NHS Gloucestershire Integrated Care Board

Governance Handbook

v1.0

1st July 2022

Contents

Version Control

Version	Date	Author	Review	Type of changes
1.0	01/07/2022	Dan Corfield	As needed	First version collated for ICB commencement 1st July 2022

Introduction and Governance Framework

1. This Governance Handbook brings together key documents which support our Constitution and best practise governance.

2. The Governance Handbook provides further detail on how the Integrated Care Board (ICB) will operate. It is a 'living document' to be updated regularly as new policies are approved and new structures and processes are implemented. On authorisation of the ICB this includes:
    - An overview of the governance framework, including the composition of the board and its statutory committees;
    - The *Scheme of Reservation and Delegation*, which sets out those decisions that are reserved for the membership as a whole and those decisions that have been delegated by the ICB or board;
    - Standing Financial Instructions, setting out the arrangements for managing the ICB's financial affairs;
    - Terms of Reference for committees of the board, and any committees held jointly with partner organisations;
    - Key policy documents, notably Standards of Business Conduct and Managing Conflicts of Interest Policy.

3. Amendments to the documents that make up the Governance Handbook are approved by the ICB board with some exceptions set out in the Scheme of Reservation and Delegation.

4. Good corporate governance is central to the work of the ICB and to its management structure and organisation. Through collaborative working with our system partners, involvement and engagement with our local population and contractual and performance management, the ICB will ensure that the highest standards of public service management are observed throughout the local health and care system.

5. With respect to the ICB itself, the board has instituted a governance structure, which meets both its statutory responsibilities and is also in accordance with the following:
    - Nolan Principles of Public Life;
    - The principles set out by the Independent Commission for Good Governance in Public Service;
    - The seven key principles of the NHS Constitution;
    - Relevant legislation such as The Equality Act 2010 and guidance such as Managing Conflicts of Interest in the NHS;
    - The standards set out in the Professional Standard Authority's guidance

6. The key features of the governance framework are:
    - The establishment and regular review of the governance arrangements by the board;
    - The responsibility of the board for setting the overall strategic direction of the ICB and for monitoring performance;
    - The role of clinical and non-clinical leaders in the board and its committees;
    - The oversight of the work by the Executive Directors through the regular reporting of their decisions;
    - The delegation of the operational management responsibilities of the ICB to the Executive Directors and their teams.

Scheme of Reservation and Delegation (SoRD)

1. Background

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

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

1.2. The Integrated Care Board 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.

1.3. ICBs are statutory bodies and as such their powers, functions and duties are conferred, in the main, by legislation. Additional responsibilities for other functions may be conferred through delegation to the ICB from other bodies (such as NHS England and NHS Improvement).

1.4. ICBs are able to delegate to a committee or sub-committee of the board, or to an individual member of the board or an employee. The legislation gives the ICB board flexibility to appoint to ICB committees and sub-committees members who are neither ICB employees nor board members. In addition, ICBS' have the power to agree with specified other statutory organisations (NHS trusts/foundation trusts, local authorities) that they will exercise their functions on behalf of the ICB or jointly with the ICB.

1.5. This Scheme of Reservation and Delegation (SoRD) sets out those decisions that are reserved to the ICB Board and those decisions that have been delegated to ICB Committees, individuals, joint committees and other statutory organisations.

2. Background	Reference
The power to obtain information from the ICB and intervene where 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 it will fail to do so.	S 14Z58 of NHS Act 2006 and s.14Z59).[1] Constitution 1.4.8
Approval of the ICB Constitution and any changes made to it; changes to the ICB constitution will not be implemented until, and are only effective from, the date of approval	Constitution 1.5.1 1.5.3
Variation of the ICB Constitution other than on application by the ICB;	para 15 Schedule 1B NHS Act 2006 Constitution 1.6.1b
Appointment of the ICB Chair, with approval of the Secretary of State	Constitution 3.3.1
Removal of the ICB Chair, subject to the approval of the Secretary of State	Constitution 3.13.4
Terminate the appointment of the Chief Executive and direct the Chair as to the appointment of a replacement where NHSE is satisfied that the ICB is failing or has failed to discharge any of its functions or there is a significant risk that the ICB will fail to do so	Constitution 3.13.6
Remuneration of ICB Chair	Constitution 3.14.1

[1] To update with the Health Bill amendment of the 2006 Act to confer on ICBs the functions of primary care commissioning.

3. Decisions and functions reserved to the ICB Board	Reference
Consideration and approval of applications to NHS England on any matter concerning changes to the ICB's Constitution, including the Standing Orders	s14Z25 (5) and s1B NHS Act (2006) constitution 1.6.1a, 1.6.3
Make arrangements to publish the ICB Constitution	Constitution s1.4.4 s. 14Z29 NHS Act (2006).
Approve arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.	s14Z34 NHS Act (2006) Constitution 1.4.5, 1.4.7, 4.2.1, 4.2.2
Formal review of the ICB Constitution at the end of year three of the ICB's establishment.	Constitution 1.6.2
Approval of the Partner Role Profiles, Nominations & Appointment process	Constitution 3.5.4
Appointment of the Board of the ICB	Constitution s2.1.4 para 3 of Sch 1B 2006 Act
Appointment of the ICB Independent Non-Executive Members	Constitution 3.11.1
Comply with directions and guidance issued by Secretary of State for Health and Social Care, NHS England; and have regard to statutory guidance including that issued by NHS England;	Constitution 4.2.1 (a, b, c, d)
Respond to reports and recommendations made by local Healthwatch organisations within the ICB area	Constitution 4.2.1 (f)

3. Decisions and functions reserved to the ICB Board	Reference
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	Constitution 4.3.2
Under section 75 of the 2006 Act, the ICB may enter partnership arrangements with a local authority including the establishment of the ICB and local authority pooled fund	Constitution 4.3.2 s. 65Z5 Health Act (2006)
Accountable for exercising its statutory functions and may grant authority to act on its behalf to: • any of its members or employees • a committee or sub-committee of the ICB	Constitution 4.3.1
Approve the SoRD and any amendments to the SoRD, which sets out: • those functions that are reserved to the board; • those functions that have been delegated to an individual or to committees and sub committees; • those functions delegated to another body or to be exercised jointly with another body, under section 65Z5 and 65Z6 of the 2006 Act	Constitution 4.4.2 & 4.4.3 s. 65Z5 and 65Z6 of the 2006 Act.
Determines the overarching vision of the ICB, the principles for working collaboratively and the joint system plan	(*New section 14Z50 of the Act refers.)*
Approve Functions and Decisions Map	Constitution 4.5.1
Establish Terms of Reference and reporting arrangements for all Committees of the Board	Constitution 4.6.3
Approval of amendments and changes to committee ToRs	Constitution 4.6.3 (c)

3. Decisions and functions reserved to the ICB Board	Reference
Receive reports from committees of the ICB including those which the ICB is required by its Constitution, or by NHS England, or the Secretary of State or by any other legislation, regulations, directions or guidance to establish and to take appropriate action	Constitution 4.6
Confirm the recommendations of committees where committees do not have executive powers	Constitution 4.6
Appoint and dismiss committees of the ICB that are directly responsible to the Board	Constitution 4.6.1
Enter into strategic or other transformation discussions with its partner organisations on an informal basis.	Constitution 4.7.5
Approve Standing Financial Instructions (SFIs)	SFIs 1.1.1 Constitution 5.2
Approve all disposals of property and/or land	SFIs 12
Approval of the arrangements for discharging the ICB's statutory financial duties.	constitution 5.2
Make arrangements for Registers of Interests to be maintained and published to: • Members of the ICB; • Members of the Board's committees and sub-committees; • Its employees.	s14Z30 NHS Act (2006) Constitution s6.3
Approve the Standards of Business Conduct Policy including the Conflicts of Interests Policy	Constitution 6.1.2
Comply with the ICB policy on conflicts of interest in line with their terms of office and/ or employment.	Constitution 6.1.3, 6.4.1
Approve the appointment of the Chair of the Audit Committee to be the Conflicts of Interests Guardian	Constitution 6.1.6

3. Decisions and functions reserved to the ICB Board	Reference
Approval of the annual NHSEI performance assessment of the ICB	Constitution 1.4.6
Approval of the ICB Long Term Plan and annual operational plan, including financial plans	Constitution 7.3.8
Approval of the ICB's Annual Report and Accounts	Constitution 7.5
Approve any urgent decisions taken by the Chair of the ICB Board for ratification in public session	SO s4.9.4 – 4.9.7
Approval of the arrangements for discharging the ICB's statutory duties associated with its commissioning functions, including but not limited to promoting the involvement of each patient, patient choice, reducing inequalities, improvement in the quality of services, obtaining appropriate advice and public engagement and consultation.	Constitution 1.4.5, 1.4.7, 4.2.1, 4.2.2
Approval of a comprehensive system of internal control, including budgetary control, that underpins the effective, efficient and economic operation of the ICB.	Constitution 4.2.2
Approval of the ICB's corporate budgets that meet the ICB's financial duties	Constitution 4.2.2
The exercise of Delegated Functions to empower the ICB to commission a range of primary care services for the people of Gloucestershire as described in the Delegation Agreement and delegated by NHS England to the ICB	S65Z5 NHS Act 2006 Delegation Agreement (ref) Delegation Agreement (ref.)
Establish effective, safe, efficient, and economic arrangements for the discharge of Delegated Functions	S65Z5 NHS Act 2006 Delegation Agreement (ref)

3. Decisions and functions reserved to the ICB Board	Reference
Develop an operational scheme of delegation defining those individuals or groups of individuals, including committees, who may discharge aspects of the Delegated Functions (this may be included in this Scheme of Reservation and Delegation) and determining the arrangements for the exercise of the Delegation Functions	S65Z5 NHS Act 2006 Delegation Agreement (ref.)
Ensuring the ICB compliance with the NHS Provider Selection Regime including approval of the ICB's Procurement Policy	Constitution 7.4.3
The ICB will comply with local authority Health Overview and Scrutiny requirements	Constitution 7.4.4
Effective discharge of legal duties in respect of initiatives that promote equality and address health inequalities.	Constitution Equality Act (2021)
Approve arrangements for handling complaints and ensuring publication of the process	Constitution 7.3.4
Approve arrangements for handling Freedom of Information requests.	Constitution 7.3.5
Approve arrangements for contributing to and working with agencies responsible for safeguarding for children's, adults and carers.	Constitution 1.4.5 Children Acts 1989 and 2004, and the Children and Families Act (2014); Adult safeguarding and carers (the Care Act 2014);
Receipt and approval a report showing the total allocations received and their proposed distribution including any sums to be held in reserve; and receive updates on significant changes to the initial allocation and the uses of such funds.	SFIs 3.2.1

3. Decisions and functions reserved to the ICB Board	Reference
Receive and review the Annual safeguarding report of safeguarding and the annual children in care report	Constitution 1.4.5
Decision to join the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes.	SFIs 14.1.4
Approve plans for public consultation in relation to service changes and reconfiguration	Constitution 1.4.7 section 14Z44
Approve Strategy for Public Involvement and Engagement – called Working with People & Communities	Constitution 1.7.3
Approve the ICB's People and OD Strategy	People Committee ToR
Approve the ICB Health & Safety Policy	Committee ToR
Approve the arrangements for discharging the ICB's statutory duties as an employer, including Human Resource and employment policies	Constitution 8
Approve any urgent decision taken by the Chair / CEO or relevant lead director in the case of committees) for ratification in public session	Standing Orders 4.9.5
Make arrangements for Board meetings to be held in public are enacted	Standing Orders 7.3.1
The joint committee for the ICB's area called the Integrated Care Partnership shall be established by the ICB and GCC the responsible local authority whose area coincides with or falls wholly or partly within the ICB's area	Interim guidance on functions and governance of the ICB

3. Decisions and functions reserved to the ICB Board	Reference
Make arrangements for partners across the ICS to develop arrangements for ensuring that the Integrated Care Partnership (ICP) and locality-based partnerships have representation from local people and communities in priority-setting and decision-making forums.	Constitution 9.1.5
Make arrangements with Gloucestershire County Council (GCC) to develop Gloucestershire NHS Integrated Care Strategy for its whole population using the best available evidence and data, covering health and social care (both children's and adult's social care), and addressing health inequalities and the wider determinants which drive these inequalities.	Interim guidance on functions and governance of the ICB
To have due regard to the ICP's - Gloucestershire NHS Integrated Care Strategy for its whole population	Interim guidance on functions and governance of the ICB

4. Decisions and functions reserved to the ICB Chair	Reference
Appointment of the Chief Executive	Constitution 3.4
Assessment, selection, and appointment of partner members is subject to the approval of the Chair	Constitution 3.5 - 3.7 inclusive
Appointment of the ICB Vice-Chair from one of the five independent Non-Executive Members	Constitution 3.11.1
Approval of appointment of the Independent Non-Executive Members	Constitution 3.11.2
Subject to satisfactory appraisal the Chair may approve the re-appointment of an independent non-executive member up to the maximum number of terms permitted for their role	Constitution 3.11.7
Approval of appointment of the Chief Medical Officer	Constitution 3.8

4. Decisions and functions reserved to the ICB Chair	Reference
Approval of appointment of the Chief Nursing Officer	Constitution 3.9
Approval of appointment of the Chief Finance Officer	Constitution 3.10
Approval of appointment of the Director of People, Culture and Engagement	Constitution 3.12.4
Approval of the appointment of the Director of Strategy and Transformation	Constitution 3.12.4
Approve the membership of commissioning boards, committees etc	Constitution 4.6.6
Authority to suspend Standing Orders with agreement of two other board members	Standing Orders 5.1
Authority to veto membership of commissioning boards / committees where the independence of the NHS is compromised.	Constitution 4.6.6

5. Decisions and functions delegated by the Board to the ICB Committees

5.1. Decisions and functions delegated by the Board to the ICB Audit Committee	Reference
To review the adequacy and effectiveness of the system of integrated governance, risk management and internal control across the whole of the ICB's activities that support the achievement of its objectives, and to highlight any areas of weakness to the Board	Committee Terms of Reference 7
To agree the risk management framework, policies and procedures ensuring that the risk management structure and processes within the ICB are robust and effective	SFIs 2.3 Committee Terms of Reference 7
Review 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.	Committee Terms of Reference 7 SFIs 2.3
Establish an auditor panel as a sub group to ensure the contract arrangements, including the procurement and selection, with the External Auditors is appropriate	Committee Terms of Reference SFIs
Internal audit services provided under arrangements proposed by the chief financial officer are approved by the Audit and Risk Assurance Committee, on behalf of the ICB board	SFIs 10.1.2
Endorse and recommend the ICB internal audit charter and annual audit plan, to the ICB board	SFIs 10.1.4

5.1. Decisions and functions delegated by the Board to the ICB Audit Committee	Reference
Ensure there is an effective internal audit function including; costs of audit services, performance of service, review and approval of the annual internal audit plan, the findings of audit work including the Head of Internal Audit Opinion and management responses to these, adequate resourcing of the function.	SFIs 10.1
Review the work and findings of the External Auditor and management responses	SFIs 10.2
Review schedules of losses and compensations and make recommendations to the Board	SFIs 11.1.5
Review the annual report and financial statements prior to submission to the Board	SFIs 2.3
To be assured that the ICB has adequate arrangements in place for the 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.	Committee Terms of Reference 7
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.	Committee Terms of Reference 7
To provide assurance to the Board that there is an effective framework in place for the management of Information Governance within the ICB including risks associated with information governance	Committee Terms of Reference 7
To monitor the integrity of financial statements of the ICB and any formal announcements relating to its financial performance, ensure systems for financial reporting to the Board are subject to review	Committee Terms of Reference 7
To be assured that the ICB has adequate arrangements for the management of declared interests and conflicts of interest, including gifts and hospitality	Committee Terms of Reference 7

5.2. Decisions and functions delegated by the Board to the ICB Remuneration Committee	Reference
Determine all aspects of remuneration for the Chief Executive, Directors and other Very Senior Managers including but not limited to salary, (including any performance-related elements) bonuses, pensions and cars	17 to 19 of Schedule 1B NHS Act 2006 s3.13.1 Constitution Committee Terms of Reference 7
Determine arrangements for termination of employment and other contractual terms and non-contractual terms for the Chief Executive, Directors and other Very Senior Managers	17 to 19 of Schedule 1B NHS Act 2006 s3.13.1 Constitution Committee Terms of Reference 7
Determine all aspects of remuneration for the Independent Non-Executive members of the ICB Board	17 to 19 of Schedule 1B NHS Act 2006 s3.13.1 Constitution Committee Terms of Reference 7
Determine the ICB pay policy for all staff	17 to 19 of Schedule 1B NHS Act 2006 Committee Terms of Reference 7
Setting any allowances for members of committees and sub-committees of the ICB who are not members of the Board	Committee Terms of Reference 7
Oversee contractual arrangements for all staff	17 to 19 of Schedule 1B NHS Act 2006 Committee Terms of Reference 7
Determine arrangements for termination payments and any special payments for all staff	17 to 19 of Schedule 1B NHS Act 2006 Committee Terms of Reference 7

5.3. Decisions and functions delegated by the Board to the ICB System Resources Committee	Reference
Committee will contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board for matters relating to system resources allocation, performance against strategic plans and strategic financial performance: • Efficiency, outcomes and value for money in the use of resources across the ICB footprint • Financial performance of the ICB • Financial performance of NHS organisations within the ICB footprint	Committee Terms of Reference 2
To agree key outcomes of the ICB financial strategy	Committee Terms of Reference 7
To agree the strategic financial framework of the ICB and monitor performance against it.	Committee Terms of Reference 7
Oversee the development of an approach with partners, including the ICB health and care partnership, to ensure the relationship between cost, performance, quality and environment sustainability are understood	Committee Terms of Reference 7

5.4. Decisions and functions delegated by the Board to the ICB Quality Committee	Reference
Develop and recommend to the ICB Board the key outcomes, quality and performance priorities to be included within the ICB strategy/ annual plan, including priorities to address variation/ inequalities in care	Committee terms of reference 7
Have oversight of and approve the Terms of Reference and work programmes for the groups reporting into the Quality Committee	Committee terms of reference 7

5.4. Decisions and functions delegated by the Board to the ICB Quality Committee	Reference
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;	Committee terms of reference 7
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	Committee terms of reference 7
Make arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.	Committee terms of reference 7
Cooperate with the Health Service Safety Investigations Body (HSSIB) when carrying out an investigation into the same or related incident, must cooperate with each other regarding practical arrangements for coordinating those investigations	Committee terms of reference 7
Make arrangements for Business Continuity & Emergency Planning	Committee terms of reference 7
Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities: • Infection control; • Medicines optimisation and safety; • Equality and diversity as it applies to people drawing on services.	Committee terms of reference 7
Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children	Committee terms of reference 7
Make arrangements for the handling of complaints	Committee terms of reference 7

5.5. Decisions and functions delegated by the Board to the ICB People Committee	Reference
Oversee the development of the people strategy, ensuring it remains current and relevant to the people drivers and requirements of the One Gloucestershire Integrated Care System	Committee terms of reference 7
Hold the People Board to account for delivering the People Strategy and its impact in the One Gloucestershire Integrated Care System, including the external reporting requirements contained within the System Oversight Framework	Committee terms of reference 7
Ensure that the ICB has well defined system EDI objectives, underpinned by strategic plans, measures and reporting arrangements that strengthen accountability and progress	Committee terms of reference 7
Oversee the strategic approach to developing system leaders, shaping culture, and facilitating behaviour change within the system, creating an environment for success	Committee terms of reference 7
Make arrangements for discharging the ICB's statutory duties as an employer, including Human Resources policies	Committee terms of reference 7

5.6. Decisions and functions delegated by the Board to the ICB Primary Care & Direct Commissioning Committee	Reference
Decisions in relation to the commissioning, management, planning (including carrying out needs assessments), and undertaking reviews, of Primary Medical Services and other ancillary activities that are necessary to exercise the delegated functions	Delegation Agreement 2015 (2A inclusive) Committee Terms of Reference 9

5.6. Decisions and functions delegated by the Board to the ICB Primary Care & Direct Commissioning Committee	Reference
The management of Delegated Funds in relation to Primary Medical Services	Delegation Agreement 2015 (2A inclusive) Committee Terms of Reference 9
Co-ordinating a common approach to the commissioning and delivery of Primary Medical Services with other health and social care bodies	Delegation Agreement 2015 (2A inclusive) Committee Terms of Reference 9
The award of GMS, PMS and APMS contracts. This includes: the design of PMS and APMS contracts; and monitoring of contracts;	Delegation Agreement 2015 (2A inclusive) Committee Terms of Reference 9
Ensure action is taken related to issuing breach/remedial notices and removing a contract where there breaches occur.	Delegation Agreement 2015 (2A inclusive) Committee Terms of Reference 9
Design and commission Enhanced Services, including re-commissioning of services (in line with the ICB SFIs (put in reference)	Delegation Agreement 2015 (2A inclusive) Committee Terms of Reference 9
Design and offer Local Incentive Schemes for Primary Medical Services providers (in line with the ICB SFIs (put in reference)	Delegation Agreement 2015 (2A inclusive) Committee Terms of Reference
Make decisions on discretionary payments or support	Delegation Agreement 2015 (2A inclusive) Committee Terms of Reference 9

5.6. Decisions and functions delegated by the Board to the ICB Primary Care & Direct Commissioning Committee	Reference
Making decision regarding local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);	Delegation Agreement 2015 (2A inclusive) Committee Terms of Reference 9
Plan and manage Primary Care Networks	Delegation Agreement 2015 (2A inclusive) Committee Terms of Reference 9
Approve Primary Medical Services provider mergers and closures	Delegation Agreement 2015 (2A inclusive) Committee Terms of Reference 9
Make decisions in relation to the Premises Costs Directions Function	Delegation Agreement 2015 (2A inclusive) Committee Terms of Reference 9 SFIs
Make procurement decisions relevant to the exercise of the Delegated Functions in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issues and updated by NHS England and in line with ICB SFIs	Delegation Agreement 2015 (2A inclusive) Terms of Reference 9
Agreeing arrangements for the delivery of Essential Services, Advance Services, and Enhanced Services across the ICB footprint	Delegati Committee Terms of Reference 9on Agreement 2015 (2A inclusive)

5.6. Decisions and functions delegated by the Board to the ICB Primary Care & Direct Commissioning Committee	Reference
Duty to consult with Local Medical Committees and other stakeholders in accordance with the duty of public involvement and consultation under section 14Z2 of the NHS Act;	Delegation Agreement Schedule (2A inclusive) Committee Terms of Reference 1.3
Approving consultations with patients, the public and other stakeholders to the extent required by the duty of public involvement and consultation under section 14Z2of the NHS Act 2006	Delegation Agreement Schedule (2A inclusive) Committee Terms of Reference 1.3
Committee shall report on and make recommendations to the ICB on the following: • Primary medical care strategy for Gloucestershire; • Planning primary medical care services in Gloucestershire (including needs assessment).	Committee Terms of Reference 9
The Committee will at the point of delegation of services related to community dentistry, pharmacy and optometry to the ICB, review its terms of reference and include these services within its committee remit.	Committee Terms of Reference 2.1.2
To publish information about such matters as may be prescribed in relation to primary medical services (including primary dental services, primary pharmacy and ophthalmic services, when delegated)	Delegation Agreement Schedule (2A inclusive)

6. Decisions and functions delegated to individual board members and employees		
Individual	**Decisions and functions delegated to the individual**	**Reference**
Chief Executive Officer	Convening a panel to advise on the appointment of ICB Board partner members	Constitution 3.5 - 3.7 inc
Chief Executive Officer	Appoint the Chief Medical Officer	Constitution 3.8.3
Chief Executive Officer	Appoint the Chief Nursing Officer	Constitution 3.9.3
Chief Executive Officer	Appoint the Chief Finance Officer	Constitution 3.10.3
Chief Executive Officer	Appoint the Director of People, Culture and Engagement	Constitution 3.12.1
Chief Executive Officer	Appoint the Director of Strategy and Transformation	Constitution 3.12.1
Chief Executive Officer	Ensure that lists of all contractors, for which the ICB is responsible, are maintained in an up to date condition; ensure that systems are in place to deal with applications, resignations, inspection of premises, etc., within the appropriate contractor's terms and conditions of service	SFIs 16.1.2
Director of People, Culture & Engagement	Ensures the ICB complies with Health and Safety laws and regulations.	Health & Safety at Work Act (1974); (2004)
Chief Nursing Officer	The CNO is designated the Accountable Emergency Officer	Quality Committee ToR
Chief Executive Officer	CEO is the accountable officer for the ICB and is personally accountable to NHS England for the stewardship of ICBs allocated resources.	SFIs 2.2.1

6. Decisions and functions delegated to individual board members and employees		
Individual	**Decisions and functions delegated to the individual**	**Reference**
Chief Executive Officer	Sets out the procedures on the seeking of professional advice regarding the supply of goods and services	SFIs 8.1.2
Chief Executive Officer	Endorses the ICB internal audit charter and annual audit plan	SFIs 10.1.4
Chief Executive Officer	To monitor and ensure compliance with Directions issued by the Secretary of State for Health and Social Care on NHS security management.	SFIs 10.3.1
Chief Financial Officer	Preparation and audit of annual accounts.	SFI 2.2.4
Chief Financial Officer	Ensuring that the allocated annual revenue and capital resource limits are not exceeded, jointly, with system partners.	SFIs 2.2.4
Chief Financial Officer	Ensure that there is an effective financial control framework in place to support accurate financial reporting, safeguard assets and minimise risk of financial loss.	SFIs 2.2.4
Chief Financial Officer	Meeting statutory requirements relating to taxation.	SFIs 2.2.4
Chief Financial Officer	Ensuring that there are suitable financial systems in place	SFIs 2.2.4
Chief Financial Officer	Meets the financial targets set for it by NHS England	SFIs 2.2.4
Chief Financial Officer	Use of incidental powers such as management of ICB assets, entering commercial agreements	SFIs 2.2.4
Chief Financial Officer	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	SFIs 2.2.4
Chief Financial Officer	Adherence to the directions from NHS England in relation to accounts preparation;	SFI 2.2.4

6. Decisions and functions delegated to individual board members and employees		
Individual	**Decisions and functions delegated to the individual**	**Reference**
Chief Financial Officer	Ensure the Governance statement and Annual Accounts & Reports are signed	SFI 2.2.4
Chief Financial Officer	Ensure that planned budgets are approved by the Board; developing the funding strategy for the ICB to support the board in achieving ICB objectives, including consideration of place-based budgets	SFI 2.2.4
Chief Financial Officer	Making use of benchmarking to make sure that funds are deployed as effectively as possible	SFI 2.2.4
Chief Financial Officer	Executive members (partner members and non-executive members) and other officers are notified of and understand their responsibilities within the SFIs	SFI 2.2.4
Chief Financial Officer	Specific responsibilities and delegation of authority to specific job titles are confirmed;	SFIs 2.2.4
Chief Financial Officer	Provide financial leadership and ensuring financial performance of the ICB including advice to the Board of the ICB;	SFIs 2.2.4
Chief Financial Officer	Identification of key financial risks and issues relating to robust financial performance and leadership and working with relevant providers and partners to enable solutions;	SFIs 2.2.4
Chief Financial Officer	Responsible for maintaining policies and processes relating to the control, management and use of resources across the ICB	SFIs 3.1.1
Chief Financial Officer	To delegate the budgetary control responsibilities to budget holders through a formal documented process	SFIs 3.1.2

6. Decisions and functions delegated to individual board members and employees		
Individual	**Decisions and functions delegated to the individual**	**Reference**
Chief Financial Officer	Financial leadership responsibility for the following statutory duties: • the duty 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	SFIs 3.1.4
Chief Financial Officer	Prepare and submit budgets for approval by the Board of the ICB. Such budgets will: • be in accordance with the aims and objectives set out in the plan; • accord with workload and staffing plans; • be produced following discussion with appropriate system partners and budget holders; • be prepared within the limits of available funds (resource limits); • identify potential risks.	SFIs 3.3.2
Chief Financial Officer	Devise and maintain systems of budgetary control.	SFIs 3.6.1
Chief Financial Officer	Responsible for establishing effective systems and processes, including robust internal control mechanisms to discharge the ICB's statutory duties related to Income, banking arrangements and debt recovery in accordance with legal and regulatory requirements	SFIs 4 (inclusive)
Chief Financial Officer	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	SFIs 5
Chief Financial Officer	Take a lead role on behalf of the ICB to ensure that there are appropriate and effective financial, contracting including procurement, monitoring and performance arrangements in place to ensure the delivery of effective health services	SFIs 6 Public Contracts Regulations 2015 (PCR)

6. Decisions and functions delegated to individual board members and employees		
Individual	**Decisions and functions delegated to the individual**	**Reference**
Chief Financial Officer	Oversee and contract for NHS Security Management Services	SFIs 10.3.3
Chief Financial Officer	Responsible for ensuring appropriate arrangements are in place to provide adequate counter fraud provision. This includes reporting requirements to the Board and Audit Committee, and defining roles and accountabilities for those involved as part of the process of providing assurance to the Board	SFIs 10.4
All Executive Directors	Responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Operating Plan and a balanced budget	SFIs 3.7.2
Chief Financial Officer	Approval of the arrangements for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data	SFIs 17 Health Records Act (2001) Records Management Code of Practice for Health and Social care 2016
Chief Financial Officer	Ensure that the payroll system has adequate internal controls and suitable arrangements for processing deductions and exceptional payments	SFIs 7.1
Chief Financial Officer	Ensure 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	SFIs 13
Chief Financial Officer	Responsible for providing robust management of grants, including the governance of grants and assurance to the ICB	SFIs 13.2

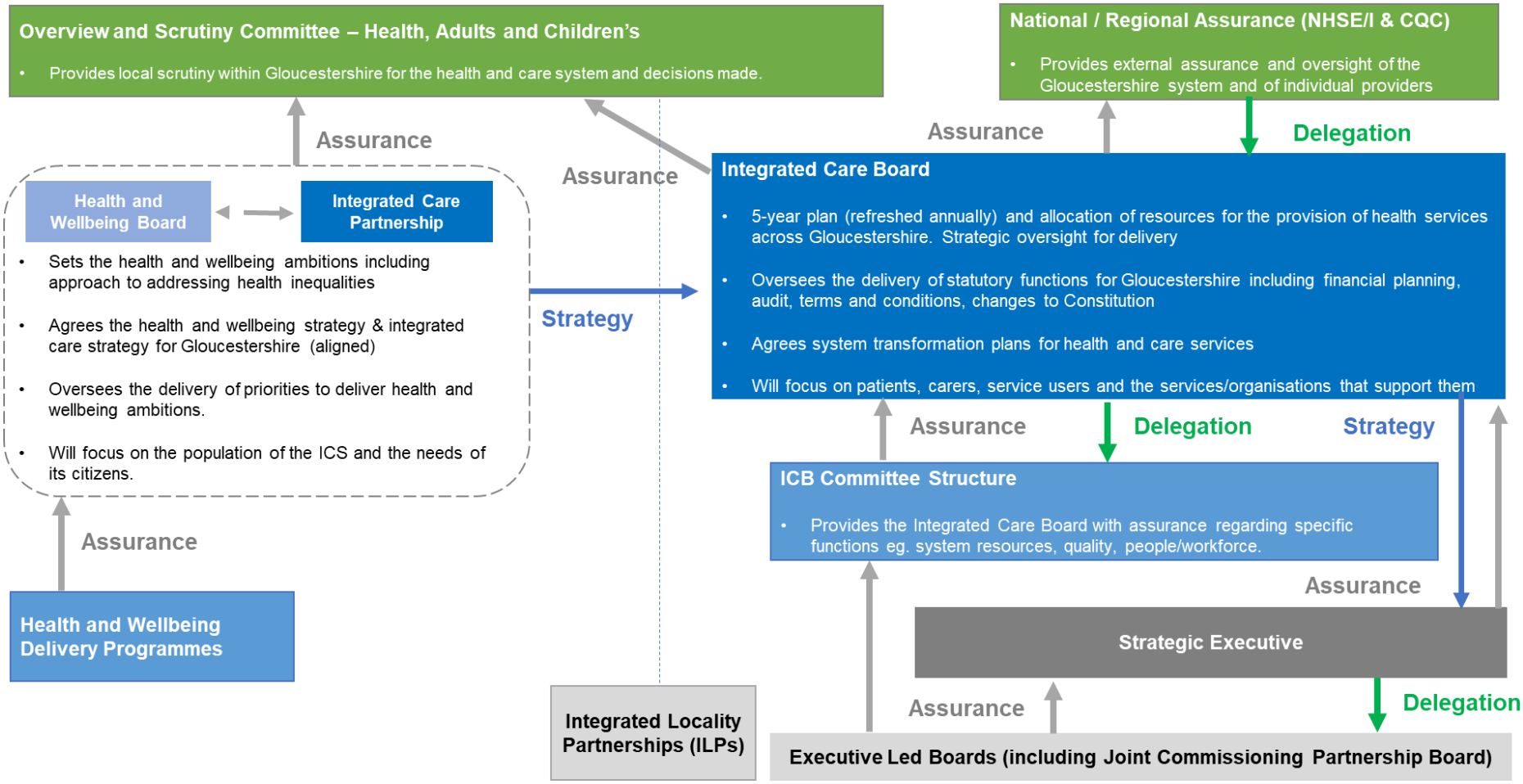
6. Decisions and functions delegated to individual board members and employees		
Individual	**Decisions and functions delegated to the individual**	**Reference**
Chief Financial Officer	Ensure that contractors who are included on ICB's approved lists receive payments and that there is no evidence of inequality in payment value or method	SFIs 16.1.3
Chief Financial Officer	Responsible for the accuracy and security of the computerised financial data of the ICB whether this is 'in house' or hosted in an outsourced arrangement	SFIs 5.1
Director of People, Culture & Engagement	Operationally responsible for; • defining and delivering the organisation's overall human resources strategy and objectives; and • overseeing delivery of human resource services to ICB employees. • management and governance frameworks that support the ICB employees' life cycle	SFIs 7.2
Director of People, Culture & Engagement	Leading 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 and care sector, with local government, the voluntary and community sector and volunteers.	Committee Terms of Reference 7

7. Decisions and functions delegated by the Board to be exercised jointly		
Joint committee	**Decisions and functions delegated to the joint committee**	**Reference**

8. Decisions and functions delegated by the Board to other statutory bodies		
Statutory body	**Decisions and functions delegated to the statutory body**	**Reference**

9. Decisions and functions delegated to the board by other organisations		
Delegating body	**Decisions and functions delegated by the delegating body**	**Reference**
NHS England	Primary Care Commissioning – reference delegation agreement *(TBC updated agreement expected)*	

Functions and Decision Map



Standing Financial Instructions (SFIs)

1. Purpose, Statutory Framework and Scope

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

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

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

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

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

1.6. Each ICB is to be established by order made by NHS England for an area within England, the order establishing an ICB makes provision for the constitution of the ICB.

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

1.8. Should any difficulties arise regarding the interpretation or application of any of these SFIs, the advice of the Chief Executive Officer or the Chief Financial Officer must be sought before acting.

1.9. Failure to comply with the SFIs may result in disciplinary action in accordance with the ICB's applicable disciplinary policy and procedure in operation at that time.

1.10. 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.

1.11. 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.

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

1.13. 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.

2. Roles and Responsibilities

2.1. Staff

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

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

2.1.2. For any and all Directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Chief Financial Officer.

2.2. Accountable Officer

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

2.2.2. The Chief Financial Officer reports directly to the ICB Chief Executive Officer and is professionally accountable to the NHS England regional finance director.

2.2.3. The Chief Executive Officer and Chief Financial Officer will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

2.2.4. The Chief Executive Officer will delegate to the Chief Financial Officer the following responsibilities in relation to the ICB:

- preparation and audit of annual accounts;
- adherence to the directions from NHS England in relation to accounts preparation;
- ensuring that the allocated annual revenue and capital resource limits are not exceeded, jointly, with system partners;
- ensuring that there is an effective financial control framework in place to support accurate financial reporting, safeguard assets and minimise risk of financial loss;
- meeting statutory requirements relating to taxation;
- ensuring that there are suitable financial systems in place (see Section 5)
- meeting the financial targets set by NHS England;
- use of incidental powers such as management of ICB assets, entering commercial agreements;
- ensuring the Governance statement and annual accounts and reports are signed;
- ensuring planned budgets are approved by the relevant Board; developing the funding strategy for the ICB to support the board in achieving ICB objectives, including consideration of place-based budgets;
- making use of benchmarking to make sure that funds are deployed as effectively as possible;
- ensuring that sufficient records are maintained to show and explain the ICB's transactions, in order to disclose, with reasonable accuracy, the financial position of the ICB at any time;
- provision of financial advice to other members of the Board and employees;
- ensuring that 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;

- provision of 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
- supporting a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and process are in place to minimise risk and;
- ensuring money drawn from the Department of Health against the financing requirement arising from the Resource Limit is required for approved expenditure only, and is drawn down only at the time of need, following best practice as set out in 'Cash Management in the NHS'.

2.3. Audit Committee

2.3.1. The Board and Chief Executive 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.

2.4. System Resources Committee

2.4.1. The Board and Chief Executive Officer should be supported by the System Resources Committee, which should provide proactive support to the board in advising on:

- matters relating to system resources allocation;
- performance against strategic plans;
- financial performance for the organisation and the NHS system performance.

2.5. Primary Care and Direct Commissioning Committee

2.5.1. The Board and Chief Executive Officer should be supported by a Primary Care and Direct Commissioning Committee, which should provide proactive support to the board in advising on:

- performance against strategic plans relevant to the committee's remit;
- financial performance for the areas within the committee's remit.

3. Management Accounting and Business Management

3.1. Chief Financial Officer responsibilities

3.1.1. The Chief Finance Officer is responsible for maintaining policies and processes relating to the control, management and use of resources across the ICB.

3.1.2. The Chief Financial Officer will delegate the budgetary control responsibilities to budget holders through a formal documented process.

3.1.3. The Chief Financial Officer will ensure:

- the promotion of compliance to the SFIs
- the promotion of long-term financial health for the NHS system (including ICS);
- budget holders are accountable for obtaining the necessary approvals and oversight of all expenditure incurred on the cost centres they are responsible for;
- the improvement of financial literacy of budget holders with the appropriate level of expertise and systems training;
- that the budget holders are supported in proportion to the operational risk; and
- the implementation of financial and resources plans that support the NHS Long Term Plan objectives.

3.1.4. In addition, the Chief Financial Officer should have financial leadership responsibility for the following statutory duties:

- the duty 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 to ensure that its expenditure does not exceed the aggregate of its allotment from NHS England and its other income; and
- the duty of the ICB, in conjunction with its partner trusts, to seek to achieve any joint financial objectives set by NHS England for the ICB and its partner trusts.

3.1.5. The Chief Financial Officer and any senior officer responsible for finance within the ICB should also promote a culture where budget holders and

decision makers consult their management accountants in key strategic decisions that carry a financial impact.

3.2. Allocations

3.2.1. The Chief Financial Officer of the ICB will:

- periodically review the basis and assumptions used by NHS England for distributing allocations and ensure that these are reasonable and realistic and secure the ICB's entitlement to funds;
- prior to the start of each financial year submit to the ICB Board for approval a report showing the total allocations received and their proposed distribution including any sums to be held in reserve; and
- regularly update the ICB Board on significant changes to the initial allocation and the uses of such funds.

3.3. Annual Planning

3.3.1. The Chief Executive Officer will compile and submit to the Board an Annual Operating Plan and Financial Budget which take into account financial targets and forecast limits of available resources. The plan will contain:

- a statement of the significant assumptions on which the plan is based;
- details of major changes in workload, delivery of services or resources required to achieve the plan.

3.3.2. Prior to the start of the financial year the Chief Financial Officer will, on behalf of the Chief Executive Officer, prepare and submit budgets for approval by the Board. Such budgets will:

- be in accordance with the aims and objectives set out in the plan;
- accord with workload and staffing plans;
- be produced following discussion with appropriate system partners and budget holders;
- be prepared within the limits of available funds (resource limits);
- identify potential risks.

3.3.3. All budget holders must provide information as required by the Chief Financial Officer to enable budgets to be compiled.

3.4. Budgetary Delegation

3.4.1. The Chief Executive Officer may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

- the amount of the budget;

- the purpose(s) of each budget heading;
- individual and group responsibilities;
- authority to exercise virement;
- achievement of planned levels of service;
- the provision of regular reports.

3.4.2. The Chief Executive Officer and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

3.4.3. Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive Officer, subject to any authorised use of virement.

3.4.4. Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive Officer, as advised by the Chief Financial Officer.

3.5. Delegation of Commissioned Services

3.5.1. NHS England may delegate services to the ICB. The Chief Executive Officer must ensure that:

- a full due diligence process has been undertaken prior to the decision to accept the delegation of services to the ICB to ensure that the ICB has a full understanding of the responsibilities associated with the services to be delegated including the risks.
- appropriate systems and processes have been put in place to ensure the management of the delegated services delegated

3.5.2. The Chief Financial Officer must ensure that appropriate financial procedures are in place covering the delegated services

3.6. Budgetary Control

3.6.1. The Chief Financial Officer will devise and maintain systems of budgetary control. These will include:

- monthly financial reports to the Board in a form approved by the Board containing:
    a) income and expenditure monitoring showing forecast year-end position;
    b) balance sheet and cash flow statement;
    c) capital project spend and projected outturn against plan;
    d) explanations of any material variances from financial, workload and manpower budgets;

e) details of any corrective action where necessary and the Chief Executive Officer's and/or Chief Financial Officer's view of whether such actions are sufficient to correct the situation.

- the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;
- investigation and reporting of variances from budgets;
- monitoring of management action to correct variances;
- arrangements for the authorisation of budget transfers.

3.7. Budget Holder Responsibilities

3.7.1. Each budget holder is responsible for ensuring that:

- they sign off their budget at the start of the year and provide accurate forecasts of out-turn on a monthly basis during the course of the year;
- any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board and to provide full variance analysis from budgeted plan and corrective actions;
- the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement;
- no permanent employees are appointed without the approval of the Chief Executive Officer other than those provided for within the available resources and manpower establishment as approved by the Board;
- they participate in finance training to develop the skills and knowledge necessary to discharge their financial management duties;
- they use the ICB's finance systems as required;
- where matters of financial control risk are identified, they are communicated to the Finance Team as a matter of urgency;
- they are accountable for their budgets and financial performance, even where contracts are negotiated on behalf of the ICB by another institution;
- they take responsibility for ensuring that new members of staff are paid the correct salary and for making sure that final payments to and from employees are correct;
- ensuring that the prices paid for goods are correct, represent value for money, that procedures are followed to prevent fraud and that all invoices are appropriately authorised and that the goods and services received are correct;
- they are available to work with the auditors and respond to questions or recommendations.

3.7.2. The Executive Team is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Operating Plan and a balanced budget.

3.8. Virements

3.8.1. Virements cover all budget transfers carried out in the financial year apart from those enacting the Annual Operating Plan. Delegated limits for virement are provided in the Detailed Scheme of Delegation.

3.9. Reserves

3.9.1. Reserves cover all expenditure budgets not currently allocated to a budget holder and are held centrally.

3.10. Capital Expenditure

3.10.1. The general rules applying to delegation and reporting shall also apply to capital expenditure.

3.11. Monitoring Returns

3.11.1. The Chief Executive Officer is responsible for ensuring that the appropriate monitoring forms are submitted to the ICB's designated external regulators.

4. Income, Banking Arrangements and Debt Recovery

4.1. Income

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

4.1.2. The Chief Financial Officer is responsible for:

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

- approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

4.1.3. All employees must inform the Chief Financial Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts and any other transactions.

4.2. Banking

4.2.1. The Chief Financial Officer is responsible for ensuring the ICB complies with any directions issued by the Secretary of State with regards to the use of specified banking facilities for any specified purposes.

4.2.2. The Chief Financial Officer will ensure that:

- the ICB holds the minimum number of bank accounts required to run the organisation effectively. These should be raised through the government banking services contract; and
- the ICB has effective cash management policies and procedures in place.;

4.3. Debt Management

4.3.1. The Chief Financial Officer is responsible for the ICB debt management plan.

4.3.2. This includes:

- a debt management plan 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 plan covers a minimum period of 3 years and must be reviewed and endorsed by the ICB Audit Committee 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.

4.3.3. The Chief Financial Officer is responsible for the appropriate recovery action on all outstanding debts.

4.3.4. Income not received should be dealt with in accordance with losses procedures.

4.3.5. Overpayments should be detected (or preferably prevented) and recovery initiated.

4.4. Security of Cash and Other Negotiable Instruments

4.4.1. The Chief Financial Officer is responsible for prescribing systems and procedures for handling cash and negotiable securities on behalf of the ICB.

4.4.2. Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

4.4.3. The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the ICB is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the ICB from responsibility for any loss.

5. Financial Systems and Processes

5.1. Provision of Financial Systems

5.1.1. The Chief Financial Officer is responsible for ensuring systems and processes are designed and maintained for the recording and verification of finance transactions such as payments and receivables for the ICB.

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

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

5.1.4. The Chief Financial Officer will, in relation to financial systems:

- promote awareness and understanding of financial systems, value for money and commercial issues;
- ensure that transacting is carried out efficiently in line with current best practice – e.g. e-invoicing;

- ensure that the ICB meets the required financial and governance reporting requirements as a statutory body by the effective use of finance systems;
- enable the prevention and the detection of inaccuracies and fraud, and the reconstitution of any lost records;
- ensure that the financial transactions of the authority are recorded as soon as, and as accurately as, reasonably practicable;
- ensure publication and implementation of all ICB business rules and ensure that the internal finance team is appropriately resourced to deliver all statutory functions of the ICB;
- ensure that risk is appropriately managed;
- ensure identification of the duties of officers dealing with financial transactions and division of responsibilities of those officers;
- ensure the ICB has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of the ICB;
- ensure that contracts for computer services for financial applications with another health organisation or any other agency 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 Financial Officer shall periodically seek assurances that adequate controls are in operation
- ensure reasonable protection of the ICB 's data, programs and computer hardware from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage;
- ensure that reasonable controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;
- ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews are being carried out.

5.1.5. The Chief Financial Officer shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

5.2. Requirements for Computer Systems which have an Impact on Corporate Financial Systems

5.2.1. Where computer systems have an impact on corporate financial systems the Chief Financial Officer shall need to be satisfied that:

- systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;
- data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
- only relevant staff have access to such data.

6. Procurement and Purchasing

6.1. Principles

6.1.1. The Chief Financial Officer will take a lead role on behalf of the ICB to ensure that there are appropriate and effective financial, contracting, monitoring and performance arrangements in place to ensure the delivery of effective health services.

6.1.2. The ICB must ensure that procurement activity is in accordance with the ICB Standing Orders, Public Contracts Regulations 2015 (PCR) and associated statutory requirements whilst securing value for money and sustainability.

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

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

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

6.1.6. All officers must ensure that any conflicts of interest are identified, declared and appropriately mitigated or resolved in accordance with the ICB standards of business conduct policy.

6.1.7. Budget holders are accountable for obtaining the necessary approvals and oversight of all expenditure incurred on the cost centres they are responsible for. This includes obtaining the necessary internal and external approvals which vary based on the type of spend, prior to procuring the goods, services or works.

6.1.8. Undertake any contract variations or extensions in accordance with PCR 2015 and the ICB procurement policy.

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

6.1.10. In all contracts entered into, the ICB shall endeavour to obtain best value for money. The Chief Executive Officer shall nominate an individual who shall oversee and manage each contract on behalf of the ICB.

7. Staff Costs and Staff-Related Non-Pay Expenditure

7.1. Payroll

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

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

7.2. Director of People, Culture and Engagement

7.2.1. The Director of People, Culture and Engagement 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.

7.2.2. Operationally the Director of People, Culture and Engagement 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.

7.2.3. The Director of People, Culture and Engagement is responsible for management and governance frameworks that support the ICB employees' life cycle.

8. Non-Pay Expenditure

8.1.1. The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive Officer will determine the level of delegation to budget managers.

8.1.2. The Chief Executive Officer shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

8.1.3. The Chief Financial Officer will:

a) advise the Chief Executive Officer on the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in the scheme of reservation and delegation;
b) be responsible for the prompt payment of all properly authorised accounts and claims;
c) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable.

9. Annual Reporting and Accounts

9.1.1. The Chief Financial Officer will ensure, on behalf of the Chief Executive Officer and ICB board, that:

- the ICB is in a position to produce its required monthly reporting, annual report, and accounts, as part of the setup of the new organisation; and
- the ICB, in each financial year, prepares a report on how it has discharged its functions in the previous financial year;

9.1.2. The annual report must, in particular, explain how the ICB has:

- discharged its duties in relating to improving quality of services, reducing inequalities, the triple aim and public involvement;
- 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.

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

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

10. Audit, Security Management and Fraud

10.1. Internal audit

10.1.1. The Chief Executive Officer, as the Accountable Officer, is responsible for ensuring there is appropriate internal audit provision in the ICB. For operational purposes, this responsibility is delegated to the Chief Financial Officer to ensure that:

a) all internal audit services provided under arrangements proposed by the Chief Financial Officer are approved by the Audit Committee, on behalf of the ICB board;
b) 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);
c) the ICB internal audit charter and annual audit plan, must be endorsed by the ICB Chief Executive Officer, Audit Committee and Board;
d) the head of internal audit must provide an annual opinion on the overall adequacy and effectiveness of the ICB Board's framework of governance, risk management and internal control as they operated during the year, based on a systematic review and evaluation;
e) the head of internal audit should attend Audit Committee meetings and have a right of access to all Audit Committee members, the Chair and Chief Executive Officer of the ICB.
f) the appropriate and effective financial control arrangements are in place for the ICB and that accepted internal and external audit recommendations are actioned in a timely manner.
g) The reporting system for Internal Audit shall be agreed between the Chief Finance Officer, the Audit Committee and the Head of Internal Audit shall comply with the guidance on reporting contained in the NHS Internal Audit Standards.

10.2. External Audit

10.2.1. The Chief Financial Officer is responsible for:

a) liaising with external audit colleagues to ensure timely delivery of financial statements for audit and publication in accordance with statutory, regulatory requirements;
b) ensuring that the ICB appoints an auditor in accordance with the Local Audit and Accountability Act 2014; in particular, the ICB must appoint a local auditor to audit its accounts for a financial year not later than 31 December in the preceding financial year; the ICB must appoint a local auditor at least once every 5 years (ICBs will be informed of the transitional arrangements at a later date); and

c) ensuring that the appropriate and effective financial control arrangements are in place for the ICB and that accepted external audit recommendations are actioned in a timely manner.

10.2.2. The External Auditor will provide an opinion on the ICB's annual financial statements, its Annual Governance Statement and Annual Report. It will make an assessment of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources. The External Auditor is also required to give a Regularity Opinion on whether expenditure has been incurred 'as intended by Parliament'.

10.2.3. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and referred on to the ICB Audit Committee if the issue cannot be resolved.

10.3. Security Management

10.3.1. In line with their responsibilities, the ICB Chief Executive Officer will monitor and ensure compliance with Directions issued by the Secretary of State for Health and Social Care on NHS security management.

10.3.2. The ICB shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health and Social Care guidance on NHS Security Management.

10.3.3. The ICB shall nominate the Chief Financial Officer to oversee and contract for NHS Security Management Services, who will report to the Board.

10.3.4. The Chief Executive Officer has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD), or equivalent, and the appointed Local Security Management Specialist (LSMS).

10.4. Fraud, Bribery and Corruption (Economic Crime)

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

10.4.2. The ICB Chief Financial Officer is responsible for ensuring appropriate arrangements are in place to provide adequate counter fraud provision which should include reporting requirements to the Board and Audit Committee, and defining roles and accountabilities for those involved as part of the process of providing assurance to the Board.

10.4.3. The CFO shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by the NHS Counter Fraud Authority guidance.

10.4.4. These arrangements should comply with the NHS requirements Government Functional Standard 013 Counter Fraud as issued by NHS Counter Fraud Authority and any guidance issued by NHS England.

11. Losses and Special Payments

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

11.1.2. The Chief Financial Officer will support a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and process are in place to minimise risks from losses and special payments.

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

11.1.4. ICBs will work with NHS England teams to ensure there is assurance over all exit packages which may include special severance payments. ICBs have no delegated authority for special severance payments and will refer to the guidance on that to obtain the approval of such payments.

11.1.5. All losses and special payments (including special severance payments) must be reported to the ICB Audit Committee.

11.1.6. For detailed operational guidance on losses and special payments, please refer to the ICB losses and special payment guide which includes delegated limits.

12. Disposals and Condemnations

12.1.1. The Chief Financial Officer must prepare procedures for the disposal of assets including condemnations and ensure that these are notified to managers.

12.1.2. When it is decided to dispose of an ICB asset, the Head of Department or authorised deputy will determine and advise the Chief Financial Officer of the

estimated market value of the item, taking account of professional advice where appropriate.

12.1.3. All unserviceable articles shall be:

a) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Financial Officer;
b) recorded by the Condemning Officer in a form approved by the Chief Financial Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Financial Officer.
c) The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Financial Officer who will take the appropriate action.

13. Capital Investments and Security of Assets and Grants

13.1. The Chief Financial Officer is responsible for:

- ensuring that at the commencement of each financial year, the ICB and its partner NHS trusts and NHS foundation trusts prepare a plan setting out their planned capital resource use;
- ensuring that the ICB and its partner NHS trusts and NHS foundation trusts exercise their functions with a view to ensuring that, in respect of each financial year, local capital resource use does not exceed the limit specified in a direction by NHS England;
- ensuring the ICB has a documented property transfer scheme for the transfer of property, rights or liabilities from the ICB's predecessor Clinical Commissioning Group;
- ensuring that there is an effective appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
- ensuring that there are processes in place for the management of all stages of capital schemes, that will ensure that schemes are delivered on time and to cost;
- ensuring that capital investment is not authorised without evidence of availability of resources to finance all revenue consequences; and
- for every capital expenditure proposal, the Chief Financial Officer is responsible for ensuring there are processes in place to ensure that a business case is produced; this should be in line with local and NHSE Business case processes as applicable.

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

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

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

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

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

- ensure the ICB asset portfolio supports its business objectives; and
- comply with NHS England policies and directives and with this guidance

13.6. Disposals of surplus assets should be made in accordance with published guidance and should be supported by a business case which should contain an appraisal of the options and benefits of the disposal in the context of the wider public sector and to secure value for money. All property or land disposals will require approval by the Board.

13.7. Grants

13.7.1. The Chief Financial Officer is responsible for providing robust management, governance and assurance to the ICB with regards to the use of specific powers under which it can make capital or revenue grants available to;

- any of its partner NHS trusts or NHS foundation trusts; and
- to a voluntary organisation, by way of a grant or loan.

13.7.2. All revenue grant applications should be regarded as competed as a default position, unless there are justifiable reasons why the classification should be amended to non-competed.

14. Legal, Risk Management and Insurance

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

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

14.1.2. The Chief Executive Officer shall ensure that the ICB has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved by the Board.

14.1.3. The programme of risk management shall include:

- a process for identifying and quantifying risks and potential liabilities;
- engendering among all levels of staff a positive attitude towards the control of risk;
- management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control,
- cost effective insurance cover, and decisions on the acceptable level of retained risk;
- contingency plans to offset the impact of adverse events;
- audit arrangements including; internal audit, clinical audit, health and safety review;
- a clear indication of which risks shall be insured;
- arrangements to review the risk management programme.

14.1.4. The Board shall decide if the ICB will insure through the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

14.1.5. ICBs are advised not to buy commercial insurance to protect against risk unless it is part of a risk management strategy that is approved by the Chief Executive Officer.

14.1.6. In any case of doubt concerning an ICB's powers to enter into commercial insurance arrangements the Chief Financial Officer should consult the Department of Health.

15. Acceptance of Gifts by Staff

15.1.1. The Chief Financial Officer shall ensure that all staff are made aware of the ICB policy on acceptance of gifts and other benefits in kind by staff which will be in line with the Bribery Act 2010. This policy follows the guidance contained in the NHS England Policy for Managing Conflicts of Interest 2017; the Code of Conduct for NHS Managers 2002; and the ABPI Code of Professional Conduct relating to hospitality/gifts from

pharmaceutical/external industry and is also deemed to be an integral part of these ICB Constitution and Standing Financial Instructions.

16. Payments to Independent Contractors

16.1.1. The ICB will approve additions to, and deletions from, approved lists of contractors, taking into account the health needs of the local population, and the access to existing services. All applications and resignations received shall be dealt with equitably, within any time limits laid down in the contractors NHS terms and conditions of service.

16.1.2. The Chief Executive Officer shall:

- ensure that lists of all contractors, for which the ICB is responsible, are maintained in an up to date condition;
- ensure that systems are in place to deal with applications, resignations, inspection of premises, etc., within the appropriate contractor's terms and conditions of service.

16.1.3. The Chief Financial Officer shall:

- ensure that contractors who are included on ICB's approved lists receive payments and that there is no evidence of inequality in payment value or method;
- maintain a system of payments such that all valid contractors' claims are paid promptly and correctly, and are supported by the appropriate documentation and signatures;
- ensure that regular independent verification of claims is undertaken, to confirm that:
  (1) rules have been correctly and consistently applied;
  (2) overpayments are detected (or preferably prevented) and recovery initiated;
  (3) suspicions of possible fraud are identified and subsequently dealt with in line with the Secretary of State for Health and Social Care’s Directions on the management of fraud and corruption.
- ensure that arrangements are in place to identify contractors receiving exceptionally high, low or no payments, and highlight these for further investigation; and
- ensure that a prompt response is made to any query raised by the NHS Business Services Authority, regarding claims from contractors submitted directly to them.

17. Retention of Records

17.1.1. The Chief Executive Officer shall be responsible for maintaining archives for all records required to be retained in accordance with “Records Management Code of Practice for Health and Social Care 2016.

17.1.2. The records held in archives shall be capable of retrieval by authorised persons.

17.1.3. Records held in accordance with NHS Code of Practice - Records Management 2006, shall only be destroyed at the express instigation of the Chief Executive Officer. Detail shall be maintained of records so destroyed.

Committee Terms of Reference

Audit Committee

1. Introduction

1.1 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.

1.2 These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.3 The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. Introduction

2.1 The Committee shall 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

2.2 The Committee shall critically review the Integrated Care Board's financial reporting and internal control principles and ensure an appropriate relationship with both internal and external auditors, and counter fraud is maintained.

2.3 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.

2.4 The Audit Committee has no executive powers, other than those delegated in the Scheme of Reservation and Delegation and specified in these terms of reference.

2.5 For the avoidance of doubt, the Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD.

3. Delegated Authority

3.1 The Audit Committee is a formal committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

3.2 The Audit Committee is authorised by the Integrated Care Board to:

- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) as outlined in these terms of reference;
- 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.

3.3 The Audit Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board

4. Membership and Structure

4.1 Membership

4.1.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

4.1.2 The Board will appoint no fewer than five members of the Committee including:

- Committee Chair who shall be an Independent Non-Executive Director of the ICB who shall not be the Chair of the System Resources Committee;
- Independent Non-Executive Director of the ICB;
- One Non-Executive Director from each of the main system Provider partners who chairs their respective Audit Committees.
- Primary Care representative.

4.1.3 Neither the Chair of the Board, nor employees of the ICB will be members of the Committee. Other members of the Committee need not be members of the Board, but they may be.

4.1.4 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.

4.2 Chair and vice chair

4.2.1 The Chair of the Committee shall be independent and therefore may not chair any other committees.

4.2.2 Committee members may appoint a Vice Chair who shall be an Independent Non-Executive Director of the ICB.

4.2.3 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR in consultation with the Chief Financial Officer.

4.3 Attendees and Participants

4.3.1 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:

- Chief Financial Officer of the ICB or their nominated deputy;
- Associate Director of Corporate Affairs with the remit for governance;
- Governance team members who cover risk management and conflicts of interests;
- Representative of Gloucestershire Counter Fraud Service;
- Representative of the ICB Auditor firm.

4.3.2 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

4.3.3 Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Board(s), Secondary and Community Providers.

4.3.4 The Chief Executive should be invited to attend the meeting at least annually.

4.3.5 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.

4.4 Attendance

4.4.1 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.

4.5 Access

4.5.1 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.

4.6 Structure

4.6.1 The structure of the Audit Committee will be developed to ensure that agenda items that are common across the NHS system are dealt with in the most effective way. Committee agendas will be structured to cover both ICB specific items and the development of audit across the system and its partnerships.

5. Quoracy

5.1 Quoracy is defined as a minimum of 50% of the Committee's core membership which must include the Chair or Vice-Chair or their nominated deputy.

5.2 Where partner members are included in the core membership of the Committee, business planners for meetings will be designed to make optimal use of partner time, meaning that they may not be required for all of every meeting. Where this is the case, their absence will not affect the quoracy of the meeting

5.3 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum

5.4 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken

6. Voting and Decision Making

6.1 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.

6.2 The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

6.3 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 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis using telephone, email or other electronic communication

7. Frequency and notice of meetings

7.1 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis using telephone, email or other electronic communication.

7.2 The Audit Committee shall meet up to six (6) times a year in accordance with the annual accounts cycle. The Chair of the Committee may convene additional meetings as required

7.3 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.

7.4 The external auditor or internal auditor may requisition a meeting of the Committee if it is deemed necessary.

7.5 The Committee shall meet in private with the internal and external auditors not less than annually.

7.6 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.

8. Committee secretariat

8.1 The Committee shall be supported with a secretariat function provided by the Corporate Governance Team. The Governance Team shall ensure that.

8.1.1 The agenda and papers are prepared and distributed in accordance with the Standing Orders at least 5 working days before the meeting, having been agreed by the Chair with the support of the relevant executive lead – Chief Financial Officer;

8.1.2 Attendance by members of the committee is monitored and reported annually as part of the Annual Governance Statement (contained within the Annual Report);

8.1.3 Records of members' appointments and renewal dates are maintained and the Board is prompted to renew membership and identify new members where necessary;

8.1.4 Good quality minutes are taken and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept;

8.1.5 The Chair is supported to prepare and deliver reports to the Board;

8.1.6 The Committee is updated on pertinent issues/ areas of interest/ policy developments;

8.1.7 Action points are taken forward between meetings and progress against those actions is monitored.

9. Remit and responsibilities of the Committee

9.1 The Audit Committee has been constituted in terms of its scope, responsibilities and membership to facilitate the ICB meeting its four fundamental purposes 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**.

9.2 Each Integrated Care Board Committee will have a remit which encompasses two primary areas of responsibility. First, the Committee will exercise the delegated authority of the Board to execute assurance against a sub-set of its statutory duties and functions. Second, it will retain oversight of

progress against the Integrated Care Board's strategic priorities through the developing partnership and integrated working of its members. This balanced approach will ensure that the governance focus of the Committee spans both current performance and risk as well as strategic development and system effectiveness. Committees will have a core membership spanning both areas of its responsibility, which can be enhanced as required by the addition of co-opted attendees or participants who are invited to contribute to the debate and deliberation of the Committee. The decision on the use of co-opted attendees or participants rests with the Chair of the Committee. The responsibilities of this Committee include:

9.3 Integrated governance, risk management and internal control

9.3.1 To review the adequacy and effectiveness of the system of integrated governance, risk management and internal control across the whole of the ICB's activities that support the achievement of its objectives, and to highlight any areas of weakness to the Board.

9.3.2 To review the financial systems and governance that are established in order to facilitate compliance with DHSC's Group Accounting Manual.

9.3.3 To review the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of the ICB's objectives, and the effectiveness of the management of principal risks.

9.3.4 To agree the risk management framework, policies and procedures ensuring that the risk management structure and processes within the ICB are robust and effective.

9.3.5 To review the quality of risk identification, management and reporting; providing scrutiny and challenge to the Corporate Risk Register and Board Assurance Framework.

9.3.6 To have oversight of system risks where they relate to the achievement of the ICB's objectives.

9.3.7 To ensure that the ICB acts consistently with the principles and guidance established in HMT's Managing Public Money.

9.3.8 To seek reports and assurance from directors and managers within the ICB and the ICS as required, concentrating on the systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

9.3.9 To review and approve on behalf of the Board those policies that ensure compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification e.g. Counter Fraud, Bribery and Corruption Policy, Standards for Business Conduct including Conflicts of Interests policy etc.

9.3.10 To identify opportunities to improve governance, risk management and internal control processes across the ICB, and the ICS where appropriate.

9.4 Internal audit

9.4.1 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:

9.4.2 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;

9.4.3 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;

9.4.4 Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation; and

9.4.5 Monitoring the effectiveness of internal audit and carrying out an annual review.

9.5 External audit

9.5.1 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:

9.5.2 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;

9.5.3 Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee; and

9.5.4 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.

9.6 Other assurance functions

9.6.1 To review the findings of assurance functions in the ICB, and to consider the implications for the governance of the ICB.

9.6.2 To review the assurance processes in place in relation to financial performance and other key governance processes and systems (e.g. risk management) across the ICB, including the completeness and accuracy of information provided.

9.6.3 To review the findings of external bodies and agencies issued by arm's length bodies or regulators and inspectors: e.g. National Audit Office, Select Committees, NHS Resolution etc and consider the implications for governance of the ICB.

9.7 Counter fraud

9.7.1 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.

9.7.2 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.

9.7.3 To ensure that the counter fraud service provides appropriate progress reports and that these are scrutinised and challenged where appropriate.

9.7.4 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.

9.7.5 To report concerns of suspected fraud, bribery and corruption to the Board and the NHSCFA.

9.8 Freedom to Speak Up

9.8.1 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.

9.9 Information Governance (IG)

9.9.1 To receive regular updates on IG compliance (including uptake & completion of data security training), data breaches and any related issues and risks.

9.9.2 To review the annual Senior Information Risk Owner (SIRO) report, the submission for the Data Security & Protection Toolkit and relevant reports and action plans.

9.9.3 To receive reports on audits to assess information and IT security arrangements, including the annual Data Security & Protection Toolkit audit.

9.9.4 To provide assurance to the Board that there is an effective framework in place for the management of risks associated with information governance.

9.10 Financial reporting

9.10.1 To monitor the integrity of the financial statements of the ICB and any formal announcements relating to its financial performance.

9.10.2 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.

9.10.3 To review the Annual Report and Financial Statements (including accounting policies) before submission to the Board focusing particularly on:

- The Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
- Changes in accounting policies, practices and estimation techniques;
- Unadjusted mis-statements in the Financial Statements;
- Significant judgements and estimates made in preparing the Financial Statements;
- Significant adjustments resulting from the audit;
- Letter of representation; and

- Qualitative aspects of financial reporting.

9.11 Conflicts of Interest

9.11.1 The Chair of the Audit Committee shall be the nominated Conflicts of Interest Guardian.

9.11.2 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.

9.12 Policies

9.12.1 Approval of policies and standard operating procedures (SOPs) as relevant to the committee's business.

9.13 Management

9.13.1 To request and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

9.13.2 The Committee may also request specific reports from individual functions within the ICB as they may be appropriate to the overall arrangements.

9.13.3 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.

9.14 Communication

9.14.1 To co-ordinate and manage communications on governance, risk management and internal control with stakeholders internally and externally.

9.14.2 To develop an approach with other committees, and with the Integrated Care Partnership, to ensure the relationship between them is understood.

10. Relationship with the ICB and other groups / committees / boards

10.1 To work closely with the other committees in the ICB where appropriate and relevant e.g. implementation of the Internal Audit recommendations.

10.2 To investigate identified areas of concern with regard to the ICB's internal controls referred by another committee or the Board of the ICB.

11. Policy and best practise

11.1 The Committee shall have regard to current best practice, policies and guidance issued by NHS England, HMFA and other relevant bodies.

12. Monitoring and Reporting

12.1 The minutes of each meeting of the Committee shall be formally recorded and retained by the Integrated Care Board. The minutes shall be submitted to the Board of the ICB.

12.2 The Chair of the Committee shall report the outcome and any recommendations of the committee to the Board of the ICB.

12.3 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.

12.4 The Committee shall agree an annual schedule of reports and their frequency for the Audit Committee meetings.

13. Conduct of the Committee

13.1 Members will be expected to conduct business in line with the ICB values and objectives.

13.2 Members of, and those attending the Committee, shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy

13.3 Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

13.4 Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

13.5 Conflicts of interests: In discharging duties transparently, conflicts of interest must be considered, recorded and managed. Members should have regard to both the ICB's policies and national guidance on managing conflicts of interest. All potential conflicts of interest must be declared and recorded at the start of each meeting. A register of interests must be maintained by the Governance Team, submitted with the Audit Committee papers and annually to the Board. If the Chair considers a conflict of interest exists then the relevant person must not take part in that item, and the Chair may require the affected member to withdraw at the relevant point.

14. Review of ToR

14.1 These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Annex 1 – Auditor Panel

1. Context and role

1.1 The Audit Committee will fulfil the role of 'Auditor Panel', as defined in the Local Audit and Accountability Act 2014 and in accordance with the Department of Health publication 'Auditor Panels – Guidance to help Health Bodies meet their Statutory Duties, September 2015'.

1.2 The principal roles of the Auditor Panel are to advise the Board of the ICB on the selection, appointment and removal of the ICB's external auditor and to appoint the internal auditor. The Auditor Panel is also responsible for advising the Board of the ICB on the purchase of 'non-audit services' from the external auditor.

1.3 The Auditor Panel will take the form of a separate section of the Audit Committee meeting and will be minuted separately.

2. Membership, Attendance, Secretary and Quorum

2.1 The membership, quoracy and committee secretary will be as per the Audit Committee and outlined in sections 3, 4 and 6.

2.2 The Chief Finance Officer will be invited to attend the meetings. In addition, the Panel may invite any other individual to attend the meetings, as appropriate.

3. Frequency and notice of meetings

3.1 The Panel will meet as and when required.

3.2 Written notice of the meetings and agendas will be provided, as part of the normal Audit Committee processes, to Panel members not less than 5 working days before the meeting.

4. *Remit and responsibilities of the Panel*

4.1 The key duties of the Panel are:

4.1.1 to advise the Board on the selection, appointment and removal of the ICB's external auditors, paying due regard for their performance;

4.1.2 the selection, appointment and removal of the ICB's internal auditors, paying due regard for their performance;

4.1.3 the maintenance of an independent relationship with the appointed external auditor;

4.1.4 the maintenance of an independent relationship with the appointed internal auditors; and

4.1.5 to advise the Board on the purchase of 'non-audit services' from the external auditor.

5. Monitoring and reporting

5.1 The minutes of each meeting of the Panel will be formally recorded and retained by the ICB and submitted to the Board of the ICB.

5.2 The Chair of the Panel shall report the outcome and any recommendations of the Panel to the Board of the ICB.

6. Review

6.1 Annually in line with the ToR for the Audit Committee.

Primary Care & Direct Commissioning Committee

1. Introduction

1.1 The Primary Care & Direct Commissioning Committee, PC&DC (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution and in accordance with Delegations made under section 65Z5 of the 2006 NHS Act[2] as amended by the Health Bill 2021.

1.2 NHS England has delegated authority to the ICB for the commissioning of primary care. Part 1 of Schedule 2A (Primary Medical Services)[3] sets provision regarding the carrying out of those Delegated Functions relating to Primary Medical Services, being in summary:

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

1.3 The committee acknowledges that, in addition to the statutory duties set out in Part 1 Schedule 2A (Primary Medical Services) that it already complies with, it must comply with the following as regards primary care:

a) *duty to consult with Local Medical Committees[4] and other stakeholders in accordance with the duty of public involvement and consultation under section 14Z2 of the NHS Act;*

1.4 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.

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[2] *See Part 1, Health Bill 2021 s.60 Joint working and delegation arrangements*

[3] *The National Health Service (Personal Medical Services Agreements) Regulations 2015*

[4] *Consultation to include Local Pharmacy Committee, Local Optical Committee and Local Dental Committee when delegated authority extends to Pharmacy, Optometry and Dental services.*

1.5 Committee members including those who are not members of the ICB Board, are bound by the Standing Orders and other policies of the ICB.

2. Purpose

2.1 The purpose of the Committee is to manage the delivery of those elements of the primary care healthcare services delegated by NHS England to the ICB. The aim will be to deliver to the people of Gloucestershire, on behalf of the ICB, services that are of high quality, clinically effective and safe, within available resources. This will be delivered through a culture of openness supported by sound governance arrangements.

2.2 The Committee is currently responsible for the commissioning of primary care. NHS England may at some point delegate authority to the ICB for the commissioning of primary dental services, primary pharmacy and ophthalmic services. The Primary Care and Direct Commissioning Committee will at the point of delegation of these services to the ICB, review its terms of reference and include these services within its committee remit.

3. Delegated Authority

3.1 The purpose of the Committee is to manage the delivery of those elements of the primary care healthcare services delegated by NHS England to the ICB. The aim will be to deliver to the people of Gloucestershire, on behalf of the ICB, services that are of high quality, clinically effective and safe, within available resources. This will be delivered through a culture of openness supported by sound governance arrangements

3.2 The PC&DC Committee is a formal committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

3.3 The PC&DC Committee is authorised by the Integrated Care Board to:

3.3.1 Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) as outlined in these terms of reference;

3.3.2 Commission any reports it deems necessary to help fulfil its obligations;

3.3.3 Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is

necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice.

3.3.4 The PC&DC Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

4. Membership

4.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

4.2 The Board will appoint the six committee members:

- Committee Chair: shall be an Independent Non-Executive Director of the ICB who is not the Chair of the Audit Committee;
- Committee Vice-Chair: Independent Non-Executive Director of the ICB with a remit for Quality;
- Chief Executive Officer or Deputy CEO of the ICB;
- ICB Chief Medical Officer;
- ICB Chief Nursing Officer;
- ICB Chief Financial Officer;

4.3 Members will possess between them knowledge, skills and experience in primary care development and contracting, patient safety and quality and technical or specialist issues pertinent to the ICB's business (such as dentistry, optometry and pharmacy). When determining the membership of the Committee, active consideration will be made to diversity and equality.

4.4 Membership will be reviewed, and other individuals may be invited to become members of the Committee as and when appropriate to meet the needs of the agenda.

4.5 <u>Attendees and other Participants</u>

4.5.1 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 Primary Care & Place;
- Deputy Director of Primary Care and Place (Primary Care Development);
- Citizen Member;
- Head of Primary Care Contracting;

- Councillor, Gloucestershire County Council.

4.5.2 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 primary care estates, workforce developments and the Training Hub.

4.5.3 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

4.5.4 If the membership of the Committee includes the Deputy CEO rather than the CEO, then the Chief Executive should be invited to attend the meeting at least annually.

4.6 Attendance

4.6.1 Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

5. Quoracy

5.1 For a meeting to be quorate a minimum of four members must be present at the meeting including:

- One Independent Non-Executive Director of the ICB;
- Chief Financial Officer or their nominated deputy.

5.2 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

6. Quoracy

6.1 The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

6.2 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.

6.3 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

7. Frequency and Notice of Meetings

7.1 The Committee shall meet up to six times a year. The Chair of the Committee may convene additional meetings as required.

7.2 Meetings of the Committee shall:

7.2.1 Be held in public; and

7.2.2 The Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

7.2.3 In accordance with the Standing Orders, the Committee may meet virtually when necessary, and members attending using electronic means such as telephone or videoconferencing shall be counted towards the quorum.

8. Committee Secretariat

8.1 The Committee shall be supported with a secretariat function provided by the Corporate Governance Team. The Governance Team shall ensure that:

8.1.1 The agenda and papers are prepared and distributed in accordance with the Standing Orders at least five (5) working days before the meeting, having been agreed by the Chair with the support of the relevant Executive Lead – Director of Primary Care & Place;

8.1.2 Attendance by members of the committee is monitored and reported annually as part of the Annual Governance Statement (contained within the Annual Report);

8.1.3 Records of members' appointments and renewal dates are maintained, and the Board is prompted to renew membership and identify new members where necessary;

8.1.4 Good quality minutes are taken and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept;

8.1.5 The Chair is supported to prepare and deliver reports to the Board;

8.1.6 The Committee is updated on pertinent issues/ areas of interest/ policy developments;

8.1.7 Action points are taken forward between meetings and progress against those actions is monitored.

8.2 All members or attendees at the Committee are required to declare any potential or actual conflict of interest before items are discussed. There will be a standing agenda item at the beginning of each meeting for this purpose. Even if an interest has been recorded in the register of interests, it must still be declared in meetings where matters relating to that interest are records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.

9. Remit and Responsibilities of the Committee

9.1 In accordance with its statutory powers under section 65Z5 of the NHS Act, NHS England has delegated the exercise of the Delegated Functions to the ICB to empower it to commission Primary Care Services for the people of Gloucestershire.

9.2 Each Integrated Care Board Committee will have a remit which encompasses two primary areas of responsibility:

9.2.1 The Committee will exercise the delegated authority of the Board to execute assurance against a sub-set of its statutory duties and functions. It will retain oversight of progress against the Integrated Care Board's strategic priorities through the developing partnership and integrated working of its members. This balanced approach will ensure that the governance focus of the Committee spans both current performance and risk as well as strategic development and system effectiveness. Committees will have a core membership spanning both areas of its responsibility, which can be enhanced as required by the addition of co-opted attendees or participants who are invited to contribute to the debate and deliberation of the

Committee. The decision on the use of co-opted attendees or participants rests with the Chair of the Committee.

9.3 The role of the Primary Care Commissioning Committee shall be to carry out delegated functions that are related to the commissioning of primary medical services from NHS England to the ICB as set out in Schedule 2A (Primary Medical Services). This includes delegated responsibility for the following:

9.3.1 The award of GMS, PMS and APMS contracts. This includes: the design of PMS and APMS contracts; and monitoring of contracts;

9.3.2 Locally defined and designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");

9.3.3 Making decision regarding local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);

9.3.4 Reviewing, analysing, and providing constructive challenge regarding primary care performance, including requesting both remedial and preventative programmes of work and individual action plans.

9.3.5 Procurement of new practice provision;

9.3.6 Discretionary payment (e.g., returner/retainer schemes);

9.3.7 Approving practice mergers;

9.3.8 Primary Care Estates Strategy;

9.3.9 Premises improvement grants and capital developments;

9.3.10 Contractual action such as issuing breach/remedial notices and removing a contract; and

9.3.11 Reporting details of 22a – i to the ICB.

9.4 The Committee shall also have oversight of the landscape, development plans and performance/usage of digital information system (notably clinical/patient information systems) and other technology, uptake of and compliance with local and national digital transformation and integration programmes, and the adoption of innovative medical technology.

9.5 Primary Care Networks (PCNs)

9.5.1 PCNs shall be accountable to the PC&DC Committee.

9.5.2 The Committee shall review the ICB plans for the management of the Network Contract Directed Enhances Services, including plans for re-commissioning these services annually where appropriate.

9.5.3 The Committee shall receive assurances that the planning of Primary Care Networks in Gloucestershire complies with published specifications and guidance including:

- Maintain or establish identified Network Areas to support the local population in the Area;
- Review any waived PCN list size requirements wherever possible and appropriate to best support the local population in the Area;
- Ensure that each PCN has at all times an accountable Clinical Director;
- Align each PCN with an ICB that would best support delivery of services to the local population in the Area;
- Collaborate and work with other ICBs as appropriate to agree which ICB will be the lead ICB for the PCN.

9.5.4 The Committee shall receive assurances that the planning of Primary Care Networks in Gloucestershire complies with published specifications and guidance including maintaining or establishing identified Network Areas to support the local population in the area.

9.5.5 The Committee shall receive highlight reports regarding the activities of Primary Care Networks, including PCN transformation and improvement plan progress, shared risks and issues, and interaction with individual member practices and Integrated Locality Partnerships (ILPs).

9.6 Financial Accountability

9.6.1 The Committee's authority for procuring services is covered in the ICB Scheme of Reservation and Delegation and Standing Financial Instructions.

9.7 The Committee shall refresh the Primary Care Strategy for Gloucestershire and report on and make recommendations to the ICB on the following:

- Primary Medical Care Strategy for Gloucestershire;
- Planning primary medical care services in Gloucestershire (including needs assessment);
- Performance management of primary care services and contracts.

9.8 The Committee may delegate some tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties' relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest. The Committee may not delegate the procurement of services to any individual or sub-committee.

9.9 The Committee shall be structured to address two core parts: statutory functions, and the transformational agenda which will link with the Clinical Programmes Approach and interface with, but not oversee, ILPs.

9.10 The Committee shall receive information regarding the allocation of operational and transformation funding provided to individual practices and PCNs, both capital and revenue, and similarly shall receive information on the use of those funds relative to the achievement of agreed objectives. The Committee shall hold practices and PCNs to account for value for money and other pertinent metrics regarding any such funding. Such monitoring and accountability notably includes, but may not be limited to, all items listed under sections 9.3 and 9.4 of these Terms of Reference.

10. Relationship with the ICB and other groups / committees / boards

10.1 The Committee has delegated authority for the commissioning of some primary care services as outlined in section 7.2, a-l.

10.2 The Committee shall make recommendations to the ICB for the primary care services and functions listed at section 7, 1-2,

10.3 The ICB Primary Care Operational Group (PCOG) shall undertake the operational management, implementation and oversight of the nationally defined primary medical care contracts and the primary medical care workstreams. In addition, the PCOG will also monitor complaints and quality.

10.4 The Primary Care Operational Group will act as a sub-committee and shall report to the Committee and submit the minutes of their meetings to the Committee for review.

10.5 The Primary Care Operational Group shall provide a timely summary highlight report of primary care planning, performance (operational and financial), quality and transformation activities for review by the PC&DC Committee

11. Policy and Best Practise

11.1 The Committee has delegated authority for the commissioning of some primary care services as outlined in section 7.2, a-l.

11.2 When considering matters, the Committee should take into account the following:

- All statutory requirements applicable to the ICB;
- NHS England requirements and standards;
- Best professional practice and standards, e.g. CIPD;
- Emerging risks and issues;
- Relevant Business Information and Data analyses.

11.3 In exercising the Delegated Functions, the Committee must have due regard to the Guidance set out at Schedule 9 and such other guidance as may be issued by NHS England from time to time, including on the Primary Care Guidance web page.

11.4 The Committee will have full authority to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, within its terms of reference and within a limit determined by the Chief Financial Officer. The Committee shall have regard to current good practice, policies and guidance from NHSE&I, the ICS and other relevant bodies.

12. Monitoring and Reporting

12.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities

12.2 The minutes of each meeting of the Committee shall be formally recorded and retained by the Integrated Care Board. The minutes shall be submitted to the Board of the ICS.

12.3 The Chair will provide assurance reports to the Board after each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

12.4 The Committee will provide an annual report to the Board to describe how it has fulfilled its terms of reference, details on progress and a summary of key achievements in delivering its responsibilities.

12.5 The Committee will undertake an annual committee effectiveness review using the existing template model.

13. Conduct of the Committee

13.1 Members will be expected to conduct business in line with the ICB values and objectives

13.2 Members of, and those attending the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

13.3 Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

13.4 Conflicts of interests: In discharging duties transparently, conflicts of interest must be considered, recorded and managed. Members should have regard to both the ICB's policies and national guidance on managing conflicts of interest. All potential conflicts of interest must be declared and recorded at the start of each meeting. A register of interests must be maintained by the Governance Team and submitted to the PC&DC Committee at each meeting and to the Board annually. If the Chair considers a conflict of interest exists then the relevant person must not take part in that item, and the Chair may require the affected member to withdraw at the relevant point.

14. Conduct of the Committee

14.1 These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

People Committee

1. Introduction

1.1 The People Committee (the Committee) is established by the Integrated Care Board (the ICB) as a Committee of the Board in accordance with its Constitution.

1.2 These Terms of Reference (ToR) will be published in the Governance Handbook which can be accessed on the ICB website. They set out the membership, remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the Board. The Terms of Reference will be subject to an annual review.

1.3 The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

1.4 For the avoidance of doubt, the Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation (SoRD).

2. Purpose

2.1 One of the functions of the ICB is to lead the implementation of the Gloucestershire People Strategy and Plan, the remit of which spans health and care across the Integrated Care System. The local strategy is aligned to the national NHS People Promise. Within this context, ‘People’ refers to the workforce of the ICB and its partner members, whether those colleagues are permanent staff, fixed-term or temporary workers or volunteers. This Committee is accountable to the ICB for all matters relating to the development of the System People Strategy and associated plans and for delivery of the Equality, Diversity and Inclusion (EDI) agenda and objectives.

2.2 The purpose of the Committee is to hold the People Board to account for achieving the intended results and benefits of the People Strategy and Plans and for reaching agreed milestones in making One Gloucestershire an increasingly equitable, diverse and inclusive health and care system. The Committee will approve the Terms of Reference for the People Board which will be reviewed on an annual basis.

2.3 The Committee will provide oversight and scrutiny of the effectiveness of the ICS People Function and will receive assurance that the function is fit for

purpose in delivering the capability necessary for the One Gloucestershire Integrated Care System to deliver its people strategy and objectives. It will receive reporting against all the leadership and people dimensions of System Oversight Framework and will examine the management of People and EDI related risks.

2.4 The Committee will oversee the strategic approach to talent management and succession planning for the ICS, ensuring that a pipeline of talent for clinical, professional, executive and non-executive leadership roles is developed and maintained as an asset for the delivery of One Gloucestershire's vision and strategy.

2.5 The Committee will examine opportunities for extending partnership and integrated working across the workforce and system capability agendas so that the conditions for enabling transformation and innovation in respect of people and EDI priorities are optimised.

2.6 The Committee will provide a forum for assurance and review of all ICB related strategies, policies and procedures relating to ICB employed staff.

2.7 The People Committee has no executive powers, other than those delegated in the SoRD and specified in these terms of reference.

3. Delegated Authority

3.1 The People Committee is a formal committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

3.2 The People Committee is authorised by the Integrated Care Board to:

3.2.1 Investigate any activity or aspects of the People and EDI agendas within its terms of reference;

3.2.2 Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) as outlined in these terms of reference;

3.2.3 Commission any reports it deems necessary to help fulfil its obligations;

3.2.4 Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice;

3.2.5 Create task and finish sub-groups in order to undertake 'deep-dive' examinations of aspects of governance and assurance related to the People and EDI agendas, as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's Constitution, Standing Orders and Scheme of Reservation and Delegation (SoRD) but may not delegate any decisions to such groups.

3.3 The People Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

4. Membership

4.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

4.2 The Board will appoint no fewer than four members of the Committee including one who is an Independent Non-Executive Member of the Board. The Committee's membership may include co-opted members of the Board.

4.3 Members will possess between them knowledge, skills and experience in:

- Equity and Equality, Diversity and Inclusion;
- Strategic workforce planning, development, innovation and transformation;
- Leadership, culture, talent and organisational development;
- System dynamics and development.
- Employment legislation and best practise.

4.4 When appointing members to the Committee, active consideration will be made to promoting diversity across the Committee's membership.

4.5 <u>Membership</u>

4.5.1 Committee members will include:

- Committee Chair: Independent NED of the ICB;
- Committee Vice-Chair: Independent NED of the ICB;
- ICB Chief Executive Officer;
- ICB Chief Nursing Officer;
- ICB Chief Medical Officer

- ICB Executive Director of People, Culture and Engagement (Chair of the ICS People Board);
- One independent Non-Executive Directors, with lead People portfolio, of one of the main system Provider partners;
- Social Services (Local Authority) representative, usually the Director of Adult Social Services.

4.6 Chair and vice chair

4.6.1 The Chair of the Committee shall be an Independent Non-Executive Member of the ICB.

4.6.2 Committee members may appoint a Vice Chair from its members.

4.6.3 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR in consultation with the Executive Lead -Director of People, Culture and Engagement.

4.7 Attendees and other Participants

4.7.1 Only members of the Committee have the right to attend Committee meetings. 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 workforce related ICS working groups, secondary, mental health and community providers and primary care subject matter experts, notably:

- Chair of the ICS Workforce Steering Group;
- Chair of the ICS Organisational Development Steering Group;
- Chair or Representative of the ICS Social Partnership Forum;
- Chair of the ICS Education and Training Steering Group.

4.7.2 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

4.8 Attendance

4.8.1 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.

4.8.2 The Chair of the ICB may also be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.

5. Quoracy

5.1 Quoracy is defined as a minimum of 50% of the Committee's core membership which must include the Chair or Vice-Chair or their nominated deputy.

5.2 Where partner members are included in the core membership of the Committee, business planners for meetings will be designed to make optimal use of partner time, meaning that they may not be required for all of every meeting. Where this is the case, their absence will not affect the quoracy of the meeting.

5.3 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.4 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

6. Quoracy

6.1 The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

6.2 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.

6.3 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis using telephone, email or other electronic communication. Where any such action has been taken between meetings, then these will be reported to the next meeting. For the avoidance of doubt, this provision applies to and facilitates the Committee's decision making by email, should this be required to expedite an urgent decision.

7. Frequency and notice of meetings

7.1 The People Committee will meet at least four (4) times a year and the typical cycle will be a quarterly meeting. Additional meetings may take place as required.

7.2 The Board, Chair or Chief Executive may ask the People Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

8. Committee secretariat

8.1 The Committee shall be supported with a secretariat function provided by the Corporate Governance Team.

8.2 The Governance Team shall ensure that:

8.2.1 The agenda and papers are prepared and distributed in accordance with the Standing Orders at least 5 working days before the meeting, having been agreed by the Chair with the support of the relevant executive lead – Director of People, Culture and Engagement;

8.2.2 Attendance by members of the committee is monitored and reported annually as part of the Annual Governance Statement (contained within the Annual Report);

8.2.3 Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;

8.2.4 Good quality minutes are taken and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept;

8.2.5 The Chair is supported to prepare and deliver reports to the Board;

8.2.6 The Committee is updated on pertinent issues/ areas of interest/ policy developments;

8.2.7 Action points are taken forward between meetings and progress against those actions is monitored.

9. Remit and responsibilities of the Committee

9.1 To ensure that the ICB has the people capability to meet its four fundamental purposes 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**.

9.2 Each Integrated Care Board Committee will have a remit which encompasses two primary areas of responsibility. First, the Committee will exercise the delegated authority of the Board to execute assurance against a sub-set of its statutory duties and functions. Second, it will retain oversight of progress against the Integrated Care Board's strategic priorities through the developing partnership and integrated working of its members. This balanced approach will ensure that the governance focus of the Committee spans both current performance and risk as well as strategic development and system effectiveness. Committees will have a core membership spanning both areas of its responsibility, which can be enhanced as required by the addition of co-opted attendees or participants who are invited to contribute to the debate and deliberation of the Committee. The decision on the use of co-opted attendees or participants rests with the Chair of the Committee.

9.3 To ensure a balanced approach to governance of the workforce agenda that embraces both assurance on statutory functions and duties alongside oversight of the transformation agenda and achieving strategic progress against agreed system priorities, including:

9.4 People Strategy - To oversee the development of the people strategy, ensuring it remains current and relevant to the people drivers and requirements of the One Gloucestershire Integrated Care System and responds to both opportunities and risks in the internal and external environment.

9.5 Equality, Diversity and Inclusion - To ensure that the ICB has well defined system EDI objectives, underpinned by strategic plans, measures and reporting arrangements that strengthen accountability and progress. To ensure that the ICB is actively learning from and adopting best practice across the NHS, and from other sectors, to deliver its planned objectives and milestones.

9.6 Health & Safety - To receive assurances that the ICB has effective, systems, policies and processes for health and safety. To receive quarterly reports on Health and Safety.

9.7 Talent Management and Succession Planning - To ensure that the ICB has a strategic approach to talent management for the One Gloucestershire Integrated Care System and that the talent system is effective in identifying, developing and retaining clinical and non-clinical talent within Gloucestershire. To extend and embed opportunities for career development within and across the system and to ensure that a wide cross section of leadership roles are supported by a pipeline of talent.

9.8 Strategic Workforce Planning, Supply, Development and Transformation - To receive assurance that a robust approach to workforce planning, supply and resourcing allows the ICB to secure and retain the workforce resources it needs over the short, medium, and longer term. To scrutinise the effectiveness of workforce development and transformation activity, testing its contribution to enabling best value out of the people working across the system.

9.9 Education, Training and Learning - To receive assurances that tests for value for money and the workforce benefits derived from education, training and learning programmes are undertaken, ensuring their alignment with the People Strategy.

9.10 Leadership, Culture and System Development - To oversee the strategic approach to developing system leaders, shaping culture, and facilitating behaviour change within the system, creating an environment for success in Gloucestershire, aligned to the four fundamental purposes of the ICS.

9.11 Accountability for People Dimensions of System Oversight Framework - To hold the People Board to account for delivering the People Strategy and its impact in the One Gloucestershire Integrated Care System, including the external reporting requirements contained within the System Oversight Framework.

9.12 Workforce Data, Intelligence and Reporting - To ensure that the ICB meets its obligations in respect of reporting against the people dimensions of the System Oversight Framework and can provide assurance to the ICB that ICB data systems and maturity are fit for this purpose. To ensure that the ICB has the necessary workforce intelligence to develop and deliver its People strategy.

10. Relationship with the ICB and other groups / committees / boards

10.1 The governance fora for the people agenda in the ICS, report into the People Committee through the following structure:

11. Policy and best practice

11.1 When considering matters, the Committee should take into account the following points:

11.1.1 All statutory requirements applicable to the ICB;

11.1.2 NHS England requirements and standards;

11.1.3 Best professional practice and standards, e.g. CIPD;

11.1.4 NHS best practice and guidance as well as best practice from respected think tanks spanning the private and voluntary sectors;

11.1.5 Emerging risks and issues.

11.2 The Committee will have full authority to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, in line with the ICB Standing Financial Instructions and delegated financial limits

12. Monitoring and Reporting

12.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

12.2 The minutes of the meetings shall be formally recorded by the Governance Team and submitted to the Board in accordance with the Standing Orders.

12.3 The Chair will provide assurance reports to the Board after each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

12.4 The Committee will provide an annual report to the Board to describe how it has fulfilled its terms of reference, details on progress and a summary of key achievements in delivering its responsibilities.

13. Conduct of the Committee

13.1 Members will be expected to conduct business in line with the ICB values and objectives.

13.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

13.3 Members must demonstrably consider the equality and diversity implications of decisions they make.

13.4 Conflicts of interests - In discharging duties transparently, conflicts of interest must be considered, recorded and managed. Members should have regard to both the ICB's policies and national guidance on managing conflicts of

interest. All potential conflicts of interest must be declared and recorded at the start of each meeting. A register of interests must be maintained by the Governance Team, submitted with the People Committee papers and annually to the Board. If the Chair considers a conflict of interest exists then the relevant person must not take part in that item, and the Chair may require the affected member to withdraw at the relevant point.

14. Review of ToR

14.1 The Committee will review its effectiveness at least annually. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Quality Committee

1. Introduction

1.1 The Quality 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.

1.2 These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.3 The Committee is a non-executive chaired committee of the Board and its members are bound by the Standing Orders and other policies of the ICB.

2. Purpose of the committee

2.1 The Quality 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 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.

2.2 The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high quality care.

2.3 The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

3. Delegated authority

3.1 The Quality Committee has been established to provide the ICB with assurance that is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Bill 2021. This includes reducing inequalities in the quality of care.

3.2 The Quality Committee is a formal committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

3.3 The Quality Committee is authorised by the Integrated Care Board to:

3.3.1 Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) as outlined in these terms of reference;

3.3.2 Commission any reports it deems necessary to help fulfil its obligations;

3.3.3 Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice.

3.3.4 The Quality Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

4. Membership

4.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

4.2 The Board will appoint no fewer than four members of the Committee including two who are Independent Non-Executive Members of the Board. Other attendees of the Committee need not be members of the Board, but they may be.

- Independent Non-Executive Director of the ICB with the remit and responsibility for Quality (Chair);
- Independent Non-Executive Director of the ICB (Vice-chair);
- ICB Chief Nursing Officer or their nominated Deputy;
- ICB Chief Medical Officer;
- One main Acute Partner executive representative;
- One main Community and Mental Health Partner executive representative;
- One Primary Care representative who shall not be the ICB Chief Medical Officer;
- One or more Local Authority representatives (Director of Public Health, Director for Adult Social Services).

4.3 Members will possess between them knowledge, skills and experience in: clinical quality and governance 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.

4.4 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

4.5 Chair and vice chair

4.5.1 The Chair of the Committee shall be an Independent Non-Executive Member of the ICB.

4.5.2 Committee members may appoint a Vice Chair who shall be an Independent Non-Executive Member of the ICB.

4.5.3 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR in consultation with the Executive Lead - Chief Nursing Officer.

4.6 Attendees and other Participants

4.6.1 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:

- One Independent Non-Executive Director of each main system Provider partner (Community & Mental Health; Acute), who chairs their equivalent committee responsible for quality.
- ICB Deputy Director of Nursing;
- ICB Associate Director of Nursing (Commissioning);
- ICB Patient Safety Specialist;
- ICS Health and Care professional leads;
- ICS Designated Nurse Safeguarding Children and Safeguarding Adults Manager;
- ICB Quality Leads;
- ICB Quality and Nursing Business Manager;
- ICB Associate Director of Corporate Affairs.

4.6.2 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

4.6.3 Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Primary Care, Secondary and Community Providers.

4.6.4 The Chief Executive should be invited to attend the meeting at least annually.

4.7 Attendance

4.7.1 Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair

5. Quoracy

5.1 Quoracy is defined as a minimum of 50% of the Committee's core membership which must include the Chair or Vice-Chair or their nominated deputy, and the Chief Nursing Officer or Chief Medical Officer (or deputy).

5.2 Where partner members are included in the core membership of the Committee, business planners for meetings will be designed to make optimal use of partner time, meaning that they may not be required for all of every meeting. Where this is the case, their absence will not affect the quoracy of the meeting.

5.3 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.4 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

6. Voting and decision-making

6.1 The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

6.2 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.

6.3 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis using telephone, email or other electronic communication

7. Frequency and notice of meetings

7.1 The Quality Committee shall meet six times a year (every other month). The Chair of the Committee may convene additional meetings as required.

7.2 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.

8. Committee secretariat

8.1 The Committee shall be supported with a secretariat function provided by the Corporate Governance Team. The Governance Team shall ensure that:

8.1.1 The agenda and papers are prepared and distributed in accordance with the Standing Orders at least 5 working days before the meeting, having been agreed by the Chair with the support of the relevant executive lead – Chief Nursing Officer;

8.1.2 Attendance by members of the committee is monitored and reported annually as part of the Annual Governance Statement (contained within the Annual Report)

8.1.3 Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;

8.1.4 Good quality minutes are taken and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept;

8.1.5 The Chair is supported to prepare and deliver reports to the Board;

8.1.6 The Committee is updated on pertinent issues/ areas of interest/ policy developments;

8.1.7 Action points are taken forward between meetings and progress against those actions is monitored.

8.2 All members or attendees at the Committee are required to declare any potential or actual conflict of interest before items are discussed. There will

be a standing agenda item at the beginning of each meeting for this purpose. Even if an interest has been recorded in the register of interests, it must still be declared in meetings where matters relating to that interest are records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.

9. Remit and Responsibilities of the committee

9.1 The Quality Committee has been constituted in terms of its scope, responsibilities and membership to facilitate the ICB meeting its four fundamental purposes 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**.

9.2 Each Integrated Care Board Committee will have a remit which encompasses two primary areas of responsibility. First, the Committee will exercise the delegated authority of the Board to execute assurance against a sub-set of its statutory duties and functions. Second, it will retain oversight of progress against the Integrated Care Board's strategic priorities through the developing partnership and integrated working of its members. This balanced approach will ensure that the governance focus of the Committee spans both current performance and risk as well as strategic development and system effectiveness. Committees will have a core membership spanning both areas of its responsibility, which can be enhanced as required by the addition of co-opted attendees or participants who are invited to contribute to the debate and deliberation of the Committee. The decision on the use of co-opted attendees or participants rests with the Chair of the Committee.

9.3 The committee will have a strong focus on the partnership agenda and will work with the System Quality Group to support the ICS to bring partners together on approaches that can't be achieved by a single organisation alone.

9.4 The responsibilities of the Quality Committee will be authorised by the ICB Board. It is expected that the Quality Committee will:

9.4.1 Be assured that there are robust processes in place for the effective management of quality;

9.4.2 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;

9.4.3 Agree and put forward the key quality priorities that are included within the ICB strategy/ annual plan;

9.4.4 Oversee and monitor delivery of the ICB key statutory requirements;

9.4.5 Review and monitor those risks on the Board Assurance F and Corporate Risk Register which relate to quality, and high-risk operational risks which could impact on care. Ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner;

9.4.6 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;

9.4.7 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;

9.4.8 Oversee and seek assurance on the effective and sustained delivery of the ICB Quality Improvement Programmes;

9.4.9 Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place;

9.4.10 Receive assurance that the ICB identifies lessons learned from all relevant sources, including, incidents, never events, complaints and claims and ensures that learning is disseminated and embedded;

9.4.11 Receive assurance that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from death (including coronial inquests and PFD report);

9.4.12 To be assured that people drawing on services are systematically and effectively involved as equal partners in quality activities;

9.4.13 Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children;

9.4.14 Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for infection prevention and control;

9.4.15 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;

9.4.16 Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety.

9.4.17 Approval of policies and standard operating procedures (SOPs) as relevant to the committee's business.

10. Relationship with the ICB and other groups / committees / boards

10.1 The Quality Committee is directly accountable to the ICB. The minutes of meetings shall be formally recorded. The Committee will advise the Audit Committee on the adequacy of assurances available and contribute to the Annual Governance Statement.

10.2 The Committee will have oversight of and approve the Terms of Reference and work programmes for the groups reporting into the Quality Committee (e.g. Infection Prevention and Control, Safeguarding Boards / Hubs etc).

10.3 The Committee will receive scheduled assurance report from its delegated groups. Any delegated groups would need to be agreed by the ICB Board.

11. Policy and best practice

11.1 The Committee shall have regard to current good practice, policies and guidance issued by the NHS England, NICE, Royal Colleges and other relevant bodies

12. Monitoring and Reporting Policy and best practice

12.1 The Chair of the Committee shall report the outcome and any recommendations of the committee to the Board of the ICB, and provide a report on assurances received, escalating any concerns where necessary.

12.2 The minutes of each meeting of the Committee shall be formally recorded and retained by the Integrated Care Board. The minutes shall be submitted to the Board of the ICB.

12.3 The Committee shall submit to the Board of the ICB an Annual Report of its work.

12.4 The Committee shall agree an annual schedule of reports and their frequency for the Quality Committee meetings.

13. Conduct of the Committee

13.1 Members will be expected to conduct business in line with the ICB values and objectives.

13.2 Members of, and those attending the Committee shall be have in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

13.3 Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

13.4 Conflicts of interests

13.4.1 In discharging duties transparently, conflicts of interest must be considered, recorded and managed. Members should have regard to both the ICB's policies and national guidance on managing conflicts of interest.

13.4.2 All potential conflicts of interest must be declared and recorded at the start of each meeting.

13.4.3 A register of interests must be maintained by the Governance Team, submitted with the Quality Committee papers and annually to the Board.

13.5 If the Chair considers a conflict of interest exists then the relevant person must not take part in that item, and the Chair may require the affected member to withdraw at the relevant point.

14. Review of ToR

14.1 These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

14.2 The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Remuneration Committee

1. Introduction

1.1. 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.

1.2. These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.3. The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. Purpose

2.1 The Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006. In summary:

2.2 Confirm the ICB Pay Policy including adoption of any pay frameworks for all employees including senior managers/directors (including board members) and Non-Executive Members excluding the Chair.

2.3 The remuneration and terms and conditions of the ICB Chair is set nationally.

2.4 The Board has also delegated the following functions to the Committee:

2.4.1 Oversight of executive board member performance in relation to any performance related pay.

2.5 The purpose of the Committee is also to take a strategic role in laying the foundations for aligning Pay and Reward Policies across the ICS such that Gloucestershire can optimise the conditions for attracting, recruiting and retaining the highest calibre senior directors and leaders (including board members) to roles across the ICB and its partner members.

3. Delegated Authority

3.1 The Remuneration Committee is a formal committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

3.2 The Remuneration Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

4. Membership

4.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution. The Board will appoint no fewer than three members of the Committee including two independent members of the Board. The Chair of the Audit Committee may not be a member of the Remuneration Committee.

- Committee Chair who shall be an Non-Executive Director of the ICB but cannot be the Chair of the Board of the ICB nor Chair of the Audit Committee;
- The Chair of the Board of the ICB (Deputy Committee Chair);
- Non-Executive Chair of the Board of one of the main provider partner organisations.

4.2 In situations where the Remuneration Committee determines the remuneration of ICB Non-Executive Member, the membership of the committee shall be:

- Non-Executive Director Chair of the Board of one of the main provider partner organisations whom shall assume the position of Chair;
- The Chair of the ICB.

4.3 Members will possess between them knowledge, skills and experience in organisational development, people management and renumeration 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.

4.4 <u>Chair and Vice Chair</u>

4.4.1 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.

4.4.2 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 to Chair the meeting.

4.4.3 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

4.5 Attendees and other Participants

4.5.1 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.

4.5.2 Meetings of the Committee may also be attended by the following individuals who are not members of the Committee for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote:

- The ICB's most senior HR Advisor or their nominated deputy;
- Chief Financial Officer or their nominated deputy;
- Chief Executive or their nominated deputy.

4.5.3 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

- No individual should be present during any discussion relating to:
- Any aspect of their own pay;
- Any aspect of the pay of others when it has an impact on them.

4.6 Attendance

4.6.1 Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

5. Quoracy

5.1 For a meeting to be quorate, a minimum of two Non-Executive Members of the Committee are required, including either the Chair of the Committee or

ICB Chair and the Non-Executive Chair of the Board of one of the main provider partner organisations.

5.2 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

5.4 In situations where the Renumeration Committee determines the remuneration of ICB Non-Executive Members, a minimum of two Non-Executive Members of the Committee are required.

6. Voting and decision making

6.1 Decisions will be guided by national NHS policy and best practice to ensure that staff are fairly motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency.

6.2 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.

6.3 Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

6.4 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The same principle will be used where the Remuneration Committee meet to determine the renumeration of ICB Non-Executive Members.

7. Frequency and notice of meetings

7.1 The Remuneration Committee shall meet at least once per year; and as the business of the ICB requires.

7.2 The Chair of the Committee may convene additional meetings as required.

7.3 The Committee shall meet in private.

7.4 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.

8. Committee secretariat

8.1 The Committee shall be supported with a secretariat function provided by the Corporate Governance Team. The Governance Team shall ensure that:

8.1.1 The agenda and papers are prepared and distributed in accordance with the Standing Orders at least 5 working days before the meeting, having been agreed by the Chair with the support of the relevant HR lead – Associate Director of Corporate Affairs

8.1.2 Attendance by members of the Committee is monitored and reported annually as part of the Annual Governance Statement (contained within the Annual Report);

8.1.3 Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;

8.1.4 Good quality minutes are taken and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept;

8.1.5 The Chair is supported to prepare and deliver reports to the Board;

8.1.6 The Committee is updated on pertinent issues/ areas of interest/ policy developments;

8.2 Action points are taken forward between meetings and progress against those actions is monitored.

9. Remit and responsibilities of the Committee

9.1 The Remuneration Committee has been constituted in terms of its scope, responsibilities, and membership to facilitate the ICB meeting its four fundamental purposes 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**.

9.2 Each Integrated Care Board Committee will have a remit which encompasses two primary areas of responsibility. First, the Committee will exercise the delegated authority of the Board to execute assurance against a sub-set of its statutory duties and functions. Second, it will retain oversight of progress against the Integrated Care Board's strategic priorities through the developing partnership and integrated working of its members. This balanced approach will ensure that the governance focus of the Committee spans both current performance and risk as well as strategic development and system effectiveness. Committees will have a core membership spanning both areas of its responsibility, which can be enhanced as required by the addition of co-opted attendees or participants who are invited to contribute to the debate and deliberation of the Committee. The decision on the use of co-opted attendees or participants rests with the Chair of the Committee.

9.3 The Committee's duties are as follows:

9.3.1 For the Chief Executive, Non-Executive Directors and other Very Senior Managers:

- Determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses, expenses, pensions and cars;
- Determine arrangements for termination of employment and other contractual terms and non-contractual terms;
- Undertake performance review/ oversight for directors/senior managers as related to any performance related pay;
- 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).

9.3.2 For all staff:

- Determine the ICB pay policy and terms and conditions of employment including the adoption of NHS terms and conditions and pay framework i.e. Agenda for Change;
- 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.

9.4 The Committee will ensure that its statutory duties and functions are executed alongside the pursuit of a system wide and strategic approach to remuneration.

9.5 The Committee is authorised by the Board of the ICB to obtain legal advice, remuneration or other professional advice, including the appointment of external advisor and/or consultants, related to its functions as it deems fit at the expense of the ICB.

9.6 Approval of any other policies and standard operating procedures (SOPs) as relevant to the committee's business.

10. Relationship with the ICB and other groups / committees / boards

10.1 The Remuneration Committee is directly accountable to the ICB. The minutes of meetings shall be formally recorded. The Committee will advise the Audit Committee on the adequacy of assurances available and contribute to the Annual Governance Statement.

11. Policy and best practice

11.1 The Committee shall have regard to current good practice, policies and guidance issued by NHS England, and other relevant bodies.

11.2 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

12. Monitoring and Reporting

12.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

12.2 The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board.

12.3 The Remuneration Committee will submit copies of its minutes and a report to the Board following each of its meetings. Where minutes and reports identify individuals, they will not be made public and will be presented at part II of the Board. Public reports will be made as appropriate to satisfy any requirements in relation to disclosure of public sector executive pay.

12.4 The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

13. Conduct of the Committee

13.1 Members will be expected to conduct business in line with the ICB values and objectives

13.2 Members of, and those attending the Committee shall act in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy

13.3 Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

13.4 Conflicts of interests: In discharging duties transparently, conflicts of interest must be considered, recorded and managed. Members should have regard to both the ICB's policies and national guidance on managing conflicts of interest. All potential conflicts of interest must be declared and recorded at the start of each meeting. A register of interests must be maintained by the Governance Team, submitted with the Remuneration Committee papers and annually to the Board. If the Chair considers a conflict of interest exists then the relevant person must not take part in that item, and the Chair may require the affected member to withdraw at the relevant point.

14. Review of ToR

14.1 These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

System Resources Committee

1. Introduction

1.1 The System Resource Committee (the Committee) is established by the Integrated Care Board (ICB) as a Committee of the Board in accordance with its Constitution. These Terms of Reference (ToR), set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.2 The Committee is an 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

2.1 NHS England and NHS Improvement have outlined the role of the ICS in the delivery of integrated care in the paper 'Integrating care: Next steps to building strong and effective integrated care systems across England'. The ICS's role is to serve four fundamental purposes:

- improving population health and healthcare;
- tackling unequal outcomes and access;
- enhancing productivity and value for money;
- helping the NHS to support broader social and economic development.

2.2 The Committee will contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board for matters relating to system resources allocation, performance against strategic plans and financial performance:

2.2.1 Efficiency, outcomes and value for money in the use of resources across the ICB footprint;

2.2.2 Financial performance of the ICB;

2.2.3 Financial performance of NHS organisations within the ICB footprint.

2.3 Specific areas covered are:

2.3.1 Improving population health and healthcare: by ensuring that resources are prioritised to support:

- improvement in health outcomes;
- increased efficiency and value for money of the delivery of healthcare across the ICS.

2.3.2 Tackling unequal outcomes and access: by ensuring that resources are prioritised to support:

- reducing health inequalities;
- increasing social justice and health equity.

2.3.3 Enhancing productivity and value for money: by ensuring that resources are prioritised to support:

- the system to take a value-based healthcare approach across organisations and programmes of care;
- delivery of enhanced efficiency, productivity and value for money through the application of rigorous management of resources, prioritisation and benefits realisation approaches.

2.3.4 Helping the NHS to support broader social and economic development, by ensuring that resources are allocated to support the strategic objectives as set out through the integrated care partnership.

2.4 Oversee the collective management of system resources and performance system/place-based and organisational levels, contributing to the wider System Oversight Framework held by the ICS Board, in particular with responsibility for providing the evidence for the domain “Finance and Use of Resources”.

2.5 Request devolution of programme funding (assuming Segment 1 earned autonomy) and take proportionate control over the deployment of improvement resources made available through regional improvement hubs.

2.6 Request access to funding to provide peer support to other organisations, and benefit from a streamlined business case approval process.

2.7 The System Resource Committee has no executive powers, other than those delegated in the SoRD and specified in these terms of reference.

3. Delegated Authority

3.1 The System Resources Committee is a formal committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

3.2 The System Resource Committee is authorised by the Board to:

3.2.1 Investigate any activity within its terms of reference;

3.2.2 Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) as outlined in these terms of reference;

3.2.3 Commission any reports it deems necessary to help fulfil its obligations;

3.2.4 Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice;

3.2.5 Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, Standing Orders and Scheme of Reservation and Delegation (SoRD) but may not delegate any decisions to such groups.

3.3 For the avoidance of doubt, the Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD.

4. Membership

4.1 <u>Membership</u>

4.1.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

4.1.2 The Board will appoint no fewer than five members of the Committee including:

- Independent Non-Executive Director of the ICB who leads on Resources (Chair);
- A Non-Executive Director who ideally holds a finance qualification – this

could be a co-opted member from one of the ICS Partner Boards (Vice Chair);
- Chief Executive Officer of the ICB;
- Chief Financial Officer of the ICB;
- Director of Strategy and Transformation of the ICB;
- Director of Operational Planning and Performance of the ICB.

4.1.3 Members will possess between them knowledge, skills and experience in accounting; risk management; strategic and financial planning; 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.

4.2 Chair and vice chair

4.2.1 In accordance with the constitution, the Committee will be chaired by an Independent Non-Executive Director of the ICB appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.

4.2.2 The Chair of the Committee shall be independent and therefore may not chair any other committees.

4.2.3 Committee members may appoint a Vice Chair who will be a Non-Executive Director who holds a finance qualification – this could be a committee member co-opted from one of the ICS Partner Boards.

4.2.4 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

4.3 Attendees and other Participants

4.3.1 Only members of the Committee have the right to attend Committee meetings, however all meetings of the Committee may also be attended by other invited and appropriately nominated individuals who are not members of the Committee. 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, mental health and community providers, notably:

- Directors of Finance of each main health system Provider partner (Community & Mental Health; Acute);

- Directors of Strategy of each main health system Provider partner (Community & Mental Health; Acute);
- Director of Finance and Director of Strategy of the Local Authority; notably as required for specific agenda items.
- One Independent Non-Executive Director of each main system partner (Community & Mental Health; Acute; Local Authority), who chairs their equivalent committee responsible for the allocation and utilisation of financial and other material resources.

4.3.2 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

4.3.3 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.

4.4 Attendance

4.4.1 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.

4.5 Structure

4.5.1 The business of the Committee shall consist of two sections:

- Organisational Finance - the business of ICB internal financial matters, equivalent to partner organisations' internal finance/resources committees.
- System Finance – the broader system financial performance and position including ongoing work regarding value.

5. Quoracy

5.1 Quoracy is defined as a minimum of 50% of the Committee's core membership which must include the Chair or Vice-Chair or their nominated deputy.

5.2 Where partner members are included in the core membership of the Committee, business planners for meetings will be designed to make optimal use of partner time, meaning that they may not be required for all of every meeting. Where this is the case, their absence will not affect the quoracy of the meeting.

5.3 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.4 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

6. Voting and decision-making

6.1 Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

6.2 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.

6.3 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication. Where any such action has been taken between meetings, then these will be reported to the next meeting. For the avoidance of doubt, this provision applies to and facilitates the Committee's decision making by email, should this be required to expedite an urgent decision.

7. Frequency and notice of meetings

7.1 The System Resource Committee will meet at least 6 times a year. Arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

7.2 The Board, Chair or Chief Executive may ask the System Resource Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

7.3 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

8. Committee secretariat

8.1 The Committee shall be supported with a secretariat function which will include ensuring that:

8.1.1 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;

8.1.2 Attendance of those invited to each meeting is monitored and those that do not meet the minimum attendance requirements are highlighting to the Chair;

8.1.3 Except in the event of urgent meetings, a minimum of ten days' notice of a meeting of the Committee will normally be provided confirming the venue, time and date together with an agenda of items to be discussed. Supporting papers will normally be issued 5 working days before the meeting;

8.1.4 All members or attendees at the Committee are required to declare any potential or actual conflict of interest before items are discussed. There will be a standing agenda item at the beginning of each meeting for this purpose. Even if an interest has been recorded in the register of interests, it must still be declared in meetings where matters relating to that interest are records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;

8.1.5 Good quality minutes are taken in accordance with the standing orders and agreed with the chair so that a record is kept of matters arising, action points and issues carried forward;

8.1.6 The Chair is supported to prepare and deliver reports to the Board;

8.1.7 The Committee is updated on pertinent issues/ areas of interest/ policy developments;

8.1.8 Action points are taken forward between meetings and progress against those is monitored.

8.2 All members or attendees at the Committee are required to declare any potential or actual conflict of interest before items are discussed. There will be a standing agenda item at the beginning of each meeting for this purpose. Even if an interest has been recorded in the register of interests, it must still be declared in meetings where matters relating to that interest are records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.

9. Remit and responsibilities of the Committee

9.1 The System Resource Committee will contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board for matters relating to system resources allocation, performance against strategic plans and strategic financial performance.

9.2 Each Integrated Care Board Committee will have a remit which encompasses two primary areas of responsibility.

9.2.1 The Committee will exercise the delegated authority of the Board to execute assurance against a sub-set of its statutory duties and functions.

9.2.2 The Committee will retain oversight of progress against the Integrated Care Board's strategic priorities through the developing partnership and integrated working of its members.

9.3 This balanced approach will ensure that the governance focus of the Committee spans both current performance and risk as well as strategic development and system effectiveness.

9.4 Committees will have a core membership spanning both areas of its responsibility, which can be enhanced as required by the addition of co-opted attendees or participants who are invited to contribute to the debate and deliberation of the Committee. The decision on the use of co-opted attendees or participants rests with the Chair of the Committee.

9.5 The Committee will provide oversight and assurance to the Board in relation to:

9.6 <u>Efficiency, Outcomes and Value for Money in the use of resources</u>:

9.6.1 <u>System Resources Allocation</u>

- Improve population health and healthcare delivery by ensuring that resources are prioritised to support improvement in health outcomes and increased efficiency and value for money of the delivery of healthcare across the ICS;
- Assure the approach to distribute the resource allocation through commissioning and direct allocation to drive agreed change based on the ICB strategy;

- Support the ICS objective of tackling unequal outcomes and access by ensuring that resources are prioritised to support programmes that reduce health inequalities and / or increase social justice and health equity;
- Support the ICS to support broader social and economic development, by ensuring that resources are allocated to support the strategic objectives as set out through the integrated care partnership;

9.6.2 Agree the proposed process regarding the deployment of system-wide transformation funding in line with SOF segmentation and earned autonomy.

9.6.3 Enhance Productivity and Value for Money:

- Provide leadership across the system to ensure a value-based healthcare approach across organisations and programmes of care;
- Assure the delivery of enhanced efficiency, productivity and value for money through the application of rigorous management of resources, prioritisation and benefits realisation approaches to ensure financial resources are used in an efficient way to deliver the objectives of the ICB;
- to monitor the identification and delivery of system efficiencies across the ICB, in particular opportunities at system level where the scale of the ICB partners together and the ability to work across organisations can be leveraged;
- to receive exception reports on any material breaches of the delivery of agreed efficiency improvement plan including the adequacy of proposed remedial action plans.

9.7 Financial Performance of the ICB

9.7.1 System financial management framework

- to agree the strategic financial framework of the ICB;
- to have oversight of the ICB financial information systems and processes to be used for financial planning in line with the strategy and national guidance;
- to oversee and recommend proposals to allocate resources where appropriate across ICS partners to address finance and performance related issues that may arise;
- to consider all major and material investment/disinvestment service changes or efficiency schemes prior to submission to the Board for approval where appropriate.

9.7.2 Financial monitoring information

- to receive assurance on the effective monitoring of the ICB in-year financial performance against plan, with consideration of underlying activity and relevant performance data as appropriate, identifying key issues and risks requiring discussion or decision by the Board;
- to oversee and challenge the financial position and financial impacts (both short and long-term) to support decision-making;
- to be assured that all plans and reports are supported by robust activity and financial information;
- to be assured that there is robust financial and activity modelling to support the ICB priority areas;
- Provide oversight of the Financial Strategy including the medium-term financial plan (MTFP)
- to be assured there is a robust understanding of where costs sit across the system, the drivers of system cost, and the impacts of service change on costs;
- to oversee the development of an approach with partners, including the ICB health and care partnership, to ensure the relationship between cost, performance, quality and environment sustainability are understood;
- to be assured that appropriate information is reported to manage financial issues, risks and opportunities across the ICB;
- to consider and comment on strategic risks on the corporate risk register.
- to have oversight of the financial position of ICS partners, and how this relates to the system control total to ensure that we achieve the best financial outcome for the system;
- to receive in year financial performance reports from ICS partners which are based on common approaches, estimates and judgements.

9.7.3 Performance

- Assure the ICB's performance against the Constitution and other Local Performance Measures.
- Assure that the underpinning systems and processes for data collection and management are robust and provide relevant, timely and accurate information to support the operational management of the organisation.

9.7.4 Capital

- Have oversight of the system estates strategy and plan to ensure it properly balances clinical, strategic and affordability drivers;

- Receive assurance that the estates plan is built into system financial plans;
- Assure the System capital programme and annual capital budgets against the capital envelope and consider actions that need to be taken to ensure that it is appropriately and completely used and recommend to the ICB;
- Consider proposals for investment in line with an agreed prioritisation process for the ICB and NHS partner organisations;
- Review recommendations from the capital prioritisation process and assure recommendation to the Board for approval.

9.8 Approval of policies and standard operating procedures (SOPs) as relevant to the committee's business.

10. Relationship with the ICB and other groups / committees / boards

10.1 The System Resources Committee is directly accountable to the ICB. The minutes of meetings shall be formally recorded. The Committee will advise the Audit Committee on the adequacy of assurances available and contribute to the Annual Governance Statement.

10.2 The Committee will have oversight of and approve the Terms of Reference and work programmes for the groups reporting into the System Resources Committee.

10.3 The Committee will receive scheduled assurance report from its delegated groups. Any delegated groups would need to be agreed by the ICB Board.

10.4 To work closely with the other committees in the ICB where appropriate and relevant e.g. implementation of the Internal Audit recommendations and receive assurances to the Audit Committee.

10.5 To work closely with the other finance/resource committees in the ICS where appropriate and relevant to ensure consistency in best practise and appropriate transparency in the oversight, monitoring and probity of the use of public resources.

10.6 To investigate identified areas of concern with regard to the ICB's internal controls referred by another committee or the Board of the ICB

11. Policy and best practice

11.1 When considering matters, the Committee should take into account the following points:

11.1.1 All statutory requirements applicable to CCGs (including Accounting, Health and Safety, Information Security, etc.);

11.1.2 NHS England requirements and standards;

11.1.3 Best professional practice and standards;

11.1.4 NHS Best practice and guidance;

11.1.5 Emerging risks and issues.

11.2 The Committee will have full authority to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, within its terms of reference and within a limit determined by the Chief Finance Officer.

12. Monitoring and Reporting

12.1 When considering matters, the Committee should take into account the following points:

12.1.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities;

12.1.2 The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board in accordance with the Standing Orders;

12.1.3 The Chair will provide assurance reports to the Board after each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action;

12.2 The Committee will provide an annual report to the Board to describe how it has fulfilled its terms of reference, details on progress and a summary of key achievements in delivering its responsibilities.

13. Conduct of the Committee

13.1 Members will be expected to conduct business in line with the ICB values and objectives.

13.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

13.3 Conflicts of interest

13.3.1 In discharging duties transparently, conflicts of interest must be considered, recorded and managed. Members should have regard to both the ICB's policies and national guidance on managing conflicts of interest.

13.3.2 All potential conflicts of interest must be declared and recorded at the start of each meeting. A register of interests must be maintained by the Chair and submitted to the Board. If the Chair considers a conflict of interest exists then the relevant person must not take part in that item, and the Chair may require the affected member to withdraw at the relevant point.

13.4 Equality and diversity

13.5 Members must demonstrably consider the equality and diversity implications of decisions they make.

14. Review of ToR

14.1 The Committee will review its effectiveness at least annually. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Joint Committees Terms of Reference

Joint Commissioning Partnership Board (JCPB)
Joint Commissioning Partnership Executive (JCPE)

1. Partnership Aim

1.1. The aim of the partnership is to work together to jointly commission adult and children's services in order to:

- achieve better integration of provided services;
- avoid duplication or gaps in services, and
- ultimately improve outcomes for citizens and patients.

2. Purpose of the Partnership

2.1. The purpose of the partnership is to oversee, monitor and make recommendations on the integrated and joint commissioning of adult, children's services, public health and early intervention/prevention services on behalf of NHS Gloucestershire Integrated Care Board (ICB) and Gloucestershire County Council (the Partners).

2.2. This involves:

- Mapping and interpreting policy – to direct new commissioning strategies
- Scoping, testing and prior approval of new joint commissioning strategies
- Assurance on the implementation of agreed strategies
- Oversight and approval of joint funding agreements and budgets (sections 75, 256 etc)

3. Membership

3.1. The membership of the Joint Commissioning Partnership comprises:

Board	Executive
ICB Chair	GCC / ICB Director of Integrated Commissioning
ICB Chief Medical Officer	ICB Chief Executive Officer
ICB Chief Executive Officer	ICB Chief Finance Officer
GCC Cabinet Portfolio Holders	GCC Finance
ICB Chief Finance Officer	GCC Director of Adult Services
GCC Director of Finance	GCC Director of Children's Services
GCC Director of Adult Services	GCC Director of Public Health

Board	Executive
GCC Director of Children's Services	
GCC Director of Public Health	
GCC/ICB Director of Integrated Commissioning	

In attendance: Minute taker JCPB and JCPE	GCC/ICB: Business Support Manager

3.2. The quorum for the meeting will be four members of the partnership and at least two from each organisation.

3.3. The partnership can, by agreement, co-opt additional members at any time and for any time period.

4. Meeting arrangements

4.1. The Board will meet on a quarterly basis and the Executive once a month. Meetings will be held in private.

4.2. The Board Chair will be either a GCC Cabinet Member or the ICB Chair. The Executive Chair will be either the ICB Chief Executive Officer or the Director of Adult Services. (The Board and Executive will always be chaired by different organisations).

4.3. Items will be set out in the agenda and sent to all members at least five working days before the meeting.

4.4. Each meeting will be invited to approve as a correct record the minutes of the previous meeting and receive any declarations of interest.

5. Duties and principal functions

5.1. To govern the work of the Partnership and to confirm its strategic direction. The Board will act as the principal focal point for discussion on emerging policies, changes to local or national circumstances and issues relating to the effective management of the services in question and to make proposals and recommendations in respect thereof, having considered and discussed them at the Partnership and following consultation with affected parties.

5.2. To oversee the commissioning and monitoring of services, including:

- Approving strategic plans and commissioning strategies;

- Recommending commissioning decisions on behalf of the County Council and the ICB;
- Receiving summary monitoring information on the delivery of commissioned services;
- Overseeing the monitoring of financial performance across all budgets within the scope of the partnership including those which are pooled, recommending corrective action as necessary;
- Ensuring effective risk management within commissioning activity;
- Evaluating how services are developed against agreed action plans;
- Ensuring service users and carers views are properly represented to the Board;
- Overseeing the continuing development of joint working between the Integrated Care Board and the County Council and the processes and relationships that underpin it.

5.3. The Partnership shall carry out its function in a manner that is consistent with the regulatory framework, including the Standing Orders, Codes of Conduct and Standing Financial Instructions of its constituent bodies.

5.4. As indicated above, the Partnership Board will be supported by an Executive Officers Group who will oversee joint commissioning in the County; to include the effective operation of service-specific Joint Commissioning Management Groups (eg the Learning Disabilities Partnership Board).

6. Decision making

6.1. The members of the partnership act within their delegated authority from their host organisation.

6.2. The ICB – where formal decisions by the ICB members of the JCP are required, these will be subject to the Standing Orders and Standing Financial Instructions of the ICB and, where appropriate, will be escalated to the ICB board for full approval.

6.3. The County Council – where formal decisions by the County Council's cabinet members are required, they will be taken through the County Council's executive processes, adhering to the statutory deadlines involved in those processes prior to the JCP meeting and be determined as decisions contemporaneously with the JCP recommendation and the Integrated Care Board decision.

7. Reporting

7.1. The Joint Commissioning Partnership Board will report to the Health and Wellbeing Board annually.

7.2. The ICB and GCC will report the work of the Board in line with their own governance arrangements.

Annex 1 - Joint / Integrated Commissioning Arrangements

Across health and social care we operate arrangements for joint commissioning through the pooling of budgets in the following areas.

Oversight of these arrangements is via Joint Commissioning Partnership Board (JCPB) / Executive (JCPE)

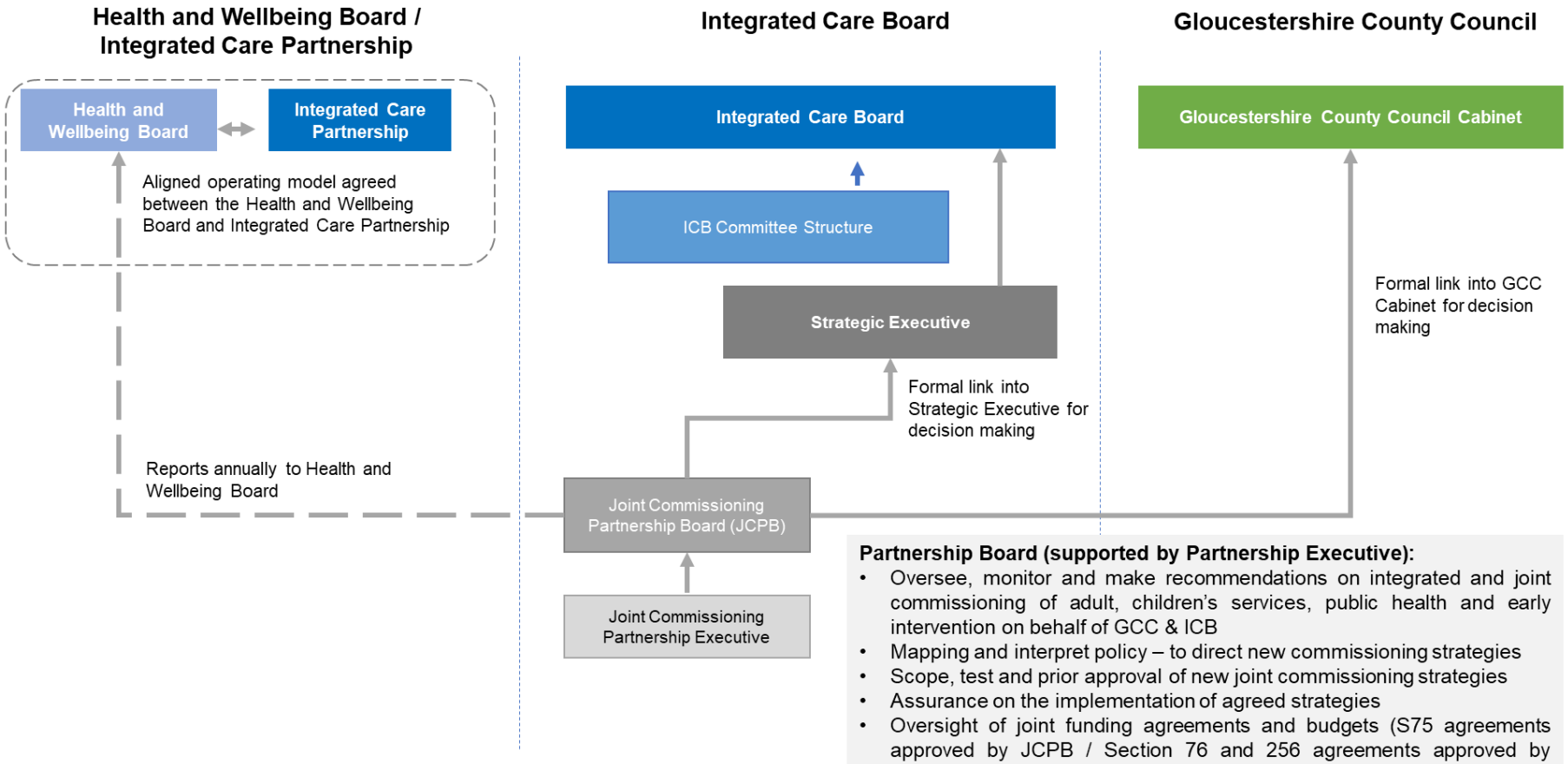
- **Section 75 of the NHS Act 2006** allows partners (NHS bodies and Local Government) to contribute to a common fund which can be used to commission health or social care services. Section 75 agreements include integrated services such as rapid response, integrated reablement team and mental health services such as liaison, crisis assessment, mental health advocacy services as well as a number of adult mental health services (such as community care and assessment and case management). Section 75 agreements include services such as sexual health services, home from hospital (provided by AgeUK), community wellbeing and substance misuse services.

- **Section 76 of the NHS Act 2006** permits the Local Authority to transfer to the NHS sums of money or resources which furthers their statutory functions. The NHS will then procure services alongside their own to help meet key objectives.

- **Section 256 of the NHS Act 2006** is a mirror image of Section 76 allowing the NHS to transfer to the Local Authority sums of money or resources which furthers their statutory objectives to provide better or more efficient health services or prevent ill health. The Local Authority will then procure services.

These arrangements are presented diagrammatically overleaf.

Joint / Integrated Commissioning Arrangements



Role Profiles of Board Members

Introduction and context common to all profiles

Introduction

The Integrated Care Board is one of the two pivotal components of the governance and accountability architecture of the One Gloucestershire Integrated Care System. Together with the Gloucestershire Health and Wellbeing Partnership, the ICB is responsible for delivering on the four fundamental purposes for Integrated Care Systems in England:

- **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**.

Remit of the Integrated Care Board

The Integrated Care Board is a unitary board and will deliver the strategy for the One Gloucestershire Integrated Care System, set by the Health and Wellbeing Partnership. The functions of the Integrated Care Board are established within the national 'Integrated Care Systems, design framework' guidance. In summary the functions and responsibilities of the ICB includes:

1. Developing a plan to meet the health needs of the population.
2. Allocating resources to deliver the plan across the system.
3. Establishing joint working arrangements with partners that embed collaboration as the basis for delivery of joint priorities.
4. Establishing governance arrangements to support collective accountability between partners.
5. Leading system wide arrangements through which the delivery of health services is ensured in line with allocated resources and conforming to national and constitutional standards.
6. Leading system implementation of the People Plan.
7. Leading system wide action on digital and data.
8. Using joined up digital and data capabilities to understand local priorities, track delivery of plans, monitor and address variation and drive continuous improvement.
9. Working alongside councils to invest in local voluntary sector and community organisations and infrastructure.
10. Driving joint working on estates, procurement, supply chain and commercial strategies.
11. Planning for, responding to and leading recovery from incidents (EPRR);
12. Functions NHS E/I will be delegating – e.g., commissioning of primary care and specialised services.

In addition, system partners in Gloucestershire have prioritised:

13. Promotion of Health and Population Health Management
14. Engagement and participation of local people and communities

Requirements for Board Members

The constitution of the Integrated Care Board sets out the membership of the Board. All members of the Board, executive, non-executive, and partner members are collectively and corporately accountable for ensuring that the ICB exercises its functions effectively, efficiently, economically, with good governance and in accordance with the terms of the ICB Constitution, as agreed by its members. Board members share responsibility for organisational performance and for shaping a healthy culture for the organisation and the system, through its interaction with system partners.

The membership of the ICB has been designed in order to ensure that mutual accountability between system partners and effective decision making is underpinned and informed by perspectives drawn from all parts of the health and care system. Board members will bring different professional and system perspectives, shaped by their expertise and experience. The collective skills and experience of the Board will support its focus on strategy, transformation and assurance and will ensure that:

- the ICB acts in the best interests of the health of the local population, across all communities and at all times and builds confidence amongst patients, public and stakeholders that healthcare is in safe hands
- the ICB plans for the provision of the highest quality services with a view to securing the best possible outcomes for patients within the resources available to Gloucestershire
- the ICB is responsive to the views of local people and adopts the principles and best practice guidance of listening to and learning from people and communities
- the ICB exercises its functions in line with the NHS Constitution, the Nolan principles, and secures the best value from public money
- the ICB adopt best practice in respect of governance and accountability and has systems of control that are reliable and robust
- the ICB meets the requirements of the NHS System Oversight Framework and operates with openness, transparency, and candour

Role Profile for Non-Executive Directors

Role of Non-Executive Directors

Non-Executive Directors will be expected to demonstrate the following behavioural qualities and either have a track record of or have the aptitude to develop the required board level competencies in respect of:

- leading and championing change and fostering innovation;

- valuing diversity and promote equity and inclusivity in all aspects of organisational operations and corporate leadership;
- Senior leadership capability that embodies a collective and distributed leadership style and builds an inclusive and compassionate culture within and across organisations;
- a commitment to hearing the diverse voices of local people and communities and embedding their involvement in the improvement, development, and evaluation of health services;
- advocacy for the role of the NHS as an anchor institution and the benefits this can bring to the Gloucestershire economy and wider social and physical environment;
- respect for the different clinical and professional perspectives that may be held by different leaders, teams and partners across the whole system and an appreciation of how to reach consensus within an inter-disciplinary context;
- able to exercise appreciative enquiry as well as critical thinking. Expertise in interpreting and evaluating data, analysis and evidence and reaching balanced judgements and conclusions;
- experience in improving outcomes for patients and tackling health inequalities
- knowledge and understanding of methods and approaches to improve the quality, performance, and value of health services;
- experience in formulating, implementing and evaluating strategy and assessing the benefits and impact delivered;
- experience of working across organisational boundaries to achieve strategic goals;
- understanding of corporate governance, stewardship of public money and assurance systems that achieve compliance with regulatory obligations and standards;
- commitment to preparing for and participating in ICB board meetings and development sessions and to working within the Code of Conduct for ICB members and the associated ‘Standards of Business Conduct’ policy.

Summary of specific role duties and responsibilities

Non-Executive Directors of the ICB have a number of responsibilities and duties in common and collectively, relating to board governance and oversight:

1. Responsible to ensure corporate accountability for the performance of the organisation, ensuring its functions are effectively and efficiently discharged and its financial obligations are met.
2. Work alongside the Chair, executive directors and partner members and as equal members of a unitary board to bring independent and respectful challenge to the plans, aims and priorities of the ICB.
3. Promoting and provide open and transparent decision-making that facilitates consensus aimed to deliver exceptional outcomes for the population.
4. Bring a range of professional expertise as well as community understanding and experience to the work of the Board, through lived experience and personal motivations that will add valuable personal insights such as:
    a. being a patient, carer or service user;

b. experience of gender and women's issues;
c. engaging with diverse social, economic and cultural groups and communities;
d. challenges of younger people;
e. mental health issues and/or living with physical chronic conditions or disability.

Each Non-Executive Director will be required to be the chair of at least one formal committee of the Board. These committees are bound by Standing Orders, Standing Financial Instructions (SFI's), the Scheme of Reservation and Delegation (SoRD), and other policies of the ICB.

All Committees have membership from the wider system partners in the ICS, not just the ICB, and Non-Executive Directors will be required to ensure these partners have appropriate voice and agency in the work of the Committee All Committees will actively consider diversity and equality in its membership, and each Non-Executive Director chair will be required to champion this and hold themselves and the Committee to account.

The scope, responsibilities and functions of each Committee are described in detail in their Terms of Reference documents which are available in the ICB Governance Handbook, and briefly summarised below:

Audit Committee

- Provide oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.
- Critically review the Integrated Care Board's financial reporting and internal control principles and ensure an appropriate relationship with both internal and external auditors, and counter fraud is maintained.
- Deliver an annual programme of business agreed before the start of the financial year, which will be flexible to new and emerging priorities and risks.
- Has delegated authority from the Board to:
    - 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);
    - 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 to fulfil its functions.
- Members of this Committee must possess between them skills and experience in: accounting, risk management, internal, external audit; and technical or specialist issues pertinent to the ICB's business.

People Committee

- Accountable to the ICB for all matters relating to the development of the System People Strategy (aligned to the NHS People Promise) and associated plans and for delivery of the Equality, Diversity and Inclusion (EDI) agenda and objectives.
- Hold the People Board to account for achieving the intended results and benefits of the People Strategy and Plans, and reaching agreed milestones in making the ICS an increasingly equitable, diverse and inclusive health and care system.
- Provide oversight and scrutiny of the effectiveness of the ICS People Function and receive assurance that it is fit for purpose in delivering the capability necessary for the delivery of the ICS people strategy and objectives.
- Receive reports against the leadership and people dimensions of System Oversight Framework and will examine the management of People and EDI related risks.
- Oversee the ICS's strategic approach to talent management and succession planning, ensuring a pipeline of talent for clinical, professional, executive and non-executive leadership roles is developed and maintained.
- Examine opportunities for extending partnership and integrated working across the system workforce agenda so that the conditions for enabling transformation in respect of people and EDI priorities are optimised
- Has delegated authority from the Board to:
    - Investigate any activity or aspects within its terms of reference;
    - Seek any information it requires within its remit, from any employee or member of the ICB;
    - 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 to fulfil its functions;
    - Create task and finish sub-groups in order to undertake 'deep-dive' examinations of aspects of governance and assurance;
- Members of this Committee must possess between them skills and experience in: Equity and EDI; strategic workforce planning, development and transformation; leadership, culture, talent and organisational development; system dynamics and development.

Primary Care & Direct Commissioning (PCDC) Committee

- Manage the delivery of those elements of the primary care healthcare services delegated by NHSEI to the ICB (see para 1.2 of the full Terms of Reference).
- Deliver, on behalf of the ICB, services that are high quality, clinically effective and safe, within available resources, through a culture of openness supported by sound governance arrangements.
- Has delegated authority from the Board to:
    - Investigate any activity or aspects within its terms of reference;
    - Seek any information it requires within its remit, from any employee or member of the ICB;

- 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 to fulfil its functions;

- Members of this Committee must possess between them skills and experience in: Equity and EDI; primary care development and contracting, patient safety and quality and technical, or specialist issues pertinent (e.g. dentistry, optometry and pharmacy).

Quality Committee

- 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 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.
- 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.
- Has delegated authority from the Board to:
  - Investigate any activity or aspects within its terms of reference;
  - Seek any information it requires within its remit, from any employee or member of the ICB;
  - 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 to fulfil its functions;
- Members of this Committee must possess between them skills and experience in: clinical quality and governance, and technical or specialist issues.

Remuneration Committee

- 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 Members (excluding the Chair)
  - Oversight of executive board member performance in relation to any performance related pay;
- Take a strategic role in laying the foundations for aligning Pay and Reward Policies across the ICS such that Gloucestershire can optimise the conditions for attracting, recruiting and retaining the highest calibre senior directors and leaders (including board members) to roles across the ICB and its partner members.
- Members of this Committee must possess between them skills and experience in: organisational development, people management and renumeration, and technical or specialist issues.

System Resources Committee

- Provide the ICB with oversight and assurance for matters relating to system resources allocation, performance against strategic plans, and financial performance:
  - Efficiency, outcomes and value for money in the use of resources across the ICB footprint;
  - Financial performance of the ICB;
  - Financial performance of NHS organisations within the ICB footprint.
- Ensuring that resources are prioritised to support:
  - Improving population health and healthcare;
  - Tackling unequal outcomes and access;
  - Enhancing productivity and value for money;
  - Helping the NHS to support broader social and economic development through the strategic objectives as set out through the integrated care partnership
- Oversee the collective management of system resources and performance system/place-based and organisational levels, contributing to the wider System Oversight Framework held by the ICS Board, in particular with responsibility for providing the evidence for the domain “Finance and Use of Resources”.
- Request devolution of programme funding (assuming Segment 1 earned autonomy) and take proportionate control over the deployment of improvement resources made available through regional improvement hubs.
- Request access to funding to provide peer support to other organisations, and benefit from a streamlined business case approval process.
- Has delegated authority from the Board to:
  - Investigate any activity or aspects within its terms of reference;
  - Seek any information it requires within its remit, from any employee or member of the ICB;
  - 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 to fulfil its functions;
  - Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee’s members/
- Members of this Committee must possess between them skills and experience in: accounting; risk management; strategic and financial planning quality and governance, and technical or specialist issues.

Role Profile for Chief Executive Officer

Role and responsibilities of the Chief Executive Officer (CEO)

The CEO will be expected to demonstrate the following behavioural qualities and either have a track record of the required board level competencies in respect of:

- exemplary track record of leading and living in accordance with the 7 Nolan Principles of Public Life[5].
- leading and developing high performing teams of directors, setting pace whilst ensuring the highest quality.
- senior leadership capability that embodies a collective and distributed leadership style and builds an inclusive and compassionate culture within and across organisations;
- leading and championing change and fostering innovation, including prioritising system-wide working across organisational boundaries to achieve strategic goals, including with regional and national agencies;
- valuing diversity and promote equity and inclusivity in all aspects of organisational operations and corporate leadership;
- a commitment to hearing the diverse voices of local people and communities and embedding their involvement in the improvement, development, and evaluation of health services;
- advocacy for the role of the NHS as an anchor institution and the benefits this can bring to the Gloucestershire economy and wider social and physical environment;
- respect for the different clinical and professional perspectives that may be held by different leaders, teams and partners across the whole system and an appreciation of how to reach consensus within an inter-disciplinary context;
- able to exercise appreciative enquiry as well as critical thinking. Expertise in interpreting and evaluating data, analysis and evidence and reaching balanced judgements and conclusions;
- experience in improving outcomes for patients and tackling health inequalities;
- knowledge and understanding of methods and approaches to improve the quality, performance, and value of health services;
- experience in formulating, implementing and evaluating strategy and assessing the benefits and impact delivered;
- understanding of corporate governance, stewardship of public money and assurance systems that achieve compliance with regulatory obligations and standards;
- commitment to preparing for and participating in ICB board meetings and development sessions and to working within the Code of Conduct for ICB members and the associated ‘Standards of Business Conduct’ policy.

[5] https://www.england.nhs.uk/non-executive-opportunities/wp-content/uploads/sites/54/2021/02/The-Nolan-Principles-of-Public-Life.pdf

Role Profile for Executives

Role of Executive Directors

Executive Directors will be expected to demonstrate the following behavioural qualities and either have a track record of or have the aptitude to develop the required board level competencies in respect of:

- leading and championing change and fostering innovation;
- valuing diversity and promote equity and inclusivity in all aspects of organisational operations and corporate leadership;
- senior leadership capability that embodies a collective and distributed leadership style and builds an inclusive and compassionate culture within and across organisations;
- a commitment to hearing the diverse voices of local people and communities and embedding their involvement in the improvement, development, and evaluation of health services;
- advocacy for the role of the NHS as an anchor institution and the benefits this can bring to the Gloucestershire economy and wider social and physical environment;
- respect for the different clinical and professional perspectives that may be held by different leaders, teams and partners across the whole system and an appreciation of how to reach consensus within an inter-disciplinary context;
- able to exercise appreciative enquiry as well as critical thinking. Expertise in interpreting and evaluating data, analysis and evidence and reaching balanced judgements and conclusions;
- experience in improving outcomes for patients and tackling health inequalities;
- knowledge and understanding of methods and approaches to improve the quality, performance, and value of health services;
- experience in formulating, implementing and evaluating strategy and assessing the benefits and impact delivered;
- experience of working across organisational boundaries to achieve strategic goals;
- understanding of corporate governance, stewardship of public money and assurance systems that achieve compliance with regulatory obligations and standards;
- commitment to preparing for and participating in ICB board meetings and development sessions and to working within the Code of Conduct for ICB members and the associated ‘Standards of Business Conduct’ policy.

Summary of specific role duties and responsibilities

ICB Chief Medical Officer
• Registered professional directly accountable to the CEO of the ICB, and professionally accountable to the regional Medical Director. • Ensure that there is a framework in place which ensures strong clinical and care professional leadership and voice in decision-making at all levels across

the system, and that these leaders are supported in their decision-making role.

- In collaboration with the ICB Chief Nurse Officer:
  - Line manage clinicians employed by the ICB;
  - Lead oversight and improvement of health service quality across the ICS, identifying performance risks and issues;
  - Support development and delivery of key clinical strategies for the ICB, engaging with a range of professionals across the ICS and other organisations, reflecting the integrated strategies of all relevant partner organisations.
- Lead programmes and projects, working with relevant providers and partners, to develop and implement solutions to ensure safe and effective standards of care for patients and tackle health inequalities.
- Lead on Medicines Optimisation and Management across the system.
- Ensure population health management, innovation and research support continuous improvements in health and wellbeing, including digitally enabled clinical transformation and the clinical and care elements of the ICS workforce plan.
- Influence and contribute to ICB plans and wider system strategies, including the delivery of the five-year ICS plan with the aim of driving innovation in clinical outcomes, reducing health inequalities and achieving better life outcomes.
- Ensure that the organisation values diversity and promotes equality and inclusivity in all aspects of its business.
- Accountable for own practice and professional conduct.
- Be part of a wider network of clinical and care professional leaders across the South West region and nationally.

ICB Chief Nurse Officer

- Registered professional directly accountable to the CEO of the ICB, and professionally accountable to the regional Chief Nurse.
- Ensure that there is a framework in place which ensures strong clinical and care professional leadership and voice in decision-making at all levels across the system, and that these leaders are supported in their decision-making role.
- In collaboration with the ICB Chief Medical Officer:
  - Line manage clinicians employed by the ICB;
  - Lead oversight and improvement of health service quality across the ICS, identifying performance risks and issues;
  - Support development and delivery of key clinical strategies for the ICB, engaging with a range of professionals across the ICS and other organisations, reflecting the integrated strategies of all relevant partner organisations.
- Lead programmes and projects, working with relevant providers and partners, to develop and implement solutions to ensure safe and effective standards of care for patients and tackle health inequalities.

- Provide professional leadership to ICB Nurses, midwives & AHPs working in commissioning, professional advisory and quality roles and functions, including Practice Nurses and non-NHS Nurses working in the system.
- Lead the development of Nurse leadership at PCN and ILP levels, ensuring that Nurses are fully engaged in the population health agenda.
- Ensure population health management, innovation and research support continuous improvements in health and wellbeing, including digitally enabled clinical transformation and the clinical and care elements of the ICS workforce plan.
- Influence and contribute to ICB plans and wider system strategies, including the delivery of the five-year ICS plan with the aim of driving innovation in clinical outcomes, reducing health inequalities and achieving better life outcomes.
- Be the ICB Caldicott Guardian and discharge the legal duties necessary for this role.
- Lead the ICB EPRR function.
- Lead cross-border working arrangements with the Welsh Health Service, managing disputes and supporting patients. Chair the cross-border network group on behalf of NHSEI and Welsh Government.
- Executive oversight of effective Infection Control and Prevention arrangements across the ICB/ICS supporting the implementation of best practice across partners.
- Ensure that the organisation values diversity and promotes equality and inclusivity in all aspects of its business.
- Accountable for own practice and professional conduct.
- Be part of a wider network of clinical and care professional leaders across the South West region and nationally.

ICB Director of Strategy and Transformation

- Experienced professional directly accountable to the CEO of the ICB.
- Develop the strategic vision and direction for the ICS, ensuring that aspirations are translated into clinically led strategies and transformation programmes.
- Support ongoing development of the governance arrangements for the ICB, Strategic Executive and key Programme Boards.
- Build and sustain effective professional relationships with senior System Leaders, Clinicians and Stakeholders.
- Maintain a good knowledge of emerging policies from government departments to assist in the thinking and definition of strategy discussions and help support stakeholders.
- Senior system executive lead for Transformation, often operating in a highly political and sensitive environment, navigating proposals for large scale service change through the necessary legislative and governance assurance requirements at both organisational and system levels and beyond.
- System Executive lead, working with relevant providers and partners, for:

  - Clinical Programmes;
  - Urgent Care and System Flow Programme;
  - Enabling Active Communities and Individuals Programme.
- Provide Executive leadership for the ICB transformation directorate and functions, with oversight of standards for best practise change management and engagement, including digitally enabled transformation and pertinent elements of the ICS workforce plan and maintaining a consistent focus on quality, integration and innovation. This will include:
  - Promoting co-production by ensuring the voices of our partners and local communities are heard and the interests of patients and the community are at the heart of all discussions and decisions;
  - Ensuring the ICB/ICS secures health and care services that are provided in line with the NHS Constitution;
  - Providing appropriate challenge; contributing to the development and embedding of the vision, aims and business objectives of the ICB/ICS.
- Influence and contribute to ICB plans and wider system strategies, including the delivery of the five-year ICS plan with the aim of driving innovation, reducing health inequalities and achieving better life outcomes.
- Ensure that the organisation values diversity and promotes equality and inclusivity in all aspects of its business.
- Accountable for own performance and professional conduct.
- Be part of a wider network of strategy and transformation leaders across the South West region and nationally.

ICB Chief Financial Officer

- Experienced professional directly accountable to the CEO of the ICB, and professionally accountable the regional Finance Director.
- Strategic leadership as a credible financial leader and key point of contact for finance across the system, to support the ICS ambitions to deliver vital programmes of improvement in line with national policy.
- Work collaboratively with system of other partners to commission and implement system change and delivery programmes, maximising finance and business intelligence contributions and adding value to individual health and wellbeing, population health and to those professions in scope of the role
- Build and sustain effective professional relationships with senior System Leaders, Clinicians and Stakeholders.
- Maintain a good knowledge of emerging policies from government departments to assist in the thinking and definition of strategy discussions and help support stakeholders.
- Draw from experience and expertise in other academic fields and industries, ensuring that the organisation benefits from innovation, research and relevant initiatives.
- Responsible, with the ICB Executive team, for ensuring that the ICB:
  - Meets financial targets set by NHSEI;

  - Operates within overall revenue and capital allocations and the administration cost limit;
  - Supports system partners to meet ICS financial targets.
- Develop the ICB funding strategy to support the Board in achieving its aims, making use of benchmarking to make sure that funds are deployed as effectively as possible.
- Lead on appropriate programmes, projects, system and processes to enable the implementation of agreed strategies.
- Influence and contribute to ICB plans and wider system strategies, including the delivery of the five-year ICS plan with the aim of driving innovation, reducing health inequalities and achieving better life outcomes.
- Be the ICB Senior Information Risk Officer and discharge the legal duties necessary for this role.
- Be the ICB lead for Estates and for Sustainability.
- Be the lead executive for the Business Intelligence function within the ICB, and to lead, with the Director of Public Health and Director of Primary Care, on the Population Health Management agenda for the ICB.
- Ensure that the organisation values diversity and promotes equality and inclusivity in all aspects of its business.
- Accountable for own performance and professional conduct.
- Be part of a wider network of strategy and transformation leaders across the South West region and nationally.

ICB Director of People, Culture and Engagement

- Experienced professional directly accountable to the CEO of the ICB.
- Strategic leadership as a credible professional and key point of contact for system People and EDI professionals to deliver vital workforce and system development programmes in line with national policy and local strategy.
- Work collaboratively with system partners to commission and implement system change and delivery programmes, maximising People, HR, OD, Engagement, EI and EDI contributions, adding value to individual health and wellbeing, population health and to those professions in scope of the role.
- Build and sustain effective professional relationships with senior System Leaders, Clinicians and Stakeholders.
- Maintain a good knowledge of emerging policies from government departments to assist in the thinking and definition of strategy discussions and help support stakeholders.
- Responsible for:
  - Leading the strategic development of people in the ICB;
  - Supporting the CEO to ensure that as an NHS statutory body the ICB is well-led;
  - Leading the application of organisational design and development to shaping the culture and ways of working across the ICB to support the strategic ambition of the ICB/ICS;

  - Leading and facilitating the production of a five-year people strategy for the ICS and associated strategic and operational plans to underpin its delivery.
  - Strategic leadership to workforce design, planning and education and training of workforce planners.
  - Leading the strategic approach to Equality, Diversity and Inclusion across the ICS and ensuring it is central to all ICS activities and decision-making
- Develop the development plan to ensure that the ICB is on track to meet the requirements of the System Oversight Framework and perform in line with segment 2 or above, as defined in the System Progression Tool.
- Ensure QI is a major enabler to delivering the strategic priorities of the ICB/ICS, developing and deploying an effective community of practice and optimising its role and contribution.
- Ensure the system-wide strategy for working with people and communities is developed collaboratively and built on best available evidence and data, covering health and social care and addressing wider determinants of health and wellbeing.
- Influence and contribute to ICB plans and wider system strategies, including the delivery of the five-year ICS plan with the aim of driving innovation, reducing health inequalities and achieving better life outcomes.
- To co-ordinate arrangements to support the learning and development of all ICB/ICS staff and teams, and take a leading role in the design and delivery of leadership development and board development programmes across the ICS
- Ensure that the organisation values diversity and promotes equality and inclusivity in all aspects of its business.
- Accountable for own performance and professional conduct.

ICB Director of Operational Planning and Performance

- Experienced professional directly accountable to the CEO of the ICB, and the ICS lead liaison Director for recovery and performance with NHSEI.
- Provide Executive leadership for system performance, responsible for ensuring the system has plans in place to deliver against all national and local performance standards including leading the delivery of key elements of the financial recovery programme through efficient and integrated system services.
- Lead system operational planning and delivery with responsibility for integrated system operational delivery plans.
- Build and sustain effective professional relationships with senior System Leaders, Clinicians and Stakeholders, and effective commissioning partnerships with other ICSs, the Local Authority and NHSEI.
- Provide system leadership for operational commissioning, including ICB contracting and procurement functions and all statutory responsibilities relating to NHS, independent sector and third sector providers.
- Responsible for:

  - Elective recovery and sustainability including key aspects of service re-design and delivery with system partners;
  - Securing and fostering strong working relationships and when appropriate joint agreements with neighbouring systems in order to ensure system delivery;
  - Financial delivery and budget management in relation to contract and elective care portfolios and the delivery of relevant key programmes of work resourced through in year regional/national funding;
  - Leading the annual contracting round and procurement processes, ensuring safe, high quality services are delivered within the resources available
- Delivery against system priorities as set out in annual system operating plans and wider ICS plans, partnership with the Clinical Programme Groups, ILPs and PCNs.
- Working with the quality teams to develop and agree supporting policies and processes for the safe delivery of services.
- Play a lead role in ensuring that clinicians and managers have access to timely and accurate performance information.
- Agreeing activity and capacity plans for services in response to changing population health needs and to address identified health inequalities.
- Influence and contribute to ICB plans and wider system strategies, including the delivery of the five-year ICS plan with the aim of driving innovation, reducing health inequalities and achieving better life outcomes.
- Ensure that the organisation values diversity and promotes equality and inclusivity in all aspects of its business.
- Accountable for own performance and professional conduct.

ICB Chief Clinical information Officer

- Registered professional directly accountable to the CEO of the ICB, and professionally accountable to the regional Director of Digital Transformation.
- Provide strategic, credible clinical leadership and be a key point of contact for clinicians across the system to deliver vital programmes of improvement in line with national policy.
- Work with national and regional teams in the commissioning and delivery of work programmes to support system change and delivery, where clinical and multi-professional contributions could be maximised.
- Build and sustain effective professional relationships with senior System Leaders, Clinicians and Stakeholders.
- Facilitate the delivery of excellent, safe patient care through the digitalisation of services and service delivery and the utilisation of information.
- Responsible for:
  - Leading strategic development, design and implementation of informatics and information technology to support better health and care, improved patient outcomes and experience, and better value and affordability;

  - Strategic oversight of the procurement, development, deployment, re-engineering, optimisation and integration of clinical information systems;
  - Leading a wide range of deployment and improvement projects across the full range of clinical information systems
- Ensuring that delivery of technology and information changes:
  - Balance the needs of improving operational performance, quality of care, and reducing delays in the patient pathway
  - Meet security and confidentiality needs
  - Enabling continuous improvement through monitoring and research to develop improved treatment methods
  - Extending patient choice and patient involvement
- Influence and contribute to ICB plans and wider system strategies, including the delivery of the five-year ICS plan with the aim of driving innovation, reducing health inequalities and achieving better life outcomes.
- Ensure that the organisation values diversity and promotes equality and inclusivity in all aspects of its business.
- Accountable for own performance and professional conduct.

Role Profile for Partner members

Role of Partner Members

Nominees can be clinical or non-clinical and must comply with the eligibility and disqualification criteria outlined in the ICB Constitution; see Appendix 1 herein.

The role of partner members is to contribute to the Integrated Care Board contemporary knowledge, insight, and subject matter expertise of differing parts of the health and care system, drawn from their perspective of leading provider and public health services in Gloucestershire.

Partner Members will be expected to demonstrate the following behavioural qualities and either have a track record of or have the aptitude to develop the required board level competencies in respect of:

- leading and championing change and fostering innovation;
- valuing diversity and promote equity and inclusivity in all aspects of organisational operations and corporate leadership;
- senior leadership capability that embodies a collective and distributed leadership style and builds an inclusive and compassionate culture within and across organisations;
- a commitment to hearing the diverse voices of local people and communities and embedding their involvement in the improvement, development, and evaluation of health services;
- advocacy for the role of the NHS as an anchor institution and the benefits this can bring to the Gloucestershire economy and wider social and physical environment;

- respect for the different clinical and professional perspectives that may be held by different leaders, teams and partners across the whole system and an appreciation of how to reach consensus within an inter-disciplinary context;
- able to exercise appreciative enquiry as well as critical thinking. Expertise in interpreting and evaluating data, analysis and evidence and reaching balanced judgements and conclusions;
- experience in improving outcomes for patients and tackling health inequalities;
- knowledge and understanding of methods and approaches to improve the quality, performance, and value of health services;
- experience in formulating, implementing and evaluating strategy and assessing the benefits and impact delivered;
- experience of working across organisational boundaries to achieve strategic goals;
- understanding of corporate governance, stewardship of public money and assurance systems that achieve compliance with regulatory obligations and standards;
- commitment to preparing for and participating in ICB board meetings and development sessions and to working within the Code of Conduct for ICB members and the associated 'Standards of Business Conduct' policy.

The following table summarises the particular requirements relating to the partner member roles.

ICB Role	Requirements
Nominated Voting Member: **NHS Foundation Trust Providers**	**Provider Perspective** *Eligibility in addition to general criteria in Appendix 1:* Be an Executive Director of one of the NHS Trusts or FTs within the ICB's area. Able to provide perspective and current experience of leading delivery of broad range of core secondary care and specialist health services to the whole population.
Nominated Voting Member: **NHS Foundation Trust Providers**	**Mental Health, Learning Disability, Autism Perspective** *Eligibility in addition to general criteria in Appendix 1:* Be an Executive Director of one of the NHS Trusts or FTs within the ICB's area. Able to provide perspective and current experience of delivering secondary care services for people with mental health needs, learning disability and autism and with expertise of delivering integrated models of provision spanning physical and mental health**.**

ICB Role	Requirements
Nominated Voting Member: **Local Authority**	**Local Authority Perspective** *Eligibility in addition to general criteria in Appendix 1:* Be the Chief Executive or hold a relevant Executive level role at Gloucestershire County Council Able to provide perspective and current experience of leading Local Authority services to the population and managing the interface between health and care and other aspects of public service delivery.
Nominated Voting Member: **Local Authority**	**Population Health and Prevention Perspective** *Eligibility in addition to general criteria in Appendix 1:* Be the Chief Executive or hold a relevant Executive level role at Gloucestershire County Council Able to provide perspective and current experience of leading public health across the county and designing and delivering interventions that promote better health outcomes, tackle health inequalities, and address the wider determinants of health and wellbeing.
Nominated Voting Member: **Primary Medical Services**	**Primary Care Perspective** *Eligibility in addition to general criteria in Appendix 1:* 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 Able to provide perspective and current experience of leading Primary Medical Services, with in-depth understanding and insight into both daytime and Out of Hours provision. Also brings wider primary care perspective including dental, community pharmacy and optometry and development of Primary Care Networks.

Risk Management Arrangements

1. Introduction

1.1. The Risk Management Framework sets out the approach and arrangements for risk management within NHS Gloucestershire Integrated Care Board (ICB).

1.2. It sets out the ICB's approach to risk and the management of risk in fulfilment of its strategic objectives. The ICB is committed to services across One Gloucestershire being of high quality, safe and promote the health and wellbeing of service users, their relatives and carers, staff and other stakeholders. The ICB ensures that there is a consistent approach to risk management systems and processes that supports continuous quality improvement and safer patient care. The management of risk is a key organisational responsibility; it is in integral part of the organisation's governance arrangements and internal controls.

1.3. Gloucestershire NHS ICB is committed to implementing the principles of good governance defined as: ***The system by which the organisation is directed and controlled to achieve its objectives and meet the necessary standards in accountability, probity and openness.***

1.4. The ICB recognises that the principles of governance must be supported by an effective risk management system which is embedded throughout the organisation and is integral to its business processes and procedures. The principles of risk management apply to all staff and in all areas of the ICB regardless of the type of risk. The Board is ultimately responsible for ensuring that an effective risk aware culture is in place and that risk is effectively managed, recorded and reported. The process of risk escalation through the committees and Board is an essential mechanism to ensuring that senior managers and executives as well as Board members are aware of emerging risks and that prompt action is taken to mitigate them.

1.5. As part of this strategy it is also acknowledged that not all risks can be eliminated. Ultimately it is for the organisation to decide which risks it is prepared to accept based on the knowledge that an effective risk assessment has been carried out and the risk has been reduced to an acceptable level as a consequence of effective controls.

1.6. At its simplest, risk management is good management practice, the early identification and assessment of risk at directorate level provide an effective management technique for managing the organisation's operational risks

which will have an effect on system wide strategic risks. Strategic and business risks are not necessarily to be avoided, but, where relevant can be embraced and explored so that new and innovative schemes and projects can develop, such as those related to the Integrated Care System (ICS) transformational programmes. Considered risk is to be encouraged, together with experimentation and innovation but within authorised limits aligned to the ICB's risk appetite. The priority is to reduce and eliminate, where possible, those risks that impact on patient safety, and reduce our financial, operational and reputational risks to tolerable levels.

2. Aim

The aim of this strategy is to set out the ICB's vision and approach to managing risk across the organisation.

3. Vision

3.1. NHS Gloucestershire Integrated Care Board (ICB) vision is:

To improve health and wellbeing of our population, we believe that by all working better together - in a more joined up way, and using the strengths of individuals, carers and local communities - we will transform the quality of support and care we provide to all local people.

3.2. The ICB's vision is that risk management is embedded in all business activities and processes of the organisation, ensuring that a risk aware culture is embraced throughout the ICB. This will be achieved through early identification, assessment, mitigation, reporting and monitoring of risk as well as sufficient resources made available to effectively manage risk to a tolerable level. As well as comprehensive and consistent risk management training to all staff within the ICB. Effective risk management is a key priority of the Board.

3.3. The purpose of Risk Management in the ICB is to:

3.3.1. Reduce the level of exposure to harm for patients, staff and stakeholders by proactively identifying, assessing, monitoring, prioritising and managing risks that threaten the delivery of the ICB's strategic and operational objectives.

3.3.2. Protect all that is of value to the ICB, by minimising and reducing risks that impact on the quality of patient care, seek to maintain high standards of patient safety, safe working environment, financial propriety, stakeholders relationships and organisational reputation.

3.3.3. Effectively manage new and emerging risks associated with the development of new technologies and transformational programmes allowing innovation and business opportunities to flourish within defined boundaries and management authority (see risk appetite).

3.3.4. Ensure that the ICB adheres to regulatory compliance, acts lawfully and operates in an open and transparent way; identifying and reporting risks at Board and committee level.

4. This risk management framework

4.1. The risk management framework applies to all staff members of the ICB, the Board, committees, ICB Operational Executive, ICS Strategic Executive and all managers as well as those staff who are contracted to provide services to the ICB such as the Commissioning Support Unit and individual employees.

4.2. The ICB's Risk management framework ensures that:

- All risks are identified, assessed, risk mitigated and monitored that have a potential adverse impact on the quality and safety of services that the ICB commissions from providers;
- All risks that relate to operational performance, financial stability and effectiveness and reputation are identified, assessed, reported, risk mitigated and monitored.
- Risks to the achievement of the ICB's operational and strategic objectives are anticipated and proactively identified.
- Effective controls are put in place, that they are well designed and applicable to mitigate the risk.
- Gaps in controls and assurances are identified and effectively managed.
- Assurances of the controls are reviewed and acted upon.
- Staff continuously learn and adapt to improve safety, quality and performance.
- Staff are trained in risk management and risk systems and processes.
- There is clarity of the roles and responsibilities of ICB staff in relation to risk management.
- Risk management systems and processes are embedded across the directorates.
- Risks are escalated to management and through the governance structure via the committees and through to the Board.

4.3. The ICB's approach to risk management

4.3.1. The Board of the ICB will work to identify and codify its approach to risk management and appetite. During the inception of the statutory ICB, the Board will use its development sessions to identify system wide risks that relate to its strategic objectives as outlined in the Long Term Plan and refreshed annually via the Operational Plan. These strategic risks will form the basis of ICB Board Assurance Framework (BAF) which will be cross-referenced with the BAF of key system partners. The BAF will be reported to the ICB at every other meeting of the Board (see Appendix 1)

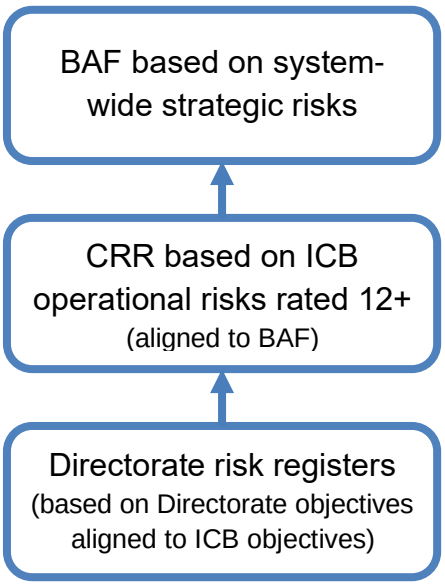
4.3.2. The Corporate Risk Register (CRR) contains those operational risks related to the delivery of operational objectives and priorities of the ICB. Risks that are rated 12 and above on Directorate risk registers will comprise the CRR. The CRR and BAF will be reported to the Audit Committee at every other meeting of the committee.

4.3.3. Directorates will continue to maintain directorate risk registers identifying those risks associated with the delivery of that directorate's objectives which will be linked to ICBs key priorities and objectives and cross referenced to the strategic objectives where appropriate. Directorate risk registers will be reported to their directorate team meetings at regular intervals to engage managers and staff.

4.3.4. The CRR will be reported to the ICB Operational Executive on a bi-monthly basis ensuring that the CRR is reviewed by the ICB executive as a whole prior to submission to the Audit Committee.

4.3.5. The BAF will be reported to the ICS Strategic Executive comprising system partners to ensure that the BAF is reviewed by senior ICS partners prior to submission to the Audit Committee and the Board.

4.3.6. During the transition phase from CCG to ICB directorates risk leads will be asked to re-appraise and update their directorate risk registers to ensure that only contemporary risks will transfer to the ICB.



5. Risk Appetite

5.1. Risk appetite is defined as '*The amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time*' ***(HMT Orange Book definition 2004).*** It is influenced by a broad range of factors including, the organisation' culture and history, current internal or external events.

5.2. The ICB has statutory and regulatory obligations to ensure that systems of control are in place to minimise all types of risk to the organisation and the individuals to whom it owes a duty of care. However, it is acknowledged that the commissioning and delivery of health and care services is not without risk especially in some more innovative areas of service redesign. An element of risk is vital in order to explore opportunities and new ways of working. The foundation of the Integrated Care System (ICS) across Gloucestershire has allowed greater opportunities to work collaboratively on service redesign and reconfiguration across organisational boundaries, develop new patient pathways and work in a 'place' based way. This has meant that ICS partners have had to work to identify new and emerging risks that affect partners including mechanisms for mitigating those risks as a collective.

5.3. Developing new and exploratory schemes and programmes can entail a greater degree of risk to the way in which staff work, the amount of resources needed and the operational design of services. Therefore staff, managers and executives need greater clarity on the level of risk that will be tolerated by the ICB and the risk boundaries in which they work.

6. The ICB's approach to risk appetite

6.1. We need to know about risk appetite because:

6.1.1. If we do not know what the ICB's collective appetite for risk is and the reasons for it, then this may lead to erratic or inopportune risk taking, exposing the organisation to a risk it cannot tolerate; or an overly cautious approach which may stifle growth, innovation and development;

6.1.2. If our leaders, Board members, executives and managers do not know the levels of risk that are legitimate for them to take, or do not take important opportunities when they arise, then service improvements may be compromised and patient and user outcomes affected.

6.2. Gloucestershire ICB will review its appetite for and attitude to risk, including setting risk tolerances for different business areas of the organisation during

the initial months of operating as an ICB. It is intended that the Board Development sessions should be used to develop the Board's approach to risk appetite and management with the help of the ICB's internal auditors.

6.3. The organisation's risk appetite will seek to address:

- The nature of the risks to be assumed;
- The amount of risk to be taken;
- The desired balance of risk versus reward.

6.4. Once the ICB's risk appetite is agreed, then risk will be managed within the risk appetite tolerances identified and within the delegated authority boundaries as set out by the ICB. Where these boundaries are exceeded prompt action will be taken to manage the risks to tolerable levels and the risk escalation procedures will be followed.

Risk appetite coding (aligned to 4Risk system)

Risk Appetite	Colour code	Types of risk to be included once agreed by the Board
Zero risk appetite		
Low risk appetite		
Medium risk appetite		
High risk appetite		

Appendix 1: 2022-23 Strategic Priorities

Our 2022/23 Priorities for Gloucestershire

The One Gloucestershire priorities are shown below and will be delivered through our priority programmes and the activities that we will deliver as partners across Gloucestershire in 2022/23. These priorities reflect what we need to do today to improve services for our patients and service users whilst continuing to work on what we will do for residents and citizens of Gloucestershire in the longer-term.

Improving health and care for our service users and patients today:

- Support improvements in **urgent and emergency care** – ensuring a range of options are available to those who need it.
- Improve access to care, recovering from the last two years. This includes **work to recover elective care**, reducing long waits whilst ensuring that those waiting are given advice and support to manage their conditions.
- Expand and improve **mental health support for people of all ages** as well as for **people with learning disabilities and autism** so they have the support needed.
- Work together to **address the financial challenge** we have across the system to narrow the financial gap and deliver efficiencies.

Making Gloucestershire a better place for residents in the future:

- **Across all priorities tackle health inequalities** across our populations drawing on data and population health approaches.
- **Improve population health through locality based working**, placing a greater focus on personal responsibility, wellbeing and prevention.
- Continue changes in **out of hospital services that enable care to be delivered closer to home**. Our Clinical Programme Approach and the work within Primary Care Networks are key to making this happen.
- **Improve integrated care across the life course** – increasing our focus on the needs of Children and Families and supporting people to age well

Transforming what we do to deliver this longer-term change:

- Bring together specialist resource across the county to deliver new models of care through **Fit for the Future**
- Ensure that we have in place the enablers to deliver on the above priorities. This includes delivering our **workforce programme** to attract new people into Gloucestershire to work across health and social care whilst supporting those existing staff as well as ensuring that we seize the opportunities presented by **data and digital technologies**.
- Successfully **transition to an Integrated Care System,** develop our five year strategy and embed new ways of working across the Gloucestershire (ICS) enabling further collaborative working across all partners and with local people and communities.

Eligible Providers of Primary Medical Services

Practice Name (71 Practices)	ODS Code
Acorn Practice	L84073
Alney Practice, The	L84606
Aspen Medical Practice	L84026
Beeches Green Surgery	L84039
Berkeley Place Surgery	L84030
Blakeney Surgery	L84029
Brockworth Surgery	L84084
Brunston & Lydbrook Practice, The	L84071
Cam and Uley Family Practice	L84060
Chipping Campden Surgery	L84043
Chipping Surgery, The	L84051
Church Street Medical	L84023
Churchdown Surgery	L84047
Cirencester Health Group	L84018
Cleevelands Medical Centre	L84036
Coleford Family Doctors	L84069
Cotswold Medical Practice	L84038
Culverhay Surgery, The	L84027
Dockham Surgery	L84046
Drybrook Surgery	L84024
Forest Health Care	L84028
Frampton Surgery	L84078
Frithwood Surgery	L84016
Gloucester Health Access Centre	Y02519
Hadwen Health	L84009
High Street Medical Centre	L84070
Hilary Cottage Surgery	L84053
Hucclecote Surgery	L84014
Kingsholm Surgery	L84081
Leckhampton Surgery, The	L84040
Locking Hill Surgery	L84032
Longlevens Surgery	L84067
Lydney Practice, The	L84011
Mann Cottage Surgery	L84068
Minchinhampton Surgery	L84005

Practice Name (71 Practices)	ODS Code
Mitcheldean Surgery	L84045
Mythe Medical Practice	L84054
Newent Family Practice	L84037
Newnham Surgery	L84615
Overton Park Surgery	L84041
Painswick Surgery	L84025
Partners in Health	L84034
Phoenix Health Group	L84012
Prestbury Park Practice (formerly Crescent Bakery Surgery until 1.7.22)	L84616
Prices Mill Surgery	L84065
Quedgeley Medical Centre	L84617
Regent Street Surgery	L84080
Rendcomb Surgery	L84063
Rosebank Health	L84050
Rowcroft Medical Centre	L84007
Royal Crescent Surgery	L84059
Royal Well Surgery	L84049
Severnbank Surgery	L84085
Severnside Medical Practice	L84052
Sixways Clinic	L84015
St Catherine's Surgery	L84058
St George's Surgery	L84008
Staunton & Corse Surgery	L84006
Stoke Road Surgery	L84048
Stonehouse Health Clinic	L84613
Stow Surgery	L84031
Stroud Valleys Family Practice	L84077
Underwood Surgery	L84003
Upper Thames Medical Group	L84010
Walnut Tree Practice	L84075
West Cheltenham Medical	Y05212
Weston House Practice (formerly Portland Practice until 1.7.21)	L84033
White House Surgery	L84072
Winchcombe Medical Centre	L84004
Yorkleigh Surgery	L84022
Yorkley & Bream Practice	L84021

Key Policy Documents

Standards of Business Conduct

Counter Fraud

Health and Safety

Working with People and Communities Strategy