NHS
North Central London
Integrated Care Board

NHS North Central London Integrated Care Board
Board of Members Meeting

Monday 4 July 2022
10:00 to 11:30am
Virtual Meeting

AGENDA
Part 1

Item	Title	Lead	Action	Page	Time
1.	**INTRODUCTION**				
1.1	Welcome and Apologies	Mike Cooke	To note	Oral	10:00 to 10:10
1.2	Declarations of Interest relating to the items on the Agenda	Mike Cooke	To note	Oral	
1.3	Declarations of Gifts and Hospitality	Mike Cooke	To note	Oral	
1.4	Update from the Chief Executive Officer	Frances O'Callaghan	To note	Oral	10:10 to 10:20
1.5	**Questions from the public received prior to the meeting relating to items on the agenda** These must relate to items that are on the agenda for this meeting and should take no longer than three minutes per person.				10:20 to 10:35
2.	**FINANCE / COMMISSIONING**				
2.1	Budget 2022/23	Phill Wells	For approval	3	10:35 to 10:45
2.2	Standing Financial Instructions	Phill Wells	For approval	12	10:45 to 10:50
3.	**GOVERNANCE**				
3.1	Clinical and Care Leadership Model	Dr Chris Caldwell / Dr Jo Sauvage	For approval	44	10:50 to 11:00
3.2	Supporting Documents to the Constitution: a) Scheme of Reservation and Delegation b) Functions and Decision Map	Ian Porter	For approval	58	11:00 to 11:05

3.3	Committee Terms of Reference: a) Audit Committee; b) Remuneration Committee; c) Strategy and Development Committee; d) Primary Care Contracting Committee; e) Individual Funding Requests Panel; f) Individual Funding Requests Appeals Panel g) Procurement Oversight Group h) Finance Committee i) Quality and Safety Committee; j) Integrated Medicines Optimisation Committee.	Ian Porter	For approval	88	11:05 to 11:15
3.4	ICB Forward Plan	Richard Dale	To note	166	11:15 to 11:25
4.	**ANY OTHER BUSINESS**				
4.1	Any Other Business				11:25 to 11:30
5.	**DATE OF NEXT MEETING – 27 September 2022 (2pm – 4pm)**				

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North Central London ICB
Board of Members Meeting
4 July 2022

Report Title	Budget 2022/23	**Date of report**	22 June 2022	**Agenda Item**	2.1
Lead Director / Manager	Phill Wells – Chief Finance Officer Designate	**Email / Tel**		phill.wells@nhs.net	
Board Member Sponsor					
Report Author	Helen Ndlovu - Assistant Director of Financial Management	**Email / Tel**		Helena.ndlovu@nhs.net	
Name of Authorising Finance Lead	Phill Wells – Chief Finance Office Designate	**Summary of Financial Implications** The June operating plan submission for NCL System shows a breakeven position. The CCG plans a core underlying deficit of c£19.3m for 2022/23. The plan includes the release of non-recurrent funding of c£23.7m to arrive at a plan surplus of £4.4m. The plan also includes c£21.2m of system growth and other funding to achieve a revised surplus of £25.6m			
Report Summary	The June Operating plan for NCL was submitted to NHS England on 20 June 2022 with a breakeven position for the system. The report provides the final plan position by provider and CCG.				
Recommendation	The Board of Members is asked to • **NOTE** the contents of this report				
Identified Risks and Risk Management Actions	The CCG reports a balanced net risk position within the 2022/23 plan, with £20.1m of identified risks matched to £20.1m of in-year recovery actions. The CCG previously reported a balance position with risks of £18.4m. In addition the system plan has a high level of risk as a result of:- • Additional excess inflation relating to utilities, • Unidentified CIP, • Risk from out of London ICBs relating to uplifts and fair shares of ERF baselines.				
Conflicts of Interest	This paper was written in accordance with the Conflicts of Interest Policy.				

Resource Implications	The CCG has identified mitigations to offset potential risks. These mitigations are non-recurrent, if non-recurrent measures are used to mitigate recurrent spend, this will impact the CCG's underlying position and the opening plan for 2022/23.
Engagement	This report is presented to the Board of Members, which includes lay members and clinicians.
Equality Impact Analysis	This report has been written in accordance with the provisions of the Equality Act 2010.
Report History and Key Decisions	The CCG financial plan was first presented to the CCG Governing Body for sign off on 27 April 2022 prior to the 28 April 2022 submission to NHS England. The Plan was approved by Governing Body members on 16 June 2022 and submitted to NHS England on 20 June 2022.
Next Steps	This report is to be reviewed by the Board of Members.
Appendices	None.

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Planning Report
2022-23

June 2022

NCL System & CCG/ICB
Planning Report
June 2022

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Please note: References to the CCG in the following report refers to both the CCG (Apr'22-Jun'22) and the ICB (Jul'22-Mar'23)

Summary 2022/23 System Plan – June Submission

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	BEH	C&I	GOSH	MEH	NMUH	RFL	RNOH	T&P	UCLH	WHIT	CCG	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
"Final" position as at 20th June 2022	**4,869**	**2,124**	**(10,620)**	**1,590**	**1,064**	**(31,100)**	**(1,150)**	**(3,763)**	**11,516**	**(112)**	**25,583**	**0**
22/23 Underlying Position	3,869	2,124	(26,624)	(5,033)	(12,352)	(93,919)	(33,865)	(1,856)	(58,379)	(2,063)	(19,278)	(247,376)
Underlying position as a % of influencable income	1.7%	1.4%	-5.8%	-2.1%	-3.2%	-9.4%	-19.8%	-3.1%	-4.8%	-0.6%	-4.4%	-5.2%
Savings target	7,000	3,011	22,848	6,420	15,166	55,244	7,546	1,800	57,111	13,829	29,825	219,800
Savings as a % of influencable income	3.0%	2.0%	5.1%	2.7%	3.9%	5.5%	4.3%	3.0%	4.7%	3.8%	6.9%	4.7%

22/23 Operating Plan overview – June Submission

- The June Operating plan submissions show a balance position for the system. This represents an improvement of £280m from the March submission of the 22/23 Plan.
- The balanced plan was achieved through:
  - Additional CIP.
  - Increased productivity.
  - Improved ERF performance.
  - Further stretched targets.
  - Confirmed additional allocation for excess inflation and other issues.
- The 22/23 position is characterised by a very high level of risk:
  - Current run rate as evidenced by the M2 reported position.
  - Unidentified CIP.
  - Additional excess inflation not in plans related to utilities.
  - Contracts risks from out of London ICBs relating to uplifts and fair shares of ERF baselines.
  - Stretch target.

Next steps

- Agreeing 22/23 contracts.
- Developing the work plan around financial governance, provider efficiency and productivity and transformational programmes to support financial recovery.
- Monitoring of ERF.
- Making decisions about services currently funded through non recurrent covid funding.
- In-year capital prioritisation processes and governance arrangements to be established to utilise in-year slippage and to establish budgets for 23/24 and 24/25.

Summary 2022/23 Plan

The CCG plans a core underlying deficit of c£19.3m for 2022/23. The plan includes the release of non-recurrent funding of c£23.7m to arrive at a plan surplus of £4.4m. The plan also includes c£21.2m of system growth and other funding to achieve a revised surplus of £25.6m

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Service Area	21/22 Recurrent Position £'000	22/23 Financial Plan £'000	Pump Priming £'000	System Growth £'000	CCG other allocations (pot 3) £'000	22/23 Revised Plan £'000
Allocation In Year - Programme	(2,544,279)	(2,811,326)	0	(61,451)	(9,495)	(2,882,271)
Allocation In Year - Admin	(29,142)	(29,358)	0	0	0	(29,358)
Allocation - Delegated Co-Comm'ing	(247,927)	(263,587)	0	0	0	(263,587)
Allocation In Year - CSF	0	0	0	0	0	0
Revenue Resource Limit Total	**(2,821,348)**	**(3,104,270)**	**0**	**(61,451)**	**(9,495)**	**(3,175,216)**
Acute	1,484,547	1,689,983	0	17,172	0	1,707,155
Mental Health	362,040	398,787	0	8,604	0	407,391
Community Services	281,413	289,028	0	6,606	3,966	299,600
Continuing Care Services	138,962	136,802	0	0	5,251	142,053
Primary Care Services	240,841	244,040	0	4,293	0	248,333
Primary Care Co-Comm'ing	247,927	263,587	0	0	0	263,587
Other Programme Services	82,083	71,962	(23,652)	3,656	190	52,156
Running Cost	29,142	29,358	0	0	0	29,358
Total Expenditure	**2,866,955**	**3,123,548**	**(23,652)**	**40,331**	**9,407**	**3,149,634**
In Year Surplus / (Deficit)	**(45,607)**	**(19,278)**	**23,652**	**21,120**	**88**	**25,583**

Summary 2022/23 Plan

For 2022/23 the CCG plans a core underlying financial deficit of **c£19.3m**. The CCG plans to release non-recurrent funding (pump-priming) of **c£23.7m**, which improves the CCG bottom line to a planned surplus of **c£4.4m**. The surplus reflects the CCG's contribution to support the financial position of NCL as a system.

In addition the submitted plan holds **c£21.2m** of system growth and other funding allocations to arrive at a revised surplus plan of **c£25.6m**. The surplus will be held on behalf of the system to be distributed throughout the year, with no impact to the financial position of the NCL system.

- The CCG's plan includes a CIP target of c£22m.
- There is zero contingency budget in the CCG plan to manage in-year risks,
- The CCGs plan includes £61.5m of system growth funding, broken down by £59.9 from the original fund plus a £1.5m contribution by the CCG.
- The CCG plans to meet the Mental Health Investment Standard (MHIS),
- The CCG has risks of c. £20.1m, which are being mitigated through recovery actions, please refer to last slide 5 for details.

2022/23 System Growth Funding Allocation

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System Growth					
System		£000s	£000s	£000s	£000s
Description of cost pressure		Original Costs reviewed	*Costs Included in the Plan*	*Other funding coverage (£9.5m)*	*Delayed Investments (removed from plan)*
Fertility Policy realignment - IVF	*Acute*	575	*575*		
Community Services Review	*Community*	5,000	*2,000*		3,000
Health Inequalities	*Community*	630	*630*		
Long Term Conditions Locally Commissioned Services	*Primary Care*	3,500			3,500
Digital Programme	*Strategy*	5,200	*3,700*		1,500
nMAbs (Neutralising Monoclonal Antibodies) -- CDMU	*Acute*	2,000			2,000
NCL Councils BCF Uplifts	*Community*	2,800		*2,800*	
BCF funding gap CCG	*Community*	1,166		*1,166*	
London Living Wage (Dom Care) - phased implementation	*Continuing Healthcare*	500			500
Extended Access Hub	*Primary Care*	800			800
Prescribing inflation above 1.7%	*Primary Care*	4,293	*4,293*		
CHC/CIC inflation above 1.7%	*Continuing Healthcare*	5,251		*5,251*	
NHSPS/CHP inflation above 2.7%	*Other Programme*	190		*190*	
Inter-sector inflation @ pan London 4% uplift (marginal impact above	*Acute*	6,322	*6,322*		
Mental Health Investment Standard Target (marginal impact above	*Mental Health*	8,778	*8,778*		
NDD	*Mental Health*	1,000			1,000
Perinatal	*Mental Health*	1,000			1,000
Single Point of Access	*Mental Health*	500			500
NHS 111 Press 2	*Mental Health*	300			300
Health Inequalities Investment	*Community*	4,000	*2,000*		2,000
Vaccine Posts	*Primary Care*	100	*0*		100
Additional CIP		- 44	*(44)*		-
Funding A&E Pressures	*Acute*	6,100	*6,100*		
CCG Commissioned high cost drugs	*Acute*	4,977	*4,977*		
Spec-Savers for bones	*Acute*	1,000	*1,000*		
Grand total		**65,938**	**40,331**	**9,407**	**16,200**
System growth and Additional funding			**59,906**	**9,495**	
CCG's contribution to the system pot			**1,545**	-	
			21,120	**88**	

System Growth Funding Allocation

This table provides a summary of the cost pressures being funded through the £61.5m system growth funding, being the original £59.9m fund plus the £1.5m contributed by the CCG.

Cost pressures require agreement through system governance and final costs may be subject to change.

Of the system funding of £61.5m, c£40.3m in included in the plan and c£21.1m is held on behalf of the system.

The CCG has received c£9.5m to cover additional cost pressures as a result of inflation, price increases within CHC and mandated BCF uplifts.

Due to financial pressures the CCG has delayed planned investments of c£16.2m.

2022/23 Risks & Mitigations

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Risks and Mitigations (£'000)

Risks	£'000 For Period 31/03/23	Risk Rating
Prescribing Activity/Price exceeding plan.	(6,700)	
Acute - activity driven contracts	(3,686)	
CHC Activity/Price exceeding plan.	(3,000)	
FNC Reviews	(2,300)	
Primary Care Enfield LCS pressure	(2,000)	
Primary Care Sunday Enhanced Access	(1,300)	
HCAS Increase	(600)	
CLCH/CNWL/CUHFT Block adjustment	(484)	
TOTAL RISKS	**(20,070)**	

Mitigations	£'000 For Period 31/03/23	Risk Rating
Pump Priming	20,070	
TOTAL MITIGATIONS	**20,070**	
NET (RISK) /OPPORTUNITIES POSITION	**0**	

Risks & Mitigations

The CCG highlights total risks of c20.1m reported outside of the planned position; the largest of these relating to prescribing, £6.7m.

The CCG will have to implement an in-year recovery plan to mitigate against the potential net risk. This may require further pump priming above the £23.7m already committed to bring the plan to a breakeven position, as highlighted in the previous slide.

The CCG reported net risks of zero as part of the April planning submission on the basis that emerging risks will require mitigation. Mitigations used to offset risks may be non-recurrent.

If non-recurrent pump priming mitigations are used to offset recurrent cost pressures this will impact on increasing cost pressures in 2023/24, and in turn the CCG's underlying position (ULP).

2022/23 Bridge from April Plan Deficit

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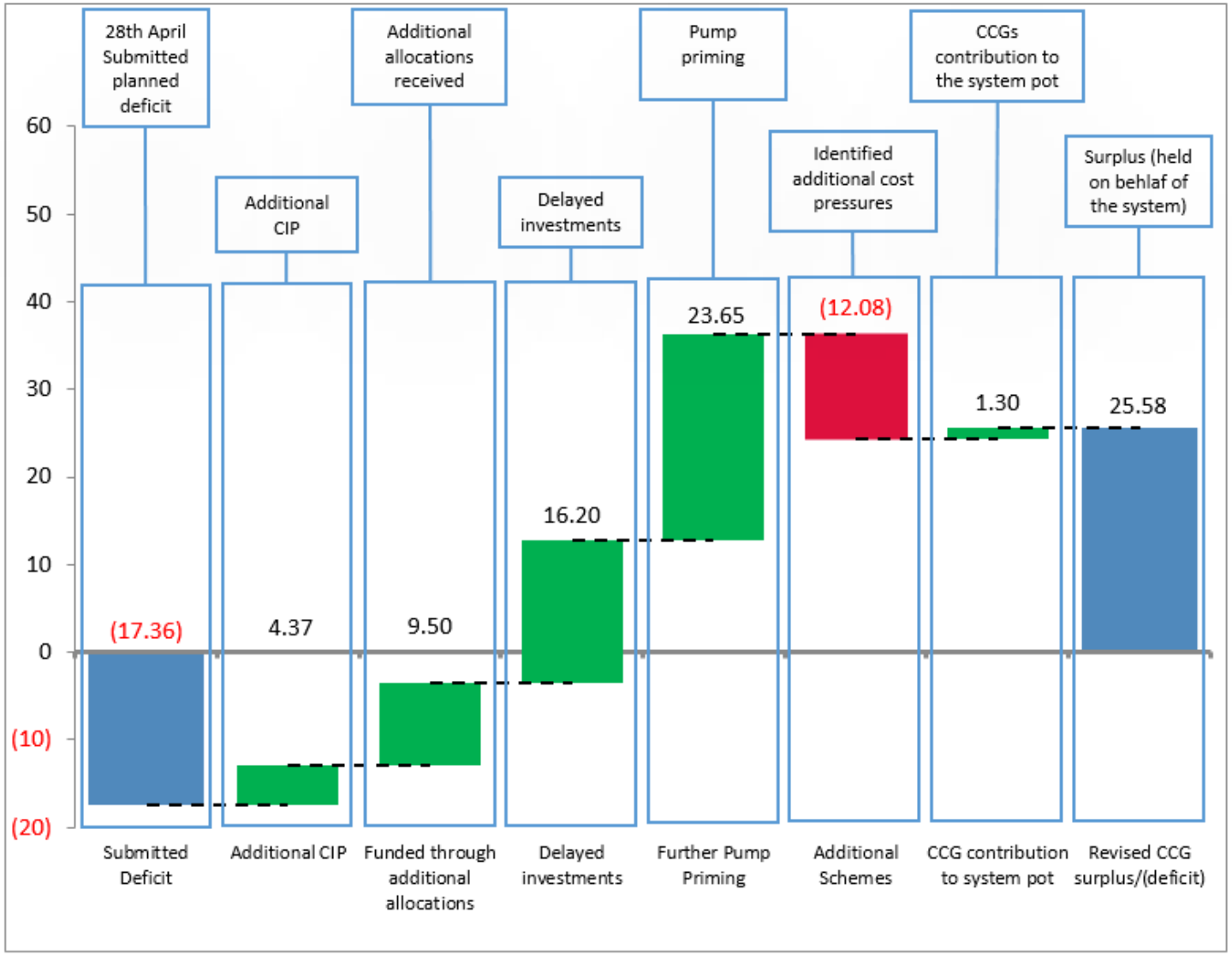

2022/23 Bridge

The waterfall to the left depicts the movement from the CCG's submitted plan on 28th April 2022 (£17.36m deficit) to the revised position submitted on 20th June 2022.

Adjustments include;

- CIP (£4.4m). Additional CIP required to support the overall system position of breakeven.
- Additional allocations (£9.5m). Additional allocations were made available to fund cost pressures, such as inflation, mandated BCF uplifts and CHC price increases.
- Delayed Investments (£16.2). The CCG recognises the financial constraints against allocations and has therefore delayed planned investments.
- Pump priming (£23.7m). In order to bridge the gap between allocation and expenditure, the CCG has planned to use non-recurrent funding.
- Additional Schemes (£12.1m). These include:
  - **£6.1m** Funding A&E Pressures
  - **£5.0m** High cost drugs
  - **£1.0m** Spec-Savers for bones
- Contribution to system pot (£1.3m). The CCG has contributed £1.3m to the system pot to reduce the system deficit.

The above adjustments result in a planned surplus of £25.6m, which is being held on behalf of the system.

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Board of Members Meeting
4 July 2022

Report Title	NCL ICB Standing Financial Instructions (SFIs) including Annex 1	**Date of report**	24 June 2022	**Agenda Item**	2.2
Lead Director / Manager	Sarah Rothenberg and Helen Ndlovu	**Email / Tel**		sarahrothenberg@nhs.net Helena.ndlovu@nhs.net	
Board Member Sponsor	Phill Wells				
Report Author	Sarah Rothenberg	**Email / Tel**		sarahrothenberg@nhs.net	
Name of Authorising Finance Lead	Phill Wells	**Summary of Financial Implications** The Standing Financial Instructions (SFIs) governance document ensures NCL ICB fulfils its statutory duty to carry out its functions effectively, efficiently and economically. The SFIs are part of NCL ICB's control environment for managing the organisation's financial affairs as they are designed to ensure regularity and propriety of financial transactions.			
Report Summary	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. The SFIs should be read in conjunction with their Annex 1 that sets out the threshold for decision making/ delegated approval limits. The SFIs are based on a template provided by NHSE and have been customised by NCL. As such, they differ in style and granularity from NCL CCG's SFIs. In contrast, Annex 1 (Delegated Approvals) is similar in form and content to NCL CCG's Annex 1. There are, however, several notable and material changes: • Committee names and job titles have been changed to align with those of the ICB; • The Strategy and Development Committee to approve up to £15m. (NCL CCG's Strategy and Commissioning Committee could approve up to £5m); • The Accountable Office and Chief Finance Officer can together approve up to £5m;				

	• The Integrated Medicines Optimisation Committee to approve up to £400k for new investments; • The Individual Funding Review Panel to approve up to £50k.
Recommendation	The Board of Members is asked to **APPROVE** the NCL ICB's SFIs.
Identified Risks and Risk Management Actions	There are no specific risks identified. However, the ICB is a new organisation and therefore a review will be carried out with a sample of stakeholders (committees and Executives) in about six months' time to review, inter alia, the appropriateness of delegation limits set out in Annex 1.
Conflicts of Interest	All decisions made under the SFIs will be made in accordance with the ICB's Conflicts of Interest Policy, ensuring conflicts of interest are managed robustly.
Resource Implications	Not applicable.
Engagement	The SFIs are based on a template provided by NHSE. They have been reviewed by NCL ICB's Accountable Officer, Chief Finance Officer and Executive Management Team as well as finance and governance officers. A review will be carried out with a sample of stakeholders (committees and Executives) in about six months' time.
Equality Impact Analysis	Not applicable.
Report History and Key Decisions	Not applicable.
Next Steps	Not applicable.
Appendices	Not applicable.

Standing Financial Instructions
NHS North Central London Integrated Care Board

V0.7 Final Draft

NHS England may update or supplement this document. Elements of this guidance are subject to change We also welcome feedback from system and stakeholders to help us continually improve our guidance and learn from implementation. The latest versions of all NHS England guidance relating to the development of ICSs can be found at ICS Guidance.

Version Control Sheet	
Document Ref	Standing Financial Instructions
Status	Draft
Integrated Care Board	North Central London Integrated Care Board
Period	1st July 2022 – 31st June 2023
Author	Sarah Rothenberg
Date of First Draft	30 May 2022
Approved by	Presented to ICB Board for approval on 4th July 2022
Approval Date	

Revision History

Version number	Date	Reviewer	Change Reference & Summary
0.1	30 May 2022		First version of the SFIs for the ICB based on NHSE Final Template v1.2 dated 30 May
0.2	9 June 2022	R Booker & Helen Ndlovu	Changes following RB review
0.3	14 June	Andy Spicer	Governance amendments
0.4	15 June	Phill Wells	Accepted AS editorial comments. Left AS substantive changes and comments unchanged as track changes
0.5	16 June	EMT	
0.6	20 June	Frances O'Callaghan and Phil Wells	Updates following feedback from 1) AS re PW's debt mgt proposal, 2) RSM on audit plan 3) inclusion of non-healthcare procurement process from current SFIs at AS's suggestion 4) Sarah Morgan re CPO role 5) acceptance of AS drafting amendments reviewed by PW and presented at EMT
0.7	24 June	ICB Board	Finalisation

Distribution History				
Version number	**Date**	**Distributed to**	**Reason for distribution**	**Action**
0.1	1 June	Rebecca Booker	Review of the first draft of the document	Amendments made
0.2	9 June	Andy Spicer	Review and Governance input	
0.3		Sarah Rothenberg	Returned with Governance comments	
0.4	15 June	Phill Wells, RB, HN	For review	Reviewed by Phill Wells
0.5	16 June	EMT	Review and comment	
0.6	24 June	FO'C, PW	AO review	
0.7	27 June	NCL ICB Board	Consideration for approval at Board meeting on 4 July 2022	

ICS implementation guidance

Integrated care systems (ICSs) are partnerships of health and care organisations that come together to plan and deliver joined up services and to improve the health of people who live and work in their area.

They exist to achieve four aims:

- **improve outcomes** in population health and healthcare
- **tackle inequalities** in outcomes, experience and access
- enhance **productivity and value for money**
- help the NHS support broader **social and economic development**.

Following several years of locally-led development, and based on the recommendations of NHS England and NHS Improvement, the government has set out plans to put ICSs on a statutory footing.

To support this transition, NHS England and NHS Improvement are publishing guidance and resources, drawing on learning from all over the country.

Our aim is to enable local health and care leaders to build strong and effective ICSs in every part of England.

Collaborating as ICSs will help health and care organisations 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.

Contents

1. Purpose and statutory framework

1.1.1 These are the Standing Financial Instructions (SFIs) for North Central London (NCL) Integrated Care Board (ICB).

1.1.2 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.

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

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

1.1.5 NCL 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.

1.1.6 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.

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

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

1.1.9 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.

1.1.10 All decisions under these Standing Financial Instructions must be made in accordance with the Conflicts of Interest Policy, ensuring conflicts of interest are managed robustly.

2. Scope

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

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

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

3. Roles and Responsibilities

3.1 Staff

3.1.1 All NCL ICB Officers are severally and collectively responsible to their employer for:

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

3.2 Accountable Officer

3.2.1 The NCL ICB Constitution provides for the appointment of the Chief Executive by the ICB Chair. The Chief Executive is the Accountable Officer for NCL ICB and is personally accountable to NHS England for the stewardship of NCL ICB's allocated resources.

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

3.2.3 The NCL Chief Executive has overall responsibility for NCL ICB's system of internal control and will delegate to the Chief Financial officer the following responsibilities in relation to the ICB:

- preparation and audit of annual accounts;
- adherence to the directions from NHS England in relation to accounts preparation;
- ensuring that the allocated annual revenue and capital resource limits are not exceeded, jointly, with system partners;

- ensuring that there is an effective financial control framework in place to support accurate financial reporting, safeguard assets and minimise risk of financial loss;
- meeting statutory requirements relating to taxation;
- ensuring that there are suitable financial systems in place (see Section 6)
- 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 & 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. The Chief Finance Officer will prepare and submit in accordance with meeting the national financial planning timetable.
- making use of benchmarking to make sure that funds are deployed as effectively as possible;
- executive members (partner members and non-executive members) and other officers are notified of and understand their responsibilities within the SFIs;
- specific responsibilities and delegation of authority to specific job titles are confirmed as prescribed in Annex 1;
- financial leadership and financial performance of the ICB;
- identification of key financial risks and issues relating to robust financial performance and leadership and working with relevant providers and partners to enable solutions; and

- the Chief Finance Officer will support a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and process are in place to minimise risk.

3.3 Audit Committee

3.3.1 The board and Accountable Officer should be supported by an audit committee, which should provide proactive support to the board in advising on:

- The risk management framework;
- 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; and
- retrospectively reviewing losses and special payments

4. Management accounting and business management

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

4.1.2 The Chief Finance Officer will delegate the budgetary control responsibilities to budget holders through a formal documented process. The Chief Finance Officer will ensure:

- the promotion of long term financial heath for the NHS system (including NCL ICS);

- budget holders are accountable for obtaining the necessary approvals and oversight of all expenditure incurred on the cost centres they are responsible for;

- the improvement of financial literacy of budget holders with the appropriate level of expertise and systems training;

- that the budget holders are supported in proportion to the operational risk; and

- the implementation of financial and resources plans that support the NHS Long term plan objectives.

4.1.3 In addition, the Chief Finance Officer should have financial leadership responsibility for the following statutory duties:

- the duty of the ICB to perform its functions as to ensure that its expenditure does not exceed the aggregate of its allotment from NHS England and its other income; and

- the duty of the ICB, in conjunction with its partner NHS trusts and foundation trusts, to seek to achieve any joint financial objectives set by NHS England for NCL ICB and its partner trusts and foundation trusts.

4.1.4 The Chief Finance Officer and *any senior officer responsible* for finance within the ICB should also promote a culture where budget holders and decision makers consult their finance business partners in key strategic decisions that carry a financial impact.

5. Income, banking arrangements and debt recovery

5.1 Income

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

5.1.2 The Chief Finance 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 NCL ICB and the prevailing risks;

5.2 Banking

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

5.2.2 The Chief Finance Officer will ensure that:

- NCL 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

- NCL ICB has effective cash management policies and procedures in place.

5.3 Debt management

5.3.1 The Chief Finance Officer is responsible for the NCL ICB debt management strategy.

5.3.2 This includes:

- a debt management strategy that covers end-to-end debt management from debt creation to collection or write-off in accordance with the losses and special payment procedures;
- ensuring the debt management strategy covers a minimum period of 3 years and must be reviewed and endorsed by the 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.

6. Financial systems and processes

6.1 Provision of finance systems

6.1.1 The Chief Finance 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 NCL ICB.

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

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

6.1.4 The Chief Finance 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 NCL ICB business rules and ensure that the internal finance team is appropriately resourced to deliver all statutory functions of the ICB;
- ensure that financial risk is appropriately managed;

- ensure identification of the duties of officers dealing with financial transactions and division of responsibilities of those officers;

- ensure NCL ICB has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of the ICB;

- ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes; and

- where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

7. Procurement and purchasing

7.1 Principles

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

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

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

7.1.4 NCL ICB must have a Procurement Policy which sets out all the legislative requirements.

7.1.5 All revenue and non-pay expenditure must be approved, in accordance with NCL ICB's SFIs, prior to an agreement being made with a third party that enters a commitment to future expenditure.

7.1.6 All officers must ensure that any conflicts of interest are identified, declared and appropriately mitigated or resolved in accordance with NCL ICB's Conflicts of Interest Policy.

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

7.1.8 Undertake any contract variations or extensions in accordance with PCR 2015 and NCL ICB's procurement policy.

7.1.9 Retrospective expenditure approval should not be encouraged. Any such retrospective breaches require approval from any committee responsible for approvals before the liability is settled. Such breaches must be reported to the Audit Committee.

7.2 Procurement outside scope of clinical procurement policy

7.2.1 For any limits less than the Current EU Threshold, the below process should be followed:

- The value of the goods and services should be the total contract value not the annual value. Where the number of years is not specified or open ended (from year to year) a 3 year period should be assumed for the purpose of this calculation.

- The Accountable Officer or their nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation or payment to the CCG, then the choice made and the reasons why should be recorded in a permanent record.

- The relevant Director or his nominated officer will maintain a full audit trail of the process used to secure the supply, which will include a list of the suppliers contacted, their responses to that request for quotation, the evaluation criteria used and a record of the outcome of that evaluation.

Threshold	No. of Tender or Quotations Required	Lowest Authority of Sign Off
£0 - £5,000	One written quotation	Responsible Budget Holder
£5,001 - £10,000	Two written quotations	Responsible Budget Holder
£10,001 – £19,999	Three written quotations	Responsible Head of Service/Assistant Director
£20,000 – Current EU Threshold	Three written quotations	Responsible Director and Finance Director

8. Staff costs and staff related non pay expenditure

8.1 Chief People Officer

8.1.1 The chief people officer (CPO) will lead the development and delivery of the long-term people strategy of NCL ICB ensuring this reflects and integrates the strategies of all relevant partner organisations within the ICS.

8.1.2 Operationally the CPO will be responsible for;

- defining and delivering the organisation's overall human resources strategy and objectives; and

- overseeing delivery of human resource services to ICB employees.

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

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

8.1.5 The CPO is responsible for management and governance frameworks that support NCL ICB employees' life cycle.

8.1.6 The CPO is responsible for ensuring the ICB's employment policies are compliant with legislation.

9. Annual reporting and Accounts

9.1.1 The Chief Finance Officer will ensure, on behalf of the Accountable Officer and NCL ICB board, that:

- NCL 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

- NCL 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 NCL ICB has:

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

- review the extent to which the board has exercised its functions in accordance with its published forward plan and capital resource use plan; and

- review any steps that the board has taken to implement any joint local health and wellbeing strategy.

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

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

9.2 Internal audit

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

- all internal audit services provided under arrangements proposed by the Chief Finance Officer are approved by the Audit Committee, on behalf of the NCL ICB board;

- NCL ICB must have an internal audit charter. The internal audit charter must be prepared in accordance with the Public Sector Internal Audit Standards (PSIAS);
- the NCL ICB internal audit charter and annual audit plan, must be endorsed by the NCL ICB Accountable Officer and presented to the Audit Committee for approval;
- the head of internal audit must provide an annual opinion on the overall adequacy and effectiveness of NCL ICB Board's framework of governance, risk management and internal control as they operated during the year, based on a systematic review and evaluation;
- the head of internal audit should attend audit and risk assurance committee meetings and have a right of access to all audit and risk assurance committee members, the Chair and Chief Executive of NCL ICB.
- the appropriate and effective financial control arrangements are in place for NCL ICB and that accepted internal and external audit recommendations are actioned in a timely manner.

9.3 External Audit

The Chief Finance Officer is responsible for:

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

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

10. Losses and special payments

10.1.1 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.

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

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

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

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

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

10.1.7 The CFO will implement a system of internal control that details the process for reporting losses, recording losses, monitoring and reporting the losses and special payments to the ICB's audit committee based on existing reporting cycles.

10.1.8 The reporting cycle should also clarify the delegated sum that the Chief Finance Officer can authorise as a loss or special payment. The delegated sum should be in line with the ICB escalation process for losses and special payments.

11. Fraud, bribery and corruption (Economic crime)

11.1.1 NCL ICB is committed to identifying, investigating and preventing economic crime.

11.1.2 The NCL ICB Chief Finance 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 defined roles and accountabilities for those involved as part of the process of providing assurance to the board. These arrangements should comply with the NHS Requirements the Government Functional Standard 013 Counter Fraud as issued by NHS Counter Fraud Authority and any guidance issued by NHS England and NHS Improvement.

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

12. Capital Investments & security of assets and Grants

12.1.1 The Chief Finance Officer is responsible for:

- ensuring that at the commencement of each financial year, NCL ICB and its partner NHS trusts and NHS foundation trusts prepare a plan setting out their planned capital resource use;

- ensuring that NCL 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 NCL 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 Finance Officer is responsible for ensuring there are processes in place to ensure that a business case is produced.

12.1.2 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.

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

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

12.1.5 NCL ICB shall have a defined and established property governance and management framework, which should:

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

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

12.2 Grants

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

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

12.2.2 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.

13. Legal and insurance

13.1.1 The Executive Director of Corporate Affairs shall ensure that the ICB has appropriate policies and procedures for legal services, the engagement of external legal advisors and the settlement of legal matters.

13.1.2 NCL ICB shall ensure it is a member of the NHS Litigation Authority indemnity scheme.

Annex 1: Delegated approvals limits

Delegated Financial Limits

		ICB Board of Members	NCL ICB Committees (Strategy & Development Committee/Finance / Procurement / Remuneration/Integrated Medicines Optimising Committee)	Individual Funding Requests	Primary Care Contracting Committee (PCCC)	Chief Executive Officer (CEO)	Chief Financial Officer (CFO)	Chief People Officer (CPO)	Chief Development and Population Health Officer (CDPHO)	Executive Directors (ED)	Finance Director (FD)	Director	Head of Service(HOS) /Assistant Director(AD) /Assistant Director of Finance(ADF)	Budget Holder	Contacts teams - (within the CDPHO directorate)
1	Allocation and control of funds														
1.1	Virement of Budgets (excluding technical adjustments within GB approved allocation)	Unlimited				£2,000,000	£1,000,000				<£500,000				
1.2	Journals (limits apply per journal rather than per line on a journal)	N/A					Unlimited				£20m and above		Up to £20m- Head of Finance/AD Finance/Senior Financial Accountant in the CSU		
1.3	New Strategic Investments/Business Cases (per annum values) - All Officer posts can approve up to a maximum contract length of 3 yrs. + 2 extension yrs. - GB & Committees do not have a max. contract length for approval purposes	Unlimited	-Strategy & Development Committee up to £15m -Integrated Medicines Optimising Committee up to £0.4m	Individual Funding Requests up to £50k	Unlimited-for delegated budgets	Up to £5m CEO and CFO acting together	Up to £5m CEO and CFO acting together <£500,000 CDPHO and CFO acting together		<£250,000 CDPHO and FD acting together <£500,000 CDPHO and CFO acting together	<£250,000 /ED and FD acting together	<£250,000 / Exec Director / CDPHO and FD acting together	<£10,000 Director and AD of Finance acting together			
1.4	Allocation of North Central London wide transformation or other funding that is not ICB specific	Unlimited			Unlimited-for delegated budgets	Unlimited	Unlimited								
2	Procurement (to be read alongside Procurement Policy and limits within Procurement Policy)														
2.1	Approval to proceed to procurement (per annum values) - All Officer posts can approve up to a maximum contract length of 3 yrs. + 2 extension yrs. - GB & Committees do not have a max. contract length for approval purposes	Unlimited	Strategy & Development Committee - £15m Report to Procurement Oversight		Unlimited-for delegated budgets	Up to £1m CEO and CFO acting together	Up to £1m CEO and CFO acting together <£500,000 CDPHO and CFO acting together		<£250,000 CDPHO and FD acting together <£500,000 CDPHO and CFO acting together	<£250,000 /ED and FD acting together	<£250,000 / Exec Director / CDPHO and FD acting together	<£10,000 Director and AD of Finance acting together			
2.2	Contract Award (per annum values) - All Officer posts can approve up to a maximum contract length of 3 yrs. + 2 extension yrs. - GB & Committees do not have a max. contract length for approval purposes	Unlimited	Strategy & Development Committee - £15m		Unlimited-for delegated budgets	Upto £5m acting with CFO	upto £5m acting with CEO <£500,000 CDPHO and CFO acting together		<£250,000 CDPHO and FD acting together <£500,000 CDPHO and CFO acting together	<£250,000 acting with FD	<£250,000 / Exec Director / CDPHO and FD acting together	<£10,000 Director and AD of Finance acting together			
2.3	Signing of contracts/Service Level Agreements (per annum values) - All Officer posts can approve up to a maximum contract length of 3 yrs. + 2 extension yrs. - GB & Committees do not have a max. contract length for approval purposes	Unlimited				Unlimited acting with CFO	Unlimited acting with CEO		<£500,000 CDPHO and FD acting together <£1,000,000 CDPHO and CFO acting together	<£250,000 acting with FD	<£250,000 / Exec Director / CDPHO and FD acting together	<£10,000 Director and AD of Finance acting together			
2.4	Complex & Individualised Commissioning (CIC) Care Placements including CHC and previously unassessed period of care (PuPOC)	Unlimited	Strategy & Development Committee - £5m			<£1,000,000 per annum CEO and CFO acting together >£1,000,000 per annum CEO and CFO acting together	<£500,000 per annum / £9,590 per week CFO & ED/CDPHO/ acting together <£1,000,000 per annum CEO and CFO acting together >£1,000,000 per annum CEO and CFO acting together		<£250,000 per annum / £4,795 per week <£500,000 per annum / £9,590 per week CFO & CDPHO acting together	<£250,000 per annum / £4,795 per week <£500,000 per annum / £9,590 per week CFO & ED/ acting together	<£182k per annum / £3,500 per week	CIC Commissioning Team - Complex & Individualised Care Director post holder (or CCG 'on call' Director / Out of Hours Director) up to £182k per annum / £3,500 per week	CIC Commissioning Team - Complex & Individualised Care Head of Service post holder up to £70k per annum / £1,336 per week CIC Commissioning Team - Complex & Individualised Care Assistant Director post holder up to £100k per annum / £1,918 per week	CIC Commissioning Team - Complex & Individualised Care Commissioner post holder up to Any Qualified Provider (AQP) rate (excluding Personal Health Budgets) CIC Commissioning Team - Complex & Individualised Care Senior Commissioner post holder up to £70k per annum / £1,336 per week	
2.5	Waiving quotations and tenders Note: - All approved waivers are reported to the Audit Committee	Unlimited	Report to the Procurement Committee			£1,000,000 with CEO and CFO acting together	£1,000,000 with CEO and CFO acting together		<£250,000 with CFO and CDPHO//ED acting together <£100,000 with FD and CDPHO//ED acting together	<£250,000 with CFO and CDPHO//ED acting together <£100,000 with FD and CDPHO//ED acting together	<£100,000 with FD and CDPHO//ED acting together				
3	Income and Expenditure (and associated purchase orders) within budget amounts														
3.1	Non- NHS: Commissioning Expenditure for agreed provider contracts (excl Complex & Individualised Care)	Unlimited				Unlimited acting with CFO	Unlimited acting with CEO		<£5m	<£500,000	<£500,000	Director of Acute Commissioning <£1m Director post holder within CDPHO Directorate <£1m Other Directors <£150,000	<£50,000	<£15,000	
3.2	Non-NHS: Ordering, invoices and payment of goods/services **(within approved budgets)**	Unlimited				Unlimited	Unlimited		<£250,000	<£250,000	<£250,000	<£150,000	<£50,000	<£15,000	
3.3	Approval of invoices against **agreed** NHS contracts/ monthly scheduled payments	Unlimited				Unlimited	Unlimited		£50m	£5m	<£25m	Director of Acute Commissioning <£25m Director post holder within CDPHO Directorate <£5m Other Directors <£500,000	<£500,000	<£100,000	
3.4	Approval of invoices without agreed NHS contracts (Low value activity (LVA))	Unlimited				<£250,000	<£250,000		<£250,000	<£250,000	<£250,000	<£150,000	<£50,000	<£15,000	Band 7 and above £5k Band 8 and above £50k Band 9 and above £250k

3.5	Approval of invoices against agreed Local Authorities contracts	Unlimited			£20m	£20m	£10m	£10m	£10m	Director of Strategic Commissioning <£1m Complex & Individualised Care Director post holder <£1m	<£50,000	<£15,000
3.6	Overtime - relating to pay	Unlimited			£5-10k	£5-10k	Up to £5k /ED/CDPHO and FD acting together	Up to £5k /ED/CDPHO and FD acting together	Up to £5k /ED/CDPHO and FD acting together			
3.7	Travel & Subsistence	Unlimited			Unlimited	Unlimited	£500	£500	£500	£500	£500	£500
3.8	Contract variations in line with approved business cases	Unlimited			Unlimited	Unlimited	<£500,000	<£250,000	<£250,000			
3.9	NHS Commissioning - where the CCG is an associate party to the contract	Unlimited			Unlimited	Unlimited	<£15m		<£15m			
3.10	NHS Commissioning - sign off of annual contracts	Unlimited			Unlimited	Unlimited	<£15m					
3.11	Approval of scheduled payments for signed contracts	Unlimited			Unlimited	Unlimited						Band 7 and above £5k Band 8 and above £50k Band 9 and above £1m
3.12	NHS Commissioning - approval of payments over SLA values	Unlimited			Unlimited	Unlimited	Unlimited with FD and /ED/CDPHO acting together	Unlimited with FD and /ED/CDPHO acting together	Unlimited with FD and /ED/CDPHO acting together			
3.13	Covid Related Expenditure (Non-Care-Placement)/**Expenditure for reasons of extreme urgency**	Unlimited	Strategy & Development Committee - £15m		<£1,000,000 CEO and CFO acting together >£1,000,000 CEO and CFO acting together	<£1,000,000 CEO and CFO acting together >£1,000,000 CEO and CFO acting together	<£100,000 acting with the FD	<£100,000 acting with the FD	<£100,000 acting with the ED//CDPHO			
3.14	Complex & Individualised Commissioning (CIC) Care Placements including CHC and previously unassessed period of care (PuPOC). Approval limits per provider in-line with agreed contracts	Unlimited	Strategy & Development Committee - £5m		Unlimited	Unlimited	<£250,000	<£250,000	<£250,000	CIC Commissioning Team - Complex & Individualised Care Director post holder £182k	CIC Commissioning Team - Complex & Individualised Care Head of Service post holder up to £70k CIC Commissioning Team - Complex & Individualised Care Assistant Director post holder up to £100k	<£15,000
4	Capital Expenditure and Assets											
4.1	Capital Works Orders	Unlimited		Unlimited-for delegated budgets	<£1,000,000	<£1,000,000	<£250,000 FD acting with the CDPHO/ED/		<£250,000 FD acting with the CDPHO/ED/			
4.2	Capital Schemes Approval (NCL)	Unlimited		Unlimited-for delegated budgets	<£1,000,000	<£1,000,000	<£250,000 FD acting with the CDPHO/ED/		<£250,000 FD acting with the CDPHO/ED/			
4.3	Entering, granting, extending and terminating leases and licences	Unlimited		Unlimited-for delegated budgets	<£2,000,000	<£2,000,000	<£250,000 FD acting with the CDPHO/ED/		<£250,000 FD acting with the CDPHO/ED/			
4.4	Capital allocation to other orgs within ICS			Unlimited-for delegated budgets	Unlimited	Unlimited						
5	Losses and Compensation (in conjunction with the Audit Committee)											
5.1	Losses due to theft, fraud and overpayment	Unlimited	Report to the Audit Committee			up to £1m- and reported to Audit committee	Up to £10,000 FD and /CDPHO/ED acting together	Up to £10,000 FD and /CDPHO/ED acting together	Up to £5,000 Up to £10,000 FD and /CDPHO/ED acting together			
5.2	Fruitless payments	Unlimited	Report to the Audit Committee			up to £1m- and reported to Audit committee	Up to £10,000 FD and /CDPHO/ED acting together	Up to £10,000 FD and /CDPHO/ED acting together	Up to £5,000 Up to £10,000 FD and /CDPHO/ED acting together			
5.3	Bad debts and claims abandoned	Unlimited	Report to the Audit Committee			up to £1m- and reported to Audit committee	Up to £10,000 FD and /CDPHO/ED acting together	Up to £10,000 FD and /CDPHO/ED acting together	Up to £5,000 Up to £10,000 FD and /CDPHO/ED acting together			
5.4	Compensation under legal obligation including redundancy	Unlimited	Report to the Audit Committee			up to £1m- and reported to Audit committee	Up to £10,000 FD and /CDPHO/ED acting together	Up to £10,000 FD and /CDPHO/ED acting together	Up to £5,000 Up to £10,000 FD and /CDPHO/ED acting together			
5.5	Extra contractual payments to contractors	Unlimited	Report to the Audit Committee			up to £1m- and reported to Audit committee	Up to £10,000 FD and /CDPHO/ED acting together	Up to £10,000 FD and /CDPHO/ED acting together	Up to £5,000 Up to £10,000 FD and /CDPHO/ED acting together			
5.6	Ex-gratia payments: personal effects	Unlimited	Report to the Audit Committee			up to £1m- and reported to Audit committee	Up to £10,000 FD and /CDPHO/ED acting together	Up to £10,000 FD and /CDPHO/ED acting together	Up to £5,000 Up to £10,000 FD and /CDPHO/ED acting together			
5.7	Ex-gratia payments: litigation and compensation	Unlimited	Report to the Audit Committee			up to £1m- and reported to Audit committee	Up to £10,000 FD and /CDPHO/ED acting together	Up to £10,000 FD and /CDPHO/ED acting together	Up to £5,000 Up to £10,000 FD and /CDPHO/ED acting together			

5.8	Ex-gratia payments: clinical negligence	Unlimited	Report to the Audit Committee		up to £1m- and reported to Audit committee		Up to £10,000 FD and /CDPHO/ED acting together	Up to £10,000 FD and /CDPHO/ED acting together	Up to £5,000 Up to £10,000 FD and /CDPHO/ED acting together
5.9	Ex-gratia payments: personal injury claims	Unlimited	Report to the Audit Committee		up to £1m- and reported to Audit committee		Up to £10,000 FD and /CDPHO/ED acting together	Up to £10,000 FD and /CDPHO/ED acting together	Up to £5,000 Up to £10,000 FD and /CDPHO/ED acting together
5.10	Ex-gratia payments: other	Unlimited	Report to the Audit Committee		up to £1m- and reported to Audit committee		Up to £10,000 FD and /CDPHO/ED acting together	Up to £10,000 FD and /CDPHO/ED acting together	Up to £5,000 Up to £10,000 FD and /CDPHO/ED acting together
5.11	Write off: NHS debtors	Unlimited	Report to the Audit Committee		up to £1m- and reported to Audit committee		Up to £10,000 FD and /CDPHO/ED acting together	Up to £10,000 FD and /CDPHO/ED acting together	Up to £5,000 Up to £10,000 FD and /CDPHO/ED acting together
5.12	Write off: non NHS debtors	Unlimited	Report to the Audit Committee		up to £1m- and reported to Audit committee		Up to £10,000 FD and /CDPHO/ED acting together	Up to £10,000 FD and /CDPHO/ED acting together	Up to £5,000 Up to £10,000 FD and /CDPHO/ED acting together
5.13	Compromise Agreements, COT3 Agreements and other types of agreements for termination or loss of office or employment (NHS England agreement must also be sought)- outside of contract	Unlimited	Remuneration Committee-Unlimited	Up to £20,000 acting with the CFO and CPO	Up to £20,000 acting with the CEO and CPO	Up to £20,000 acting with the CEO or CFO			
6	Other								
6.1	Establishment Control Process			Unlimited	Unlimited	Unlimited			
	Banking Arrangements								

Note on non-financial factors

This document relates specifically to financial limits. However, all staff should be aware that changes to service delivery models including but not limited to quality, operational performance and/or the balance of risk between the commissioner(s) and the provider(s) may be material regardless of the financial impact. These types of changes may require approval at a more senior level or by a committee so staff should refer to the relevant governance processes and policies.

Note on VAT

All of the above revenue amounts are exclusive of VAT. VAT will be added to the approved values as appropriate.

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
Monday, 4 July 2022

Report Title	Clinical and Care Leadership Model	**Date of report**	23 June 2022	**Agenda Item**	3.1
Lead Director / Manager	Dr Josephine Sauvage, Chief Medical Officer and Chris Caldwell, Chief Nursing Officer	**Email / Tel**		josephine.sauvageccg@nhs.net chris.caldwell@nhs.net	
Board Member Sponsor	Dr Josephine Sauvage and Chris Caldwell				
Report Author	ICS Transition PMO	**Email / Tel**		Northcentrallondonics@nhs.net	
Name of Authorising Finance Lead	Phill Wells	**Summary of Financial Implications** Financial summary outlined within the paper. The ICB will be working within this financial envelope to deliver the new Clinical and Care Leadership Model. Further work to be undertaken with finance as a key next step in developing the Clinical and Care Leadership Model.			
Report Summary	The establishment of ICSs offers a unique opportunity to embed multi-professional clinical and care leadership across NCL. We have begun developing a new model utilising the following principles: • Shaping and steering system-wide transformation with a commitment to key outcomes and embedding a population health approach • Supporting place-based partnerships to translate system priorities into local priorities • Developing and leading integrated neighbourhood teams Work has taken place over the last year, ahead of the appointment of the Chief Medical Officer (CMO) and Chief Nursing Officer (CNO). Progress to date includes initial engagement with existing clinical leads across the system through surveys, baseline work to capture current roles across the system, costing work, producing a 'draft model' of proposed key clinical and care leadership roles and drafting job descriptions.				

	Engagement on the draft model is underway with clinical leads in NCL and the wider system and recruitment has begun to recruit to the roles which will support transition to the new model.
Recommendation	The Board of Members is asked to: • **ENDORSE** the strategic shape of the emerging clinical leadership model. • **APPROVE** the next steps in developing the Clinical and Care Leadership Model (C&CL) and to delegate responsibility for the Chief Medical Officer and Chief Nursing Officer to further develop the model and commence implementation • **ENDORSE** the short-term continuation of the CCG's clinical leadership / Individual Funding Requests (IFR) model in the interim period and the supporting remuneration rates.
Identified Risks and Risk Management Actions	Ensuring clinical representation on NCL committees and forums has been identified as a risk due to the loss of clinical leadership from Governing Body members. To mitigate the risk, bridging roles from July to September 2022 have been established until the approach to the new Clinical and Care Leadership Model is approved by the ICB.
Conflicts of Interest	Not applicable.
Resource Implications	The financial implications of the Clinical and Care Leadership will be carefully considered as part of the ongoing development of the model. The proposed model will not provide any additional financial strain on the equivalent Clinical Leadership budget for the CCG – and will also look to contribute to the ICB's financial efficiency programme. The ICB's Remuneration Committee will meet to determine sessional rates for Clinical Leads to be applied to the new model.
Engagement	Engagement has been undertaken with the following boards, forums and meetings: • ICS Steering Committee • Executive Management Team • Transition Board • CCG Governing Body • Webinars with Clinical Leads • Clinical Advisory Group • UCL Health Alliance • GP Provider Alliance.
Equality Impact Analysis	Not applicable.
Report History and Key Decisions	Over May and June 2022, the Clinical and Care Leadership Model has been shared through the following channels: • Letter to clinical leads, 30th May • Clinical leads webinar (Primary Care), 30th May • EMT, 31st May • Governing Body Seminar, 9th June • ICS Steering Committee, 10th June • Clinical leads webinar, 16th June

Next Steps	• Continue socialisation & engagement of the plans across the system to capture feedback and iterate the model. • While we proceed with immediate implementation of key roles as outlined and continue the design phase, we will maintain short-term continuation of the CCG's clinical leadership (including the Individual Funding Request roles) – as an interim model, including the supporting remuneration rates until 30th September 2022. • Understand how the NCL C&CL model will connect with the UCL Health Alliance model as outlined in national guidance. • Confirm clinical and care leadership is embedded within emerging ICB committees and forums. • Prepare paper for Remuneration Committee to agree sessional rates for clinical leadership roles (details in the paper) • Prepare update to return to the ICB Board on the clinical leadership model and financial implications. • On-board 'bridging' roles for clinical leadership in the five boroughs from 1st July to 30th September. • On-board Deputy Medical Director role as soon as possible.
Appendices	• Appendix A - Clinical Leadership Model options (final slide of paper)

North Central London
Integrated Care Board

Developing NCL's Clinical & Care Leadership Model

Update for ICB Board

July 2022

Overview

North Central London
Integrated Care Board

- The establishment of ICSs offers a unique opportunity to embed multi-professional clinical and care leadership across NCL, evolving from the current model of CCG clinical leadership and building on existing provider collaboration. As part of this, engagement has taken place with Clinical Leads, Governing Body members and key leads from other professional groups across the system since last summer. This process will be ongoing and the model will be refined as our thinking develops.
- Working across partners – it is recognised that the ICB funded leadership is only a component part of the wider clinical and care community. Working with system partners, including the UCL Health Alliance and GP Alliance, we will co-design a clinical and care leadership model to reflect the changing culture and needs of the ICB and ICS, while maintaining pace around key areas of work and clinical / professional leadership within NCL (preferred option shown in Appendix A on final slide)
- As part of this, the ICB will be transparent on costs, adopting an “open book” approach with partners building on the work already underway in areas such as the design of clinical networks.
- Arrangements for 22/23 will build on our current approach and signal inclusivity and collaboration.
- Work is underway to develop and socialise the proposed model, including:
  - Development of a draft model of key clinical & care leadership roles
  - Drafting job descriptions and role profiles
  - Holding webinars for GB members, Primary Care leads and wider clinical community.

Background

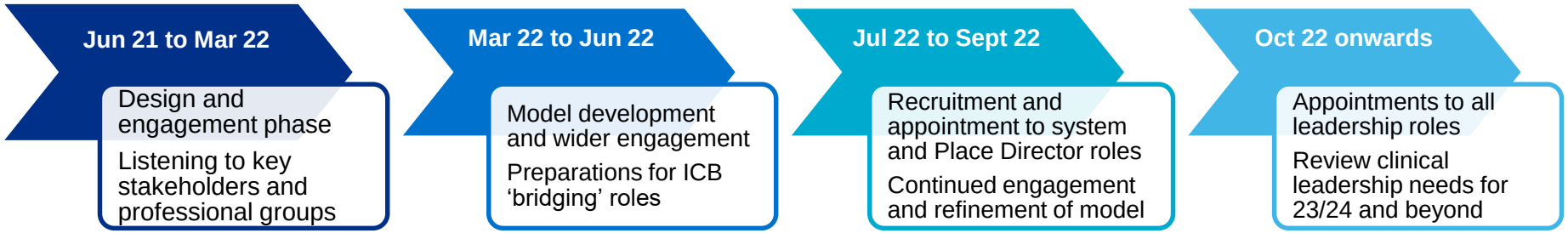
North Central London
Integrated Care Board

The development of clinical and care leadership for NCL ICS requires two distinct areas of work:

- Developing **a future framework/model for ICS clinical and care leadership** that ensures that clinical and care professional leaders are fully integrated into decision-making on all aspects of ICS functions and governance at every level of the system. This will help to create an environment in which distributed leadership can be supported to thrive, as well as strengthening leadership capacity and capability.

- Agreeing **next steps for the current clinical leadership resources in our system**; supporting our clinical leads as we transition into the new model, building from their experience and best practices.

Timeline of NCL Clinical Leadership Development



Embedding clinical leadership in ICB decision making

NHS
North Central London
Integrated Care Board

Clinical and care professional leadership will need to play various roles in NCL from statutory to strategic, service redesign and quality improvement through to more technical roles. These are currently undertaken by approximately 80 clinical leads based on sessional time. As the ICB governance structure develops, work is underway to ensure clinical and care leadership is embedded across NCL committees and forums.

Recognising that there would be transitional requirements, all clinical leads noted above were offered extended tenure (until 30th September) in early 2022, when the delay in passing the Health & Care Act became apparent.

More recently the governance context of the ICS has required the development of five 'bridging' roles to provide capacity & continuity of borough-based clinical leadership supporting essential in-flight work, until 30th September, given cessation of formal CCG functions on 30th June 2022.

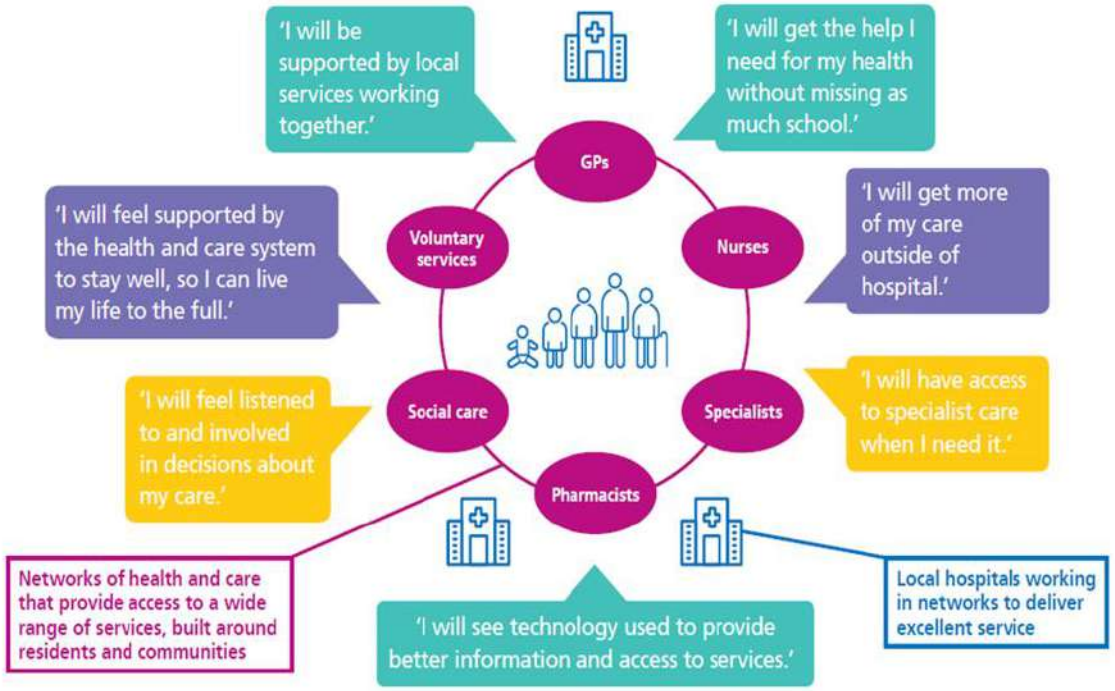
Moving forward, it is anticipated that the future clinical and care leadership model will provide:

- More flexible approach, as it can flex over time by utilising vacancies in the current model
- Greater staff continuity / retaining some primary care 'voice'
- Sessional leads who can be targeted where needed with a greater focus on 'doing'
- Allowance for multi professional leadership at system & place level
- Small leadership team to work as 'cabinet'
- Provide leads with the opportunity to undertake a wider breadth of leadership, rather than propagating a 'silo based' approach.

Our Vision for an Integrated Care System in NCL – We want our residents to Start Well, Live Well, Age Well

North Central London
Integrated Care Board

We asked our residents what Integrated Care means for them; and this is what they told us…



Our Integrated Care system can not just focus on how healthcare services operate. Evidence shows that as little as 10% of a population's health and wellbeing is linked to access to healthcare.

Therefore our clinical and multi-professional leadership should look at wider determinants , including:

Principles of Clinical & Care Leadership in NCL

NHS
North Central London
Integrated Care Board

NCL is committed to developing a model of strong clinical and care professional leadership drawing from across organisations in our system and built around our residents' needs, moving away from traditional models of historic institutional hierarchy and recognising that a new culture of collaboration is being instilled.

The emerging **NCL ICS framework** is based around 'Start Well', 'Live Well', 'Age Well' and 'Work Well'.

We need to build a leadership network across system, place and neighbourhood. The key functions and responsibilities for roles at each level will include:

- Shaping and steering **system-wide transformation** with a commitment to key outcomes (e.g. reduced inequalities) and reorienting the system to embed a population health approach.
- Supporting **place-based partnerships** to translate system priorities into local priorities, development and delivery of integrated care pathways, shaping and leading local engagement with patients, residents and political leaders.
- Developing and leading **integrated neighbourhood teams**, working closely with PCNs and acting as trusted leaders within the local community and building effective relationships with patients/ residents.

Summary of progress

NHS
North Central London
Integrated Care Board

- ✓ The proposed model of key clinical and care leadership roles has been developed through wider engagement with existing clinical leads across the system through surveys, baseline work to capture current roles across the system, costing work and drafting job descriptions.
- ✓ A letter from designate CMO and Chief Nurse has gone out to all clinical leads with an update on the process.
- ✓ The Deputy Medical Director role has been shared across system forums and recruitment to the post is underway.
- ✓ Five bridging leadership roles are undergoing recruitment to replace the current Governing Body member roles and provide interim clinical leadership at NCL committees and forums. These positions are on a fixed contract aligning with the current extension timeline for existing clinical leads.
- ✓ Job descriptions are in development for four system Clinical and Care Directors (Primary Care, Children's, Young People & Maternity & Neonatal, Population Health & Local Care and Mental Health, Learning Disabilities & Autism).
- ✓ Job descriptions are in development for Clinical and Care Directors for each borough. They will work with the CMO to provide dedicated and visible senior clinical leadership within and across NCL boroughs.
- ✓ An operating model for clinical & professional leads will be developed during 22/23 through engagement with key stakeholders.
- ✓ Work is underway to align pharmacy optimisation and digital transformation as the clinical and care leadership model develops.
- ✓ Work will also continue to embed clinical leadership in all ICB committees and forums.

Financial context and considerations

North Central London
Integrated Care Board

Work is on-going to accurately cost the new Clinical & Care Leadership Model. In 2021/22 funding was based on the existing Clinical & Care model, with c80+ clinical leads spread across a range of areas. The budget for this model was c£1.9m, which included funding for 8 of the 10 Safeguarding Clinical & Care Leads. The ICB will be working within this financial envelope to deliver the new Clinical & Care Leadership Model. The ICB will be transparent on costs, adopting an "open book" approach with partners building on the work already underway in areas such as the design of clinical networks.

Organisational efficiency programme

The financial position for the ICB in 2022/23 is extremely challenging and there is a savings target of £18m within the latest financial plan submitted to NHSE. As a result a 5% vacancy factor has been requested on all pay budgets.

2022/23

The current model will be in-situ until 30th September and all clinical lead contracts have been extended to this date. As such half of the above budget will be earmarked to fund this period. In addition, the ICB will incur costs for the Deputy CMO, along with the five bridging leadership roles (expected to be in place by 1st July).

The remaining envelope will be used to fund the rest of the financial year from Q2 (1st October onwards). A more detailed financial analysis will be provided once a clearer idea of sessions and sessional rates have been agreed.

2023/24 onwards

A recurrent model will be finalised following agreement on sessional rates at the ICB's Remuneration Committee and confirmation of the expected number of sessions per role. This will allow the ICB to accurately reflect the cost of the model to ensure affordability. In the meantime there is modelling work on-going to understand the financial impact of varying scenarios.

Development of the model – Next steps

North Central London
Integrated Care Board

- Continue socialisation & engagement of the plans across the system to capture feedback and iterate the model.
- While we proceed with immediate implementation of key roles as outlined and continue the design phase, we will maintain short-term continuation of the CCG's clinical leadership (including the Individual Funding Request roles) – as an interim model, including the supporting remuneration rates until 30th September 2022.
- Understand how the NCL C&CL model will connect with the UCL Health Alliance model as outlined in national guidance.
- Confirm clinical and care leadership is embedded within emerging ICB committees and forums.
- Prepare paper for Remuneration Committee to agree sessional rates for clinical leadership roles (detail on next slide)
- Prepare update to return to the ICB Board on the clinical leadership model and financial implications.
- On-board 'bridging' roles for clinical leadership in the five boroughs from 1st July to 30th September.
- On-board Deputy Medical Director role as soon as possible.

Next steps on remuneration

North Central London
Integrated Care Board

Interim Remuneration Arrangements (detail)

As part of the interim measures to support the clinical leadership arrangements through transition, the remuneration rates as previously set by the CCG Remuneration Committee, are continuing to be utilised through until the end of September 2022. As part of this interim model, and following the end of elected borough-based roles on the CCG Governing Body, clinical 'place-based' roles are being recruited to on a short-term basis – again using previously set remuneration rates for clinical leads.

Similarly, to maintain capacity and continuity through the period of transition, arrangements have been made for the short-term continuation of clinical and independent support to the Individual Funding Requests (IFR) Committee and IFR Appeals Committee. The short-term remuneration arrangements for this have been set in accordance with:

- The previously agreed sessional rates for clinical leads (as above);
- The nationally set pay scales used to determine remuneration for non-executive capacity in the ICB.

The ICB's Remuneration Committee will need to consider sessional rates to be applied for the future clinical leadership model and IFR arrangements beyond this interim period.

Appendix A - Clinical & Care Leadership Model options

North Central London
Integrated Care Board

Clinical and care professional leadership will need to play various roles in NCL, from statutory to strategic; service redesign and quality improvement through to more technical roles. These are currently undertaken by approximately 80 clinical leads based on sessional time. Following an assessment of 3 potential options, Option 2 was identified as offering the most flexible approach.

Option 1 Senior clinical leadership model	Option 2 Mixed model	Option 3 Existing model
• Small concentrated cohort of largely full-time senior clinical & care leaders inc. Digital • 5 place-based clinical leaders	• 1-3 full-time (or similar) senior leaders reporting to the CMO • 5 place-based clinical leaders and 5 system directors • 10-15 sessional clinical leads with specific remits	• Retain existing model of 80+ sessional clinical leads spread across a range of areas

Key benefits of option 2, the mixed model, include;

- More flexible approach as can flex over time by utilising vacancies in the current model
- Greater staff continuity / retains some primary care 'voice'
- Sessional leads can be targeted where needed
- Allows for multi professional leadership at place level
- Small leadership team to work as 'cabinet'

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
4 July 2022

Report Title	Approval of the Scheme of Reservation and Delegation	**Date of report**	24 June 2022	**Agenda Item**	3.2a
Lead Director / Manager	Ian Porter, Executive Director of Corporate Affairs	**Email / Tel**		ian.porter3@nhs.net	
ICB Member Sponsor					
Report Author	Andrew Spicer, Head of Governance and Risk	**Email / Tel**		Andrew.spicer1@nhs.net	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications** The Scheme of Reservation and Delegation sets out which authorities the ICB Board of Members has reserved for itself and which it has delegated. This includes financial authorities.			
Report Summary	NHS North Central London Integrated Care Board ('ICB') is a statutory organisation that was formally established on 1st July 2022. Its Constitution was approved by NHS England. Under the Constitution the Board of Members decides which of its powers and authorities are reserved to the Board of Members and which are delegated to its committees and to individuals. This is set out in the Scheme of Reservation and Delegation ('SORD'). The SORD supports the ICB's smooth and effective operations and discharge of its statutory duties by ensuring that a robust but flexible governance structure is in place and that functions and decisions are appropriately delegated. <u>ICB Policies</u> All CCG policies will transfer to the ICB and be rebranded with minor amendments to reflect the ICB. Any policies that require a significant change will be presented to the appropriate forum for approval as per the SORD.				
Recommendation	The Board of Members is asked to **REVIEW** and **APPROVE** the Scheme of Reservation and Delegation.				
Identified Risks and Risk Management Actions	The SORD enables and empowers the ICB to undertake its work efficiently and effectively, provide flexibility and allow for system change whilst maintaining robust safeguards and governance				
Conflicts of Interest	This paper was written in accordance with the Conflicts of Interest Policy.				

Resource Implications	This report supports the ICB in making effective and efficient use of its resources.
Engagement	This report is presented to the Board of Members of the ICB which includes Non-Executive Members, Partner Members, the UCL Health Alliance Member and clinicians.
Equality Impact Analysis	This report has been written in accordance with the provisions of the Equality Act 2010.
Report History and Key Decisions	This is the first report which requests the Board of Members to review and approve the SORD.
Next Steps	Not applicable.
Appendices	None.

NHS NORTH CENTRAL LONDON
INTEGRATED CARE BOARD
SCHEME OF RESERVATION AND DELEGATION

1 SCHEME OF RESERVATION AND DELEGATION

1.1 The Scheme of Reservation and Delegation ('SORD') sets out those decisions that are reserved for the Board of Members as a whole and those decisions that have been delegated.

1.2 The ICB remains accountable for all of its functions including those it has delegated.

1.3 The SORD must be adhered to.

1.4 Where authority has been delegated to a committee or sub-committee of the Board of Members the authority is delegated to the committee or sub-committee that oversees the substantive function and/or any successor committee and does not refer to the working title of any individual committee.

1.5 The Board of Members may decide to reserve authorities to itself. These may only be exercised by the Board of Members unless the Board of Members agree otherwise.

1.6 Where authority is delegated to the Chief Executive the Chief Executive may decide to further delegate the authority.

1.7 Where authority is delegated to the Chief Finance Officer the Chief Finance Officer may decide to further delegate the authority.

1.8 The Governance Team shall be notified in writing where authority is delegated in accordance with clauses 1.5 to 1.7 above.

1.9 The delegations are set out below:

Function	Decision	Reserved to the Board of Members Only	Delegated to a Committee or Sub-Committee	Delegated to the Chair	Delegated to the Chief Executive	Delegated to the Chief Finance Officer	Delegated to other ICB Member or Employee
Strategy and Planning	Approval of the ICB's vision, values, strategic direction and strategic objectives	✓					
Strategy and Planning	Approval of the ICB's commissioning strategies	✓					
Strategy and Planning	Approval of the ICB's estate strategies	✓					
Strategy and Planning	Approval of the ICB's communications and engagement strategies	✓					
Strategy and Planning	Approval of the ICB's Digital strategies	✓					
Strategy and Planning	Approval of the ICB's Workforce strategies	✓					
Regulation and Control	Approval of the ICB's Equality and Diversity Strategy	✓					
Regulation and Control	Approval of the ICB's strategic	✓					

Function	Decision	Reserved to the Board of Members Only	Delegated to a Committee or Sub-Committee	Delegated to the Chair	Delegated to the Chief Executive	Delegated to the Chief Finance Officer	Delegated to other ICB Member or Employee
	approach to clinical leadership						
Strategy and Planning	Approval of all other ICB strategies unless otherwise delegated	✓					
Strategy and Planning	Approval of the ICB's medium and long term financial plan	✓					
Strategy and Planning	Approval of the NCL system plan	✓					
Strategy and Planning	Approval of the ICB's commissioning plans		✓ Strategy and Development Committee				
Budgets	Approval of the ICB's organisational budgets	✓					
Budgets	Approval of variations to the approved budget where variation would have a significant impact on the overall approved levels of		✓ Finance Committee				

Function	Decision	Reserved to the Board of Members Only	Delegated to a Committee or Sub-Committee	Delegated to the Chair	Delegated to the Chief Executive	Delegated to the Chief Finance Officer	Delegated to other ICB Member or Employee
	income and expenditure or the ICB's ability to achieve its agreed strategic objectives						
Budgets	Approval of managers' budgets from within the limits set in the organisational budgets					✓	
Functions	Approval of the commissioning of services (including care packages)		✓ Delegated as per the Board of Members' committee structure and the ICB's governance framework				
Functions	Approval of MOUs with partner organisations		✓ Delegated as per the Board of Members' committee structure and the ICB's				

Function	Decision	Reserved to the Board of Members Only	Delegated to a Committee or Sub-Committee	Delegated to the Chair	Delegated to the Chief Executive	Delegated to the Chief Finance Officer	Delegated to other ICB Member or Employee
			governance framework				
Functions	Decision making at System level strategic forums		✓ Delegated as per the Board of Members' committee structure and the ICB's governance framework				
Functions	Approval of the arrangements for individual funding requests		✓ Individual Funding Requests Panel				
Functions	Approval of the arrangements for discharging the ICB's statutory financial duties		✓ Finance Committee				
Functions	Approval of the arrangement for discharging the ICB's statutory				✓		

Function	Decision	Reserved to the Board of Members Only	Delegated to a Committee or Sub-Committee	Delegated to the Chair	Delegated to the Chief Executive	Delegated to the Chief Finance Officer	Delegated to other ICB Member or Employee
	duties as an employer						
Functions	Approval of the arrangements for supporting NHS England in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services		✓ Primary Care Contracting Committee				
Functions	Approval of the arrangements for discharging the ICB's statutory duties regarding medicines.		✓ Integrated Medicines Optimisation Committee				
Functions	Approval of medicines investment decisions		✓ Delegated as per the Board of Members' committee structure and the ICB's governance framework				

Function	Decision	Reserved to the Board of Members Only	Delegated to a Committee or Sub-Committee	Delegated to the Chair	Delegated to the Chief Executive	Delegated to the Chief Finance Officer	Delegated to other ICB Member or Employee
Regulation and Control	Approval of the Constitution	✓					
Regulation and Control	Approval of the Standing Financial Instructions	✓					
Regulation and Control	Approval of the Scheme of Reservation and Delegation	✓					
Regulation and Control	Approval of the ICB's Risk Management arrangements		✓ Audit Committee				
Regulation and Control	Approval of the ICB's Equality and Diversity Policies other than HR policies				✓		
Regulation and Control	Approval of the annual reports for Workforce Race Equality Standard and Workforce Disability Equality Standard	✓					
Regulation and Control	Approval of corporate		✓				

Function	Decision	Reserved to the Board of Members Only	Delegated to a Committee or Sub-Committee	Delegated to the Chair	Delegated to the Chief Executive	Delegated to the Chief Finance Officer	Delegated to other ICB Member or Employee
	governance and information governance policies		Audit Committee				
Regulation and Control	Approval of quality, safety and clinical effectiveness policies		✓ Quality and Safety Committee				
Regulation and Control	Approval of finance policies		✓ Finance Committee				
Regulation and Control	Approval of Individual Funding Requests Policies		✓ Individual Funding Requests Panel				
Regulation and Control	Approval of commissioning policies other than Individual Funding Requests and Primary Care.		✓ Strategy and Development Committee				
Regulation and Control	Approval of primary care policies		✓				

Function	Decision	Reserved to the Board of Members Only	Delegated to a Committee or Sub-Committee	Delegated to the Chair	Delegated to the Chief Executive	Delegated to the Chief Finance Officer	Delegated to other ICB Member or Employee
			Primary Care Contracting Committee				
Regulation and Control	Approval of the Board committee structure	✓					
Regulation and Control	Approval of all policies not referenced in this Scheme of Reservation and Delegation		✓ Delegated to the appropriate committee or sub-committee as per its Terms of Reference				
Regulation and Control	Approval of the Terms of Reference for committees and sub-committees of the Board of Members	✓					
Regulation and Control	Approval of the ICB's counter fraud and security management arrangements		✓ Audit Committee				
Regulation and Control	Approval of the ICB's annual Information						✓

Function	Decision	Reserved to the Board of Members Only	Delegated to a Committee or Sub-Committee	Delegated to the Chair	Delegated to the Chief Executive	Delegated to the Chief Finance Officer	Delegated to other ICB Member or Employee
	Governance Toolkit submission						Delegated to the SIRO
Regulation and Control	Approval of a comprehensive system of internal control, including budgetary control, that underpins the effective, efficient and economic operation of the ICB		✓ Audit Committee				
Regulation and Control	Appointment of ICB's auditors		✓ Audit Committee				
Regulation and Control	Approval of the ICB's annual audit plan		✓ Audit Committee				
Risk Sharing	Approval of the ICB's arrangements for risk sharing and or risk pooling with other organisations		✓ Finance Committee				

Function	Decision	Reserved to the Board of Members Only	Delegated to a Committee or Sub-Committee	Delegated to the Chair	Delegated to the Chief Executive	Delegated to the Chief Finance Officer	Delegated to other ICB Member or Employee
Human Resources	Approval of all HR policies except for pay policies				✓		
Human Resources	Approval of staff recruitment processes and policies				✓		
Human Resources	Approval of the ICB's staff and operational structures				✓		
Human Resources	Approval of the recruitment of staff and clinical leads from within establishment				✓		
Human Resources	Approval of the recruitment of staff and clinical leads outside of the establishment				✓		
Human Resources	Approval of the arrangements for recruiting interim staff members				✓		
Human Resources	Approval of appraisal and disciplinary			✓			

Function	Decision	Reserved to the Board of Members Only	Delegated to a Committee or Sub-Committee	Delegated to the Chair	Delegated to the Chief Executive	Delegated to the Chief Finance Officer	Delegated to other ICB Member or Employee
	arrangements for the Chief Executive						
Human Resources	Approval of the remuneration and pensions of ICB Members (except for ICB Chair), officers, clinical leads and employees at the VSM level		✓ Remuneration Committee				
Human Resources	Setting pay policies for employees below VSM level		✓ Remuneration Committee				
Human Resources	Approving pay, terms and conditions for staff and expenses below VSM level				✓		
Human Resources	Approval of the appointment of ICB Members			✓			

Function	Decision	Reserved to the Board of Members Only	Delegated to a Committee or Sub-Committee	Delegated to the Chair	Delegated to the Chief Executive	Delegated to the Chief Finance Officer	Delegated to other ICB Member or Employee
Human Resources	Approve the arrangements for identifying and appointing the Chief Executive and Chief Finance Officer			✓			
Human Resources	Approve the arrangements for ICB succession planning			✓			
Annual Report And Accounts	Approval of the ICB's Annual Report and accounts		✓ Audit Committee				
Operations	Approval of the ICB's arrangements for business continuity and emergency planning				✓		
Operations	Approval of legal claims and expense policies				✓		
Operations	Approval of legal action including but not limited to litigation and settlement of claims				✓		
Operations	Approval of						

Function	Decision	Reserved to the Board of Members Only	Delegated to a Committee or Sub-Committee	Delegated to the Chair	Delegated to the Chief Executive	Delegated to the Chief Finance Officer	Delegated to other ICB Member or Employee
	Compromise Agreements, COT3 Agreements and other types of agreements for termination or loss of office or employment (HR Treasury/NHS England agreement must also be sought where guidance applies)- outside of contract under £20,000				✓ Chief Executive and Chief Finance Officer must agree together	✓ Chief Executive and Chief Finance Officer must agree together	
Operations	Approval of Compromise Agreements, COT3 Agreements and other types of agreements for termination or loss of office or employment (HM Treasury/NHS England agreement must also be sought where guidance applies)- outside of		✓ Remuneration Committee				

Function	Decision	Reserved to the Board of Members Only	Delegated to a Committee or Sub-Committee	Delegated to the Chair	Delegated to the Chief Executive	Delegated to the Chief Finance Officer	Delegated to other ICB Member or Employee
	contract for £20,000 and above						
Operations	Approval of the ICB's arrangements for managing complaints				✓		
Operations	Approval of the ICB's arrangements for dealing with media enquiries				✓		
Operations	Approval of the arrangements for commissioning support services				✓		
Operations	Approval of the arrangements for corporate support services				✓		
Operations	Approval of the operational arrangements to support partnership, joint and/or delegated commissioning arrangements with other organisations				✓		
Operations	Approval of the operational arrangements to				✓		

Function	Decision	Reserved to the Board of Members Only	Delegated to a Committee or Sub-Committee	Delegated to the Chair	Delegated to the Chief Executive	Delegated to the Chief Finance Officer	Delegated to other ICB Member or Employee
	support Integrated Care Systems and Place						
Operations	Approval of the operational arrangements for handling and signing of Freedom Of Information requests				✓		
Operations	Approval of planning submissions to NHS England				✓		
Operations	Passporting/transfer of external funds.				✓ Chief Executive and Chief Finance Officer must agree together	✓ Chief Executive and Chief Finance Officer must agree together	
Operations	Approval of ICBs accommodation arrangements					✓ Chief Finance Officer and Executive	✓ Chief Finance Officer and Executive

Function	Decision	Reserved to the Board of Members Only	Delegated to a Committee or Sub-Committee	Delegated to the Chair	Delegated to the Chief Executive	Delegated to the Chief Finance Officer	Delegated to other ICB Member or Employee
						Director of Corporate Affairs must agree together	Director of Corporate Affairs must agree together
Operations	Approval of all other operational arrangements				✓		
Joint and/or Delegated Exercise of Functions	Approval of the arrangements for any functions exercisable by the ICB to be exercised by or jointly with any one or more other relevant bodies (another ICB, NHS England, an NHS trust, NHS	✓					

Function	Decision	Reserved to the Board of Members Only	Delegated to a Committee or Sub-Committee	Delegated to the Chair	Delegated to the Chief Executive	Delegated to the Chief Finance Officer	Delegated to other ICB Member or Employee
	foundation trust, local authority, combined authority or any other prescribed body)						
Partnership Working	Approval of the arrangements for partnership working with other organisations that do not require the formal delegation of functions				✓		
Partnership Working	Letters of support for provider reconfigurations and capital programmes.				✓ Chief Executive and Chief Finance Officer must agree together	✓ Chief Executive and Chief Finance Officer must agree together	
Better Care Fund	Approval of the arrangements for the Better Care Fund		✓ Strategy and Development Committee				

NHS
North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
4 July 2022

Report Title	Approval of the Functions and Decisions Map	**Date of report**	24 June 2022	**Agenda Item**	3.2b
Lead Director / Manager	Ian Porter, Executive Director of Corporate Affairs	**Email / Tel**		ian.porter3@nhs.net	
ICB Member Sponsor					
Report Author	Andrew Spicer, Head of Governance and Risk Sarah Murray, Senior Consultant Lucie McFarlane, Junior Consultant	**Email / Tel**		Andrew.spicer1@nhs.net sarah.murray4@nhs.net lucie.mcfarlane@nhs.net	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications** The Functions and Decisions Map assists with the transparency of financial decision making by providing a high level overview of how ICB decisions are made.			
Report Summary	NHS North Central London Integrated Care Board ('ICB') is a statutory organisation that was formally established on 1 July 2022. Its Constitution was approved by NHS England. Under the Constitution the ICB is required to have a Functions and Decisions Map ('Map') and publish it on the ICB's website. The Map sets out a high level overview of the ICB's governance structure, which includes its key functions and how the functions are exercised in accordance with the Scheme of Reservation and Delegation ('SORD'). The Map is not intended to duplicate or be a substitute for the SORD and therefore it refers the reader to the SORD for greater detail.				
Recommendation	The Board of Members is asked to **REVIEW** and **APPROVE** the Functions and Decisions Map.				
Identified Risks and Risk Management Actions	The Functions and Decisions Map assists the ICB in ensuring it operates in accordance with its Constitution and provides increased public transparency on decision making.				
Conflicts of Interest	This paper was written in accordance with the Conflicts of Interest Policy.				

Resource Implications	This report supports the ICB in making effective and efficient use of its resources.
Engagement	This report is presented to the Board of Members of the ICB which includes Non-Executive Members, Partner Members, the UCL Health Alliance Member and clinicians.
Equality Impact Analysis	This report has been written in accordance with the provisions of the Equality Act 2010.
Report History and Key Decisions	This is the first report which request the Board of Members to review and approve the Functions and Decisions Map.
Next Steps	If the Functions and Decisions Map is approved the next step is to publish it on the ICB's website and staff intranet.
Appendices	None.

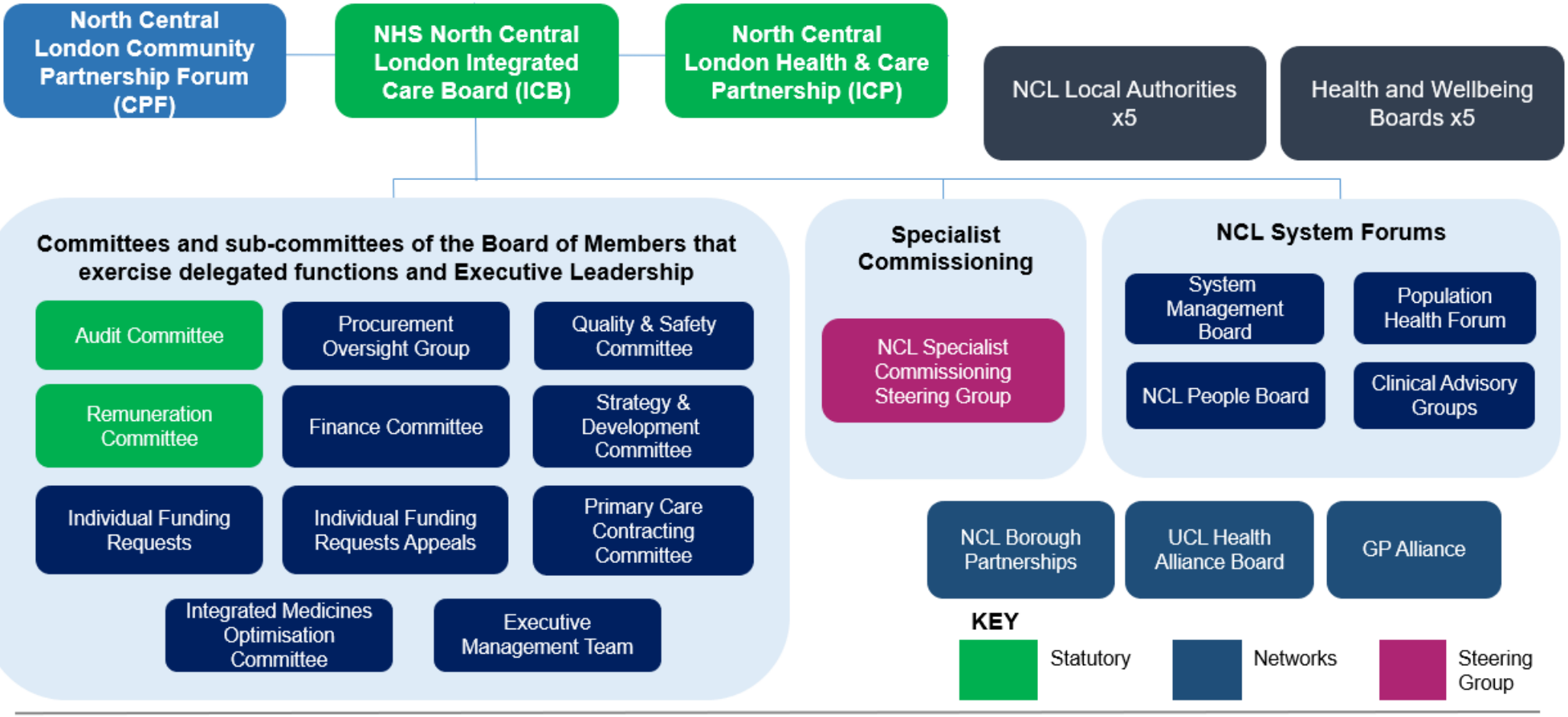
NHS
North Central London
Integrated Care Board

NHS North Central London Integrated Care Board Functions & Decisions Map

4th July 2022

Version 1

ICB Governance Structure



Key Functions

A high level overview of the governance structure is set out below. For greater detail of the Integrated Care Board's key functions and how they are exercised please see the Scheme of Reservation and Delegation, which is published on our website.

Board of Members

The Integrated Care Board ('ICB') has a Board of Members which has overall accountability and responsibility for the discharge of the ICB's functions (including all statutory requirements of the Integrated Care Board). The Board of Members will take an active role in decision making and oversight, meeting regularly to enact business.

The Board of Members sets the culture of the organisation, taking a supportive approach to subsidiarity and working with Borough Partnerships to develop our collective approach and learn what works best in different settings in order to deliver improved health outcomes for North Central London residents and patients.

Audit Committee

The purpose of this committee is to provide oversight and scrutiny of the effectiveness and robustness of the governance and assurance processes on which the Board of Members relies. This includes but is not limited to:

a) Integrated governance, risk management, internal and external controls;
b) Internal and external audit;
c) Counter fraud arrangements; and
d) Financial reporting.

Remuneration Committee

The purpose of this committee is to:

a) Approve the remuneration and terms of service for Integrated Care Board members except for the Chair;
b) Approve the remuneration and terms of service for Integrated Care Board officers, clinical leads and employees at the Very Senior Manager level;
c) Set the pay policy for employees below the Very Senior Manager level. For the avoidance of doubt the Remuneration Committee does not approve employee pay below the Very Senior Manager level or the Integrated Care Board's staffing structures. These are delegated to the Integrated Care Board's Chief Executive.

Strategy and Development Committee

The purpose of the Committee is to:

a) Oversee the development of the North Central London system plan, the Integrated Care Board's commissioning strategies and plans and ensure they:
    - 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;
b) Approve the commissioning of health services which deliver the North Central London system plan, the Integrated Care Board's commissioning strategies and plans;
c) Provide assurance to the Board of Members that the Integrated Care Board is discharging its statutory commissioning functions effectively;

d) Ensure that all of the Integrated Care Board's strategic commissioning priorities and plans are congruent and aligned across boroughs;
e) Oversee the Primary Care Contracting Committee, the Individual Funding Request ('IFR') Panel and the IFR Appeals Panel;
f) Oversee the development of service improvement strategies across the range of health services commissioned by the Integrated Care Board.

Primary Care Contracting Committee

This is a sub-committee of the Strategy and Development Committee. Its purpose is to:

a) Provide oversight, scrutiny and decision making for primary medical services;
b) Make decisions in relation to the commissioning and management of primary medical services contracts;
c) Have oversight of GP practice quality and performance; and
d) Provide oversight and assurance of the primary care budget delegated from NHS England.

Individual Funding Requests Panel

This is a sub-committee of the Strategy and Development Committee. Its purpose is to consider and make decisions on Individual Funding Requests ('IFR') applications.

Individual Funding Requests Appeals Panel

This is a sub-committee of the Strategy and Development Committee. Its purpose is to consider Applicants' appeals against decisions made by the Individual Funding Requests Panel.

Procurement Oversight Group

The purpose of this committee is to:

a) Be a non-conflicted forum which provides oversight and scrutiny of key procurements undertaken by the Integrated Care Board and ensure that the procurement regime is followed correctly, properly evidenced, is transparent, and that conflicts of interest are appropriately managed;
b) Provide assurance to the Board of Members and other committees and sub-committees as appropriate that conflicts of interest are properly managed throughout the development of the business case, the approval process and that the procurement routes for services are appropriate;
c) Ensure that procurement processes are proportionate to the cost and complexity of the services to be procured;
d) Review and approve Single Tender Waivers on the Board of Member's behalf where the financial value is in excess of that delegated to the Chief Executive and Chief Finance Officer under the Standing Financial Instructions;
e) Approve service models where these have been remitted to the Procurement Oversight Group by the Board of Members or one of its committees or sub-committees;
f) Have oversight of any procurement where the contract value is £500,000 (five hundred thousand pounds) or greater across the life of the contract and/or any other procurement where the Board of Members and/or any of its commissioning committees request oversight by the Procurement Oversight Group.

Finance Committee

The purpose of the Committee is to:

a) Provide oversight and scrutiny of the ICB's finances, budgets, financial performance and efficiency plans;
b) Oversee the development and delivery of a robust, viable and sustainable system financial plan that support's the ICB's objectives;
c) Support the ICB in its wider financial system leadership role and in particular the development and delivery of system financial plans, achieving the system control total (revenue and capital) and ensuring the financial performance of NHS organisations within the NCL Integrated Care System;
d) Ensure health and social inequalities are taken into account in financial decision-making.

Quality and Safety Committee

The purpose of this committee is to provide oversight, scrutiny and assurance of the following areas on behalf of the Board of Members and to provide robust recommendations and/or directions for actions:

a) The quality and safety of commissioned services;
b) Reducing inequalities in care;
c) The effectiveness of patient care and high quality patient experience;
d) Provider service quality performance;
e) Continuous quality improvement;
f) Safeguarding and complaints.

Integrated Medicines Optimisation Committee

The purpose of the Committee is to:

a) Provide oversight and assurance on the ICB's statutory functions on medicines;
b) Provide oversight and assurance on medicines to ensure:
    - Safe and clinically effective use of medicines;
    - Improved clinical outcomes;
    - Best value of medicines use; and
    - The promotion of proper use of medicines;
    - Safe and consistent access to medicines in the context of care pathways which cross multiple providers;
c) Oversee the development and implementation of the ICB's medicines management strategy and procedures;
d) Ensure co-operation and consistency of approach to medicines optimisation across the NCL Integrated Care System;
d) Oversee the arrangements for sponsorship and/or joint working with the pharmaceutical industry.

ICB Executive Management Team

The Executive Management Team provides executive leadership to the Integrated Care Board, ensuring the effective management and running of the organisation. The Executive Management Team have delegated decision making authorities in line with the Integrate Care Board's governance framework.

North Central London Specialist Commissioning Steering Group

Decisions for specialist commissioning are currently made by NHS England. However, a substantial percentage of this activity and spend is expected to be delegated to Integrated Care Boards from 1st April 2023.

To support the transition of the services that are being delegated the North Central London Specialist Commissioning Steering Group has been established. It is a joint forum between NHS providers and commissioners with input from NHSE London Region and focuses on clinical priorities, finances and contract matters related to the specialist services that will be delegated to Integrated Care Boards.

The North Central London Specialist Commissioning Steering Group will also coordinate North Central London Integrated Care Board's input into the North London Programme Board (consisting of representation from the Integrated Care Board plus our partners in North East and North West London, East of England and South East Region). The North London Programme Board will be responsible for signing off Clinical Network Workplans and any Business Cases arising from either individual Integrated Care Board, NHS Providers or clinical networks. The North Central London Specialist Commissioning Steering Group will report to either the Integrated Care Board of Members or the Strategy and Development Committee as appropriate.

Forums for Partnership Working with other Organisations

Health and Care Partnership Committee

This joint committee is the Integrated Care Partnership committee. It is a statutory joint committee between the Integrated Care Board and the Local Authorities in North Central London. Its role is to develop the Integrated Care Strategy for North Central London and to facilitate joint action to improve health and care services and to influence the wider determinants of health and broader social and economic development.

Community Partnership Forum

This forum ensures effective community and citizen participation in the work of the wider Integrated Care System. It includes important system partners such as Healthwatch and other community groups.

Population Health Forum

This forum is responsible for developing the North Central London Integrated Care System's approach to population health and overseeing its delivery, addressing health inequalities and inequity of access and outcomes. The forum is a key link between Borough Partnerships and their activities and North Central London wide strategies and priorities and will lead and support the development of relationships between organisations in the Integrated Care System partnership to support the delivery of population health improvements. The forum will understand and champion the needs of our local population (and population cohorts) with a focus on reducing inequalities and steer and guide the ongoing evolution of the North Central London Population Health Strategy.

System Management Board

This is responsible for providing strategic oversight to reduce inequalities, reviewing system wide transformation programmes, investment and disinvestment decisions, and ensuring their alignment with medium and longer term Integrated Care Board priorities. The group will provide assurance to the Board of Members about key programmes of work.

NCL People Board

This is a unitary board to provide strategic vision, effective challenge and advice to North Central London organisations and support governance and performance management of programmes and projects to deliver our vision of our community receiving high quality health and care services delivered by a representative and diverse workforce. It is also the vehicle that will support the development of our North Central London Integrated Care System through workforce transformation in response to the NHS Long Term Plan and People Plan.

Clinical Advisory Group

The North Central London Clinical Advisory Group provides robust assurance about the clinical service change decisions that are being taken and provide a clear and transparent audit trail of the rationale for decisions to effect clinical service changes. The North Central London Clinical Advisory Group will be the interface between the London Clinical Advisory Group regarding clinical services that may impact North Central London and vice versa.

NCL Borough Partnerships

North Central London's five Borough Partnerships are active multiagency partnerships. Their role is to foster collaborative working in support of accelerating joint working to provide targeted care to their communities. Partnerships continue to mature locally. There are common features, and many priorities are consistent, but with local nuance within each partnership.

UCL Health Alliance

This is a multi-sector alliance for North Central London, that models collaboration, joint accountability, person-centred care and an outcomes focus throughout our system. The focus will be on both physical and mental health needs and consider whole pathways, working with other partners, from prevention through to complete tertiary treatment to address health inequality and access to treatment and care.

GP Alliance

The GP Provider Alliance brings together General Practice with a unified provider voice to strategically lead, influence and enable Primary Care provision at the North Central London level. The alliance ensures that our systems provide the best possible services for our communities, optimise health gains and reduce inequalities.

NHS
North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
4 July 2022

Report Title	Approval of Terms of Reference	**Date of report**	24 June 2022	**Agenda Item**	3.3
Lead Director / Manager	Ian Porter, Executive Director of Corporate Affairs	**Email / Tel**		ian.porter3@nhs.net	
ICB Member Sponsor					
Report Author	Andrew Spicer, Head of Governance and Risk	**Email / Tel**		Andrew.spicer1@nhs.net	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications** The Committee Terms of Reference include delegated areas of authority for commissioning and other expenditure on behalf of the Board of Members.			
Report Summary	NHS North Central London Integrated Care Board ('ICB') is a statutory organisation that was formally established on 1 July 2022. Under its Constitution the Board of Members is required to establish and Audit Committee and a Remuneration Committee. It may also establish other committees and sub-committees to assist in discharging its statutory functions. It is proposed that the Board of Members establish 5 committees and 4 sub-committees. This paper requests the Board of Members to approve the Terms of Reference for its committees and sub-committees as follows: <u>Audit Committee</u> The purpose of this committee is to provide oversight and scrutiny of the effectiveness and robustness of the governance and assurance processes on which the Board of Members relies. This includes but is not limited to: a) Integrated governance, risk management, internal and external controls; b) Internal and external audit; c) Counter fraud arrangements; and d) Financial reporting. <u>Remuneration Committee</u> The purpose of this committee is to: a) Approve the remuneration and terms of service for ICB Board members except for the Chair; b) Approve the remuneration and terms of service for ICB officers, clinical leads and employees at the Very Senior Manager level; c) Set the pay policy for employees below the Very Senior Manager level. For the avoidance of doubt the Remuneration Committee does not approve employee pay below the Very Senior Manager level or the ICB's staffing structures. These are delegated to the ICB's Chief Executive.				

Strategy and Development Committee

The purpose of this committee is to:

a) Oversee the development of the NCL system plan, the ICB's commissioning strategies and plans and ensure they:
   - 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;
b) Approve the commissioning of health services which deliver the NCL system plan, the ICB's commissioning strategies and plans;
c) Provide assurance to the Board of Members that the ICB is discharging its statutory commissioning functions effectively;
d) Ensure that all of the ICB's strategic commissioning priorities and plans are congruent and aligned across boroughs;
e) Oversee the Primary Care Contracting Committee, the Individual Funding Request ('IFR') Panel and the IFR Appeals Panel;
f) Oversee the development of service improvement strategies across the range of health services commissioned by the ICB.

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a) Provide oversight, scrutiny and decision making for primary medical services;
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Procurement Oversight Group

The purpose of this committee is to:

a) Be a non-conflicted forum which provides oversight and scrutiny of key procurements undertaken by the ICB and ensure that the procurement regime is followed correctly, properly evidenced, is transparent, and that conflicts of interest are appropriately managed;
b) Provide assurance to the Board of Members and other committees and sub-committees as appropriate that conflicts of interest are properly managed throughout the development of the business case, the approval process and that the procurement routes for services are appropriate;
c) Ensure that procurement processes are proportionate to the cost and complexity of the services to be procured;
d) Review and approve Single Tender Waivers on the Board of Member's behalf where the financial value is in excess of that delegated to the Chief Executive and Chief Finance Officer under the Standing Financial Instructions;
e) Approve service models where these have been remitted to the Procurement Oversight Group by the Board of Members or one of its committees or sub-committees;

	f) Have oversight of any procurement where the contract value is £500,000 (five hundred thousand pounds) or greater across the life of the contract and/or any other procurement where the Board of Members and/or any of its commissioning committees request oversight by the Procurement Oversight Group. <u>Finance Committee</u> The purpose of the Committee is to: a) Provide oversight and scrutiny of the ICB's finances, budgets, financial performance and efficiency plans; b) Oversee the development and delivery of a robust, viable and sustainable system financial plan that support's the ICB's objectives; c) Support the ICB in its wider financial system leadership role and in particular the development and delivery of system financial plans, achieving the system control total (revenue and capital) and ensuring the financial performance of NHS organisations within the NCL Integrated Care System; d) Ensure health and social inequalities are taken into account in financial decision-making. <u>Quality and Safety Committee</u> The purpose of this committee is to provide oversight, scrutiny and assurance of the following areas on behalf of the Board of Members and to provide robust recommendations and/or directions for actions: a) The quality and safety of commissioned services; b) Reducing inequalities in care; c) The effectiveness of patient care and high quality patient experience; d) Provider service quality performance; e) Continuous quality improvement; f) Safeguarding and complaints. <u>Integrated Medicines Optimisation Committee</u> This is a sub-committee of the Quality and Safety Committee. Its purpose is to: a) Provide oversight and assurance on the ICB's statutory functions on medicines; b) Provide oversight and assurance on medicines to ensure: • Safe and clinically effective use of medicines; • Improved clinical outcomes; • Best value of medicines use; • The promotion of proper use of medicines; • Safe and consistent access to medicines in the context of care pathways which cross multiple providers; c) Oversee the development and implementation of the ICB's medicines management strategy and procedures; d) Ensure co-operation and consistency of approach to medicines optimisation across the NCL Integrated Care System; e) Oversee the arrangements for sponsorship and/or joint working with the pharmaceutical industry. **Community Participants** The draft Terms of Reference include references to Community Participants being invited to meetings as Standing Participants. The ICB has not yet made a decision on whether to have Community Participants at committee and sub-committee meetings and will make the decision in due course as part of its wider approach to engagement.
Recommendation	The Board of Members is asked to **NOTE** the report and **APPROVE** the following Terms of Reference: a) Audit Committee; b) Remuneration Committee; c) Strategy and Development Committee;

	d) Primary Care Contracting Committee; e) Individual Funding Requests Panel; f) Individual Funding Requests Appeals Panel; g) Procurement Oversight Group; h) Finance Committee; i) Quality and Safety Committee; j) Integrated Medicines Optimisation Committee.
Identified Risks and Risk Management Actions	The committee Terms of Reference include provisions for risk management. In addition, each committee will provide oversight and scrutiny of the ICB's key risks within the areas of their remit. The most significant risks will be reported at each meeting of the Board of Members through the Board Assurance Framework report.
Conflicts of Interest	This paper was written in accordance with the Conflicts of Interest Policy.
Resource Implications	This report supports the ICB by providing oversight and scrutiny of the ICB's key areas and in making effective and efficient use of its resources.
Engagement	This report is presented to the Board of Members of the ICB which includes Non-Executive Members, Partner Members, the UCL Health Alliance Member and clinicians. The Terms of Reference were developed through engagement with the Executive Management Team and other key ICB members of staff who are subject matter experts.
Equality Impact Analysis	This report has been written in accordance with the provisions of the Equality Act 2010.
Report History and Key Decisions	Not applicable.
Next Steps	Upon approval of the Terms of Reference the committees and sub-committees will be mobilised. Any further amendments to Terms of Reference will be presented to the Board of Members for approval and the Terms of Reference will be subject to annual review.
Appendices	The paper contains the following draft Terms of Reference for approval: a) Audit Committee; b) Remuneration Committee; c) Strategy and Development Committee; d) Primary Care Contracting Committee; e) Individual Funding Requests Panel; f) Individual Funding Requests Appeals Panel; g) Procurement Oversight Group; h) Quality and Safety Committee; i) Integrated Medicines Optimisation Committee.

NHS North Central London
Integrated Care Board
Audit Committee
Terms of Reference

1. Introduction

1.1 The Audit Committee ('Committee') is established in accordance with the Constitution of NHS North Central London Integrated Care Board ('ICB'). It is a committee of the ICB's Board of Members.

1.2 These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the Committee.

2. Purpose

2.1 The purpose of the Committee is to carry out the duties listed in sections 3 to 12 below:

3. Integrated Governance, Risk Management and Internal Control

3.1 The Committee will:

a) Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the ICB's activities that support the achievement of the organisational objectives and priorities;
b) Approve the ICB's risk management framework, corporate governance and information governance policies;
c) Seek assurance on the operation of the control environment, corporate governance framework, risk management framework. This includes for risk management reviewing the overall completeness of, and confidence in, the sources of assurance;
d) Review the adequacy and effectiveness of:
    - All risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances;
    - The underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
    - The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications;
    - The policies and procedures for all work related to counter fraud and security as required by NHS Counter Fraud Authority;
    - The policies and procedures for managing conflicts of interest;
    - The policies and procedures for managing gifts and hospitality.

3.2 In carrying out this work the Committee will primarily utilise the work of internal audit, external audit, counter fraud and other assurance functions, but it will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management an internal control, together with an indication of their effectiveness.

3.3 These will be evidenced through the Committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it. As part of its integrated approach the Committee will have effective relationships with other key ICB Board of Member committees so that it underpins processes and linkages. However, these other committees must not usurp the Committee's role.

4. Internal Audit

4.1 The Committee shall ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards 2013 and provides appropriate independent assurance to the Committee, Chief Executive and ICB Board of Members. This will be achieved by:

a) Supporting the provision of the internal audit service and the costs involved;
b) Reviewing and approving the audit strategy, 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;
c) Considering the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources;
d) Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation;
e) Monitoring the effectiveness of internal audit and carrying out an annual review.

5. External Audit

5.1 The Committee shall review and monitor the external auditors' 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:

a) Supporting the appointment and performance of the external auditors;
b) 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;
c) Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact of the audit fee;
d) Reviewing all external audit reports, including the report to those charged with governance (before its submission to the Board of Members as appropriate) and any work undertaken outside of the annual audit plan, together with the appropriateness of management responses;
e) Ensuring that there is in place a clear policy for the engagement of external auditors when supplying non-audit services.

6. Information Governance

6.1 The Committee shall:

a) Receive regular updates on Information Governance ('IG') compliance (including uptake & completion of data security training), data breaches and any related issues and risks;
b) Review the annual Senior Information Risk Owner ('SIRO') report and the submission for the Data Security & Protection Toolkit audit;

c) Provide assurance to the Board of Members that there is an effective framework in place for the management of risks associated with Information Governance.

7. Other Assurance Functions

7.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the ICB, and consider the implications for the governance of the ICB.

7.2 These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (for example, the Care Quality Commission, NHS Litigation Authority etc) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies etc).

7.3 In addition, where required the Committee will review the work of other committees within the ICB, whose work can provide relevant assurance to the Committee's own areas of responsibility.

8. Counter Fraud

8.1 The Committee shall satisfy itself that the ICB has adequate arrangements in place for counter fraud and security that meet NHS Counter Fraud Authority's standards and shall review the outcomes of work in these areas. This will be achieved by:

a) Considering the provision of the counter fraud service and the costs involved;
b) Reviewing and approving the counter fraud strategy, annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the needs of the organisation;
c) Considering the major findings of internal audit work and management's response;
d) Ensuring that the counter fraud function is adequately resourced and has appropriate standing within the organisation;
e) Monitoring the effectiveness of counter fraud and carrying out an annual review.

9. Management

9.1 The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

9.2 The Committee may also request specific reports from individual functions within the organisation.

10. Financial Reporting

10.1 The Committee shall monitor the integrity of the financial statements of its organisation and any formal announcements relating to its financial performance.

10.2 The Committee should ensure that the systems for financial reporting to the Board of Members, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

10.3 The Committee shall review the annual report and financial statements focussing particularly on:

a) The wording in the annual governance statement and other disclosures relevant to the terms of reference of the Committee;
b) Changes in, and compliance with, accounting policies, practices and estimation techniques;

c) Unadjusted misstatements in the financial statements;
d) Significant judgments in preparation of the financial statements;
e) Significant adjustments resulting from the audit;
f) Letters of representation;
g) Explanations for significant variances;
h) Ease of understanding of the contents for patients and the public.

11. Whistleblowing

11.1 The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

12. Reporting

12.1 The Committee shall report to the Board of Members on how it discharges its responsibilities;

12.2 The minutes of the Committee's meetings shall be formally recorded by the Secretariat and submitted to the Board of Members as required. The Committee Chair shall draw to the attention of the Board of Members any issues that require disclosure to the full Board of Members, or require executive action.

12.3 The Committee will report to the Board of Members at least annually on its work in support of the annual governance statement, specifically commenting on:
a) The fitness for purpose of the assurance framework;
b) The completeness and 'embeddedness' of risk management in the organisation;
c) The integration of governance arrangements;
d) The appropriateness of evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business;
e) The robustness of the processes behind the quality accounts.

12.4 The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

13. Membership

13.1 The Committee shall comprise of the following voting members:
a) The Non-Executive Member who is the Chair of the Audit Committee;
b) Two additional Non-Executive Members;
c) A clinician.

13.2 The roles referred to in the list of voting members above describe the substantive roles and any equivalent successor roles and not the individual title or titles.

13.3 In accordance with the ICB's Constitution all voting members of the Committee must be approved by the ICB's Chair.

13.4 The list of voting members is set out in Schedule 1. Schedule 1 does not form part of the Terms of Reference and may be amended without the need to formally amend these Terms of Reference.

13.5 Voting members may nominate deputies to represent them in their absence.

14. Participants and Observers

14.1 The following people shall attend Committee meetings as standing participants:

a) Chief Finance Officer
b) Executive Director of Corporate Affairs;
c) Internal Auditors;
d) External Auditors;
e) Counter Fraud;
f) 2 Community Participants **(TBC)**

14.2 Participants at Committee meetings are non-voting.

14.3 The roles referred to in the list of standing participants above describe the substantive roles and any equivalent successor roles and not the individual title or titles.

14.4 The Chief Executive will be invited to attend an audit committee meeting at least once per year to discuss the process for assurance that supports the annual governance statement and the annual report and accounts. The list of standing participants is contained in Schedule 1. Schedule 1 does not form part of the Terms of Reference and may be amended without the need to formally amend these Terms of Reference.

14.5 Standing participants may nominate deputies to represent them in their absence.

14.6 The Committee may invite or allow additional people to attend meetings as participants. Participants may present at meetings and contribute to the relevant discussions but are not allowed to participate in any formal vote.

14.7 The Committee may invite or allow people to attend meetings as observers. Observers may not present at meetings, contribute to any discussion or participate in any formal vote.

14.8 The Committee may call additional experts to attend meetings on a case by case basis to inform discussion.

15. Chair

15.1 The Committee Chair shall be the Non-Executive Member who is the Audit Committee Chair**.** The Chair may nominate a deputy to represent them in their absence.

16. Voting

16.1 The ICB has agreed to use a collective model of decision making that seeks to find consensus between system partners and make decisions based on unanimity as the norm. This includes working though difficult issues where appropriate. If it is not possible to achieve unanimity a vote will be required. Voting shall be as per clause 16.2 below.

16.2 Each voting member of the Committee shall have one vote with resolutions passing by simple majority. In the event of a tied vote the Committee Chair shall have the casting vote.

17. Quorum

17.1 The Committee will be considered quorate when at least 3 voting members are present.

17.2 If any representative is conflicted on a particular item of business they will not count towards the quorum for that item of business. If this renders a meeting or part of a meeting inquorate

a non-conflicted person may be temporarily appointed or co-opted onto the Committee to satisfy the quorum requirements.

17.3 If a meeting is not quorate the Committee Chair may adjourn the meeting to permit the appointment or co-option of additional members if necessary.

18. Secretariat

18.1 The Secretariat to the Committee shall be provided by the Corporate Affairs Directorate.

19. Frequency of Committee Meetings

19.1 The Committee will meet up to five times a year. However, the Committee Chair may call additional meetings or cancel meetings as necessary.

20. Notice of Meetings

20.1 Notice of a Committee meeting shall be sent to all Committee members no less than 7 days in advance of the meeting.

20.2 The meeting shall contain the date, time and location of the meeting.

21. Agendas and Circulation of Papers

21.1 Before each Committee meeting an agenda setting out the business of the meeting will be sent to every Committee member no less than 7 days in advance of the meeting.

21.2 Before each Committee meeting the papers of the meeting will be sent to every Committee member no less than 7 days in advance of the meeting.

21.3 If a Committee member wishes to include an item on the agenda they must notify the Committee Chair via the Secretariat no later than 7 days prior to the meeting. The decision as to whether to include the agenda item is at the absolute discretion of the Committee Chair.

22. Minutes of Meetings

22.1 The minutes of the proceedings of a meeting shall be prepared by the Corporate Services Directorate and submitted for agreement at the following meeting.

23. Authority

23.1 The Committee is accountable to the Board of Members and will operate as one of its committees. The Committee must act within the remit of these terms of reference and has no executive powers other than those specifically set out in these terms of reference.

23.2 The Committee is authorised by the Board of Members to obtain at the ICB's expense outside legal or other professional advice on any matters within the Committee's Terms of Reference. They are authorised to seek any information they require from any employees or officers and all employees and officers are directed to co-operate with any request made in this regard.

23.3 The Committee is authorised by the Board of Members to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if they consider this necessary.

23.4 The Committee may meet privately with the internal and external auditors at their absolute discretion.

23.5 The Head of Internal Audit, representatives of external audit and counter fraud specialists have a right of access to the Committee Chair.

24. Reporting Responsibilities

24.1 The Committee will report to the Board of Members on all matters within its duties and responsibilities.

24.2 The Committee may make recommendations to the Board of Members it considers appropriate on any area within its remit.

25. Delegated Authority

25.1 The Committee may agree to delegate its authority to a Committee member or members to make decisions on the Committee's behalf outside of a Committee meeting at its absolute discretion on a case by case basis.

26. Virtual Meetings and Decision Making

26.1 Committee meetings may be held in person or virtually.

26.2 There are circumstances where time-critical decisions need to be made and it is not possible and/or reasonably practicable and/or a good use of resources to hold a physical meeting (either in person or virtually) in sufficient time. In these circumstances decisions may be made virtually using the protocol for virtual decision making.

27. Sub-Committees

27.1 The Committee may appoint sub-committees to advise the Committee and assist it in carrying out its duties. The Committee may not delegate any of its functions, powers or decision making authority to a sub-committee.

28. Conflicts of Interest

28.1 Conflicts of Interest shall be dealt with in accordance with the Conflicts of Interest Policy and NHS England statutory guidance for managing conflicts of interest.

28.2 The Committee shall have a Conflicts of Interest Register that will be presented as a standing item on the Committee's agenda. In addition, an opportunity to declare any new or relevant declarations of interest will be listed as a standing item on the Committee's agenda

29. Gifts and Hospitality

29.1 Gifts and Hospitality shall be dealt with in accordance with the Conflicts of Interest Policy, and NHS England statutory guidance for managing conflicts of interest.

29.2 The Committee shall have a Gifts and Hospitality Register and Committee members will have an opportunity to declare any new or relevant declarations of relevant gifts and hospitality as a standing item on the Committee's agenda

30. Standards of Business Conduct

30.1 Committee members and any attendees or observers must maintain the highest standards of personal conduct and in this regard must comply with:
30.1.1 The law of England and Wales;
30.1.2 The NHS Constitution;
30.1.3 The Nolan Principles;
30.1.4 The standards of behaviour set out in the ICB's Constitution;
30.1.5 The Standards of Business Conduct Policy;
30.1.6 The Conflicts of Interest Policy
30.1.7 The Counter Fraud, Bribery and Corruption Policy,
30.1.8 Any additional regulations or codes of practice relevant to the Committee.

30.2 The Committee will have access to sufficient resources to carry out its duties and Committee members will be provided with appropriate and timely training.

31. Review of Terms of Reference

31.1 These Terms of Reference will be reviewed from time to time, reflecting the experience of the Committee in fulfilling its functions and the wider experience of the ICB.

31.2 These Terms of Reference will be formally reviewed annually. These Terms of Reference may be varied or amended by the Board of Members.

Date Approved by the Board of Members: [insert date]
Date of Next Review: [insert date]

Schedule 1
List of Members

The voting members of the Committee are:

Position	Name

Committee Chair:

Position	Name

The standing participants are:

Position	Name

NHS North Central London
Integrated Care Board
Remuneration Committee
Terms of Reference

1. Introduction

1.1 The Remuneration Committee ('Committee') is established in accordance with the Constitution of NHS North Central London Integrated Care Board ('ICB'). It is a committee of the ICB's Board of Members.

1.2 These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the Committee.

2. Purpose

2.1 The purpose of the Committee is to:

a) Approve the remuneration and terms of service for ICB Board members except for the Chair;
b) Approve the remuneration and terms of service for ICB office holders, clinical leads and employees at the Very Senior Manager level;
c) Set pay policies for employees below the Very Senior Manager level. For the avoidance of doubt the Remuneration Committee does not approve employee pay below the Very Senior Manager level or the ICB's staffing structures. These are delegated to the ICB's Chief Executive.

3. Role

3.1 The Committee will:

a) Approve ICB pay policies;
b) Approve the remuneration and terms of service for ICB Board members except for the Chair; ICB officers, clinical leads and employees at the Very Senior Manager level. This includes pension rights and any compensation payments;
c) Ensure arrangements for remuneration and any allowances agreed by the Remuneration Committee are in line with the ICB pay policies, any other relevant ICB policies and any guidance issued by NHS England or other relevant body.
d) Review the appropriateness and relevance of the remuneration policy including the taking into account all factors which are deemed necessary including relevant legal and regulatory requirements, NHS England guidance and NHS terms and conditions of service;
e) Obtain reliable and up to date information about remuneration in comparable organisations in terms of scale and complexity. To assist the Committee with this obligation the Committee shall have full authority to appoint remuneration consultants and to commission, purchase and/or obtain any reports, surveys or information which it deems necessary at the expense of the ICB but within any budgetary restraints imposed by the Board of Members;
f) Be responsible for establishing the selection criteria, selecting, appointing and setting the terms of reference for any remuneration consultant or consultants who advise the Committee;
g) Approve payments for additional responsibilities and provisions for other benefits for ICB Members, office holders, clinical leads and employees at the Very Senior Manager level;

h) Approve and monitor the level and structure of remuneration packages for ICB members (excluding the Chair), officers and clinical leads;
i) Ensure that contractual terms of termination and any payments made are fair to the ICB and to the individual, that failure is not rewarded and that the duty to mitigate loss is fully recognised;
j) Approve termination and/or compensation payments;
k) Approve the policy for authorising claims for expenses by the ICB members, officers and clinical leads;
l) Approve allowances under any pension scheme the ICB may establish as an alternative to the NHS Pension Scheme;
m) Approve the provision of other contractual and/or non-contractual benefits outside of national agreement and approved local HR policies where this is necessary including but not limited to lease cars, season ticket loans, recruitment and retention payments;
n) Work and liaise as necessary with the Board of Members, all other ICB committees and sub-committees;
o) Declare the relationship between the remuneration of the highest paid director in the ICB and the median remuneration of the ICB's workforce in its annual report in line with the Hutton Fair Pay Review.

4. Membership

4.1 The Committee shall comprise of the following voting members:
a) Three Non- Executive Members.

4.2 The roles referred to in the list of voting members above describe the substantive roles and any equivalent successor roles and not the individual title or titles.

4.3 In accordance with the ICB's Constitution all voting members of the Committee must be approved by the ICB's Chair.

4.4 It is a principle of the Committee that no one will decide or vote on their own remuneration. Therefore when the Committee is undertaking its role in relation to Non-Executive Members the voting membership of the Committee shall comprise the following:
a) The Chair of the ICB;
b) Two Members of the Board who are not Executive Directors or Non-Executive Members.

4.5 The list of voting members is set out in Schedule 1. Schedule 1 does not form part of the Terms of Reference and may be amended without the need to formally amend these Terms of Reference.

4.6 Voting members may nominate deputies to represent them in their absence.

5. Participants and Observers

5.1 The following people shall attend Committee meetings as standing participants:
a) Executive Director of Corporate Affairs;
b) Chief People Officer.

5.2 Participants at Committee meetings are non-voting.

5.3 The roles referred to in the list of standing participants above describe the substantive roles and any equivalent successor roles and not the individual title or titles.

5.4 The list of standing participants is contained in Schedule 1. Schedule 1 does not form part of the Terms of Reference and may be amended without the need to formally amend these Terms of Reference.

5.5 Standing participants may nominate deputies to represent them in their absence.

5.6 The Committee may invite or allow additional people to attend meetings as participants. Participants may present at meetings and contribute to the relevant discussions but are not allowed to participate in any formal vote.

5.7 The Committee may invite or allow people to attend meetings as observers. Observers may not present at meetings, contribute to any discussion or participate in any formal vote.

5.8 The Committee may call additional experts to attend meetings on a case by case basis to inform discussion.

6. Chair

6.1 The Committee Chair shall be a Non-Executive Member**.** The Chair may nominate a deputy to represent them in their absence.

6.2 It is a principle of the Committee that no one will decide or vote on their own remuneration.

6.3 When the Committee is undertaking its role in relation to Non-Executive Members the voting Committee members may appoint one of the members to be the Chair. The Chair may nominate a deputy to represent them in their absence.

6.4 Notwithstanding the provisions of section 6.3 above the ICB Chair is prohibited from being the Chair of the Remuneration Committee as per section 29.8(b) of the ICB's Constitution.

7. Voting

7.1 The ICB has agreed to use a collective model of decision making that seeks to find consensus between system partners and make decisions based on unanimity as the norm. This includes working though difficult issues where appropriate. If it is not possible to achieve unanimity a vote will be required. Voting shall be as per clause 7.2 below.

7.2 Each voting member of the Committee shall have one vote with resolutions passing by simple majority. In the event of a tied vote the Committee Chair shall have the casting vote.

8. Quorum

8.1 The Committee will be considered quorate when at least 2 voting members are present.

8.2 If any representative is conflicted on a particular item of business they will not count towards the quorum for that item of business. If this renders a meeting or part of a meeting inquorate a non-conflicted person may be temporarily appointed or co-opted onto the Committee to satisfy the quorum requirements.

8.3 If a meeting is not quorate the Committee Chair may adjourn the meeting to permit the appointment or co-option of additional members if necessary.

9. Secretariat

9.1 The Secretariat to the Committee shall be provided by the Corporate Affairs Directorate.

10. Frequency of Committee Meetings

10.1 Committee meetings will be held as required but may hold additional meetings as and when necessary. The Committee Chair may call additional meetings or cancel meetings as necessary.

11. Notice of Meetings

11.1 Notice of a Committee meeting shall be sent to all Committee members no less than 7 days in advance of the meeting.

11.2 The meeting shall contain the date, time and location of the meeting.

12. Agendas and Circulation of Papers

12.1 Before each Committee meeting an agenda setting out the business of the meeting will be sent to every Committee member no less than 7 days in advance of the meeting.

12.2 Before each Committee meeting the papers of the meeting will be sent to every Committee member no less than 7 days in advance of the meeting.

12.3 If a Committee member wishes to include an item on the agenda they must notify the Committee Chair via the Secretariat no later than 7 days prior to the meeting. The decision as to whether to include the agenda item is at the absolute discretion of the Committee Chair.

13. Minutes of Meetings

13.1 The minutes of the proceedings of a meeting shall be prepared by the Secretariat and submitted for agreement at the following meeting.

14. Authority

14.1 The Committee is accountable to the Board of Members and will operate as one of its committees. The Committee must act within the remit of these terms of reference and has no executive powers other than those specifically set out in these terms of reference.

14.2 The Committee is authorised by the Board of Members to obtain at the ICB's expense outside legal or other professional advice on any matters within the Committee's Terms of Reference.

15. Reporting Responsibilities

15.1 The Committee will report to the Board of Members on all matters within its duties and responsibilities.

15.2 The Committee may make recommendations to the Board of Members it considers appropriate on any area within its remit.

16. Delegated Authority

16.1 The Committee may agree to delegate its authority to a Committee member or members to make decisions on the Committee's behalf outside of a Committee meeting at its absolute discretion on a case by case basis.

17. Virtual Meetings and Decision Making

17.1 Committee meetings may be held in person or virtually.

17.2 There are circumstances where time-critical decisions need to be made and it is not possible and/or reasonably practicable and/or a good use of resources to hold a physical meeting (either in person or virtually) in sufficient time. In these circumstances decisions may be made virtually using the protocol for virtual decision making.

18. Sub-Committees

18.1 The Committee may appoint sub-committees to advise the Committee and assist it in carrying out its duties. The Committee may not delegate any of its functions, powers or decision making authority to a sub-committee.

19. Conflicts of Interest

19.1 Conflicts of Interest shall be dealt with in accordance with the Conflicts of Interest Policy and NHS England statutory guidance for managing conflicts of interest.

19.2 The Committee shall have a Conflicts of Interest Register that will be presented as a standing item on the Committee's agenda. In addition, an opportunity to declare any new or relevant declarations of interest will be listed as a standing item on the Committee's agenda.

20. Gifts and Hospitality

20.1 Gifts and Hospitality shall be dealt with in accordance with the Conflicts of Interest Policy, and NHS England statutory guidance for managing conflicts of interest.

20.2 The Committee shall have a Gifts and Hospitality Register and Committee members will have an opportunity to declare any new or relevant declarations of relevant gifts and hospitality as a standing item on the Committee's agenda

21. Standards of Business Conduct

21.1 Committee members and any attendees or observers must maintain the highest standards of personal conduct and in this regard must comply with:

a) The law of England and Wales;
b) The NHS Constitution;
c) The Nolan Principles;
d) The standards of behaviour set out in the ICB's Constitution;
e) The Standards of Business Conduct Policy;
f) The Conflicts of Interest Policy
g) The Counter Fraud, Bribery and Corruption Policy,
h) Any additional regulations or codes of practice relevant to the Committee.

21.2 The Committee will have access to sufficient resources to carry out its duties and Committee members will be provided with appropriate and timely training.

22. Review of Terms of Reference

22.1 These Terms of Reference will be reviewed from time to time, reflecting the experience of the Committee in fulfilling its functions and the wider experience of the ICB.

22.2 These Terms of Reference will be formally reviewed annually. These Terms of Reference may be varied or amended by the Board of Members.

Date Approved by the Board of Members: [insert date]
Date of Next Review: [insert date]

Schedule 1
List of Members

The voting members of the Committee are:

Position	Name
Non- Executive Member	
Non- Executive Member	
Non- Executive Member	

Committee Chair:

Position	Name
Non- Executive Member	

The voting members of the Committee when the Committee is undertaking its role in relation to Non-Executive Members:

Position	Name
The Chair of the ICB;	
Member of the Board who is not an Executive Director	
Member of the Board who is not an Executive Director	

Committee Chair when the Committee is undertaking its role in relation to Non-Executive Members:

Position	Name

The standing participants are:

Position	Name
Executive Director of Corporate Services	
Chief People Officer	

NHS North Central London
Integrated Care Board
Strategy and Development Committee
Terms of Reference

1. Introduction

1.1 The Strategy and Development Committee ('Committee') is established in accordance with the Constitution of NHS North Central London Integrated Care Board ('ICB'). It is a committee of the ICB's Board of Members.

1.2 These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the Committee.

2. Purpose

2.1 The purpose of the Committee is to:

a) Oversee the development of the NCL system plan, the ICB's commissioning strategies and plans and ensure they:
   - 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;

b) Approve the commissioning of health services which deliver the NCL system plan, the ICB's commissioning strategies and plans;

c) Provide assurance to the Board of Members that the ICB is discharging its statutory commissioning functions effectively;

d) Ensure that all of the ICB's strategic commissioning priorities and plans are congruent and aligned across boroughs;

e) Oversee the Primary Care Contracting Committee, the Individual Funding Request ('IFR') Panel and the IFR Appeals Panel;

f) Oversee the development of service improvement strategies across the range of health services commissioned by the ICB.

3. Role

3.1 The Committee will:

a) Provide clinical and senior management leadership for at scale and transformational strategic developments and service improvement strategies;

b) Oversee the development and implementation of the ICB's Population Health and Inequalities Improvement strategy and corresponding commissioning framework which supports delivery of the wider long term objectives aligned to NHS policy direction/guidance;

c) Approve the ICB's annual plan and/or key national plan submissions to regulators as required;

d) Approve the development, recommissioning, de-commissioning and/or reconfiguration of system-wide healthcare services;

e) Oversee the development of collaborative, joint and/or delegated commissioning arrangements to support population health and inequalities improvements across North Central London;

f) Oversee and approve the ICB's approach to a) Digital and b) Estates;

g) Approve business cases, service specifications and authorise investment expenditure from within the Committee's delegated authority limits;

h) Identify and ensure the delivery of strategic redesign work streams, including clinical input to these;
i) Monitor and review the effectiveness and the implementation of development or service improvement strategies, plans and redesign work streams;
j) Oversight of the annual contracting round;
k) Ensure that investments are affordable, value for money, sustainable and are underpinned by a robust and deliverable efficiency plans, where appropriate;
l) Make decisions on behalf of the ICB on recommendations from the System Delivery Board as appropriate;
m) Ensure place alignment with system-wide priorities and objectives;
n) Ensure that service development decisions reflect the ICB's patient and public and equality and diversity strategies;
o) Review performance issues that require a service improvement decision, service development and/or contract action and make decisions, provide advice and guidance or make recommendations to the Board of Members as appropriate;
p) Consider and act upon the commissioning implications of any issues referred by the Board of Members or any of its committee or sub-committee;
q) Determine arrangements to enable patients to make informed choices (for example, through the provision of relevant and timely information and where appropriate the development of personal budgets and care plans);
r) Provide assurance to the Board of Members that significant service development and improvement risks are being properly managed and agree remedial actions where necessary;
s) Make recommendations to the Board of Members and/or any of its committees as appropriate;
t) Consider Individual Funding Requests ('IFR') applications where the value exceeds the IFR Panel's financial authority limits (this is currently set at £50,000 per year per case);
u) Consider any matter referred from the Primary Care Contracting Committee;
v) Consider any matter referred from the Medicines Management Committee;
w) Provide oversight and give due to regard to the Primary Care Strategy forum.

4. Membership

4.1 The Committee shall comprise of the following voting members:
a) ICB Chair;
b) Non-Executive Member;
c) Two Partner Members or one Partner Member and the UCL Health Alliance Member;
d) Chief Executive;
e) Chief Finance Officer;
f) Chief Medical Officer;
g) Chief Nursing Officer;
h) Chief Development and Population Health Officer;
i) Executive Director of Place;
j) Executive Director of Transformation and Performance.

4.2 The roles referred to in the list of voting members above describe the substantive roles and any equivalent successor roles and not the individual title or titles.

4.3 In accordance with the ICB's Constitution all voting members of the Committee must be approved by the ICB's Chair.

4.4 The list of voting members is set out in Schedule 1. Schedule 1 does not form part of the Terms of Reference and may be amended without the need to formally amend these Terms of Reference.

4.5 Voting members may nominate deputies to represent them in their absence.

5. Participants and Observers

5.1 The following people shall attend Committee meetings as standing participants:

a) A representative from Public Health;
b) A representative from the GP Provider Alliance;
c) A representative from the VCSE Alliance;
d) A Community Participant **(TBC)**.

5.2 Participants at Committee meetings are non-voting.

5.3 The roles referred to in the list of standing participants above describe the substantive roles and any equivalent successor roles and not the individual title or titles.

5.4 The list of standing participants is contained in Schedule 1. Schedule 1 does not form part of the Terms of Reference and may be amended without the need to formally amend these Terms of Reference.

5.5 Standing participants may nominate deputies to represent them in their absence.

5.6 The Committee may invite or allow additional people to attend meetings as participants. Participants may present at meetings and contribute to the relevant discussions but are not allowed to participate in any formal vote.

5.7 The Committee may invite or allow people to attend meetings as observers. Observers may not present at meetings, contribute to any discussion or participate in any formal vote.

5.8 The Committee may call additional experts to attend meetings on a case by case basis to inform discussion.

6. Chair

6.1 The Committee Chair shall be ICB Chair**.** The Chair may nominate a deputy to represent them in their absence.

7. Voting

7.1 The ICB has agreed to use a collective model of decision making that seeks to find consensus between system partners and make decisions based on unanimity as the norm. This includes working though difficult issues where appropriate. If it is not possible to achieve unanimity a vote will be required. Voting shall be as per clause 7.2 below.

7.2 Each voting member of the Committee shall have one vote with resolutions passing by simple majority. In the event of a tied vote the Committee Chair shall have the casting vote.

8. Quorum

8.1 The Committee will be considered quorate when at least five voting members are present which must include:

a) ICB Chair;

b) Chief Executive or Chief Finance Officer;
c) Chief Medical Officer or Chief Nursing Officer;
d) A Partner Member or the UCL Health Alliance Member;
e) Chief Development and Population Health Officer or Executive Director of Place or Executive Director of Transformation and Performance.

8.2 If any representative is conflicted on a particular item of business they will not count towards the quorum for that item of business. If this renders a meeting or part of a meeting inquorate a non-conflicted person may be temporarily appointed or co-opted onto the Committee to satisfy the quorum requirements.

8.3 If a meeting is not quorate the Committee Chair may adjourn the meeting to permit the appointment or co-option of additional members if necessary.

9. Secretariat

9.1 The Secretariat to the Committee shall be provided by the Corporate Affairs Directorate.

10. Frequency of Committee Meetings

10.1 Committee meetings will be held bi-monthly but may hold additional meetings as and when necessary. The Committee Chair may call additional meetings or cancel meetings as necessary.

11. Notice of Meetings

11.1 Notice of a Committee meeting shall be sent to all Committee members no less than 7 days in advance of the meeting.

11.2 The meeting shall contain the date, time and location of the meeting.

12. Agendas and Circulation of Papers

12.1 Before each Committee meeting an agenda setting out the business of the meeting will be sent to every Committee member no less than 7 days in advance of the meeting.

12.2 Before each Committee meeting the papers of the meeting will be sent to every Committee member no less than 7 days in advance of the meeting.

12.3 If a Committee member wishes to include an item on the agenda they must notify the Committee Chair via the Secretariat no later than 7 days prior to the meeting. The decision as to whether to include the agenda item is at the absolute discretion of the Committee Chair.

13. Minutes of Meetings

13.1 The minutes of the proceedings of a meeting shall be prepared by NCL ICB Governance and Risk Team and submitted for agreement at the following meeting.

14. Authority

14.1 The Committee is accountable to the Board of Members and will operate as one of its committees. The Committee must act within the remit of these terms of reference and has no executive powers other than those specifically set out in these terms of reference.

14.2 The Committee is authorised by the Board of Members to obtain at the ICB's expense outside legal or other professional advice on any matters within the Committee's Terms of Reference.

15. Reporting Responsibilities

15.1 The Committee will report to the Board of Members on all matters within its duties and responsibilities.

15.2 The Committee may make recommendations to the Board of Members it considers appropriate on any area within its remit.

16. Delegated Authority

16.1 The Committee may agree to delegate its authority to a Committee member or members to make decisions on the Committee's behalf outside of a Committee meeting at its absolute discretion on a case by case basis.

17. Virtual Meetings and Decision Making

17.1 Committee meetings may be held in person or virtually.

17.2 There are circumstances where time-critical decisions need to be made and it is not possible and/or reasonably practicable and/or a good use of resources to hold a physical meeting (either in person or virtually) in sufficient time. In these circumstances decisions may be made virtually using the protocol for virtual decision making.

18. Sub-Committees

18.1 The Committee has three sub-committees with delegated functions and authorities which are:

a) The Primary Care Contracting Committee;
b) The Individual Funding Requests Panel;
c) The Individual Funding Requests Appeals Panel.

18.2 The Committee may appoint additional sub-committees to advise the Committee and assist it in carrying out its duties. The Committee may not delegate any of its functions, powers or decision making authority to any of its additional sub-committees.

19. Conflicts of Interest

19.1 Conflicts of Interest shall be dealt with in accordance with the Conflicts of Interest Policy and NHS England statutory guidance for managing conflicts of interest.

19.2 The Committee shall have a Conflicts of Interest Register that will be presented as a standing item on the Committee's agenda. In addition, an opportunity to declare any new or relevant declarations of interest will be listed as a standing item on the Committee's agenda.

20. Gifts and Hospitality

20.1 Gifts and Hospitality shall be dealt with in accordance with the Conflicts of Interest Policy, and NHS England statutory guidance for managing conflicts of interest.

20.2 The Committee shall have a Gifts and Hospitality Register and Committee members will have an opportunity to declare any new or relevant declarations of relevant gifts and hospitality as a standing item on the Committee's agenda

21. Standards of Business Conduct

21.1 Committee members and any attendees or observers must maintain the highest standards of personal conduct and in this regard must comply with:

a) The law of England and Wales;
b) The NHS Constitution;
c) The Nolan Principles;
d) The standards of behaviour set out in the ICB's Constitution;
e) The Standards of Business Conduct Policy;
f) The Conflicts of Interest Policy;
g) The Counter Fraud, Bribery and Corruption Policy;
h) Any additional regulations or codes of practice relevant to the Committee.

21.2 The Committee will have access to sufficient resources to carry out its duties and Committee members will be provided with appropriate and timely training.

22. Review of Terms of Reference

22.1 These Terms of Reference will be reviewed from time to time, reflecting the experience of the Committee in fulfilling its functions and the wider experience of the ICB.

22.2 These Terms of Reference will be formally reviewed annually. These Terms of Reference may be varied or amended by the Board of Members.

Date Approved by the Board of Members: [insert date]
Date of Next Review: [insert date]

Schedule 1
List of Members

The voting members of the Committee are:

Position	Name
ICB Chair	
Non-Executive Member;	
Two Partner Members or one Partner Member and the UCL Health Alliance Member;	
Chief Executive	
Chief Finance Officer;	
Chief Medical Officer	
Chief Nursing Officer	
Chief Development and Population Health Officer	
Executive Director of Place	
Executive Director of Transformation and Performance	

Committee Chair:

Position	Name
ICB Chair	

The standing participants are:

Position	Name
A representative from Public Health	

A representative from the GP Provider Alliance	
A representative from the VCSE Alliance	
A Community Participant **(TBC)**	

NHS North Central London
Integrated Care Board
Primary Care Contracting Committee
Terms of Reference

1. Introduction

1.1 The Primary Care Contracting Committee ('Committee') is established in accordance with the Constitution of NHS North Central London Integrated Care Board ('ICB'). It is a sub-committee of the ICB Strategy and Development Committee.

1.2 These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the Committee.

2. Purpose

2.1 The purpose of the Committee is to:

a) Provide oversight, scrutiny and decision making for primary medical services;
b) Make decisions in relation to the commissioning and management of primary medical services contracts;
c) Have oversight of quality and performance in primary medical services; and,
d) Provide oversight and assurance of the primary care budget delegated from NHS England.

3. Role

3.1 The Committee will:

a) Make decisions for the commissioning and management of Primary Medical Services Contracts, including but not limited to the following activities:
   - Decisions in relation to GP core contracts and directed enhanced services;
   - Making recommendations in relation to Local Enhanced Services;
   - Decisions in relation to the establishment of GP practices (including branch surgeries) and closure of GP practices;
   - Decisions about 'discretionary' payments permissible under Guidelines;
   - Management of delegated primary care funds;
   - Decisions about commissioning for out of area registered patients;
   - Approval of practice mergers;
   - Planning primary medical care services in the area, including carrying out needs assessments and monitoring of list size changes;
   - Ensuring the ICB and providers of primary medical services uphold the duty to engage Undertaking reviews of primary medical care services;
   - Ensure there is appropriate oversight of primary care procurements;
   - Decisions in relation to the management of poor performance, which –without limitation – include, use of remedial and breach notices and application of wider contract terms and , decisions and liaison with NHSE and the CQC where the CQC has reported non-compliance with standards (excluding any decisions in relation to the performers list which remains with NHSE);
   - Application of the Premises Cost Directions in the planning, approval and funding of primary care estate;
   - Approve the elements of ICB estates schemes that pertain to primary care rent, rates or patient access;

- Coordinating a consistent approach to the commissioning of primary care services aligned to the primary care strategy and ICB Population Health and Inequalities Improvement Strategy; and
- Such other ancillary activities that are necessary in order to exercise the Delegated Functions.

b) Give due regard to the Primary Medical Care Policy and Guidance Manual, Delegation Agreements with NHS England and ICB commissioning policies and frameworks;
c) Shape and set ICB commissioning policies and frameworks for primary care contracts;
e) Oversee and approve primary care workforce plans that pertain to national primary care contracts including but not limited to minimum staffing numbers and the Additional Roles Reimbursement Scheme ('ARRS'); and,
f) Oversee and approve Digital plans that pertain or have implications for primary care access service models. This may include but is not limited to online consultation models.
g) Receive information on and give due regard to Primary Care strategy and policy set at a national and local level.

4. Membership

4.1 The Committee shall comprise of the following voting members:
a) Two Non-Executive Members;
b) A non-conflicted independent primary care clinician;
c) Chief Development and Population Health Officer;
d) Chief Medical Officer or Chief Nursing Officer;
e) Executive Director of Place;
f) Director of Finance.

4.2 The roles referred to in the list of voting members above describe the substantive roles and any equivalent successor roles and not the individual title or titles.

4.3 In accordance with the ICB's Constitution all voting members of the Committee must be approved by the ICB's Chair.

4.4 The list of voting members is set out in Schedule 1. Schedule 1 does not form part of the Terms of Reference and may be amended without the need to formally amend these Terms of Reference.

4.5 Voting members may nominate deputies to represent them in their absence.

5. Participants and Observers

5.1 The following people shall attend Committee meetings as standing participants:
a) Director of Primary Care Transformation and Programmes;
b) Assistant Director of Primary Care Contracts;
c) Clinical Director for Primary Care;
d) Chief People Officer;
e) A representative from the Quality Directorate;
f) A Director of Public Health;
g) Healthwatch Representative;
h) LMC Representative;
i) Community Participants (TBC);
j) VCSE Alliance Representative.

5.2 Participants at Committee meetings are non-voting.

5.3 The roles referred to in the list of standing participants above describe the substantive roles and any equivalent successor roles and not the individual title or titles.

5.4 The list of standing participants is contained in Schedule 1. Schedule 1 does not form part of the Terms of Reference and may be amended without the need to formally amend these Terms of Reference.

5.5 Standing participants may nominate deputies to represent them in their absence.

5.6 The Committee may invite or allow additional people to attend meetings as participants. Participants may present at meetings and contribute to the relevant discussions but are not allowed to participate in any formal vote.

5.7 The Committee may invite or allow people to attend meetings as observers. Observers may not present at meetings, contribute to any discussion or participate in any formal vote.

5.8 The Committee may call additional experts to attend meetings on a case by case basis to inform discussion.

6. Chair

6.1 The Committee Chair shall be a Non-Executive Member**.** The Chair may nominate a deputy to represent them in their absence.

7. Voting

7.1 The ICB has agreed to use a collective model of decision making that seeks to find consensus between system partners and make decisions based on unanimity as the norm. This includes working though difficult issues where appropriate. If it is not possible to achieve unanimity a vote will be required. Voting shall be as per clause 7.2 below.

7.2 Each voting member of the Committee shall have one vote with resolutions passing by simple majority. In the event of a tied vote the Committee Chair shall have the casting vote.

8. Quorum

8.1 The Committee will be considered quorate when at least the following voting members are present:

a) The Chair;
b) A Clinician; and
c) An Executive Director.

8.2 If any representative is conflicted on a particular item of business they will not count towards the quorum for that item of business. If this renders a meeting or part of a meeting inquorate a non-conflicted person may be temporarily appointed or co-opted onto the Committee to satisfy the quorum requirements.

8.3 If a meeting is not quorate the Committee Chair may adjourn the meeting to permit the appointment or co-option of additional members if necessary.

9. Secretariat

9.1 The Secretariat to the Committee shall be provided by the Corporate Affairs Directorate.

10. Frequency of Committee Meetings

10.1 Committee meetings will be held bi-monthly but may hold additional meetings as and when necessary. The Committee Chair may call additional meetings or cancel meetings as necessary.

11. Notice of Meetings

11.1 Notice of a Committee meeting shall be sent to all Committee members no less than 7 days in advance of the meeting.

11.2 The meeting shall contain the date, time and location of the meeting.

12. Agendas and Circulation of Papers

12.1 Before each Committee meeting an agenda setting out the business of the meeting will be sent to every Committee member no less than 7 days in advance of the meeting.

12.2 Before each Committee meeting the papers of the meeting will be sent to every Committee member no less than 7 days in advance of the meeting.

12.3 If a Committee member wishes to include an item on the agenda they must notify the Committee Chair via the Secretariat no later than 7 days prior to the meeting. The decision as to whether to include the agenda item is at the absolute discretion of the Committee Chair.

13. Minutes of Meetings

13.1 The minutes of the proceedings of a meeting shall be prepared by the Secretariat and submitted for agreement at the following meeting.

14. Meetings Held in Public

14.1 Meetings of the Committee shall be held in public unless the Committee resolves to exclude the public from a meeting. In which case the meeting, in whole or in part, may be held in private. The Committee may also exclude non-voting attendees and observers. Meetings or parts of meetings held in public will be referred to as 'Meeting Part 1'. Meetings or parts of meetings held in private will be referred to as 'Meeting Part 2.'

14.2 Attendees, observers and the public may be excluded from all or part of a meeting at the Committee's absolute discretion whenever publicity would be prejudicial to the public interest by reason of:

a) The confidential nature of the business to be transacted;
b) The matter is commercially sensitive or confidential;
c) The matter being discussed is part of an on-going investigation;
d) The matter to be discussed contains information about individual practitioners, patients or other Individuals which includes sensitive personal data;
e) Information in respect of which a claim to legal professional privilege could be maintained in legal proceedings is to be discussed;
f) Other special reason stated in the resolution and arising from the nature of that business or of the proceedings;
g) Any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time; or
h) Allowing the meeting to proceed without interruption, disruption and/or general disturbance.

15. Questions from the Public and Deputations

15.1 The Committee may receive questions from the public at its absolute discretion in line with the ICB's protocol for public questions which is available on the ICB's website.

15.2 The Committee may receive, at its absolute discretion, Deputations from members of the public or interested parties to make the Committee aware of a particular concern or concerns they have.

15.3 Any Deputations should be sent to the Committee secretariat who will pass it to the Chair for consideration.

15.4 Any Deputations must be received by the Committee secretariat at least three working days before a Committee meeting is due to take place to be eligible to be heard at that Committee meeting. However, where it is not possible to comply with this deadline due to the papers of the meeting being published later or due to a public holiday the Deputations must be submitted within a reasonable time.

15.5 Any Deputations not received within this time will not be eligible to be heard at that Committee meeting. However, on a strictly case by case basis there may be times where it would be highly beneficial to the Committee's business to waive this requirement due to the relevance or content of the Deputations. In these circumstances the Chair may do so on a case by case basis and without setting any precedents of future or further waivers.

15.6 Any Deputations must take the form of a written request together with a statement setting out what the Deputation is about. If any Deputation fails to set out this information it will be rejected.

15.7 Any Deputations which are not relevant to the Committee's business will be rejected

15.8 The Chair may accept or reject any relevant and properly completed Deputations on a strictly case by case basis at his/her absolute discretion and without setting any precedents for future or further decisions.

15.9 If a request is agreed the interested party and/or parties will be invited to a Committee meeting where the Committee will consider the Deputation.

15.10 The Chair may decide how much time to allocate to any Deputations at his/her absolute discretion on a case by case basis and without setting any precedents for future or further decisions on time allocated for Deputations.

15.11 Nothing in this section 15 shall limit, prohibit or otherwise restrict the Committee's powers contained in sections 4, 5, 14 or 16 of these Terms of Reference.

16. Confidentiality

16.1 Members of the Committee shall respect the confidentiality requirements set out in these Terms of Reference unless separate confidentiality requirements are set out for the Committee in which event these shall be observed.

16.2 Committee meetings may in whole or in part be held in private as per section 14 above. Any papers relating to these agenda items will be excluded from the public domain. For any meeting or any part of a meeting held in private all members and/or attendees must treat the contents of the meeting and any relevant papers as strictly private and confidential.

16.3 Decisions of the Committee will be published by Committee members except where matters under consideration or when decisions have been made in private and so excluded from the public domain in accordance with section 14 above.

17. Authority

17.1 The Committee is accountable to the ICB Strategy and Development Committee and will operate as one of its sub-committees. The Committee must act within the remit of these terms of reference and has no executive powers other than those specifically set out in these terms of reference.

17.2 The Committee is authorised by the Board of Members to obtain at the ICB's expense outside legal or other professional advice on any matters within the Committee's Terms of Reference.

18. Reporting Responsibilities

18.1 The Committee will report to ICB Strategy and Development Committee on all matters within its duties and responsibilities.

18.2 The Committee may make recommendations to the ICB Board of Members, the Strategy and Development Committee and/or any other committee it considers appropriate on any area within its remit.

19. Delegated Authority

19.1 The Committee may agree to delegate its authority to a Committee member or members to make decisions on the Committee's behalf outside of a Committee meeting at its absolute discretion on a case by case basis.

20. Virtual Meetings and Decision Making

20.1 Committee meetings may be held in person or virtually.

20.2 There are circumstances where time-critical decisions need to be made and it is not possible and/or reasonably practicable and/or a good use of resources to hold a physical meeting (either in person or virtually) in sufficient time. In these circumstances decisions may be made virtually using the protocol for virtual decision making.

20.3 In addition to the general authority set out in clause 20.2 above, due to the nature of primary care commissioning the Committee recognises that some urgent and immediate decisions may need to be made outside of Committee meetings and that the use of the protocol for virtual decision making is not appropriate. The Committee may therefore delegate urgent and immediate decisions that need to be made outside of Committee timescales in accordance with clauses 20.4 – 20.5 and 20.8 below.

20.4 Urgent decisions requiring a response within 24 hours will be made collectively by the following people or their nominated deputies:

a) The Committee Chair;
b) A non-conflicted clinician;
c) Executive Director of Place.

20.5 Immediate decisions requiring a response within 2 weeks will be made at a Committee meeting where practicable or by the protocol for virtual decision making. Where this is not practicable the following people or their nominated deputies will collectively make the decision:

a) The Committee Chair;
b) A non-conflicted clinician;
c) Executive Director of Place.

20.6 Due to the nature of primary care commissioning the Committee recognises that the following non-contentious, low risk, decisions may be made outside of Committee meetings by those listed in clause 20.7 below:

- Requests to add or remove a partner;
- Retirement of a partner and adding of a new partner;
- Partnership changes- 24 hour retirement;
- Increases in practice boundaries.

20.7 The following people or their nominated deputies may collectively make the non-contentious, low risk decisions set out in clause 20.6 above:

a) The Committee Chair;
b) A non-conflicted clinician;
c) Executive Director of Place.

20.8 Decisions made outside of Committee meetings will be reported to the Committee at the next Committee meeting. This may be in a public or private part of the meeting depending on the nature of the business and the decision(s) made.

21. Sub-Committees

21.1 The Committee may not appoint sub-committees but may appoint working groups to advise the Committee and assist it in carrying out its duties. The Committee may not delegate any of its functions, powers or decision making authority to a sub-committee.

22. Conflicts of Interest

22.1 Conflicts of Interest shall be dealt with in accordance with the Conflicts of Interest Policy and NHS England statutory guidance for managing conflicts of interest.

22.2 The Committee shall have a Conflicts of Interest Register that will be presented as a standing item on the Committee's agenda. In addition, an opportunity to declare any new or relevant declarations of interest will be listed as a standing item on the Committee's agenda

23. Gifts and Hospitality

23.1 Gifts and Hospitality shall be dealt with in accordance with the Conflicts of Interest Policy, and NHS England statutory guidance for managing conflicts of interest.

23.2 The Committee shall have a Gifts and Hospitality Register and Committee members will have an opportunity to declare any new or relevant declarations of relevant gifts and hospitality as a standing item on the Committee's agenda

24. Standards of Business Conduct

24.1 Committee members and any attendees or observers must maintain the highest standards of personal conduct and in this regard must comply with:

a) The law of England and Wales;
b) The NHS Constitution;
c) The Nolan Principles;
d) The standards of behaviour set out in the ICB's Constitution;

e) The Standards of Business Conduct Policy;
f) The Conflicts of Interest Policy
g) The Counter Fraud, Bribery and Corruption Policy,
h) Any additional regulations or codes of practice relevant to the Committee.

24.2 The Committee will have access to sufficient resources to carry out its duties and Committee members will be provided with appropriate and timely training.

25. Review of Terms of Reference

25.1 These Terms of Reference will be reviewed from time to time, reflecting the experience of the Committee in fulfilling its functions and the wider experience of the ICB.

25.2 These Terms of Reference will be formally reviewed annually. These Terms of Reference may be varied or amended by the ICB's Board of Members.

Date Approved by the Board of Members: [insert date]
Date of Next Review: [insert date]

Schedule 1
List of Members

The voting members of the Committee are:

Position	Name
Non-Executive Member	
Non-Executive Member	
Non-conflicted independent primary care clinician	
Chief Development and Population Health Officer	
Chief Medical Officer or Chief Nursing Officer	
Executive Director of Place	
Director of finance	

Committee Chair:

Position	Name
Non-Executive Member	

The standing participants are:

Position	Name
Director of Primary Care Transformation and Programmes	
Assistant Director of Primary Care Contracts	
Clinical Director for Primary Care	
Chief People Officer	
A representative from the Quality Directorate	
A Director of Public Health	
Healthwatch Representative	
LMC Representative	
Community Participants (TBC)	
VCSE Alliance Representative	

NHS North Central London
Integrated Care Board
Individual Funding Request Panel
Terms of Reference

1. Introduction

1.1 The Individual Funding Requests Panel ('Panel') is established in accordance with the Constitution of NHS North Central London Integrated Care Board ('ICB'). It is a sub-committee of the Strategy and Development Committee.

1.2 These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the Panel.

2. Purpose

2.1 The purpose of the Panel is to consider and make decisions on Individual Funding Requests ('IFR') applications.

3. Role

3.1 The Panel will:

a) Make decisions on individual funding requests applications;
b) Properly consider and follow the ICB's IFR Policy when determining the outcome of individual funding requests applications;
c) Remit decisions for individual funding requests over the panel's financial authority limits to the appropriate decision makers;
d) Act within its delegated authorities from the Board of Members;
e) Have due regard to any relevant quality and safety issues which may arise as agreed by panel members.

4. Financial Authority Limits

4.1 The Panel has the authority to approve IFR requests up to a maximum value of £50,000 (fifty thousand pounds) per year per case. The Panel may not approve IFR applications that exceed this limit.

4.2 The Panel may consider IFR applications which have a greater financial value than the delegated financial authority limits set out in section 4.1 above but does not have the power to approve them. The Panel's decision making powers are set out in section 6 below.

5. Duty as to Affordability and to Meet Financial Control Total

5.1 The Panel has a duty to ensure the IFRs it approves are affordable and will not cause the ICB to breach its financial control total.

6. Decisions

6.1 The Panel may make the following decisions on IFRs that are within their delegated financial authority limits:

a) To reject the application;

b) To reject the application due to insufficient information;
c) To defer decision on the application pending further information;
d) To approve the application without conditions;
e) To approve the application with conditions.

6.2 The Panel may make the following decisions on IFRs that are in excess of their delegated financial authority limits:
a) To reject the application;
b) To reject the application due to insufficient information;
c) To defer decision on the application pending further information;
d) To recommend the application for approval without conditions;
e) To recommend the application for approval with conditions.

6.3 If IFR is outside of the Panel's delegated financial authority limits the decision on whether to approve or reject an application shall be made by the Strategy and Development Committee.

7. Membership

7.1 The Panel shall comprise of the following voting members:
a) An Independent Member;
b) Three clinicians;
c) Commissioning representative;
d) Medicines Management Representative.

4.2 The roles referred to in the list of voting members above describe the substantive roles and any equivalent successor roles and not the individual title or titles.

4.3 In accordance with the ICB's Constitution all voting members of the Panel must be approved by the ICB's Chair.

4.4 The list of voting members is set out in Schedule 1. Schedule 1 does not form part of the Terms of Reference and may be amended without the need to formally amend these Terms of Reference.

4.5 Voting members may nominate deputies to represent them in their absence.

5. Participants and Observers

5.1 The following people shall attend Panel meetings as standing participants:
a) An IFR Specialist.

5.2 Participants at Panel meetings are non-voting.

5.3 The roles referred to in the list of standing participants above describe the substantive roles and any equivalent successor roles and not the individual title or titles.

5.4 The list of standing participants is contained in Schedule 1. Schedule 1 does not form part of the Terms of Reference and may be amended without the need to formally amend these Terms of Reference.

5.5 Standing participants may nominate deputies to represent them in their absence.

5.6 The Panel may invite or allow additional people to attend meetings as participants. Participants may present at meetings and contribute to the relevant discussions but are not allowed to participate in any formal vote.

5.7 The Panel may invite or allow people to attend meetings as observers. Observers may not present at meetings, contribute to any discussion or participate in any formal vote.

5.8 The Panel may call additional experts to attend meetings on a case by case basis to inform discussion.

6. Chair

6.1 The Panel Chair shall be the Independent Member or a clinician**.** The Chair may nominate a deputy to represent them in their absence.

7. Voting

7.1 The ICB has agreed to use a collective model of decision making that seeks to find consensus between system partners and make decisions based on unanimity as the norm. This includes working though difficult issues where appropriate. If it is not possible to achieve unanimity a vote will be required. Voting shall be as per clause 7.2 below.

7.2 Each voting member of the Panel shall have one vote with resolutions passing by simple majority. In the event of a tied vote the Panel Chair shall have the casting vote.

8. Quorum

8.1 The Panel will be considered quorate when at least three voting members are present which must include:

a) Chair;
b) A clinician or where the Chair is a clinician an Independent Member;
c) An officer.

8.2 Notwithstanding section 8.1 above, for drugs cases the Medicines Management Representative must be present

8.3 If any representative is conflicted on a particular item of business they will not count towards the quorum for that item of business. If this renders a meeting or part of a meeting inquorate a non-conflicted person may be temporarily appointed or co-opted onto the Panel to satisfy the quorum requirements.

8.4 If a meeting is not quorate the Panel Chair may adjourn the meeting to permit the appointment or co-option of additional members if necessary.

9. Secretariat

9.1 The Secretariat to the Panel shall be provided by the IFR Administrator.

10. Frequency of Panel Meetings

10.1 Panel meetings will be held monthly where needs dictate, but may hold additional meetings as and when necessary. The Panel Chair may call additional meetings or cancel meetings as necessary.

11. Notice of Meetings

11.1 Notice of a Panel meeting shall be sent to all Panel members no less than 7 days in advance of the meeting.

11.2 The meeting shall contain the date, time and location of the meeting.

12. Agendas and Circulation of Papers

12.1 Before each Panel meeting an agenda setting out the business of the meeting will be sent to every Panel member no less than 7 days in advance of the meeting.

12.2 Before each Panel meeting the papers of the meeting will be sent to every Panel member no less than 7 days in advance of the meeting.

12.3 If a Panel member wishes to include an item on the agenda they must notify the Panel Chair via the Secretariat no later than 7 days prior to the meeting. The decision as to whether to include the agenda item is at the absolute discretion of the Panel Chair.

13. Minutes of Meetings

13.1 The minutes of the proceedings of a meeting shall be prepared by the Secretariat and submitted for agreement at the following meeting.

14. Authority

14.1 The Panel is accountable to the Strategy and Development Committee and will operate as one of its sub-committees. The Panel must act within the remit of these terms of reference and has no executive powers other than those specifically set out in these terms of reference.

14.2 The Panel is authorised by the Board of Members to obtain at the ICB's expense outside legal or other professional advice on any matters within the Panel's Terms of Reference.

15. Reporting Responsibilities

15.1 The Panel will report to the Strategy and Development Committee on all matters within its duties and responsibilities.

15.2 The Panel may make recommendations to the Board of Members, Strategy and Development Committee and/or any other committee it considers appropriate on any area within its remit.

16. Delegated Authority

16.1 The Panel may agree to delegate its authority to a Panel member or members to make decisions on the Panel's behalf outside of a Panel meeting at its absolute discretion on a case by case basis.

17. Virtual Meetings and Decision Making

17.1 Panel meetings may be held in person or virtually.

17.2 There are circumstances where time-critical decisions need to be made and it is not possible and/or reasonably practicable and/or a good use of resources to hold a physical meeting (either in person or virtually) in sufficient time. In these circumstances decisions may be made virtually using the protocol for virtual decision making.

18. Sub-Committees

18.1 The Panel may not appoint sub-committees. The Panel may not delegate any of its functions, powers or decision making authority to a sub-committee.

19. Conflicts of Interest

19.1 Conflicts of Interest shall be dealt with in accordance with the Conflicts of Interest Policy and NHS England statutory guidance for managing conflicts of interest.

19.2 The Panel shall have a Conflicts of Interest Register that will be presented as a standing item on the Panel's agenda. In addition, an opportunity to declare any new or relevant declarations of interest will be listed as a standing item on the Panel's agenda

20. Gifts and Hospitality

20.1 Gifts and Hospitality shall be dealt with in accordance with the Conflicts of Interest Policy, and NHS England statutory guidance for managing conflicts of interest.

20.2 The Panel shall have a Gifts and Hospitality Register and Panel members will have an opportunity to declare any new or relevant declarations of relevant gifts and hospitality as a standing item on the Panel's agenda

21. Standards of Business Conduct

21.1 Panel members and any attendees or observers must maintain the highest standards of personal conduct and in this regard must comply with:

a) The law of England and Wales;
b) The NHS Constitution;
c) The Nolan Principles;
d) The standards of behaviour set out in the ICB's Constitution;
e) The Standards of Business Conduct Policy;
f) The Conflicts of Interest Policy;
g) The Counter Fraud, Bribery and Corruption Policy;
h) Any additional regulations or codes of practice relevant to the Panel.

21.2 The Panel will have access to sufficient resources to carry out its duties and Panel members will be provided with appropriate and timely training.

22. Review of Terms of Reference

22.1 These Terms of Reference will be reviewed from time to time, reflecting the experience of the Panel in fulfilling its functions and the wider experience of the ICB.

22.2 These Terms of Reference will be formally reviewed annually. These Terms of Reference may be varied or amended by the Board of Members.

Date Approved by Board of Members: [insert date]
Date of Next Review: [insert date]

Schedule 1
List of Members

The voting members of the Panel are:

Position	Name
Independent Member	
Clinician	
Clinician	
Clinician	
Commissioning Representative	
Medicines Management Representative	

Panel Chair:

Position	Name

The standing participants are:

Position	Name
IFR Specialist	

NHS North Central London
Integrated Care Board
Individual Funding Request Appeals Panel
Terms of Reference

1. Introduction

1.1 The Individual Funding Requests Appeals Panel ('Appeals Panel') is established in accordance with the Constitution of NHS North Central London Integrated Care Board ('ICB'). It is a sub-committee of the Strategy and Development Committee.

1.2 These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the Appeals Panel.

2. Purpose

2.1 The purpose of the Appeals Panel is to consider Applicants' appeals against decisions made by the Individual Funding Requests Panel ('Panel').

3. Role

3.1 The Appeals Panel will:

a) Consider and decide on appeals against decisions taken by the Panel;
b) Give proper consideration to appeals when determining the outcome;
c) Act within the delegated authority from the Board of Members;
d) Follow the Individual Funding Requests ('IFR') Policy.

3.2 The role of the appeals process is not to consider the clinical merits of the case but whether due process has been followed in the IFR decision-making process.

4. Financial Authority Limits

4.1 The Appeals Panel has no authority to approve IFR requests.

5. Duty as to Affordability and to Meet Financial Control Total

5.1 The Appeals Panel has no authority to approve IFR requests.

6. Decisions

6.1 The Appeals Panel may make the following decisions:

a) To reject the appeal;
b) To defer decision on the appeal pending further information;
c) To approve the appeal and remit the decision on the individual funding request to the Panel without conditions.

6.2 The Appeals Panel may approve appeals where the Panel:

a) Has acted beyond its lawful powers;
b) Reached a decision that no other reasonable CCG could have reached;
c) Acted unfairly;
d) Failed to follow proper procedures;

e) Placed undue weight on irrelevant matters and this made a material difference to the IFR decision;
f) Breached the patient's human rights;
g) Breached the Equality Act 2010.

7. Membership

7.1 The Appeals Panel shall comprise of the following voting members:
a) An Independent Member;
b) Three clinicians;
c) Commissioning representative;
d) Medicines Management Representative.

4.2 The roles referred to in the list of voting members above describe the substantive roles and any equivalent successor roles and not the individual title or titles.

4.3 In accordance with the ICB's Constitution all voting members of the Appeals Panel must be approved by the ICB's Chair.

4.4 The list of voting members is set out in Schedule 1. Schedule 1 does not form part of the Terms of Reference and may be amended without the need to formally amend these Terms of Reference.

4.5 Voting members may nominate deputies to represent them in their absence.

5. Participants and Observers

5.1 The following people shall attend Appeals Panel meetings as standing participants:
a) An IFR Specialist.

5.2 Participants at Appeals Panel meetings are non-voting.

5.3 The roles referred to in the list of standing participants above describe the substantive roles and any equivalent successor roles and not the individual title or titles.

5.4 The list of standing participants is contained in Schedule 1. Schedule 1 does not form part of the Terms of Reference and may be amended without the need to formally amend these Terms of Reference.

5.5 Standing participants may nominate deputies to represent them in their absence.

5.6 The Appeals Panel may invite or allow additional people to attend meetings as participants. Participants may present at meetings and contribute to the relevant discussions but are not allowed to participate in any formal vote.

5.7 The Appeals Panel may invite or allow people to attend meetings as observers. Observers may not present at meetings, contribute to any discussion or participate in any formal vote.

5.8 The Appeals Panel may call additional experts to attend meetings on a case by case basis to inform discussion.

6. Chair

6.1 The Appeals Panel Chair shall be the Independent Member or a clinician**.** The Chair may nominate a deputy to represent them in their absence.

7. Voting

7.1 The ICB has agreed to use a collective model of decision making that seeks to find consensus between system partners and make decisions based on unanimity as the norm. This includes working though difficult issues where appropriate. If it is not possible to achieve unanimity a vote will be required. Voting shall be as per clause 7.2 below.

7.2 Each voting member of the Appeals Panel shall have one vote with resolutions passing by simple majority. In the event of a tied vote the Appeals Panel Chair shall have the casting vote.

8. Quorum

8.1 The Appeals Panel will be considered quorate when at least three voting members are present which must include:

a) Chair;
b) A clinician or where the Chair is a clinician an Independent Member;
c) An officer.

8.2 Notwithstanding section 8.1 above, for drugs cases the Medicines Management Representative must be present

8.3 If any representative is conflicted on a particular item of business they will not count towards the quorum for that item of business. If this renders a meeting or part of a meeting inquorate a non-conflicted person may be temporarily appointed or co-opted onto the Appeals Panel to satisfy the quorum requirements.

8.4 If a meeting is not quorate the Appeals Panel Chair may adjourn the meeting to permit the appointment or co-option of additional members if necessary.

9. Secretariat

9.1 The Secretariat to the Appeals Panel shall be provided by the IFR Administrator.

10. Frequency of Appeals Panel Meetings

10.1 Appeals Panel meetings will be held as and when necessary.

11. Notice of Meetings

11.1 Notice of an Appeals Panel meeting shall be sent to all Appeals Panel members no less than 7 days in advance of the meeting.

11.2 The meeting shall contain the date, time and location of the meeting.

12. Agendas and Circulation of Papers

12.1 Before each Appeals Panel meeting an agenda setting out the business of the meeting will be sent to every Appeals Panel member no less than 7 days in advance of the meeting.

12.2 Before each Appeals Panel meeting the papers of the meeting will be sent to every Appeals Panel member no less than 7 days in advance of the meeting.

12.3 If an Appeals Panel member wishes to include an item on the agenda they must notify the Appeals Panel Chair via the Secretariat no later than 7 days prior to the meeting. The decision as to whether to include the agenda item is at the absolute discretion of the Appeals Panel Chair.

13. Minutes of Meetings

13.1 The minutes of the proceedings of a meeting shall be prepared by the Secretariat and submitted for agreement at the following meeting.

14. Authority

14.1 The Appeals Panel is accountable to the Strategy and Development Committee and will operate as one of its sub-committees. The Appeals Panel must act within the remit of these terms of reference and has no executive powers other than those specifically set out in these terms of reference.

14.2 The Appeals Panel is authorised by the Board of Members to obtain at the ICB's expense outside legal or other professional advice on any matters within the Appeals Panel's Terms of Reference.

15. Reporting Responsibilities

15.1 The Appeals Panel will report to the Strategy and Development Committee on all matters within its duties and responsibilities.

15.2 The Appeals Panel may make recommendations to the Board of Members, Strategy and Development Committee and/or any other committee it considers appropriate on any area within its remit.

16. Delegated Authority

16.1 The Appeals Panel may agree to delegate its authority to an Appeals Panel member or members to make decisions on the Appeals Panel's behalf outside of a Appeals Panel meeting at its absolute discretion on a case by case basis.

17. Virtual Meetings and Decision Making

17.1 Appeals Panel meetings may be held in person or virtually.

17.2 There are circumstances where time-critical decisions need to be made and it is not possible and/or reasonably practicable and/or a good use of resources to hold a physical meeting (either in person or virtually) in sufficient time. In these circumstances decisions may be made virtually using the protocol for virtual decision making.

18. Sub-Committees

18.1 The Appeals Panel may not appoint sub-committees. The Appeals Panel may not delegate any of its functions, powers or decision making authority to a sub-committee.

19. Conflicts of Interest

19.1 Conflicts of Interest shall be dealt with in accordance with the Conflicts of Interest Policy and NHS England statutory guidance for managing conflicts of interest.

19.2 The Appeals Panel shall have a Conflicts of Interest Register that will be presented as a standing item on the Appeals Panel's agenda. In addition, an opportunity to declare any new or relevant declarations of interest will be listed as a standing item on the Appeals Panel's agenda

20. Gifts and Hospitality

20.1 Gifts and Hospitality shall be dealt with in accordance with the Conflicts of Interest Policy, and NHS England statutory guidance for managing conflicts of interest.

20.2 The Appeals Panel shall have a Gifts and Hospitality Register and Appeals Panel members will have an opportunity to declare any new or relevant declarations of relevant gifts and hospitality as a standing item on the Appeals Panel's agenda

21. Standards of Business Conduct

21.1 Appeals Panel members and any attendees or observers must maintain the highest standards of personal conduct and in this regard must comply with:

a) The law of England and Wales;
b) The NHS Constitution;
c) The Nolan Principles;
d) The standards of behaviour set out in the ICB's Constitution;
e) The Standards of Business Conduct Policy;
f) The Conflicts of Interest Policy;
g) The Counter Fraud, Bribery and Corruption Policy;
h) Any additional regulations or codes of practice relevant to the Appeals Panel.

21.2 The Appeals Panel will have access to sufficient resources to carry out its duties and Appeals Panel members will be provided with appropriate and timely training.

22. Review of Terms of Reference

22.1 These Terms of Reference will be reviewed from time to time, reflecting the experience of the Appeals Panel in fulfilling its functions and the wider experience of the ICB.

22.2 These Terms of Reference will be formally reviewed annually. These Terms of Reference may be varied or amended by the Board of Members.

Date Approved by Board of Members: [insert date]
Date of Next Review: [insert date]

Schedule 1
List of Members

The voting members of the Appeals Panel are:

Position	Name
Independent Member	
Clinician	
Clinician	
Clinician	
Commissioning Representative	
Medicines Management Representative	

Appeals Panel Chair:

Position	Name

The standing participants are:

Position	Name
IFR Specialist	

NHS North Central London
Integrated Care Board
Procurement Oversight Group
Terms of Reference

1. Introduction

1.1 The Procurement Oversight Group ('Committee') is established in accordance with the Constitution of NHS North Central London Integrated Care Board ('ICB'). It is a committee of the ICB's Board of Members.

1.2 These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the Committee.

2. Purpose

2.1 The purpose of the Committee is to:

a) Be a non-conflicted forum which provides oversight and scrutiny of key procurements undertaken by the ICB and ensure that the procurement regime is followed correctly, properly evidenced, is transparent, and that conflicts of interest are appropriately managed;
b) Provide assurance to the Board of Members and other committees and sub-committees as appropriate that conflicts of interest are properly managed throughout the development of the business case, the approval process and that the procurement routes for services are appropriate;
c) Ensure that procurement processes are proportionate to the cost and complexity of the services to be procured;
d) Review and approve Single Tender Waivers on the Board of Member's behalf where the financial value is in excess of that delegated to the Chief Executive and Chief Finance Officer under the Standing Financial Instructions;
e) Approve service models where these have been remitted to the Procurement Oversight Group by the Board of Members or one of its committees or sub-committees;
f) Have oversight of any procurement where the contract value is £500,000 (five hundred thousand pounds) or greater across the life of the contract and/or any other procurement where the Board of Members and/or any of its commissioning committees request oversight by the Procurement Oversight Group.

3. Role

3.1 The Committee shall:

a) Ensure the ICB is operating under the correct procurement regime that is legally in force in England at the time;
b) On establishment of the Committee the NHS Provider Selection regime will not be in place. The ICB is required to act in accordance with the National Health Service (Procurement, Patient Choice and Competition) (No.2 Regulations 2013) and the Public Contracts Regulations 2015 until these are replaced by the NHS Provider Selection Regime. This includes but is not limited to:
    - Ensuring that services are commissioned free of bias and that procurement decisions are defendable from scrutiny and challenge;

- Ensuring that robust tender documentation, clear evaluation criteria, and an appropriate evaluation panel with non-conflicted subject matter experts is in place;
- Ensuring robust scrutiny of the process, documented evidence and final award documentation to ensure that the decision made aligns to both the process included in the tender documentation and to the original business case;
- Review ICB business case proposals to ensure procurement implications have been tested prior to the business case decision and to agree the most appropriate procurement route to market;
- Ensuring conflicts of interest are managed appropriately throughout the commissioning cycle;
- Oversee the implementation of the NHS Provider Selection Regime when it comes into force;

c) Ensure that when the NHS Provider Selection Regime comes into force that procurement decisions are taken appropriately and properly evidenced in line with the law and NHS England guidance;
d) Ensure that conflicts of interest are managed appropriately throughout the commissioning cycle, the development of business cases and when making decisions under the Provider Selection Regime;
e) Ensure that there is a clear procurement process in place that follows best practice and is proportionate to the complexity and cost;
f) Approve service models where these have been remitted to the Committee by the Board of Members or one of its committees or sub-committees;
g) Provide oversight of compliance with the ICB's Procurement Policy;
h) Oversee the ICB's approach to delivering the Procurement Target Operating Model (or its successor) including as part of a wider Integrated Care System;
i) Ensure the ICB has a robust procurement savings plan and oversee its delivery;
j) Ensure that procurement risks have been considered and mitigated;
k) Provide advice, guidance and recommendations on any area within its remit to the Board of Members and/or any of its committees or sub-committees as appropriate;
l) Review and approve Single Tender Waivers on behalf of the Board of Members where the financial value is in excess of that delegated to the Chief Executive and Chief Finance Officer under the Standing Financial Instructions;
m) Oversee the Register of Procurement Decisions and ensure that Single Tender Waivers are included.

4. Membership

4.1 The Committee shall comprise of the following voting members:
a) Two Non-Executive Members;
b) Chief Medical Officer or Chief Nursing Officer;
c) An independent non-conflicted clinician;
d) Chief Finance Officer;
e) Executive Director of Corporate Affairs

4.2 The roles referred to in the list of voting members above describe the substantive roles and any equivalent successor roles and not the individual title or titles.

4.3 In accordance with the ICB's Constitution all voting members of the Committee must be approved by the ICB's Chair.

4.4 The list of voting members is set out in Schedule 1. Schedule 1 does not form part of the Terms of Reference and may be amended without the need to formally amend these Terms of Reference.

4.5 Voting members may nominate deputies to represent them in their absence.

5. Participants and Observers

5.1 The following people shall attend Committee meetings as standing participants:
a) Chief Development and Population Health Officer;
b) A procurement specialist.

5.2 Participants at Committee meetings are non-voting.

5.3 The roles referred to in the list of standing participants above describe the substantive roles and any equivalent successor roles and not the individual title or titles.

5.4 The list of standing participants is contained in Schedule 1. Schedule 1 does not form part of the Terms of Reference and may be amended without the need to formally amend these Terms of Reference.

5.5 Standing participants may nominate deputies to represent them in their absence.

5.6 The Committee may invite or allow additional people to attend meetings as participants. Participants may present at meetings and contribute to the relevant discussions but are not allowed to participate in any formal vote.

5.7 The Committee may invite or allow people to attend meetings as observers. Observers may not present at meetings, contribute to any discussion or participate in any formal vote.

5.8 The Committee may call additional experts to attend meetings on a case by case basis to inform discussion.

6. Chair

6.1 The Committee Chair shall be a Non-Executive Member**.** The Chair may nominate a deputy to represent them in their absence.

7. Voting

7.1 The ICB has agreed to use a collective model of decision making that seeks to find consensus between system partners and make decisions based on unanimity as the norm. This includes working though difficult issues where appropriate. If it is not possible to achieve unanimity a vote will be required. Voting shall be as per clause 7.2 below.

7.2 Each voting member of the Committee shall have one vote with resolutions passing by simple majority. In the event of a tied vote the Committee Chair shall have the casting vote.

8. Quorum

8.1 The Committee will be considered quorate when at least the following voting members are present:
a) The Chair;
b) A Clinician; and,
c) An Executive Director.

8.2 If any representative is conflicted on a particular item of business they will not count towards the quorum for that item of business. If this renders a meeting or part of a meeting inquorate

a non-conflicted person may be temporarily appointed or co-opted onto the Committee to satisfy the quorum requirements.

8.3 If a meeting is not quorate the Committee Chair may adjourn the meeting to permit the appointment or co-option of additional members if necessary.

9. Secretariat

9.1 The Secretariat to the Committee shall be provided by the Corporate Affairs Directorate.

10. Frequency of Committee Meetings

10.1 Committee meetings will be held monthly but may hold additional meetings as and when necessary. The Committee Chair may call additional meetings or cancel meetings as necessary.

11. Notice of Meetings

11.1 Notice of a Committee meeting shall be sent to all Committee members no less than 7 days in advance of the meeting.

11.2 The meeting shall contain the date, time and location of the meeting.

12. Agendas and Circulation of Papers

12.1 Before each Committee meeting an agenda setting out the business of the meeting will be sent to every Committee member no less than 7 days in advance of the meeting.

12.2 Before each Committee meeting the papers of the meeting will be sent to every Committee member no less than 7 days in advance of the meeting.

12.3 If a Committee member wishes to include an item on the agenda they must notify the Committee Chair via the Secretariat no later than 7 days prior to the meeting. The decision as to whether to include the agenda item is at the absolute discretion of the Committee Chair.

13. Minutes of Meetings

13.1 The minutes of the proceedings of a meeting shall be prepared by Corporate Affairs Directorate and submitted for agreement at the following meeting.

14. Authority

14.1 The Committee is accountable to the Board of Members and will operate as one of its committees. The Committee must act within the remit of these terms of reference and has no executive powers other than those specifically set out in these terms of reference.

14.2 The Committee is authorised by the Board of Members to obtain at the ICB's expense outside legal or other professional advice on any matters within the Committee's Terms of Reference.

15. Reporting Responsibilities

15.1 The Committee will report to the Board of Members on all matters within its duties and responsibilities.

15.2 The Committee may make recommendations to the Board of Members it considers appropriate on any area within its remit.

16. Delegated Authority

16.1 The Committee may agree to delegate its authority to a Committee member or members to make decisions on the Committee's behalf outside of a Committee meeting at its absolute discretion on a case by case basis.

17. Virtual Meetings and Decision Making

17.1 Committee meetings may be held in person or virtually.

17.2 There are circumstances where time-critical decisions need to be made and it is not possible and/or reasonably practicable and/or a good use of resources to hold a physical meeting (either in person or virtually) in sufficient time. In these circumstances decisions may be made virtually using the protocol for virtual decision making.

18. Sub-Committees

18.1 The Committee may appoint sub-committees to advise the Committee and assist it in carrying out its duties. The Committee may not delegate any of its functions, powers or decision making authority to a sub-committee.

19. Conflicts of Interest

19.1 Conflicts of Interest shall be dealt with in accordance with the Conflicts of Interest Policy and NHS England statutory guidance for managing conflicts of interest.

19.2 The Committee shall have a Conflicts of Interest Register that will be presented as a standing item on the Committee's agenda. In addition, an opportunity to declare any new or relevant declarations of interest will be listed as a standing item on the Committee's agenda

20. Gifts and Hospitality

20.1 Gifts and Hospitality shall be dealt with in accordance with the Conflicts of Interest Policy, and NHS England statutory guidance for managing conflicts of interest.

20.2 The Committee shall have a Gifts and Hospitality Register and Committee members will have an opportunity to declare any new or relevant declarations of relevant gifts and hospitality as a standing item on the Committee's agenda

21. Standards of Business Conduct

21.1 Committee members and any attendees or observers must maintain the highest standards of personal conduct and in this regard must comply with:

a) The law of England and Wales;
b) The NHS Constitution;
c) The Nolan Principles;
d) The standards of behaviour set out in the ICB's Constitution;
e) The Standards of Business Conduct Policy;
f) The Conflicts of Interest Policy
g) The Counter Fraud, Bribery and Corruption Policy,
h) Any additional regulations or codes of practice relevant to the Committee.

21.2 The Committee will have access to sufficient resources to carry out its duties and Committee members will be provided with appropriate and timely training.

22. Review of Terms of Reference

22.1 These Terms of Reference will be reviewed from time to time, reflecting the experience of the Committee in fulfilling its functions and the wider experience of the ICB.

22.2 These Terms of Reference will be formally reviewed annually. These Terms of Reference may be varied or amended by the Board of Members.

Date Approved by the Board of Members: [insert date]
Date of Next Review: [insert date]

Schedule 1
List of Members

The voting members of the Committee are:

Position	Name
Non-Executive Member	
Non-Executive Member	
Chief Medical Officer or Chief Nursing Officer	
An independent non-conflicted clinician	
Chief Finance Officer	
Executive Director of Corporate Affairs	

Committee Chair:

Position	Name
Non-Executive Member	

The standing participants are:

Position	Name
Procurement specialist	

NHS North Central London
Integrated Care Board
Finance Committee
Terms of Reference

1. Introduction

1.1 The Finance Committee ('Committee') is established in accordance with the Constitution of NHS North Central London Integrated Care Board ('ICB'). It is a committee of the ICB's Board of Members.

1.2 These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the Committee.

2. Purpose

2.1 The purpose of the Committee is to:

a) Provide oversight and scrutiny of the ICB's finances, budgets, financial performance and efficiency plans;
b) Oversee the development and delivery of a robust, viable and sustainable system financial plan that support's the ICB's objectives;
c) Support the ICB in its wider financial system leadership role and in particular the development and delivery of system financial plans, achieving the system control total (revenue and capital) and ensuring the financial performance of NHS organisations within the NCL Integrated Care System;
d) Ensure health and social inequalities are taken into account in financial decision-making.

3. Role

3.1 The Committee has two key areas of focus:

a) The ICB's internal financial functions;
b) The ICB's wider system leadership.

3.2 In relation to the ICB's internal financial functions the Committee shall:

a) Oversee the development and implementation of the ICB's medium and long term financial plan (ensuring they demonstrate ongoing value and recovery) and monitor performance against them;
b) Consider and agree, where appropriate in-year changes to budgets in line with Standing Financial Instructions ('SFI') and budget approval policies;
c) Maintain oversight of the finances for the annual contracting round;
d) Oversee the ICB's approach to organisational budget setting;
e) Review the ICB's SFIs and make recommendations to the Board of Members;
f) Review progress against key financial targets;
g) Consider any remedial action required and recommend appropriate financial improvement strategies to the ICB;
h) Review the ICB's investments for affordability and make decisions on whether to suspend, postpone, withdraw or decline investments where they are unaffordable, not delivering the return required and/or unsustainable;
i) Provide oversight and scrutiny of the ICB's SEP;
j) Review the ICB's SEP monitor progress against implementation plans and ensure consistency of approach;

k) Make decisions on suspending, postponing, withdrawing or declining investments where the SEP schemes or the SEP element of an investment is unrealistic, under developed, not value for money and/or is unsustainable;
l) Oversee the design and development of mitigating actions for SEP non-delivery and/or budget overspend where required such as development of an in-year recovery plan and emergency measures to ensure financial stability;
m) Hold individual directors and/or teams and/or SEP project leads to account for delivery of SEP; and,
n) Advise on best practice and policy in relation to financial management.

3.3 In relation to the ICB's wider system leadership the Committee shall:
a) Oversee the development of the system financial plan;
b) Advise on and oversee the process regarding the deployment of system-wide transformation funding;
c) Oversee capital prioritisation and ensure capital is budgeted and delivered within the ICS capital resource limit;
d) Work with ICS partners to identify and allocate resources where appropriate to address finance and performance related issues that may arise;
e) Advise the Board of Members on any changes to NHS and non-NHS funding regimes and consider how the funding available to the ICB can be best used within the system to achieve the best outcomes for the local population;
f) Work with ICS partners to identify and agree common approaches across the system such as financial reporting, estimates and judgements;
g) Work with ICS partners to seek assurance over the financial reports from system bodies and provide feedback to them (being clear on how this role interacts with that of the audit committee);
h) Understand where costs sit across a system, system cost drivers and the impacts of service change on costs and make recommendations/take decisions accordingly;
i) Ensure the delivery of the system financial target.

3.4 In relation to the ICB internal financial functions and wider system leadership (as appropriate), the Committee shall:
a) Oversee national ICB level financial submissions;
b) Ensure appropriate information is available to manage financial issues, risks and opportunities;
c) Provide oversight and scrutiny of financial risks regarding the ICB and wider system;
d) Agree key outcomes to assess delivery of the financial strategy;
e) Monitor and report to the Board of Members overall financial performance against national and local metrics, highlighting areas of concern;
f) Monitor and report to the Board of Members key service performance which should be taken into account when assessing the financial position System efficiencies;
g) Ensure system efficiencies are identified and monitored 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;
h) Ensure financial resources are used in an efficient way to deliver the objectives of the ICB;
i) Review exception reports on any material breaches of the delivery of agreed efficiency improvement plan including the adequacy of proposed remedial action plans;
j) Oversee the ICB and system approach to capital allocations.

4. Membership

4.1 The Committee shall comprise of the following voting members:
a) ICB Chair;
b) Two Non-Executive Members;

c) Chief Executive;
d) Chief Finance Officer;
e) Three Sector Representatives who bring sector experience and perspective to Committee's deliberation from North Central London ('NCL') Integrated Care System ('ICS') NHS Trusts/Foundations Trusts- who are Chief Executives and/or Directors of Finance.

4.2 The roles referred to in the list of voting members above describe the substantive roles and any equivalent successor roles and not the individual title or titles.

4.3 In accordance with the ICB's Constitution all voting members of the Committee must be approved by the ICB's Chair.

4.4 The list of voting members is set out in Schedule 1. Schedule 1 does not form part of the Terms of Reference and may be amended without the need to formally amend these Terms of Reference.

4.5 Voting members may nominate deputies to represent them in their absence.

5. Participants and Observers

5.1 The following people shall attend Committee meetings as standing participants:
a) Chief Development and Population Health Officer;
b) Executive Director of Place;
c) Executive Director of Performance and Transformation.

5.2 Participants at Committee meetings are non-voting.

5.3 The roles referred to in the list of standing participants above describe the substantive roles and any equivalent successor roles and not the individual title or titles.

5.4 The list of standing participants is contained in Schedule 1. Schedule 1 does not form part of the Terms of Reference and may be amended without the need to formally amend these Terms of Reference.

5.5 Standing participants may nominate deputies to represent them in their absence.

5.6 The Committee may invite or allow additional people to attend meetings as participants. Participants may present at meetings and contribute to the relevant discussions but are not allowed to participate in any formal vote.

5.7 The Committee may invite or allow people to attend meetings as observers. Observers may not present at meetings, contribute to any discussion or participate in any formal vote.

5.8 The Committee may call additional experts to attend meetings on a case by case basis to inform discussion.

6. Chair

6.1 The Committee Chair shall be ICB Chair or another Non-Executive Member**.** The Chair may nominate a deputy to represent them in their absence.

7. Voting

7.1 The ICB has agreed to use a collective model of decision making that seeks to find consensus between system partners and make decisions based on unanimity as the norm. This includes working though difficult issues where appropriate. If it is not possible to achieve unanimity a vote will be required. Voting shall be as per clause 7.2 below.

7.2 Each voting member of the Committee shall have one vote with resolutions passing by simple majority. In the event of a tied vote the Committee Chair shall have the casting vote.

8. Quorum

8.1 The Committee will be considered quorate when at least 3 voting members are present which must include:

a) The Committee Chair;
b) An Executive Director;
c) A Sector Representative.

8.2 If any representative is conflicted on a particular item of business they will not count towards the quorum for that item of business. If this renders a meeting or part of a meeting inquorate a non-conflicted person may be temporarily appointed or co-opted onto the Committee to satisfy the quorum requirements.

8.3 If a meeting is not quorate the Committee Chair may adjourn the meeting to permit the appointment or co-option of additional members if necessary.

9. Secretariat

9.1 The Secretariat to the Committee shall be provided by the Corporate Affairs Directorate.

10. Frequency of Committee Meetings

10.1 Committee meetings will be held monthly but may hold additional meetings as and when necessary. The Committee Chair may call additional meetings or cancel meetings as necessary.

11. Notice of Meetings

11.1 Notice of a Committee meeting shall be sent to all Committee members no less than 7 days in advance of the meeting.

11.2 The meeting shall contain the date, time and location of the meeting.

12. Agendas and Circulation of Papers

12.1 Before each Committee meeting an agenda setting out the business of the meeting will be sent to every Committee member no less than 7 days in advance of the meeting.

12.2 Before each Committee meeting the papers of the meeting will be sent to every Committee member no less than 7 days in advance of the meeting.

12.3 If a Committee member wishes to include an item on the agenda they must notify the Committee Chair via the Secretariat no later than 7 days prior to the meeting. The decision as to whether to include the agenda item is at the absolute discretion of the Committee Chair.

13. Minutes of Meetings

13.1 The minutes of the proceedings of a meeting shall be prepared by the Secretariat and submitted for agreement at the following meeting.

14. Authority

14.1 The Committee is accountable to the Board of Members and will operate as one of its committees. The Committee must act within the remit of these terms of reference and has no executive powers other than those specifically set out in these terms of reference.

14.2 The Committee is authorised by the Board of Members to obtain at the ICB's expense outside legal or other professional advice on any matters within the Committee's Terms of Reference.

15. Reporting Responsibilities

15.1 The Committee will report to the Board of Members on all matters within its duties and responsibilities.

15.2 The Committee may make recommendations to the Board of Members it considers appropriate on any area within its remit.

16. Delegated Authority

16.1 The Committee may agree to delegate its authority to a Committee member or members to make decisions on the Committee's behalf outside of a Committee meeting at its absolute discretion on a case by case basis.

17. Virtual Meetings and Decision Making

17.1 Committee meetings may be held in person or virtually.

17.2 There are circumstances where time-critical decisions need to be made and it is not possible and/or reasonably practicable and/or a good use of resources to hold a physical meeting (either in person or virtually) in sufficient time. In these circumstances decisions may be made virtually using the protocol for virtual decision making.

18. Sub-Committees

18.1 The Committee may appoint sub-committees to advise the Committee and assist it in carrying out its duties. The Committee may not delegate any of its functions, powers or decision making authority to a sub-committee.

19. Conflicts of Interest

19.1 Conflicts of Interest shall be dealt with in accordance with the Conflicts of Interest Policy and NHS England statutory guidance for managing conflicts of interest.

19.2 The Committee shall have a Conflicts of Interest Register that will be presented as a standing item on the Committee's agenda. In addition, an opportunity to declare any new or relevant declarations of interest will be listed as a standing item on the Committee's agenda

20. Gifts and Hospitality

20.1 Gifts and Hospitality shall be dealt with in accordance with the Conflicts of Interest Policy, and NHS England statutory guidance for managing conflicts of interest.

20.2 The Committee shall have a Gifts and Hospitality Register and Committee members will have an opportunity to declare any new or relevant declarations of relevant gifts and hospitality as a standing item on the Committee's agenda

21. Standards of Business Conduct

21.1 Committee members and any attendees or observers must maintain the highest standards of personal conduct and in this regard must comply with:

a) The law of England and Wales;
b) The NHS Constitution;
c) The Nolan Principles;
d) The standards of behaviour set out in the ICB's Constitution;
e) The Standards of Business Conduct Policy;
f) The Conflicts of Interest Policy
g) The Counter Fraud, Bribery and Corruption Policy,
h) Any additional regulations or codes of practice relevant to the Committee.

21.2 The Committee will have access to sufficient resources to carry out its duties and Committee members will be provided with appropriate and timely training.

22. Review of Terms of Reference

22.1 These Terms of Reference will be reviewed from time to time, reflecting the experience of the Committee in fulfilling its functions and the wider experience of the ICB.

22.2 These Terms of Reference will be formally reviewed annually. These Terms of Reference may be varied or amended by the Board of Members.

Date Approved by the Board of Members: [insert date]
Date of Next Review: [insert date]

Schedule 1
List of Members

The voting members of the Committee are:

Position	Name
ICB Chair or another Non-Executive Member	
Two Non-Executive Members	
Chief Executive	
Chief Finance Officer	
Sector Representative who brings sector experience and perspective to Committee's deliberation from NCL NHS Trusts/Foundations Trusts, who is a Chief Executive or a Director of Finance.	
Sector Representative who brings sector experience and perspective to Committee's deliberation from NCL NHS Trusts/Foundations Trusts, who is a Chief Executive or a Director of Finance.	
Sector Representative who brings sector experience and perspective to Committee's deliberation from NCL NHS Trusts/Foundations Trusts, who is a Chief Executive or a Director of Finance.	

Committee Chair:

Position	Name

The standing participants are:

Position	Name
Chief Development and Population Health Officer	
Executive Director of Place	
Executive Director of Transformation and Performance	

NHS North Central London
Integrated Care Board
Quality and Safety Committee
Terms of Reference

1. Introduction

1.1 The Quality and Safety Committee ('Committee') is established in accordance with the Constitution of NHS North Central London Integrated Care Board ('ICB'). It is a committee of the ICB's Board of Members.

1.2 These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the Committee.

2. Purpose

2.1 The purpose of the Committee is to provide oversight, scrutiny and assurance of the following areas on behalf of the Board of Members and to provide robust recommendations and/or directions for actions:

a) The quality and safety of commissioned services;
b) Reducing inequalities in care;
c) The effectiveness of patient care and high quality patient experience;
d) Provider service quality performance and quality improvement initiatives;
e) Continuous quality improvement and shared learning across the system;
f) Safeguarding and complaints.

3. Role

3.1 The Committee will:

a) Oversee and monitor delivery of the ICB key statutory requirements;
b) Ensure that quality, patient safety and patient experience are at the core of the ICB's approach to commissioning and oversee the development and embedding of a culture within the ICB which supports this approach;
c) Provide oversight and scrutiny of commissioned services to ensure that they are being delivered safely to a high quality;
d) Ensure that the ICB is delivering its functions in a way that secures continuous improvement in the quality of services against each of the dimensions of quality set out in the Shared Commitment to Quality, demonstrating a culture of learning and that reduces inequalities in the quality of care;
e) Ensure there is an effective system of quality governance and internal control in place that supports the ICB to effectively deliver its strategic objectives and provide sustainable, high quality care;
f) Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place and ensure that system learning is demonstrated by Integrated Care System providers;
g) Ensure that there are robust processes in place for the effective management of quality and safeguarding;
h) Scrutinise structures in place to support quality planning, safeguarding, control and improvement to be assured that the structures operate effectively and timely action is taken to address areas of concern;
i) Agree and put forward the key quality priorities that are included within the ICB strategy/ annual plan, including priorities to address variation and/or inequalities in care;
j) Ensure the effectiveness of ICB's patient safety strategy;

k) Ensure that the clinical effectiveness of commissioned services is maintained and all clinical pathways and integrated care initiatives meet the required safety and quality standards;
l) Oversee the ICB's clinical governance and clinical risk management arrangements;
m) Provide oversight and scrutiny of quality, quality improvement initiatives, safety and performance risks;
n) Consider escalation of areas of concern from System Quality Group;
o) Approve quality, safety and clinical effectiveness policies on behalf of the Board of Members;
p) 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, NHSE 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;
q) 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;
r) Advise on best practice and policy in relation to quality, safety and patient experience
s) Oversee and seek assurance on the effective and sustained delivery of the ICB Quality Improvement Programmes;
t) Ensure 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;
u) Ensure that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from deaths (including coronial inquests and Prevention of Future Deaths ('PFD') reports);
v) Ensure that people drawing on services are systematically and effectively involved as equal partners in quality activities;
w) Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children;
x) Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for infection prevention and control;
y) 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;
z) Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety;
aa) Review reports about services that are managed by Local Authorities and funded (whole or in part) by the ICB;
bb) Review and scrutinise the impact of proposals on quality, safety and patient experience and recommend and/or give directions on appropriate actions;
cc) Have oversight of the process and compliance issues concerning patient safety incidents, Serious Incidents ('SIs'), be informed of all Never Events and informing the Board of Members of any escalation or sensitive issues in good time, and review exception reports in respect of clinical risks;
dd) Monitor performance of providers against CQUINs and to support development of future CQUINs;
ee) Provide oversight of the Integrated Medicines Optimisation Committee and receive and scrutinise reports from the Integrated Medicines Optimisation Committee as appropriate;
ff) Oversee and approve the Terms of Reference for the System Quality Group.

4. Membership

4.1 The Committee shall comprise of the following voting members:
a) Two Non-Executive Members

b) Chief Nursing Officer;
c) Chief Medical Officer;
d) Executive Director of Transformation and Performance;
e) Three Sector Representatives who bring sector experience and perspective to Committee's deliberation from:
    - Primary and/or community care;
    - Mental health or Acute;
    - Local Authority.

4.2 The roles referred to in the list of voting members above describe the substantive roles and any equivalent successor roles and not the individual title or titles.

4.3 In accordance with the ICB's Constitution all voting members of the Committee must be approved by the ICB's Chair.

4.4 The list of voting members is set out in Schedule 1. Schedule 1 does not form part of the Terms of Reference and may be amended without the need to formally amend these Terms of Reference.

4.5 Voting members may nominate deputies to represent them in their absence.

5. Participants and Observers

5.1 The following people shall attend Committee meetings as standing participants:
a) Two Community Participants (TBC)
b) A Healthwatch representative

5.2 Participants at Committee meetings are non-voting.

5.3 The roles referred to in the list of standing participants above describe the substantive roles and any equivalent successor roles and not the individual title or titles.

5.4 The list of standing participants is contained in Schedule 1. Schedule 1 does not form part of the Terms of Reference and may be amended without the need to formally amend these Terms of Reference.

5.5 Standing participants may nominate deputies to represent them in their absence.

5.6 The Committee may invite or allow additional people to attend meetings as participants. Participants may present at meetings and contribute to the relevant discussions but are not allowed to participate in any formal vote.

5.7 The Committee may invite or allow people to attend meetings as observers. Observers may not present at meetings, contribute to any discussion or participate in any formal vote.

5.8 The Committee may call additional experts to attend meetings on a case by case basis to inform discussion.

6. Chair

6.1 The Committee Chair shall be a Non-Executive Member. The Chair may nominate a deputy to represent them in their absence.

7. Voting

7.1 The ICB has agreed to use a collective model of decision making that seeks to find consensus between system partners and make decisions based on unanimity as the norm. This includes working though difficult issues where appropriate. If it is not possible to achieve unanimity a vote will be required. Voting shall be as per clause 7.2 below.

7.2 Each voting member of the Committee shall have one vote with resolutions passing by simple majority. In the event of a tied vote the Committee Chair shall have the casting vote.

8. Quorum

8.1 The Committee will be considered quorate when at least the following voting members are present:

a) The Chair;
b) ICB Chief Nurse or ICB Chief Medical Officer; and,
c) A Sector Representative.

8.2 If any representative is conflicted on a particular item of business they will not count towards the quorum for that item of business. If this renders a meeting or part of a meeting inquorate a non-conflicted person may be temporarily appointed or co-opted onto the Committee to satisfy the quorum requirements.

8.3 If a meeting is not quorate the Committee Chair may adjourn the meeting to permit the appointment or co-option of additional members if necessary.

9. Secretariat

9.1 The Secretariat to the Committee shall be provided by Corporate Affairs Directorate.

10. Frequency of Committee Meetings

10.1 Committee meetings will be held bi-monthly but may hold additional meetings as and when necessary. The Committee Chair may call additional meetings or cancel meetings as necessary.

11. Notice of Meetings

11.1 Notice of a Committee meeting shall be sent to all Committee members no less than 7 days in advance of the meeting.

11.2 The meeting shall contain the date, time and location of the meeting.

12. Agendas and Circulation of Papers

12.1 Before each Committee meeting an agenda setting out the business of the meeting will be sent to every Committee member no less than 7 days in advance of the meeting.

12.2 Before each Committee meeting the papers of the meeting will be sent to every Committee member no less than 7 days in advance of the meeting.

12.3 If a Committee member wishes to include an item on the agenda they must notify the Committee Chair via the Secretariat no later than 7 days prior to the meeting. The decision as to whether to include the agenda item is at the absolute discretion of the Committee Chair.

13. Minutes of Meetings

13.1 The minutes of the proceedings of a meeting shall be prepared by the Secretariat and submitted for agreement at the following meeting.

14. Authority

14.1 The Committee is accountable to the Board of Members and will operate as one of its committees. The Committee must act within the remit of these terms of reference and has no executive powers other than those specifically set out in these terms of reference.

14.2 The Committee is authorised by the Board of Members to obtain at the ICB's expense outside legal or other professional advice on any matters within the Committee's Terms of Reference.

15. Reporting Responsibilities

15.1 The Committee will report to the Board of Members on all matters within its duties and responsibilities.

15.2 The Committee may make recommendations to the Board of Members and/or any other committee or sub-committee it considers appropriate on any area within its remit.

16. Delegated Authority

16.1 The Committee may agree to delegate its authority to a Committee member or members to make decisions on the Committee's behalf outside of a Committee meeting at its absolute discretion on a case by case basis.

17. Virtual Meetings and Decision Making

17.1 Committee meetings may be held in person or virtually.

17.2 There are circumstances where time-critical decisions need to be made and it is not possible and/or reasonably practicable and/or a good use of resources to hold a physical meeting (either in person or virtually) in sufficient time. In these circumstances decisions may be made virtually using the protocol for virtual decision making.

18. Sub-Committees

18.1 The Committee has a sub-committee with delegated functions and authorities which is:

a) Integrated Medicines Optimisation Committee.

18.2 The Committee may appoint additional sub-committees to advise the Committee and assist it in carrying out its duties. The Committee may not delegate any of its functions, powers or decision making authority to any of its additional sub-committees.

19. Conflicts of Interest

19.1 Conflicts of Interest shall be dealt with in accordance with the Conflicts of Interest Policy and NHS England statutory guidance for managing conflicts of interest.

19.2 The Committee shall have a Conflicts of Interest Register that will be presented as a standing item on the Committee's agenda. In addition, an opportunity to declare any new or relevant declarations of interest will be listed as a standing item on the Committee's agenda

20. Gifts and Hospitality

20.1 Gifts and Hospitality shall be dealt with in accordance with the Conflicts of Interest Policy, and NHS England statutory guidance for managing conflicts of interest.

20.2 The Committee shall have a Gifts and Hospitality Register and Committee members will have an opportunity to declare any new or relevant declarations of relevant gifts and hospitality as a standing item on the Committee's agenda

21. Standards of Business Conduct

21.1 Committee members and any attendees or observers must maintain the highest standards of personal conduct and in this regard must comply with:

a) The law of England and Wales;
b) The NHS Constitution;
c) The Nolan Principles;
d) The standards of behaviour set out in the ICB's Constitution;
e) The Standards of Business Conduct Policy;
f) The Conflicts of Interest Policy
g) The Counter Fraud, Bribery and Corruption Policy,
h) Any additional regulations or codes of practice relevant to the Committee.

21.2 The Committee will have access to sufficient resources to carry out its duties and Committee members will be provided with appropriate and timely training.

22. Review of Terms of Reference

22.1 These Terms of Reference will be reviewed from time to time, reflecting the experience of the Committee in fulfilling its functions and the wider experience of the ICB.

22.2 These Terms of Reference will be formally reviewed annually. These Terms of Reference may be varied or amended by the Board of Members.

Date Approved by the Board of Members: [insert date]
Date of Next Review: [insert date]

Schedule 1
List of Members

The voting members of the Committee are:

Position	Name
Non-Executive Member	
Non-Executive Member	
ICB Chief Nurse	
ICB Chief Medical Officer	
Executive Director of Transformation and Performance	
Three Sector Representatives who bring sector experience and perspective to Committee's deliberation from: • Primary and/or community care; • Mental health or Acute; • Local Authority	

Committee Chair:

Position	Name
Non-Executive Member	

The standing participants are:

Position	Name
Community Participants TBC	
Community Participants TBC	
A Healthwatch representative	

NHS North Central London
Integrated Care Board
Integrated Medicines Optimisation Committee
Terms of Reference

1. Introduction

1.1 The Integrated Medicines Optimisation Committee ('Committee') is established in accordance with the Constitution of NHS North Central London Integrated Care Board ('ICB'). It is a sub-committee of the ICB Quality and Safety Committee.

1.2 These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the Committee.

2. Purpose

2.1 The purpose of the Committee is to:

a) Provide oversight and assurance on the ICB's statutory functions on medicines;
b) Provide oversight and assurance on medicines to ensure:
   - Safe and clinically effective use of medicines;
   - Improved clinical outcomes;
   - Best value of medicines use;
   - The promotion of proper use of medicines;
   - Safe and consistent access to medicines in the context of care pathways which cross multiple providers;
c) Oversee the development and implementation of the ICB's medicines management strategy and procedures;
d) Ensure co-operation and consistency of approach to medicines optimisation across the NCL Integrated Care System;
d) Oversee the arrangements for sponsorship and/or joint working with the pharmaceutical industry

3. Role

3.1 The Committee has two key areas of focus:

a) The ICB's internal medicines functions;
b) The ICB's wider system leadership.

3.2 In relation to the ICB's internal medicines functions the Committee shall:

a) Oversee and monitor implementation of the ICB's medicines management strategy, policies and procedures;
b) Ensure the ICB meets its constitutional requirements in making treatments available to patients and has the appropriate governance and systems in place to support treatment decision-making;
c) Provide advice, guidance and/or instructions to the ICB on medicines optimisation, medicines safety, medicines related quality improvements, medicine management and pharmaceutical and prescribing matters;
d) Approve medicines investments in line with the Committee's delegated financial authority limits;
e) Provide advice and support on cost effective, evidence based, best value prescribing to the ICB;

f) Monitor prescribing spend and efficiencies, inform and provide advice to the ICB on budget pressures, budget setting and financial forward planning in relation to medicines and prescribing;
g) Identify cost improvement opportunities and form solutions to enable CIP initiatives to be successful;
h) Approve ICB medicines policies, prescribing guidelines, clinical pathways and any other information, including information for patients, involving medicines. Engage relevant clinical opinion from stakeholder organisations in the development of proposals and recommendations on the management of medicines;
i) Oversee and advise on the impact and implementation of relevant medicines related national, regional and system policies and guidance;
j) Consider recommendations from the NCL Joint Formulary ('JFC') and the NCL Medicines Optimisation Board ('MOB');
k) Approve the NCL ICB prescribing recommendations list for GP practices and relevant commissioned services as appropriate;
l) Consider and make recommendations on the introduction and impact of new medicines as appropriate and their impact on ICB policies, resources, services and commissioning. This includes the implications for services arising from the managed introduction of a new medicines or the use of an established medicine for a new indication;
m) Advise on the management of entry of new medicines, or new indications for existing medicines, into the health and social care economy. Make prescribing recommendations for the use of medicines incorporating recommendations from NICE and commissioning decisions for drugs and advise on medicines use in order to ensure the best use of medicines and associated resources across the healthcare system locally, resulting in a clear commissioning framework for medicines use;
n) Ensure that processes underpinning local decision-making about medicines and treatments are consistent with the NHS Constitution and in accordance with common law, and that NICE recommendations and good practice guidance are taken in to consideration;
o) Review reports on assurance and performance against the NHS Oversights Framework and the results of controlled drugs prescribing monitoring, investigation, and actions to prevent inappropriate or fraudulent prescribing;
p) Contribute to the development of solutions to medicines or prescribing issues identified;
q) Provide support on medicines management issues to all relevant directorates, teams, and groups within the ICB;
r) Ensure that medicines management issues are fed into the wider clinical and corporate governance of the ICB as appropriate;
s) Review and make decisions on sponsorship and/or joint working with the pharmaceutical industry as per the ICB's Sponsorship and Joint Working With The Pharmaceutical Industry Policy (the policy is approved by the Audit Committee);
t) Oversee and monitor the arrangements agreed under the Sponsorship and Joint Working With The Pharmaceutical Industry Policy;
u) Make recommendations for amendments to the Sponsorship and Joint Working With The Pharmaceutical Industry Policy to the Audit Committee.

3.3 In relation to the ICB's wider system leadership the Committee shall:

a) Ensure the ICB works collaboratively with partner organisations across the North Central London Integrated Care System ('ICS') and Borough Partnerships ('BPs') as appropriate and particularly in regards to:
    - Population health and prevention, reducing variation and optimising outcomes for our populations;
    - Advising on pharmacy and prescribing related workforce developments, including within GP practices and Primary Care Networks ('PCNs') and ensuring collaboration with the North Central London workforce programme regarding

integration and modernisation of the workforce to deliver new care models, educating and training;
- Ensuring the provision of care in respect of medicines is delivered within the most appropriate care setting to meet the pharmaceutical and medicines optimisation needs of the local population;
- Supporting the reduction in avoidable medication waste to ensure NHS resources are used efficiently;

b) Consider NICE recommendations, impact for the ICB as a commissioner and the ICS system and advise on implementation;
c) Ensure principles of medicines optimisation are embedded in to practice, ensuring medicines deliver value, are clinically-effective and cost-effective and ensure people get the right choice of medicines, at the right time, and are engaged in the process by their clinical team;
d) Promote prescribing practice standardisation and reduce variation to ensure optimal outcomes for patients and reduce risk and support patient safety with regard to medicines;
e) Monitor inappropriate prescribing and, where appropriate, advise on steps to manage this;
f) Advise on strategies to support self-care and prevention of ill health;
g) Have an overview of implementation of MHRA, National and local drug / patient safety alerts within the local health economy;
h) Support risk management, assurance, audit and research relevant to medicines-related issues.

3.4 In relation to its ICB internal medicines functions and wider system leadership (as appropriate), the Committee shall:
a) Oversee and approve Medicines investments within the Committee's delegated financial authority limits;
b) Provide oversight and scrutiny of medicines risks regarding the ICB and wider system;
c) Provide reports to the Board of Members, the Quality and Safety Committee and/or the Strategy and Development Committee as required.

3.5 The Committee will also ensure that the committee is patient focussed and that patients have been engaged in the development of relevant proposals.

4. Membership

4.1 The Committee shall comprise of the following voting members:
a) A Non-Executive Member;
b) A clinical member of the Board of Members other than the Chief Medical Officer or Chief Nursing Officer;
c) Chief Medical Officer;
d) Chief Pharmaceutical Officer;
e) Chief Nursing Officer;
f) Executive Director of Place;
g) A director of finance.

4.2 The roles referred to in the list of voting members above describe the substantive roles and any equivalent successor roles and not the individual title or titles.

4.3 In accordance with the ICB's Constitution all voting members of the Committee must be approved by the ICB's Chair.

4.4 The list of voting members is set out in Schedule 1. Schedule 1 does not form part of the Terms of Reference and may be amended without the need to formally amend these Terms of Reference.

4.5 Voting members may nominate deputies to represent them in their absence.

5. Participants and Observers

5.1 The following people shall attend Committee meetings as standing participants:

a) Clinical and Care Director (prescriber)
b) Assistant Directors/Heads of Medicines Management;
c) 2 Community Members (TBC);
d) 5 Sector members who bring sector experience and perspective to Committee's deliberations.

5.2 Participants at Committee meetings are non-voting.

5.3 The roles referred to in the list of standing participants above describe the substantive roles and any equivalent successor roles and not the individual title or titles.

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5.7 The Committee may invite or allow people to attend meetings as observers. Observers may not present at meetings, contribute to any discussion or participate in any formal vote.

5.8 The Committee may call additional experts to attend meetings on a case by case basis to inform discussion.

6. Chair

6.1 The Committee Chair shall be the Non-Executive Member. The Chair may nominate a deputy to represent them in their absence.

7. Voting

7.1 The ICB has agreed to use a collective model of decision making that seeks to find consensus between system partners and make decisions based on unanimity as the norm. This includes working though difficult issues where appropriate. If it is not possible to achieve unanimity a vote will be required. Voting shall be as per clause 7.2 below.

7.2 Each voting member of the Committee shall have one vote with resolutions passing by simple majority. In the event of a tied vote the Committee Chair shall have the casting vote.

8. Quorum

8.1 The Committee will be considered quorate when at least the following voting members are present:

a) The Chair;
b) A Clinician; and,
c) An Executive Director.

8.2 If any representative is conflicted on a particular item of business they will not count towards the quorum for that item of business. If this renders a meeting or part of a meeting inquorate a non-conflicted person may be temporarily appointed or co-opted onto the Committee to satisfy the quorum requirements.

8.3 If a meeting is not quorate the Committee Chair may adjourn the meeting to permit the appointment or co-option of additional members if necessary.

9. Secretariat

9.1 The Secretariat to the Committee shall be provided by Corporate Affairs Directorate.

10. Frequency of Committee Meetings

10.1 Committee meetings will be held bi-monthly but may hold additional meetings as and when necessary. The Committee Chair may call additional meetings or cancel meetings as necessary.

11. Notice of Meetings

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12.2 Before each Committee meeting the papers of the meeting will be sent to every Committee member no less than 7 days in advance of the meeting.

12.3 If a Committee member wishes to include an item on the agenda they must notify the Committee Chair via the Secretariat no later than 7 days prior to the meeting. The decision as to whether to include the agenda item is at the absolute discretion of the Committee Chair.

13. Minutes of Meetings

13.1 The minutes of the proceedings of a meeting shall be prepared by the Secretariat and submitted for agreement at the following meeting.

14. Authority

14.1 The Committee is accountable to the ICB Quality and Safety Committee and will operate as one of its sub-committees. The Committee must act within the remit of these terms of reference and has no executive powers other than those specifically set out in these terms of reference.

14.2 The Committee is authorised by the Board of Members to obtain at the ICB's expense outside legal or other professional advice on any matters within the Committee's Terms of Reference.

15. Reporting Responsibilities

15.1 The Committee will report to Board of Members, ICB Quality and Safety Committee and/or the Strategy and Development Committee where appropriate on all matters within its duties and responsibilities as required.

15.2 The Committee may make recommendations to the ICB Board of Members, the Quality and Safety Committee and/or the Strategy and Development Committee and/or any other committee it considers appropriate on any area within its remit.

16. Delegated Authority

16.1 The Committee may agree to delegate its authority to a Committee member or members to make decisions on the Committee's behalf outside of a Committee meeting at its absolute discretion on a case by case basis.

17. Virtual Meetings and Decision Making

17.1 Committee meetings may be held in person or virtually.

17.2 There are circumstances where time-critical decisions need to be made and it is not possible and/or reasonably practicable and/or a good use of resources to hold a physical meeting (either in person or virtually) in sufficient time. In these circumstances decisions may be made virtually using the protocol for virtual decision making.

17.3 In addition to the general authority set out in clause 17.2 above, due to the nature of its remit the Committee recognises that some urgent and immediate decisions may need to be made outside of Committee meetings and that the use of the protocol for virtual decision making is not appropriate. The Committee may therefore delegate urgent and immediate decisions that need to be made outside of Committee timescales in accordance with clauses 17.4 – 17.5 and 17.8 below.

17.4 Urgent decisions requiring a response within 24 hours will be made collectively by the following people or their nominated deputies:

a) The Committee Chair;
b) A Clinical member of the Committee;
c) Executive Director of Place.

17.5 Immediate decisions requiring a response within 2 weeks will be made at a Committee meeting where practicable or by the protocol for virtual decision making. Where this is not practicable the following people or their nominated deputies will collectively make the decision:

a) The Committee Chair;
b) A Clinical member of the Committee;
c) Executive Director of Place.

17.6 Due to the nature of its remit the Committee recognises that non-contentious, low risk, decisions may be made outside of Committee meetings by those listed in clause 17.7 below. The Committee shall agree a list of those decision that fall within the remit of this clause 17.6.

17.7 The following people or their nominated deputies may collectively make the non-contentious, low risk decisions set out in clause 17.6 above:

a) The Committee Chair;
b) A Clinical member of the Committee;
c) Executive Director of Place.

17.8 Decisions made outside of Committee meetings will be reported to the Committee at the next Committee meeting.

18. Sub-Committees

18.1 The Committee may not appoint sub-committees but may appoint working groups to advise the Committee and assist it in carrying out its duties. The Committee may not delegate any of its functions, powers or decision making authority to a sub-committee.

19. Conflicts of Interest

19.1 Conflicts of Interest shall be dealt with in accordance with the Conflicts of Interest Policy and NHS England statutory guidance for managing conflicts of interest.

19.2 The Committee shall have a Conflicts of Interest Register that will be presented as a standing item on the Committee's agenda. In addition, an opportunity to declare any new or relevant declarations of interest will be listed as a standing item on the Committee's agenda

20. Gifts and Hospitality

20.1 Gifts and Hospitality shall be dealt with in accordance with the Conflicts of Interest Policy, and NHS England statutory guidance for managing conflicts of interest.

20.2 The Committee shall have a Gifts and Hospitality Register and Committee members will have an opportunity to declare any new or relevant declarations of relevant gifts and hospitality as a standing item on the Committee's agenda

21. Standards of Business Conduct

21.1 Committee members and any attendees or observers must maintain the highest standards of personal conduct and in this regard must comply with:

a) The law of England and Wales;
b) The NHS Constitution;
c) The Nolan Principles;
d) The standards of behaviour set out in the ICB's Constitution;
e) The Standards of Business Conduct Policy;
f) The Conflicts of Interest Policy
g) The Counter Fraud, Bribery and Corruption Policy,
h) Any additional regulations or codes of practice relevant to the Committee.

21.2 The Committee will have access to sufficient resources to carry out its duties and Committee members will be provided with appropriate and timely training.

22. Review of Terms of Reference

22.1 These Terms of Reference will be reviewed from time to time, reflecting the experience of the Committee in fulfilling its functions and the wider experience of the ICB.

22.2 These Terms of Reference will be formally reviewed annually. These Terms of Reference may be varied or amended by the Board of Members.

Date Approved by the Board of Members: [insert date]
Date of Next Review: [insert date]

Schedule 1
List of Members

The voting members of the Committee are:

Position	Name
A Non-Executive Member	
A clinical member of the Board of Members other than the Chief Medical Officer or Chief Nursing Officer	
Chief Medical Officer	
Chief Pharmaceutical Officer	
Chief Nursing Officer	
Executive Director of Place	
A director of finance	

Committee Chair:

Position	Name
A Non-Executive Member	

The standing participants are:

Position	Name
Clinical and Care Director (prescriber)	
Assistant Director / Heads of Medicines Management	
2 Community Members (TBC)	
5 Sector members who bring sector experience and perspective to Committee's deliberations	

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
4 July 2022

Report Title	ICB Forward Plan	**Date of report**	22 June 2022	**Agenda Item**	3.4
Lead Director / Manager	Richard Dale, Executive Director of Performance and Transformation, NCL ICB Designate Ian Porter, Executive Director of Corporate Affairs, NCL ICB Designate	**Email / Tel**		richard.dale@nhs.net ian.porter3@nhs.net	
Board Member Sponsor	Not applicable.				
Report Author	Transition PMO Team	**Email / Tel**		Northcentrallondonics@nhs.net	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications** Not applicable.			
Report Summary	The draft ICB Forward Plan is included in the following slides. This plan builds on work undertaken by the Steering Committee and Transition Board. It brings together the work progressed with designate executives to map out the day 100 priorities of the Integrated Care Board and key strategic decisions needed in the first few months of the Board's establishment. Key strategic decisions include agreeing the ICB Population Health Strategy, Start Well Care Models and the Quality Strategy. The plan will ensure NCL meet the requirements of nationally and locally set priorities and milestones. In addition to the key strategic decisions, assurance items such as finance and performance will be regularly included as agenda items. Whilst the plan is still being iterated, it sets out the likely key decisions and discussions at both Board meetings and seminars through this calendar year. Moving forward work will continue with designate executives to map out further strategic decisions through the coming months.				

Recommendation	The Board of Members is asked to **NOTE** the ICB Forward Plan
Identified Risks and Risk Management Actions	Not applicable.
Conflicts of Interest	Not applicable.
Resource Implications	Not applicable.
Engagement	Not applicable.
Equality Impact Analysis	Not applicable.
Report History and Key Decisions	Not applicable.
Next Steps	The ICB Forward plan will be iterated following the feedback from Integrated Care Board Members.
Appendices	Appendix: ICB Forward Plan (powerpoint)

NHS
North Central London
Integrated Care Board

ICB Forward Plan

DRAFT ICB Forward Plan

North Central London
Integrated Care Board

KEY
Board Meeting
Seminar

AUG '22	SEPT	OCT	NOV
• Financial Planning • Digital Strategy • Winter Planning • Community & Mental Health Service Reviews – Investment & Delivery Plan	• Quality Strategy & Annual Plan • IVF Policy (tbc) • Working with People & Communities and VCSE Strategy • Community & Mental Health Services Reviews – Investment & Delivery Plan • Start Well	• ICB Population Health Strategy & Outcomes Framework • UEC / Discharge • ICB Medicines Management Model • Estates Strategy	• 5 Year ICB Plan • Approach to NCL Workforce Strategy • ICB Population Health Strategy & Outcomes Framework

DEC	JAN	FEB	MAR '23
• Community, MH review Implementation Plan • CHC / CIC Strategy • Delegated Commissioning Arrangements • ICB Strategic Commissioning Cycle	• ED&I Strategy • Primary Care Strategy • Place Development	• Outcomes from Safe & Well Review • Procurement Regulation Requirements	• Annual WRES and WDES (tbc) • 2023/4 Contracts approach • 2023/4 Budget • 111 Procurement – contract award • Commissioning & Procurement Frameworks