representatives or non executives.

It is not envisaged that voting will be ether necessary or encouraged.

6.3 Frequency

At least monthly with opportunity for use and linkages with the ICS forums established and supported by the ICB, or system partners such as the collaboratives.

The Committee shall meet at such times and place as the Chair may direct on giving reasonable written notice to members. Meetings will be scheduled to ensure that they do not conflict with known existing Board meetings and are synchronized so that members can properly engage their organisations ahead of meetings.

On occasion it may be necessary to arrange extraordinary meetings at short notice. In these circumstances the Chair will give as much notice as possible to members.

Meetings will not, usually, be open to the public and will have the ability to schedule meetings as either face to face or electronically.

Papers for the meeting will be issued ideally one week in advance of the date the meeting is due to take place and no later than 4 working days.

6.4 Format

An agenda for each meeting will be agreed with the Chair. Periodic calls for items supporting discussion will also be made from the membership.

It Is anticipated that the meeting may initially have both a business and developmental focus as it established and defines its role. Sufficient time will be allocated to items to enable full exploration of issues, constructive challenge and reflection.

Advice, opinion and engagement may be sought from amongst the membership outside of the regular meetings, either as a group or on an individual basis.

6.5 Reporting

The outputs of the group will be reported to the Board.

Meeting paperwork and content can be shared within the system finance community.

7. Assurance

The assurance required of and from the group is an area which will require development as and when it discharges its functions and responsibilities. The role of audit and the audit committee will be key in this process as will any oversight arrangements established by NHSE.

8. Conduct

All members are required to make open and honest declarations of the interest at the commencement of each meeting or to notify the Chair of any actual, potential or perceived conflict in advance of the meeting.

All members are required to uphold the Nolan Principles and all other relevant NHS Code of Conduct requirements.

9. Review

The scope, purpose, performance and role of ELT will be reviewed at least annually but initially after no longer than 6 months.

NHS
Cheshire and Merseyside

C&M ICB Executive

Terms of Reference

Document revision history

Date	Version	Revision	Comment	Author / Editor
XX	1.0	Initial ToRs		Ben Vinter

Review due
Xxx xxx 2022/3

1. Introduction

NHS C&M has been established 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

2. Purpose

The ICB Executive is established in accordance with NHS Cheshire & Merseyside's Constitution. These terms of reference set out the membership, remit, responsibilities, and reporting arrangements of the ICB Executive and shall have effect as if incorporated into the Constitution.

All management functions of NHS C&M (with the exception of those delegated to individuals or to another committee of the Integrated Care Board (the Board) or reserved to the ICB as detailed in the Scheme of Reservation and Delegation) are delegated to the ICB Executive for day-to-day management and delivery. The ICB Executive will make recommendations on delivery of strategy and commissioning plans and take day to day decisions on performance management and risk management to provide robust assurance to the Board.

3. Responsibilities / duties

The scope of ICB Executive is to support the Board in undertaking its statutory duties as NHS Cheshire & Merseyside. The Committee will fulfil its purpose by fulfilling its responsibilities:

3.1 Overarching responsibilities:

- Ensure the effective operational management of NHS C&M, through providing effective leadership and direction to the work of the organisation
- Support NHS C&M to deliver its plans, strategies, and statutory duties
- Promote robust clinical and corporate governance across the organisation
- Support the Board in setting the vision and delivering the organisation's strategic objectives
- Provide support to the development of its nine places across Cheshire & Merseyside, and the wider Integrated Care System (ICS) and all of its parts and partner interactions

3.2 Other responsibilities:

- Provide direction (as a Category 1 responder) in the event of emergency planning, preparedness, and response, and ensure NHS C&M supports its Partners with system, and as appropriate, with borough wide planning and activity
- Make decisions in respect of system QIPP and financial recovery, any such decision shall be reported to the next meeting of the Board for ratification
- Act in accordance with the NHS C&M Constitution, Standing Orders, Prime Financial Policies and Scheme of Reservation & Delegation
- Oversee NHSE assurance planning and responses

- Ensure that all NHS C&M strategies/ plans are fully aligned and integrated enabling effective delivery
- Co-ordinate its business with the ICS wide partners, as appropriate, on matters relevant to the partnership
- Approve, or recommend for approval (dependent on SoRD), a wide range of policies and procedures, ensuring effective implementation of all such policies
- Monitor the implementation of the Organisational Development Strategy
- Will provide support to ensure that the ICB, its committees and the ICP function optimally

Specific Duties of the ICB Executive:

3.3 Governance

The ICB Executive will

- commission reports and audit/surveys it deems necessary to help fulfil its obligations as authorised by the Board
- when a steady state has been achieved the executive will review and ratify minor policy changes, recommending to the Board for approval any new policies or policies requiring significant updates/ changes
- oversee the development of key governance, assurance and risk systems; ensuring processes are in place so that NHS C&M is compliant with its statutory requirements and has sound internal control arrangements
- ensure appropriate arrangements in respect of information governance are in place
- ensure NHS C&M is compliant with Health and Safety legislation including the Corporate Manslaughter Act and Local Security Management Services (LSMS) requirements
- ensure NHS C&M is compliant with its statutory duties under the Civil Contingencies Act
- monitor all workforce performance targets and recommend remedial action plans when performance is below target.
- consider and review workforce plans in line with management costs

3.4 Risk

The ICB Executive will

- promote good risk management and ensure effective corporate governance systems and processes are embedded across the organisation that also promote effective partnership working and integration
- scrutinise and challenge risk assessment and risk assurances provided by the Corporate Risk Register (CRR) and Body Assurance Framework (BAF) to ensure that robust controls are evident across the organisation. This should include scrutiny of entries contained in all areas of the BAF and CRR
- develop and implement the NHS C&M Risk Management Strategy

4. Sub-groups & Administration

The ICB Executive is authorised to create sub-groups or working groups as are necessary to fulfil its responsibilities within its terms of reference

Appropriate secretarial support will be provided to ensure appropriate support to the Chair in relation to the organisation and conduct of meetings. The Secretary's duties will include:

- Agreement of agendas with the Chair and attendees and collation of papers
- Keeping a record of minutes/ actions, key issues, matters arising and issues to be carried forward

Key action points may also be taken by any attendee, and any executive decision made in respect of Quality, Innovation, Productivity & Innovation (QIPP) or financial recovery will be submitted to the Board for ratification via an accountability report.

5. Delegated Powers and Authority

The ICB Executive will act with the authority of the C&M Integrated Care Board covering the scope of its remit through regular reporting, discussions, investigation and action.

6. Membership & Attendance

6.1 Members

Chief Executive (Chair) and direct reports as relevant

Notified, named deputies to support attendance and participation is encouraged.

6.2 In attendance

The group may invite representatives from the wider system, ICB, ICS, NHSE/I region or supporting staff such as secretariat, governance, performance, direct commissioning, local authority or transformation colleagues as required to support discussions.

7. Meetings

7.1 Leadership

The ICB Executive is Chaired by the Chief Executive. In the absence of the Chief Executive the committee will be chaired by a designated deputy relevant for each occasion, as appropriate.

7.2 Quorum

Quorum will be three members, which must include the Chief Executive (or nominated deputy) and Executive Director of Finance (or nominated deputy).

It is not envisaged that voting will be ether necessary or encouraged.

7.3 Frequency

ICB Executive meetings will be held weekly. It will be necessary for ICB Executive quoracy to be maintained for any decisions relating to QIPP and financial recovery in this instance.

Meetings will not, usually, be open to the public and will have the ability to schedule meetings as either face to face or electronically.

Papers for the meeting will be issued ideally one week in advance of the date the meeting is due to take place and no later than 4 working days.

7.4 Emergency Powers & Urgent Decisions

In the case of urgent decisions and extraordinary circumstances, every attempt will be made for the team to meet virtually. Where this is not possible the most senior or appropriate decision maker may exercise their powers in lien with delegations.

7.5 Format

An agenda for each meeting will be agreed with the Chair. Calls for items supporting discussion will also be made from the membership.

It Is anticipated that the meeting may initially have both a business and developmental focus as it established and defines its role. Sufficient time will be allocated to items to enable full exploration of issues, constructive challenge and reflection.

Advice, opinion and engagement may be sought from amongst the membership outside of the regular meetings, either as a group or on an individual basis.

7.6 Reporting

The outputs of the group will be reported to the Board.

8. Behaviours and Conduct

Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

Members shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

All members are required to make open and honest declarations of the interest at the commencement of each meeting or to notify the Chair of any actual, potential or perceived conflict in advance of the meeting.

All members are required to uphold the Nolan Principles and all other relevant NHS Code of Conduct requirements.

9. Review

The ICB Executive will review its effectiveness at least annually

These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

NHS
Cheshire and Merseyside

C&M ICB

Quality & Performance Committee

Terms of Reference

Document revision history

Date	Version	Revision	Comment	Author / Editor
XX	1.0	Initial ToRs		Ben Vinter

Review due
Xxx xxx 2022/3

1. Introduction

NHS C&M has been established 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 Quality & Performance Committee (the "Committee") has been established in accordance with the Integrated Care Board's (ICBs) constitution.

These terms of reference, which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. Purpose

The Quality and Performance Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality (safe, effective, person-centred, well-led, sustainable and equitable), 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, coupled with a focus on performance.

The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care. The committee will focus on quality performance data and information and consider the levels of assurance that the ICB can take from performance oversight arrangements within the ICS and actions to address any performance issues.

3. Responsibilities / duties

The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

<u>Quality</u>

- Ensure that there are robust processes in place for the effective management of quality, safety and patient experience.
- Scrutinise structures in place to support quality planning, control and improvement, to be assured that the structures operate effectively and timely action is taken to address areas of concern

- Oversee development of the ICB's key quality priorities, including priorities to address variation/ inequalities in care, and recommend these priorities to the ICB for inclusion in the ICB Strategy / Annual Plan
- Oversee and monitor delivery of the ICB key statutory requirements
- Review and monitor those risks on the BAF and Corporate Risk Register which relate to quality, and high-risk operational risks which could impact on care.
- Oversee and scrutinise the ICB's response to all relevant (as applicable to quality) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the DHSC, NHSEI and other regulatory bodies / external agencies (e.g. CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained
- Maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation and assure the ICB that these are disseminated and implemented across all sites
- Oversee and seek assurance on the effective and sustained delivery of the ICB Quality Improvement Programs
- Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place
- Ensure processes are in place to enable the ICB to identify lessons learned from all relevant sources, including, incidents, never events, complaints and claims and ensures that learning is disseminated and embedded
- Ensure that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from death (including coronial inquests and PFD report)
- Ensure that mechanisms are in place to systematically and effectively involve people that use services as equal partners in quality activities
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for infection prevention and control
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for equality and diversity as it applies to people drawing on services
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety

<u>Performance</u>

- Receive, review and scrutinise the integrated performance reports for the ICB with a focus on quality, safety and patient experience and outcomes.
- Ensure that contract quality performance is monitored on a monthly basis (or other periods as agreed for certain contract types as appropriate)
- Identify and scrutinise significant variations from plan of all Key Performance Indicators (KPIs)
- Scrutinise the appropriateness and robustness of any management actions to address identified performance issues in relation to the quality of services.
- Ensure actual and forecast contract over-performance or under-performance is quantified in financial terms and activity terms
- Benchmark recovery plans against trajectories
- Agree which of the underperforming contracts need to be brought to the attention of the ICB

- Ensure the implementation of the priorities set out in the Operational Planning Guidance
- Oversee the ongoing delivery of procurements and any major service change, with a focus on quality, safety and patient experience in line with statutory requirements
- In relation to quality of services, seek assurance that the procurement of services is consistent with relevant laws and that conflicts of interest have been declared, managed and published as required

In particular, the Committee will provide assurance to the ICB on the delivery of the following statutory duties:

- Duties in relation children including safeguarding, promoting welfare, SEND (including the Children Acts 1989 and 2004, and the Children and Families Act 2014); and
- Adult safeguarding and carers (the Care Act 2014).

In order to deliver this, the responsibilities of the Committee will include:

- Ensuring the ICB is informed in a timely manner of significant risks, issues and mitigation plans relating to quality and performance (in line with the remit of the Committee).

4. Delegated Powers and Authority

The Committee is authorised by the Board to:

- Request further investigation or assurance on any area within its remit
- Obtain such internal information as is necessary and expedient to the fulfil its functions
- Undertake, where necessary, 'deep dives' into specific issues that will enable it to gain a greater level of understanding and assurance into specific issues that fall within its remit
- Bring matters to the attention of other committees to investigate or seek assurance where they fall within the remit of that committee
- Make recommendations to the ICB
- Escalate issues to the ICB
- Produce an annual work plan to discharge its responsibilities
- Approve the terms of reference of any sub-groups to the committee (e.g. System Quality Groups, Infection Prevention and Control, Local Maternity and Neonatal System, SEND Partnership Board)
- Delegate responsibility for specific aspects of its duties to sub-groups. The terms of reference of any sub-groups shall be approved by the Committee.

For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference other than the committee being permitted to meet in private.

5. Membership & Attendance

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

Membership of the Committee may be drawn from the ICB Board membership; the ICB' executive leadership team; officers of the ICB; members or officers of other bodies in the wider health and social care system; other individuals/representatives as deemed appropriate.

The Committee members shall be:

- Non-Executive Member of the ICB (Chair)
- Non-Executive Member of the ICB (Deputy Chair)
- ICB Director of Nursing & Care
- ICB Medical Director
- ICB Director of Performance and Planning
- At least 2 x lay members with lived experience (e.g. Healthwatch, patient safety partners)
- Up to two ICB Partner Members (or their representatives)

All Committee members may appoint a deputy to represent them at meetings of the Committee. Committee members should inform the Committee Chair of their intention to nominate a deputy to attend/act on their behalf and any such deputy should be suitably briefed and suitably qualified (in the case of clinical members).

The Committee may also request attendance by appropriate individuals to present agenda items and/or advise the Committee on particular issues.

Attendees

Only members of the Committee have the right to attend Committee meetings but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

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.

6. Meetings

6.1 Leadership

The Committee shall be chaired by a Non-Executive Member of the ICB. The Deputy Chair shall be a Member of the ICB.

If the Chair, or Deputy Chair, is unable to attend a meeting, they may designate an alternative ICB member to act as Chair.

If the Chair is unable to chair an item of business due to a conflict of interest, another member of the committee will be asked to chair that item.

6.2 Quorum

A meeting of the Committee is quorate if the following are present:

- At least one Non-Executive Members of the ICB*;
- At least one ICB Partner Member of the ICB*;
- The Director of Nursing & Care or Medical Director*;
- At least one provider representative*
- At least one local authority representative*

*If regular members are not able to attend they should make arrangements for a representative to attend and act on their behalf.

6.3 Decision-making and voting

Decisions should be taken in accordance with the Standing Orders.

The Committee will usually make decisions by consensus. Where this is not possible, the Chair may call a vote.

Only voting members, as identified in the "Membership" section of these terms of reference, may cast a vote.

A person attending a meeting as a representative of a Committee member shall have the same right to vote as the Committee member they are representing.

In accordance with paragraph 6, no member (or representative) with a conflict of interest in an item of business will be allowed to vote on that item.

Where there is a split vote, with no clear majority, the Chair will have the casting vote.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

6.4 Frequency

The Committee will meet in private.

The Committee will generally meet monthly and arrangements and notice for calling meetings are set out in the Standing Orders.

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.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

6.5 Administrative Support

The Committee shall be supported with a secretariat function. Which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept

- The Chair is supported to prepare and deliver reports to the Board
- The Committee is updated on pertinent issues/ areas of interest/ policy developments; and
- Action points are taken forward between meetings.

6.6 Accountability and Reporting Arrangements

The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board.

The Committee will submit copies of its minutes and a report to the Board following each of its meetings. Public reports will be made as appropriate to satisfy any requirements in relation to disclosure of public sector executive pay.

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.

7. Behaviours and Conduct

Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

Members of, and those attending, the Committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

All members shall comply with the ICB's Managing Conflicts of Interest Policy at all times. In accordance with the ICBs' policy on managing conflicts of interest, Committee members should:

- Inform the chair of any interests they hold which relate to the business of the Committee.
- Inform the chair of any previously agreed treatment of the potential conflict / conflict of interest.
- Abide by the chair's ruling on the treatment of conflicts / potential conflicts of interest in relation to ongoing involvement in the work of the Committee.
- Inform the chair of any conflicts / potential conflicts of interest in any item of business to be discussed at a meeting. This should be done in advance of the meeting wherever possible.
- Declare conflicts / potential conflicts of interest in any item of business to be discussed at a meeting under the standing "declaration of interest" item.
- Abide by the chair's decision on appropriate treatment of a conflicts / potential conflict of interest in any business to be discussed at a meeting.

As well as complying with requirements around declaring and managing potential conflicts of interest, Committee members should:

- Comply with the ICBs' policies on standards of business conduct which include upholding the Nolan Principles of Public Life
- Attend meetings, having read all papers beforehand
- Arrange an appropriate deputy to attend on their behalf, if necessary
- Act as 'champions', disseminating information and good practice as appropriate

- Comply with the ICBs' administrative arrangements to support the Committee around identifying agenda items for discussion, the submission of reports etc.

Equality diversity and inclusion
Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

8. Review

The Committee will review its effectiveness at least annually

These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

NHS
Cheshire and Merseyside

C&M ICB

System Primary Care Committee

Terms of Reference

Document revision history

Date	Version	Revision	Comment	Author / Editor
XX	1.0	Initial ToRs		Ben Vinter

Review due
Xxx xxx 2022/3

1. Introduction

NHS C&M has been established 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 System Primary Care Committee has been established to oversee the ICB's exercise of its statutory powers relating to the provision of primary medical services under the NHS Act 2006, as amended by the Health and Care Act 2022,

2. Purpose

NHS C&M has established a series of Primary Care Committees (nine of which sit within place-based arrangements, the tenth being a System-wide Primary Care Committee with oversight of the full Cheshire & Merseyside area) to function as the corporate decision-making forum for the management of the delegated functions and the exercise of the delegated powers.

These Terms of Reference relate to the NHS C&M System-wide Primary Care Committee. Please see separate Place-Based Primary Care Committee ToR for the role of those committees within each place.

3. Statutory Framework

The Health and Care Act 2022 amends the NHS Act 2006 by inserting the following provisions:

13YB Directions in respect of functions relating to provision of services

(1) NHS England may by direction provide for any of its relevant functions to be exercised by one or more integrated care boards.

(2) In this section "relevant function" means—

(a) any function of NHS England under section 3B(1) (commissioning functions);

(b) any function of NHS England, not within paragraph (a), that relates to the provision of—

(i) primary medical services,

(ii) primary dental services,

(iii) primary ophthalmic services, or

(iv) services that may be provided as pharmaceutical services, or as local pharmaceutical services, under Part 7;

(c) any function of NHS England by virtue of section 7A or 7B (exercise of Secretary of State's public health functions);

(d) any other functions of NHS England so far as exercisable in connection with any functions within paragraphs (a) to (c).

82B Duty of integrated care boards to arrange primary medical services

(1) Each integrated care board must exercise its powers so as to secure the provision of primary medical services to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility.

(2) For the purposes of this section an integrated care board has responsibility for— (a) the group of people for whom it has core responsibility (see section 14Z31), and (b) such other people as may be prescribed (whether generally or in relation to a prescribed service).

In exercising its functions, NHS C&M must comply with the statutory duties set out in NHS Act, as amended by the Health and Care Act 2022, including:

a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 1989 and section 14Z32 of the 2009 Act);
b) Exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act);
c) section 14Z34 (improvement in quality of services),
d) section 14Z35 (reducing inequalities),
e) section 14Z38 (obtaining appropriate advice),
f) section 14Z40 (duty in respect of research),
g) section 14Z43 (duty to have regard to effect of decisions)
h) section 14Z44 (public involvement and consultation),
i) sections 223GB to 223N (financial duties), and
j) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

In addition NHS C&M will follow the Procurement, Patient Choice and Competition (no2) Regulations 2013 and any subsequent procurement legislation that applies to the ICB.

4. Delegated Powers and Authority – Role of the Committee

The Committee is established as a Committee of NHS C&M Integrated Care Board (ICB) in accordance with the NHS Act, as amended by the Health and Care Act 2022, and is subject to any directions made by NHS England or by the Secretary of State.

The Committee has been established in accordance with the above statutory provisions to enable collective decision-making on the review, planning and procurement of primary care services in relation to GP primary medical services and community pharmacy as part of the NHS C&M's statutory commissioning responsibilities across Cheshire & Merseyside under delegated authority from NHS England.

In performing its role, the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS C&M and NHS England. The agreement will sit alongside the delegation and terms of reference in accordance with the NHS C&M constitution.

In carrying out its role, the Committee will work alongside the nine place-based Primary Care Committees, providing oversight and assurance of effective primary care services across Cheshire & Merseyside. The Committee will also work closely with the Pharmaceutical Services Regulations Committee (PSRC).

The functions of the Committee are undertaken in line with NHS C&M's desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

4.1 Commissioning of Primary Medical Services

The role of the System Primary Care Committee shall be to oversee, coordinate and promote alignment of the functions amongst Places relating to the commissioning of primary medical services under section 82B of the NHS Act in relation to GP primary medical services and community pharmacy. This includes the following:

- Develop a system-wide Primary Care Strategy including implementing the GP Forward View, or successor, through robust contractual arrangements with general practices and appropriate developmental support.
- To review and consider the aggregate position of agreed service specifications and contractual proposals for all NHS C&M commissioned services from primary care providers
- Develop outline framework/ expectations in regard to GMS, PMS and APMS contracts (including the oversight and monitoring of contracts, approving material contractual action such as removing a contract)
- Newly designed enhanced services
- Performance monitoring, oversight and assurance, on agreed schemes and services, and compliance to NHSE/I; escalating issues on to NHSE/I in line with first level Delegation
- Making recommendations related to alignment of decisions on 'discretionary' payment in Place (e.g., returner/retainer schemes).
- To co-ordinate a common approach to the commissioning and delivery of primary care services
- To manage the budget for commissioning of primary care services, including delegated rents and rates in line with Premises Directions.

4.2 Commissioning of Community Pharmacy

- Develop outline framework/ expectations in regard to Community Pharmacy – National requirements Core and Enhanced. Including associated budgets, quality assurance and all existing NHSEI functions.
- Local discretionary/ non-core schemes

4.3 Additional responsibilities

- The NHS C&M Primary Care Committee will also carry out the following activities:
- Support Primary Care development across Cheshire & Merseyside including oversight of:
- primary care networks (PCNs) ongoing development as the foundations of out-of-hospital care and building blocks of place-based partnerships
- Workforce, resilience and sustainability
- Maximisation of GP Contract opportunities such as ARRS (Additional roles) and QOF outcomes
- To plan, including needs assessment, for primary care services across Cheshire & Merseyside and to support planning at scale for primary care
- Oversight of the development of an integrated Estates programme across Cheshire & Merseyside

- To consolidate risk reviews of primary care services, aggregating findings and supporting solutions/ mitigations at places
- To ensure contract proposals achieve health improvement and value for money
- To oversee quality and safety of services delivered in primary care – receiving regular reports from the ICB Quality and Performance Committee and Finance, Investment and Our Resources Committee providing updates and assurance on primary care related quality, finance and performance issues
- Ensure that conflicts of interest have been mitigated in line with the NHS C&M Conflicts of Interest Policy, and all actions/ decisions involving consultation with Committee members or GPs will record any declarations of interest.
- Development of an integrated Estates programme at local level using flexibilities available through PCN arrangements, mixed estates with other partners, premises improvement grants and capital investment monies
- Ratifying time limited Place based recommendations related to this committee's remit or determining to 'call-in' such a recommendation and provide an alternative course of action

4.4 Risk Management

The Committee will ensure the appropriate management of risks in relation to primary care; receiving regular reporting of primary care related Corporate Risks, and relevant Board Assurance Framework (BAF) – these will include reference to relevant Place Delivery Assurance risks – both strategic and corporate as per NHS C&M Risk Management Strategy.

5. Membership & Attendance

5.1 Members

The membership shall consist of the following voting members:

- At least 1 ICB NED (Chair)
- At least 1 ICB Partner Member (1 to be the Deputy Chair)
- Assistant Chief Executive (or Deputy)
- Associate Director of Primary Care
- Representative from each of the recognised primary care professional groups in accordance with the remit of the Committee (i.e. general practice and community pharmacy)
- Director of Nursing
- Director of Finance
- Medical Director (or Associate Medical Director for Primary Care)
- Independent GP
- At least 2 Place Directors or designate

In attendance by invitation:

- Healthwatch nominated representative
- Public Health representative
- Local Medical Committee (LMC) representative
- Pharmaceutical Services Regulations Committee (PSRC) representative

All Committee members may appoint a deputy to represent them at meetings of the Committee. Committee members should inform the Chair of their intention to nominate a deputy to attend/act on their behalf and any such deputy should be suitably briefed and suitably qualified (in the case of clinical members).

The Committee may also request attendance by appropriate individuals to present agenda items and/or advise the Committee on particular issues.

5.2 Attendees

Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

Meetings of the Committee may also be attended by the following individuals who are not members of the Committee for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote.

The 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. Meetings

6.1 Leadership

The Committee is Chaired by an ICB NED.

6.2 Quorum

A meeting of the Committee is quorate if the following are present:

- At least five Committee members in total, including;
  - At least one NED or system Partner*
  - At least one Clinical Member*
  - At least two ICB Directors (or their nominated deputies).

**If regular members are not able to attend they should make arrangements for a representative to attend and act on their behalf.*

6.3 Decision-making and voting

Decisions should be taken in accordance with the financial delegation of the Executive Directors and directors present and/or any authority delegated to the committee by the ICB. These terms of reference will be reviewed against the ICB Scheme of Reservation and Delegation once that document is formally approved by the ICB.

The Committee will usually make decisions by consensus. Where this is not possible, the Chair may call a vote.

Only voting members, as identified in the “Membership” section of these terms of reference, may cast a vote.

A person attending a meeting as a representative of a Committee member shall have the same right to vote as the Committee member they are representing.

In accordance with ICB policy, no member (or representative) with a conflict of interest in an item of business will be allowed to vote on that item.

Where there is a split vote, with no clear majority, the Chair will have the casting vote.

6.4 Frequency

The Committee will normally meet in private.

The Committee will normally meet six times each year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

The Board, ICB Chair, Committee Chair, or Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want advice.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

6.5 Administrative Support

The Committee shall be supported with a secretariat function. Which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead
- Records of members' appointments and renewal dates are retained and the Board is prompted to renew membership and identify new members where necessary
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept
- The Chair is supported to prepare and deliver reports to the Board
- The Committee is updated on pertinent issues/ areas of interest/ policy developments; and
- Action points are taken forward between meetings.

6.6 Accountability and Reporting Arrangements

The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board.

The Committee will submit copies of its minutes and a key issues report to the ICB following each of its meetings. The Committee will also provide a key issues report to each of the place-based

primary care committees and will receive an equivalent report from each of the place-based primary care committees.

The Committee will receive regular key-issues reports from the Pharmaceutical Services Regulations Committee (PSRC).

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.

The outputs of the group may be reported to NHSE/I supporting assurance, awareness and interaction.

7. Behaviours & Conduct

Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

Members of, and those attending, the Committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

All members shall comply with the ICB's Managing Conflicts of Interest Policy at all times. In accordance with the ICB's policy on managing conflicts of interest, Committee members should:

- Inform the chair of any interests they hold which relate to the business of the Committee.
- Inform the chair of any previously agreed treatment of the potential conflict / conflict of interest.
- Abide by the chair's ruling on the treatment of conflicts / potential conflicts of interest in relation to ongoing involvement in the work of the Committee.
- Inform the chair of any conflicts / potential conflicts of interest in any item of business to be discussed at a meeting. This should be done in advance of the meeting wherever possible.
- Declare conflicts / potential conflicts of interest in any item of business to be discussed at a meeting under the standing "declaration of interest" item.
- Abide by the chair's decision on appropriate treatment of a conflicts / potential conflict of interest in any business to be discussed at a meeting.

As well as complying with requirements around declaring and managing potential conflicts of interest, Committee members should:

- Comply with the ICB's policies on standards of business conduct which include upholding the Nolan Principles of Public Life
- Attend meetings, having read all papers beforehand
- Arrange an appropriate deputy to attend on their behalf, if necessary
- Act as 'champions', disseminating information and good practice as appropriate
- Comply with the ICB's administrative arrangements to support the Committee around identifying agenda items for discussion, the submission of reports etc.

Equality diversity and inclusion
Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

8. Review

The Committee will review its effectiveness at least annually

These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

SCHEDULE 1 – DELEGATED FUNCTIONS

A. Decisions in relation to the commissioning, procurement and management of Primary Medical Services Contracts, including but not limited to the following activities:

   i. decisions in relation to Enhanced Services
   ii. decisions in relation to Local Incentive Schemes (including the design of such schemes)
   iii. decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices
   iv. decisions about 'discretionary' payments
   v. decisions about commissioning urgent care (including home visits as required) for out of area registered patients

B. The approval of practice mergers
C. Planning primary medical care services in the Area, including carrying out needs assessments
D. Undertaking reviews of primary medical care services in the Area
E. Decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list)
F. Management of the Delegated Funds in the Area
G. Premises Costs Directions functions
H. Co-ordinating a common approach to the commissioning of primary care services with other commissioners in the Area where appropriate; and
I. Such other ancillary activities as are necessary in order to exercise the Delegated Functions.

SCHEDULE 2 – RESERVED FUNCTIONS OF NHSE

A. Management of the national performers list
B. Management of the revalidation and appraisal process
C. Administration of payments in circumstances where a performer is suspended and related performers list management activities
D. Capital Expenditure functions
E. Public Health Section 7A functions under the NHS Act
F. Functions in relation to complaints management
G. Decisions in relation to the Prime Minister's Challenge Fund; and
H. Such other ancillary activities that are necessary in order to exercise the Reserved Functions

NHS
Cheshire and Merseyside

C&M ICB Transformation Committee

Terms of Reference

Document revision history

Date	Version	Revision	Comment	Author / Editor
XX	1.0	Initial ToRs		Ben Vinter

Review due
Xxx xxx 2022/3

1. Introduction

NHS C&M has been established 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 Transformation Committee (the "Committee") has been established in accordance with the NHS C&M constitution.

These terms of reference, which must be published on the NHS C&M website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the ICB.

The Committee is an executive led forum, with non-executive involvement and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of NHS C&M.

2. Role and Purpose

The Committee has been established to support NHS C&M in the delivery of its statutory duties and provide assurance to the Board in relation to the delivery of strategy in alignment of those duties. It shall:

- Provide a Board, Place and Provider Collaborative leadership forum to consider the development and implementation of the commissioning strategy and policy of the ICB securing continuous improvement of the quality of services
- Connect with and ensure alignment of system programmes as may be developed by any of the system's constituent parts: progammes reporting to the ICP (digital, population health), the collaborative, and place or the ICB boards.
- Connect with, refer issues for clinical consideration to and develop responses to actions or issues identified by the ICB's Clinical and Care Professional Advisory Council.
- Retain a focus on health inequalities and improved outcomes and ensure that the delivery of the ICB's strategic and operational plans are achieved within financial allocations
- Have delegated authority to make decisions within the limits as set out in the ICB's Schemes of Reservation and Delegation.

The Committee will also provide assurance to the ICB on the delivery of the following statutory duties:

- *Duty to commission certain specified health services*
- *Duty as to reducing inequalities*
- *Duty as to patient choice*
- *Duty to obtain appropriate advice*
- *Duty to promote innovation*
- *Duty in respect of research*
- *Duty to promote integration*
- *Duty as to public involvement and consultation (in accordance with ICB direction and potential Place implementation)*

In order to deliver this, the responsibilities of the Committee will include:

a) Overseeing the development and review of the ICB commissioning plan in response to the ICP's developed strategy,
b) Developing the ICB's operational commissioning plans and annual commissioning intentions on the advice of the Quality and Performance Committee (making recommendations to the ICB on their approval), supporting alignment of Place priorities at an aggregate level and engaging with partners including collaboratives of delivery potential.
c) Overseeing the development of work programmes that support the ICB's strategy and operational plans, including oversight of areas developing joint commissioning with partner organisations (and making recommendations to the ICB on their approval as required).
d) Overseeing the development and delivery of work programmes that support national, regional and system priorities, strategies and plans (and making recommendations to the ICB on their approval as required).
e) Receiving reports on contractual performance and financial management and escalating issues to the ICB as appropriate.
f) Receiving assurance on the ICBs' provider collaboratives' development processes.
g) Linking with the ICB's Specialised Commissioning arrangements and Primary Care Committees to ensure the system wide, population based approach is implemented to delegated NHSE functions
h) Overseeing the coordination and integration of services to support the delivery of effective, high quality, accessible services, including via an aggregated view ICB Better Care Fund implementation.
i) Ensuring that commissioning activities promote the health and wellbeing of communities as well as addressing health inequalities, prioritising investment / disinvestment and commissioning activities to ensure cost effective care is delivered; developing an evidence-based commissioning/decommissioning framework
j) Ensuring commissioning policies follow the principle of proportionate universalism with the ambition to reduce health inequalities and reduce avoidable mortality.
k) Ensuring that commissioning decisions are underpinned and informed by communications and engagement with the membership and local population as appropriate.
l) Ensuring linkages are made with the ICBs clinical and care professionals leadership council to ensure clinical connections and alignment with the remit of this group
m) Taking account of collaborative commissioning activities, including those of clinical networks, to ascertain if they will have wider contracting / financial implications for the ICB (for referral to the Finance Committee / ICB if appropriate).
n) Overseeing the rigorous and ongoing analytical review of the drivers of longer term system pressures, so that solutions to these pressures may be developed with a collaborative approach.
o) Overseeing and providing senior Board level sponsorship to programmes integral the social value contribution of the ICB:
    - VSFSE
    - Anchor institutions
    - Sustainability
    - Partnership initiatives
p) Making recommendations on investment and significant commissioning decisions to the ICB.

3. Authority

The Committee is authorised by the ICB to:

- Request further investigation or assurance on any area within its remit
- Bring matters to the attention of other committees to investigate or seek assurance where they fall within the remit of that committee
- Make recommendations to the ICB
- Escalate issues to the ICB
- Produce an annual work plan to discharge its responsibilities
- Approve the terms of reference of any sub-groups to the committee
- Delegate responsibility for specific aspects of its duties to sub-groups. The terms of reference of any subgroups shall be approved by the Committee.

For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference, other than the committee being permitted to meet in private.

4. Membership & Attendance

4.1 Members

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

Membership of the Committee may be drawn from the ICB: Board membership; ICB executive; supporting officers; wider partners in the wider health and social care system; other individuals / representatives as deemed appropriate.

The Committee members shall be:

- Non-Executive Director
- One of the Primary Medical Services ICB Partner Member
- Chair of the C&M Primary Care Leadership Group
- ICB Director of Nursing
- Associate Medical Director (Transformation)
- Executive Director of Finance or designate
- Assistant Chief Executive (Chair of the Committee)
- Two Place Directors
    - o one of whom will be the lead for the ICB on specialised commissioning
    - o one of whom will be an integrated ICB / LA appointment
- Local authority representative from public health or commissioning
- Local authority representative from DASS or DCS[1]
- Consultant in population health
- A representative from each of the C&M Provider Collaboratives

The ICB Chief Executive may attend as determined necessary.

[1] linked to place director nomination to ensure full coverage

All Committee members may appoint a deputy to represent them at meetings of the Committee. Committee members should inform the Chair of their intention to nominate a deputy to attend/act on their behalf and any such deputy should be suitably briefed and suitably qualified (in the case of clinical members).

The Committee may also request attendance by appropriate individuals to present agenda items and/or advise the Committee on particular issues.

4.2 Attendees

Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

Meetings of the Committee may also be attended by the following individuals who are not members of the Committee for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote.

The 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. Meetings

5.1 Leadership

The Committee shall be chaired by an executive. They will appoint a Deputy Chair.

If the Chair, or Deputy Chair, is unable to attend a meeting, they may designate an alternative ICB Member or ICB director to act as Chair.

If the Chair is unable to chair an item of business due to a conflict of interest, another member of the Committee will be asked to chair that item.

5.2 Quorum

A meeting of the Committee is quorate if the following are present:

- At least five Committee members in total;
- At least one NED or system Partner*
- At least one Clinical Member*
- At least two ICB Directors (or their nominated deputies).

**If regular members are not able to attend they should make arrangements for a representative to attend and act on their behalf.*

5.3 Decision-making and voting

Decisions should be taken in accordance with the financial delegation of the Executive Directors and directors present, in line with the NHS C&M Scheme of Reservation & Delegation.

The Committee will usually make decisions by consensus. Where this is not possible, the Chair may call a vote.

Only voting members, as identified in the "Membership" section of these terms of reference, may cast a vote.

A person attending a meeting as a representative of a Committee member shall have the same right to vote as the Committee member they are representing.

In accordance with paragraph 6, no member (or representative) with a conflict of interest in an item of business will be allowed to vote on that item.

Where there is a split vote, with no clear majority, the Chair will have the casting vote.

5.4 Frequency

The Committee will meet in private.

The Committee will normally meet six times each year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

The Board, Chair or Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want advice.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

5.5 Administrative Support

The Committee shall be supported with a secretariat function. Which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
- Records of members' appointments and renewal dates are retained and the Board is prompted to renew membership and identify new members where necessary;
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept;
- The Chair is supported to prepare and deliver reports to the Board;
- The Committee is updated on pertinent issues/ areas of interest/ policy developments; and
- Action points are taken forward between meetings.

5.6 Accountability and Reporting Arrangements

The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board.

The Committee will submit copies of its minutes and a report to the ICB following each of its meetings. Public reports will be made as appropriate to satisfy any requirements in relation to disclosure of public sector executive pay.

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.

6. Behaviours and Conduct

Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

Members of, and those attending, the Committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

All members shall comply with the ICB's Managing Conflicts of Interest Policy at all times. In accordance with the ICBs' policy on managing conflicts of interest, Committee members should:

- Inform the chair of any interests they hold which relate to the business of the Committee.
- Inform the chair of any previously agreed treatment of the potential conflict / conflict of interest.
- Abide by the chair's ruling on the treatment of conflicts / potential conflicts of interest in relation to ongoing involvement in the work of the Committee.
- Inform the chair of any conflicts / potential conflicts of interest in any item of business to be discussed at a meeting. This should be done in advance of the meeting wherever possible.
- Declare conflicts / potential conflicts of interest in any item of business to be discussed at a meeting under the standing "declaration of interest" item.
- Abide by the chair's decision on appropriate treatment of a conflicts / potential conflict of interest in any business to be discussed at a meeting.

As well as complying with requirements around declaring and managing potential conflicts of interest, Committee members should:

- Comply with the ICBs' policies on standards of business conduct which include upholding the Nolan Principles of Public Life
- Attend meetings, having read all papers beforehand
- Arrange an appropriate deputy to attend on their behalf, if necessary
- Act as 'champions', disseminating information and good practice as appropriate
- Comply with the ICBs' administrative arrangements to support the Committee around identifying agenda items for discussion, the submission of reports etc.

Equality diversity and inclusion
Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

7. Review

The Committee will review its effectiveness at least annually

These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

NHS
Cheshire and Merseyside

NHS C&M ICB Policies Approach and Governance

Cheshire and Merseyside
Integrated Care Board Meeting

Cheshire and Merseyside

Date of meeting:	01/07/2022
Agenda Item No:	ICB/22/**09**
Report title:	**NHS C&M ICB Policies Update**
Report Author & Contact Details:	Katherine Coleman, Programme Delivery Manager (katherine.coleman5@nhs.net)/ Ben Vinter, ICB Governance Lead (ben.vinter@nhs.net)
Report approved by:	Clare Watson, Assistant Chief Executive

Purpose and any action required	**Decision/ Approve** →	X	**Discussion/ Gain feedback** →		**Assurance** →		**Information/ To Note** →	

Committee/Advisory Group previously presented
ICB Transition Board

Executive Summary and key points for discussion

The ICB will, in time, form its own view on the polices it needs and with that its own policy framework and governance for review and adoption.

However on day one, 1 July 2022, the ICB will adopt a limited number of policies as it is required to do. It will also receive or inherit a number of policies from CCGs or with staff or other assets and liabilities it becomes responsible for from this point. Such a mixed picture and the need to determine the way forward and the governance for such a transition are perhaps inevitable in a change process of this size and complexity.

The change process referred to is governed by the ICB Transition Board. This Board is facilitated and supported by the Director of Transition and Transition team. Through oversight of a number of task and finish groups the Transition Team have supported the close down of CCGs and the stand-up of the ICB. In respect of policies the team have, unconnected to this point from the ICB executive team, formed a view on the optimal policy framework and prioritisation for development of an ICB policy framework.

The Transition Board recommended priortisation framework, described above, is set out at annex two and provides a guide which can inform the work and prioritisation of the ICB as it progresses its activities of policy review, development and adoption in this space.

The ICB needs to be aware of the policies it inherits and the way in which they may be categorised:

I. Those it has already overseen the development of and determined
   - Conflicts of interest and Standards of Business Conduct Policies and a, Strategy for Engaging People & Communities
   - SORD and related Standing Financial Instructions and received ICB Constitution

II.	Those which it has received, and which cannot be changed at this time i.e., Contractual HR policies (Pay Protection, Long Service and Special Leave) that must transfer with staff as per TUPE/COSOP legal requirements
III.	A framework provided by CCGs which it is proposed the ICB adopt in order to guide consistent practice across its geography so as to maximise consistency and efficiency. In this space the Transition Board has recognised and encouraged the adoption of Cheshire CCG policies as a result of their recent wholesale review, following merger, and therefore the relative high degree of assurance that the ICB can take from this situation
IV.	Those which have been developed by task and finish groups and which should be welcomed but which require review and adoption through appropriate ICB governance – in the interim they may exist and operate as appropriate subject matter expert / professional lead guidance notes or protocols for interim activity.
V.	Commissioning Policies - which are received by the ICB and subject to specific legal advice (see section 6) subject to a discreet ICB discussion that cannot be changed without consultation

Recommendation/ Action needed:	The Board is asked to: • **NOTE** the contractual HR policies that are to be transferred to the ICB alongside transferring employees from former organisations, in line with TUPE/COSOP requirements • **ENDORSE** the decision to adopt Cheshire CCG's policy suite as the ICB policy suite from 1 July 2022 • **AGREE** how the ICB would like to govern the process of policy review, development and adoption of its ICB policy framework and suite of policies moving forwards. Recommended course of action is delegation to the ICB Executive, who may establish a task and finish group, providing leadership and sponsorship with sign off via committees. • **NOTE** the ICB's intention and requirement, over time, to develop a single suite of commissioning policies, which will support application of equitable and consistent approaches across C&M.

Consideration for publication	
Meetings of the Integrated Care Board will be held in public and the associated papers will be published unless there are specific reasons as to why that should not be the case. This paper will therefore be deemed public unless any of the following criteria apply (please insert **'x'** as appropriate:	
The item involves sensitive HR issues	
The item contains commercially confidential issues	
Some other criteria. Please outline below:	

Which purpose(s) of an Integrated Care System does this report align with?	
Please insert **'x'** as appropriate:	
1. Improve population health and healthcare	X
2. Tackle health inequality, improving outcome and access to services	X
3. Enhancing quality, productivity and value for money	X

Cheshire and Merseyside
Integrated Care Board Meeting

Which purpose(s) of an Integrated Care System does this report align with?	
4. Helping the NHS to support broader social and economic development	

C&M ICB Priority report aligns with:	
Please insert **'x'** as appropriate:	
1. Delivering today	X
2. Recovery	
3. Getting Upstream	
4. Building systems for integration and collaboration	

Governance and Risk					
Does this report provide assurance against any of the risks identified in the Board Assurance Framework or any other corporate risk? (*please list*) N/A					
What level of assurance does it provide? N/A					
Limited		**Reasonable**		**Significant**	
Any other risks? ~~Yes~~ / No. If yes please identify within the body of the report.					
Is this report required under NHS guidance or for statutory purpose? (*please specify*) N/A					
Any Conflicts of Interest associated with this paper? If Yes please state what they are and any mitigations. N/A					
Any current services or roles that may be affected by issues within this paper? N/A					

Document Development	Process Undertaken	Yes	No	N/A	Comments (i.e. date, method, impact e.g. feedback used)
	Financial Assessment/ Evaluation			X	
	Patient / Public Engagement			X	
	Clinical Engagement			X	
	Equality Analysis (EA) - any adverse impacts identified?			X	
	Legal Advice needed?			X	
	Report History – has it been to other groups/ committee input/ oversight (Internal/External)	X			T&F Group oversight of all draft policies, reporting through to Transition Board. NED engagement of core governance policies.

Next Steps:	Implementation of recommended task and finish group approach
Responsible Officer to take forward actions:	Clare Watson, Assistant Chief Executive
Appendices:	N/A – Annexes included in report.

NHS C&M ICB Policies Approach and Governance

1. Executive Summary

The ICB will, in time, form its own view on the polices it needs and with that its own policy framework and governance for review and adoption.

However on day one, 1 July 2022, the ICB will adopt a limited number of policies as it is required to do. It will also receive or inherit a number of policies from CCGs or with staff or other assets and liabilities it becomes responsible for from this point. Such a mixed picture and the need to determine the way forward and the governance for such a transition are perhaps inevitable in a change process of this size and complexity.

The change process referred to is governed by the ICB Transition Board. This Board is facilitated and supported by the Director of Transition and Transition team. Through oversight of a number of task and finish groups the Transition Team have supported the close down of CCGs and the stand-up of the ICB. In respect of policies the team have, unconnected to this point from the ICB executive team, formed a view on the optimal policy framework and prioritisation for development of an ICB policy framework.

The Transition Board recommended prioritisation framework, described above, is set out at Annex 2 and provides a guide which can inform the work and prioritisation of the ICB as it progresses its activities of policy review, development and adoption in this space.

The ICB needs to be aware of the policies it inherits and the way in which they may be categorised:

VI. Those it has already overseen the development of and determined
- Conflicts of interest and Standards of Business Conduct Policies and a Strategy for Engaging People & Communities
- SORD and related Standing Financial Instructions and received ICB Constitution

VII. Those which it has received, and which cannot be changed at this time i.e., Contractual HR policies (Pay Protection, Long Service and Special Leave) that must transfer with staff as per TUPE/COSOP legal requirements

VIII. A framework provided by CCGs which it is proposed the ICB adopt in order to guide consistent practice across its geography so as to maximise consistency and efficiency. In this space the Transition Board has recognised and encouraged the adoption of Cheshire CCG policies as a result of their recent wholesale review, following merger, and therefore the relative high degree of assurance that the ICB can take from this situation

IX. Those which have been developed by task and finish groups and which should be welcomed but which require review and adoption through appropriate ICB governance – in the interim they may exist and operate as appropriate subject matter expert / professional lead guidance notes or protocols for interim activity.

X. Commissioning Policies - which are received by the ICB and subject to specific legal advice (see section 6) subject to a discreet ICB discussion that cannot be changed without consultation

2. Introduction

This report seeks to describe a proposed course of action both in relation to policies for adoption by the ICB upon its statutory commencement; and a proposal for how the ICB should govern and source support, review and development of its policy framework including the potential adoption of work that has been progressed by Task and Finish Groups on policies.

3. Policies

3.1 Core Constitutional Policies for adoption

The Shadow ICB Board has overseen the development of a set of core policies in relation to the ICB Constitution, drafted in conjunction with designate Executives of the ICB Board. They have also been engaged upon with the Chair and Non-Executive Directors of the Board. These are:

- Conflicts of interest, Standards of Business Conduct, Public Involvement and Framework for Engagement and Empowerment
- Standing Financial Instructions and related Scheme of Operational Reservation and Delegation

It is proposed that these are adopted or noted on 1st July 2021 by NHS C&M ICB.

3.2 Contractual HR Policies to be received by the ICB

The ICB are the receiver for circa 1200 staff from associated 'sender' organisations across Cheshire and Merseyside (CCG's, Alder Hey Children's Hospital NHS Trust and Liverpool University Hospitals NHS Foundation Trust).

As part of TUPE/COSOP guidance recommended within the HR Framework from NHSE/I which guides this transition, there is a legal requirement to identify and transfer any HR policies that are identified as 'contractual' i.e., tied to employee's terms and conditions for employment with their former employer. Where this is the case, these policies will be received by the ICB as part of the staff transfer and cannot be changed without consultation with affected employees.

A review was undertaken which identified three contractual policies which the ICB will receive on 1 July as described above. These are:

- Pay Protection
- Retirement and Long Service (Long Service element is contractual)
- Flexible Working and Special Leave (Special Leave element is contractual)

It is noteworthy that the policy content and terms within these policies are considered to be consistent across the former CCGs and that any proposed change to these will be progressed in conjunction with Staff Side representatives and consultation with C&M ICB employees. Policies are attached to the employee and their last employing organisation.

All other HR policies are considered to be non-contractually tied meaning staff will be managed in accordance with the policies in the ICB HR Management suite, once these are formally endorsed.

4. CCG Policy Framework

Upon its establishment the ICB are recommended to adopt a policy framework to enable the organisation to operate effectively and in equitable manner across Cheshire and Merseyside. The recommendation from the Transition Programme is that the most pragmatic approach for the ICB is to adopt an interim policy framework from one CCG, supporting consistency and clarity across the system while a governance process to support review and adoption of a new policy suite is implemented.

The Transition Board has recommended the use of Cheshire CCG's policy framework and suite of policies as they were reviewed in their entirety due to their recent merger from 4 discreet Cheshire CCGs, until such time that the ICB seeks to further refine and implement its requirements including a significant amount of work progressed by Task and Finish Groups to develop a suite of draft policies for consideration. It is wholeheartedly acknowledged that there are multiple examples of CCGs' policies containing valuable and good practice, but that the proposed step recognises and responds to the immediate requirement for a single ICB policy framework which can be further refined and reflect wide best practice and CCG experience at the appropriate time.

The Board can and should take a relatively high degree of assurance that the proposed use of the Cheshire policy suite are operationally fit for purpose to sustain the operations of the ICB initially, subject to further development in 2022/23. Therefore – if endorsed as an approach - Policy references to Cheshire CCG should be assumed and read going forward as relating to the C&M ICB, comparable executive portfolios will relate to the relevant ICB Director portfolio and Governing Body equates to the ICB.

A summary of the current Cheshire CCG policy suite for adoption is provided in Annex 1.

5. Transition Programme Task and Finish Group draft policy development

The Transition Board and associated Task and Finish Groups, have proposed a draft target policy areas with recommended phases for review and implementation of policies, which can be used to guide the work of the proposed Policy Task and Finish Group subject to confirmation by the ICB Board. The target policy areas have been categorised into three phases of development and review.

These recommended considerations are in many areas accompanied by draft reviewed and proposed policies which can be adopted subject to agreement of the relevant governance process and sponsorship by the relevant ICB lead. In the interim their content may provide valuable supplementary operational guidance. To this point, these drafts have been developed utilising a combination of: formal and information guidance from NHSE/I, review of existing CCG policies for good practice and subject matter expertise within task and finish groups. These policies remain in draft due to the requirement to now seek formal endorsement of an approach and thereafter agreement under an appropriate ICB governance mechanisms.

The draft policy areas and phasing are noted in Annex 2 – and may be used as a target policy framework and guide by the Task and Finish Group if this recommended approach is adopted.

6. Commissioning policies

As the successor body to the 9 former Clinical Commissioning Groups (CCGs) within Cheshire & Merseyside, the ICB inherits the clinical commissioning policies of each CCG through the national transfer order.

A review of these policies identified a degree of variation between a small number of CCG commissioning policies. The ICB formally acknowledges the position and, noting the public law test, we will be reasonable and rational in setting out the actions we will take to remedy the position.

The ICB intends to promote equity and equality through all our practices and reduce and mitigate any risk in significant variation or inequity across Cheshire and Merseyside over time. These values will guide our future thinking.

Overtime the ICB is required to have commissioning policies that set out what services are available for the ICB's population as a whole and which are based on eligibility criteria.

The ICB will publish a statement on its website (www.cheshireandmerseyside.nhs.uk) acknowledging the situation it has inherited, the action it is taking to remedy the situation and the interim arrangements to be operated while a formal review process is undertaken. The ICB will follow this legal advice.

7. Summary

In conclusion, the Board are asked to note the recommendations and supporting narrative within the report which has described the position in relation to policies.

Noting that there are a number of policies which have been inherited from CCGs and former employing organisations of transferring staff and a proposal to adopt the Cheshire CCG policy

framework as the ICB's interim framework. Proposed governance to support ICB decision making and a target guide framework has also been referenced.

8. Recommendations

The Board is asked to:

- **NOTE** the contractual HR policies that are to be transferred to the ICB alongside transferring employees from former organisations, in line with TUPE/COSOP requirements
- **ENDORSE** the decision to adopt Cheshire CCG's policy suite as the ICB policy suite from 1 July 2022
- **AGREE** how the ICB would like to govern the process of policy review, development and adoption of its ICB policy framework and suite of policies moving forwards. Recommended course of action is delegation to the ICB Executive, who may establish a task and finish group, providing leadership and sponsorship with sign off via committees
- **NOTE** the ICB's intention and requirement, over time, to develop a single suite of commissioning policies, which will support application of equitable and consistent approaches across C&M.

Annex 1

Cheshire CCG Policy Framework – proposed for adoption on 1 July 2022

FIN-002	Commissioning Decision Policy	Finance
FIN-003	Procurement Policy	Finance
FIN-004	Off Payroll Worker Policy	Finance
GOV-001	Agenda for Change (AfC) Rebanding	Corporate / HR
GOV-002	Alcohol & Substance Misuse Policy	Corporate / HR
GOV-003	Annual Leave Policy	Corporate / HR
GOV-004	Anti-Fraud, Bribery & Corruption Policy	Governance
GOV-006	Freedom of Information Policy	Information Governance
GOV-007	Human Rights Policy	Corporate / HR
GOV-008	Whistleblowing Policy	Corporate / HR
GOV-009	Subject Access Request (SAR) Policy	Information Governance
GOV-010	Shared Parental Leave Policy	Corporate / HR
GOV-011	Staff Volunteering Policy	Corporate / HR
GOV-012	Family Leave Policy	Corporate / HR
GOV-013	Work Experience	Corporate / HR
GOV-014	Travel and Expenses Policy	Corporate / HR
GOV-015	Recruitment and Selection Policy	Corporate / HR
GOV-016	Learning and Development Policy	Corporate / HR
GOV-017	Bullying and Harrassment Policy	Corporate / HR
GOV-018	Attendance Management Policy	Corporate / HR
GOV-019	Career Break Policy	Corporate / HR
GOV-020	Professional Registration Policy	Corporate / HR
GOV-021	Retirement Policy	Corporate / HR
GOV-022	Disciplinary Policy	Corporate / HR
GOV-023	Grievance and Disputes Policy	Corporate / HR
GOV-024	Corporate Records Management and Retention	Corporate / HR
GOV-026	Management of Organisational Change	Corporate / HR
GOV-027	Social Media Policy	Corporate / HR
GOV-028	Staff Secondment Policy	Corporate / HR
GOV-029	Performance Management Policy	Corporate / HR
GOV-030	Lone Worker Policy	Corporate / HR
GOV-031	Sponsorship Policy	Governance
GOV-032	Pay Protection Policy[1]	Corporate / HR
GOV-033	Other Leave Policy	Corporate / HR
GOV-034	PDR and Pay Progression Policy & Procedure	Corporate / HR

[1] Noting that staff transferring into the ICB will be managed in line with former Pay Protection policies as per section 3.2

GOV-035	Job Matching and Rebanding Policy	Corporate / HR
GOV-036	IG Handbook	Information Governance
GOV-037	IG Staff Code of Conduct	Information Governance
Q&S-001	Safeguarding Adults Policy	Safeguarding
Q&S-002	Claims Management Policy	Quality
Q&S-003	Commissioned Service Standards for Safeguarding Children / Looked After Children and Adults at Risk Policy	Safeguarding
Q&S-004	Safeguarding Children Policy	Safeguarding
Q&S-005	Complaints, Compliments, Patient Advice & Liaison Service (PALS) Policy	Quality
Q&S-006	Managing Safeguarding Allegations Against Staff Policy and Procedures	Safeguarding
Q&S-007	Safeguarding Children Training Strategy Policy	Safeguarding

Annex 2

Transition Programme Proposed Policy Areas and Suggested Phasing

There are a total of 102 policy areas recommended by the Transition Board for consideration for inclusion in the ICB Policy suite (note this does not include commissioning policies). These have been risk assessed into three phases for review and endorsement by the ICB Board.

Please see below the Transition Boards recommended ICB policy areas and suggested phasing. These cover similar policy themes to the ones outlined above in Appendix 1, such as: Governance, Corporate and Quality.

Theme	Phase 1	Phase 2	Phase 3	Unspecified	Total
Corporate	31	9	18	1	58
Governance	10	2	8	7	27
Quality	8	1	0	6	15
Unspecified					2